Part 18

CHIP covered services

Part 18

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: • Hospital-provided Physician or Provider services • Semi-private room and board (or private if medically necessary as certified by attending doctor) • 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 • 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 – Histological examination of tissue samples	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), 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 income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy. Services include: • 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).

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
(continued) Inpatient General Acute and Inpatient Rehabilitation Hospital Services	• Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: – all stages of reconstruction on the affected breast; – external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – 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: – 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.	Inpatient 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. 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.
Skilled Nursing Facilities (Include rehabilitation hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	Not a covered benefit.

Part 18

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center	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: • 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 • 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. • 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 • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: – all stages of reconstruction on the affected breast; – external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed surgery and reconstruction on the other breast to produce symmetrical appearance; and – treatment of physical complications from the mastectomy and treatment of lymphedemas.	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 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. (1) 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. (2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy. (3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis.

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
(continued) Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center	• 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: – 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.	(4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once 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 members 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. (5) 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.

Part 18

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Physician/ Physician Extender Professional Services	Services include, but are not limited to, the following: • 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, inpatient and outpatient 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: – 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 interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: – all stages of reconstruction on the affected breast; – external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – 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.	Services include, but are not limited to the following: • 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, inpatient and outpatient 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: – 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 interpretive components)

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
(continued) Physician/ Physician Extender Professional Services	• Physician and professional services for a mastectomy and breast reconstruction include: – all stages of reconstruction on the affected breast; – external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – 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 Cesarean section. • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician 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. • 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: – 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.	• 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 confirmation. • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT. • 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.

Part 18

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	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 in the physician's files 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, 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 members 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).

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Limitation: Applies only to CHIP members.	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center	CHIP Members: Covers prenatal services and birthing services rendered in a licensed birthing center. CHIP Perinate Newborn Members: Covers services rendered to a newborn immediately following delivery.	Covers prenatal services and birthing 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.

Part 18

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
(continued) Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center		Visits after the initial visit must include: • interim history (problems, marital 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 members 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).
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which 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: • 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 • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)	Not a covered benefit, with the exception of a limited set of disposable medical supplies, published at www.txvendordrug.com/formulary/limited-hhs.shtml and only when they are obtained from a CHIP-enrolled pharmacy provider.

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • 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. • 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	Not a covered benefit.
Inpatient Mental Health Services	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: • Neuropsychological and psychological testing. • 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 • Does not require PCP referral	Not a covered benefit.

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • 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 – Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • 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, Division 1, §412.303(48). 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 (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services • Does not require PCP referral	Not a covered benefit.
Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Does not require PCP referral	Not a covered benefit.

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Outpatient Substance Abuse Treatment Services	Services include, but are not limited to, the following: • 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 which 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 • Does not require PCP referral	Not a covered benefit.
Rehabilitation Services	Services include, but are not limited to, the following: • 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: • Physical, occupational and speech therapy • Developmental assessment	Not a covered benefit.
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six (6) 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 • Up to a maximum of 120 days with a 6 month life expectancy • Patients electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis	Not a covered benefit.

Part 18

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. • Covered services include, but are not limited to, the following: • 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, seven (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, removal of cysts, and treatment relating to oral abscess of tooth or gum origin.	MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the 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 with delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit • Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include, but are not limited to, the following: • 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.	Not a covered benefit.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One (1) examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One (1) pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.

COVERED BENEFIT	CHIP MEMBERS AND CHIP PERINATAL NEWBORN MEMBERS	CHIP PERINATAL MEMBERS (Unborn child)
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month period limit for a plan-approved program • Health Plan defines plan-approved program. • May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
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 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.

To get auxiliary aids and services, or to get written or oral interpretation to understand the information given to you, including materials in alternative formats such as large print, braille or other languages, please call BCBSTX CHIP Customer Service at 1-888-657-6061 (TTY/TDD 7-1-1).

Blue Cross and Blue Shield of Texas complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Texas does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Texas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Texas has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-710-6984 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-710-6984 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-710-6984 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-710-6984 (TTY: 711) पर कॉल करें।

ابـ .دشاب یم مهارف امش یارب ناگیار تروص هب ینابز تلایهست ،دینک یم وگتفگ یسراف نابز هب رگا :هجوت 1-855-710-6984 (TTY: 711) دیریگب سامت.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-710-6984 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-710-6984（TTY: 711）まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-710-6984 (TTY: 711).

BlueCross BlueShield
of Texas