X. ENROLLMENT PERIOD FAMILY COPAYMENT MAXIMUM

Under this plan, there is a limit per family on the Co-payments that YOU must pay for Covered Health Services each enrollment period. It is YOUR responsibility to keep up with how much YOU have paid for Covered Health Services and to provide proof to CHIP. CHIP will notify YOU of the amount of YOUR Co-payment maximum and will provide YOU with a simplified form that YOU can use to keep up with the amount of Co-payments that YOU have paid.

YOU must notify CHIP when the maximum Co-payment under the Plan has been paid. When YOU notify CHIP about reaching the Co-payment maximum, CHIP will issue a new Member ID Card for each CHILD in YOUR family. The new Member ID Card will notify participating Physicians and providers to waive Co-payments for the remainder of the enrollment period for the CHILD.

XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES

These health services when medically necessary must be furnished in the most appropriate and least restrictive setting in which services can be safely provided; must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the Member's physical health or the quality of life.

Emergency Care is a covered CHIP service and must be provided in accordance with **Section VII. D. Emergency Services**. Please refer to **Section II Definitions**, for the definition of "Emergency and Emergency Condition" and the definition of "Emergency Services and Emergency Care" to determine if an Emergency Condition exists.

There is no lifetime maximum on benefits; however, 12-month, enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-payments apply until a family reaches its specific enrollment period co-payment maximum. Co-payments do not apply to preventive services or pregnancy-related assistance.

Covered Benefit	Limitations	Co-payments*
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: ▪ 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	▪ [Requires][May require][Does not require] authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ [Requires][May require][Does not require] 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.	$15 inpatient co-payment per admission.

Covered Benefit	Limitations	Co-payments*
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; and - histological examination of tissue samples. ▪ 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. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the		

Covered Benefit	Limitations	Co-payments*
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		
Skilled Nursing Facilities (Includes 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	▪ [Requires][May require][Does not require] authorization and physician prescription. ▪ 60 days per 12-month period limit.	None
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	▪ [Requires][May require][Does not require] prior authorization and physician prescription.	$0 co-payment for generic drugs. $3 co-payment for brand drugs.

Covered Benefit	Limitations	Co-payments*
▪ 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. ▪ 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. ▪ 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		

Covered Benefit	Limitations	Co-payments*
- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. ▪ 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; - 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		
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, in-patient and outpatient services ▪ Laboratory, x-rays, imaging and pathology services, including technical	[Requires][May require][Does not require] authorization for specialty services.	$3 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
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; - 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		

Covered Benefit	Limitations	Co-payments*
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. ▪ 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. ▪ 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.		

Covered Benefit	Limitations	Co-payments*
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)	None
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.	None.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies 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: ▪ 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 ▪ Other artificial aids including surgical implants ▪ Hearing aids ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME	▪ [Requires][May require][Does not require] prior authorization and physician prescription. ▪ $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).	None

Covered Benefit	Limitations	Co-payments*
12-month period limit. ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.		
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.	▪ [Requires][May require][Does not require] 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
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.	▪ [Requires][May require][Does not require] 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	$15 inpatient co-payment.

Covered Benefit	Limitations	Co-payments*
	medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	
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)	▪ [Requires][May require][Does not 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,	$3 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
	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 (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	
Inpatient Substance Abuse Treatment Services Inpatient substance abuse treatment 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.	▪ [Requires][May require][Does not require] prior authorization for non-emergency services. ▪ Does not require PCP referral.	$15 inpatient co-payment.
Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment 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	▪ [Requires][May require][Does not require] prior authorization. ▪ Does not require PCP referral.	$3 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
▪ 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.		
Rehabilitation Services 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	▪ [Requires][May require][Does not require] prior authorization and physician prescription.	None
Hospice Care Services Services include, but are not limited to: ▪ 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.	▪ [Requires][May require][Does not require] 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
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	▪ [Requires][May require][Does not require] authorization for post-stabilization	$3 co-payment for non-emergency ER.

Covered Benefit	Limitations	Co-payments*
Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: ▪ 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	services.	
Transplants Covered services include: ▪ 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.	▪ [Requires][May require][Does not require] authorization.	None
Vision Benefit Covered services include: ▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without	▪ The health plan may reasonably limit the cost of the frames/lenses. ▪ [Requires][May require][Does not require] authorization for protective and	$3 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
authorization ▪ One pair of non-prosthetic eyewear per 12-month period	polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation	▪ [Requires][May require][Does not require] authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit). ▪ [Requires][May require][Does not require] authorization for additional visits.	$3 co-payment for office visit.
Tobacco Cessation Program Covered up to $100 for a 12- mon period limit for a plan- approved program	▪ [Requires][May require][Does not require] authorization. ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements.	None
[Value-added Services]		None

* Co-payments do not apply to preventive services or pregnancy-related assistance.

EXCLUSIONS

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

- Dental devices solely for cosmetic purposes
- 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
- 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 services.
- 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).

DME/SUPPLIES

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Dental Devices	X		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets,	X		Eligible for coverage when used during covered

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Wound Care			home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.