



CHIP Perinatal Program Newborn Schedule of Benefits

Covered Benefit	Limitations	Co-payments
<p>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</p> <p>Services include:</p> <ul style="list-style-type: none"> ▪ Hospital-provided Physician or Provider services ▪ Semi-private room and board (or private if medically necessary as certified by attending) ▪ General nursing care ▪ Special duty nursing when medically necessary ▪ ICU and services ▪ Patient meals and special diets ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Surgical dressings, trays, casts, splints ▪ Drugs, medications and biologicals ▪ Blood or blood products that are not provided free-of-charge to the patient and their administration ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy ▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care ▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care. ▪ Surgical implants. ▪ Other artificial aids including surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> ▪ all stages of reconstruction on the affected breast; ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas. 	<ul style="list-style-type: none"> ▪ Does require authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ Requires authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section. 	<p>None</p>

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<ul style="list-style-type: none"> ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. 		
<p>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</p> <p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility 	<ul style="list-style-type: none"> ▪ Requires authorization and physician prescription ▪ 60 days per 12-month period limit. 	None
<p>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center</p> <p>Services include but are not limited to 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:</p> <ul style="list-style-type: none"> ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech therapy ▪ Renal dialysis ▪ Respiratory services ▪ Radiation and chemotherapy ▪ Blood or blood products that are not provided free-of-charge to the patient and the administration of these products ▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility, ▪ Surgical implants. ▪ Other artificial aids including surgical implants 	<ul style="list-style-type: none"> ▪ May require prior authorization and physician prescription 	None

Covered Benefit	Limitations	Co-payments
<ul style="list-style-type: none"> ▪ Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: <ul style="list-style-type: none"> - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. 		
<p>Physician/Physician Extender Professional Services</p> <p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician-performed technical and 	<p>May require authorization for specialty services</p>	<p>None</p>

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<p>interpretive components)</p> <ul style="list-style-type: none"> ▪ Physician and professional services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. 		
<p>Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.</p>	<p>Covers services rendered to a newborn immediately following delivery.</p>	<p>None</p>
<p>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</p> <p>Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to:</p> <ul style="list-style-type: none"> ▪ Orthotic braces and orthotics ▪ Dental devices ▪ Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Hearing aids 	<p>May require prior authorization and physician prescription</p> <ul style="list-style-type: none"> ▪ \$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). 	<p>None</p>

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<ul style="list-style-type: none"> ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A) 		
<p>Home and Community Health Services</p> <p>Services that are provided in the home and community, including, but not limited to:</p> <ul style="list-style-type: none"> ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies. 	<ul style="list-style-type: none"> ▪ Requires prior authorization and physician prescription ▪ Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker. ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24- hour skilled nursing services. ▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services. 	None
<p>Inpatient Mental Health Services</p> <p>Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:</p> <ul style="list-style-type: none"> ▪ Neuropsychological and psychological testing. 	<ul style="list-style-type: none"> ▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. 	None
<p>Outpatient Mental Health Services</p> <p>Mental health services, including for serious mental illness, provided on an outpatient basis, include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. ▪ Neuropsychological and psychological testing ▪ Medication management ▪ Rehabilitative day treatments ▪ Residential treatment services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development) 	<ul style="list-style-type: none"> ▪ May require prior authorization. ▪ Does not require PCP referral. ▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, 	None

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	<p>Division 1, §412.303(31). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.</p>	
<p>Inpatient Substance Abuse Treatment Services</p> <p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. 	<ul style="list-style-type: none"> ▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral. 	None
<p>Outpatient Substance Abuse Treatment Services</p> <p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services ▪ Partial hospitalization ▪ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. ▪ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training. 	<ul style="list-style-type: none"> ▪ May require prior authorization. ▪ Does not require PCP referral. 	None
<p>Rehabilitation Services</p> <p>Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following:</p> <ul style="list-style-type: none"> ▪ Physical, occupational and speech therapy ▪ Developmental assessment 	<ul style="list-style-type: none"> ▪ Requires prior authorization and physician prescription 	None

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<p>Hospice Care Services</p> <p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death ▪ Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. 	<ul style="list-style-type: none"> ▪ Requires authorization and physician prescription ▪ Services apply to the hospice diagnosis. ▪ Up to a maximum of 120 days with a 6 month life expectancy. ▪ Patients electing hospice services may cancel this election at anytime. 	None
<p>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</p> <p>Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery.</p> <p>Covered services include but are not limited to the following:</p> <ul style="list-style-type: none"> ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services ▪ Emergency ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts. 	<ul style="list-style-type: none"> ▪ May require authorization for post-stabilization services 	None
<p>Transplants</p> <p>Services include but are not limited to the following:</p> <ul style="list-style-type: none"> ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses. 	<ul style="list-style-type: none"> ▪ Requires authorization 	None

Covered Benefit	Limitations	Co-payments
<p>Vision Benefit</p> <p>Services include:</p> <ul style="list-style-type: none"> ▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization ▪ One pair of non-prosthetic eyewear per 12-month period 	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <ul style="list-style-type: none"> ▪ Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. 	<p>None</p>
<p>Chiropractic Services</p> <p>Covered services do not require physician prescription and are limited to spinal subluxation</p>	<ul style="list-style-type: none"> ▪ Does not require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit) ▪ Does not require authorization for additional visits. 	<p>None</p>
<p>Tobacco Cessation Program</p> <p>Covered up to \$100 for a 12- month period limit for plan- approved program</p>	<ul style="list-style-type: none"> ▪ May require authorization ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements. 	<p>None</p>
<p>Case Management and Care Coordination Services</p>	<ul style="list-style-type: none"> ▪ These services include outreach, informing, case management, care coordination and community referral. 	<p>None</p>

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATE NEWBORNS

All the following exclusions match those found in the CHIP program.

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- 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 of sickness or injury.
- 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, unless otherwise pre-authorized by Health Plan.
- 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 and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- 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 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).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child 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 parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.
- 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 and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- 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).