Texas Children's® Health Plan

The best decision a family can make.

CHIP Perinate Program Unborn Schedule of Benefits

Covered Benefit	Limitations	Co-payments

Inpatient General Acute
 	
Services include:
Covered medically necessary Hospital-provided services
▪ Operating, recovery and other treatment rooms
▪ Anesthesia and administration (facility technical component)
▪ Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).
▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  ▪ dilation and curettage (D&C) procedures,
  ▪ appropriate provider-administered medications,
  ▪ ultrasounds, and
  ▪ histological examination of tissue samples.
	For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit.
	
	For CHIP Perinates in families with incomes above 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.
		None

Covered Benefit	Limitations	Co-payments

Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center
 	
Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:
▪ X-ray, imaging, and radiological tests (technical component)
▪ Laboratory and pathology services (technical component)
▪ Machine diagnostic tests
▪ Drugs, medications and biologicals that are medically necessary prescription and injection drugs
▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  ▪ dilation and curettage (D&C) procedures,
  ▪ appropriate provider-administered medications,
  ▪ ultrasounds, and
  ▪ histological examination of tissue samples.
	Emergency room visits for pregnancy related issues and post stabilization does not require an authorization.
	
	No out of network benefits.
	
	Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth.
	Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy.
	
	Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.
	
	Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.
	
	Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.
		None

Covered Benefit	Limitations	Co-payments
Physician/Physician Extender Professional Services Services include, but are not limited to the following: ▪ Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medically necessary medications, biologicals and materials administered in Physician's office ▪ Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. - Administration of anesthesia by Physician (other than surgeon) or CRNA - Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. - Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	Provider must be in-network. No out of network benefits. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT.	None
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Applies only to CHIP Perinate Members (unborn child) with incomes at 186% FPL to 200% FPL.	None

Covered Benefit	Limitations	Co-payments
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; (2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and ▪ laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).	None.

Covered Benefit	Limitations	Co-payments
Prenatal care and prepregnancy family services and supplies Covered services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: One visit every four weeks for the first 28 weeks or pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.	No out of network benefits. Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).	None

Covered Benefit	Limitations	Co-payments
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. ▪ Stabilization services related to the labor and delivery of the covered unborn child. ▪ Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. ▪ Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.	None

Covered Benefit	Limitations	Co-payments
Case Management Services Case management services are a covered benefit for the Unborn Child.	These covered services include outreach informing, case management, care coordination and community referral.	None
Care Coordination Services Care coordination services are a covered benefit for the Unborn Child.		None
Drug Benefits Services include, but are not limited to, the following: ▪ Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and ▪ Drugs and biologicals provided in an inpatient setting.	Services must be medically necessary for the unborn child.	None

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. “Initial Perinatal Newborn admission” means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, “External Review by Independent Review Organization”).
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor and delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment of injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.

- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.).
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse that do not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).