

## Driscoll Children's Health Plan

<b>Call us:</b>	<b>Member Services</b> <b>1-877-451-5598</b> (toll-free) For hearing impaired: <b>1-800-855-2880</b> (TTY) toll-free Interpreter Services also available
<b>Se Habla Español</b>	
<b>Write us:</b>	Driscoll Children's Health Plan P.O. Box 6609 Corpus Christi, TX 78466-6609
<b>Regular Business Hours:</b>	8:00 – 5:00 CST, Monday through Friday except for state approved holidays
<b>Before 8:00 or after 5:00</b>	Call and leave a message. We will return your call the next working day.
<b>24 Hour Behavioral Health Hotline</b>	<b>1-877-330-3312 (English or Spanish)</b> with information on services. Other interpretive services available. <b>If there is an emergency or crisis, go to the ER or call 9-1-1.</b>
<b>Vision and Eye Care Number</b>	<b>1-888-268-2334</b> for questions regarding eye exams and glasses
<b>Dental Care Number</b>	<b>1-866-561-5892</b> for questions about dental care
<b>Pharmacist Help Line</b>	Call <b>1-866-274-9154</b> (toll-free) if you need help getting a prescription filled.
<b>CHIP Help Line</b>	<b>1-800-647-6558</b>

### ***Welcome to Driscoll Children's Health Plan***

By choosing the Driscoll Children's Health Plan (DCHP), your child will get all the CHIP health benefits – plus more.

- Your own doctor
- Friendly and confidential staff
- Access to Driscoll Children's Hospital and many other hospitals
- Free health education for children of any age
- Assurance of access to care regardless of nationality, race, religion, origin and gender

If you have any questions or concerns about access of care, and feel that you were not allowed access to care because of nationality, race, religion, origin, or gender, please contact DCHP Member Services at **1-877-451-5598** as soon as possible. Your concern will be investigated and resolved quickly.

The doctor you chose when you enrolled with DCHP CHIP will be your child's Primary Care Provider (PCP) and will help take care of all your child's health care needs.

First things first. These are a few important things about your child's health care.

- You will receive a DCHP ID card, if you have not already received one.
- Your PCP's name will be on the DCHP ID card. Please check the ID card to make sure the names on it are correct.
- Get to know your child's doctor. Make an appointment with your PCP as soon as possible.
- Call your PCP for appointments. Tell them your child is a DCHP CHIP member.
- Call your PCP whenever your child needs health care.
- Follow your PCP's advice.
- Carry your child's DCHP ID card with you at all times.
- Use the hospital emergency room only for emergencies.

This Member Handbook answers many questions about DCHP. We hope you read it soon. Keep it in a place where you can find it easily.

Please feel free to call or write us if you have any questions. At DCHP we are ready to help you any time during the day or night. We have special services for people who have trouble reading, hearing, seeing, or speak a language other than English or Spanish. If member materials, including this handbook, are needed in a different way due to reading, seeing or language problems, notify Member Services at **1-877-451-5598** as soon as possible. DCHP will provide these materials to you at no cost.

Again, Welcome!

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## Driscoll Children's Health Plan and CHIP

Laws passed by the U.S. Congress and the Texas Legislature started the Children's Health Insurance Program (CHIP) in Texas. CHIP helps children of families that have incomes too high to qualify for Medicaid but too low to easily afford private family coverage.

By choosing the Driscoll Children's Health Plan (DCHP), we can provide CHIP health services to your children from birth through age 18. Health care through DCHP CHIP is available in these south Texas counties:

- Aransas
- Bee
- Brooks
- Calhoun
- Goliad
- Jim Wells
- Karnes
- Kenedy
- Kleberg
- Live Oak
- Nueces
- Refugio
- San Patricio
- Victoria


DCHP is a not-for-profit Health Maintenance Organization (HMO) licensed by the Texas Department of Insurance.

## Your CHIP ID Card

You will get a CHIP Identification (ID) card after you enroll in DCHP. A copy of the DCHP ID card is shown below.

Information about your child

PCP name and phone

 <b>Driscoll Children's HEALTH PLAN</b> Children's Health Insurance Program (CHIP)	<b>Important Information/Información importante</b> Member Services (toll-free) / Departamento de Servicios para Miembros (gratis) <span style="float: right;">1-877-451-5598</span> TTY for hearing impaired / TTY para personas con problemas del oído <span style="float: right;">1-800-855-2880</span> 24 Hour Behavioral Health Hotline / Línea de Servicios de Salud Mental <span style="float: right;">1-877-330-3312</span> Vision Services / Servicios para la vista <span style="float: right;">1-888-268-2334</span> Prescription Drugs (Call CHIP hotline) <span style="float: right;">1-866-274-9154</span>
Member Name: JOHN DOE      Co-Payment Amounts/Co-pagos: Member ID#: A0000000      Office Visit: \$5.00 Effective Date: 01/01/2006      ER: \$5.00 PCP: Joe B. Doctor      In-Patient: \$25.00 PCP Phone #: (361) 000-0000      RX Brand: \$10.00 Effective Date of PCP: 01/01/2006      RX Generic: \$10.00  Customer Service Phone #: 1-877-451-5598	<p><b>In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours.</b></p> <p><b>En caso de emergencia, llame al 911 ó vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de las 24 horas.</b></p> <p><small><b>NOTICE TO PROVIDER:</b> The member whose name appears on the face of this card is covered by Driscoll Children's Health Plan for CHIP services. For provider billing or UM questions, 1-877-324-3627. The toll free UM FAX is 1-866-741-5650. <b>Submit Claims to:</b> DCHP CHIP, P.O. Box 3668, Corpus Christi, TX 78463-3668.</small></p> <p style="text-align: center;"><u>CHIP prescription drug is covered by the CHIP Prescription Drug Benefit with the State of Texas.</u></p> <p style="text-align: center;">CAREMARK Help Desk 1-800-345-5413                  BIN: 004336 PCN: ADV Rx GRP: RX4020</p> <p style="text-align: right;">Rev 06</p>

Each of your children will have a different card. You will not get a new DCHP CHIP card every month. You will get a new one if you lose your ID, or if you call us to change your Primary Care Physician (PCP).

## Reading the DCHP CHIP ID Card

The front of the DCHP CHIP ID card shows important information about your child, the PCP's name and PCP's phone number. It also shows the amounts (co-payments) you may have to pay for your doctor visits or for prescriptions. The back of the card shows important phone numbers for emergencies or other help from DCHP Member Services.

## Using the DCHP CHIP ID Card

Carry your child's DCHP CHIP ID Card with you when your child gets any health care services. You **must** show your CHIP ID Card each time for any health service.

## If you lose an ID Card or Move

If you lose the DCHP CHIP ID Card, call us right away at 1-877-451-5598 to get a new one. If you move or change phone numbers, call us so we can send you another ID card. We always need to have your correct address and phone number.

## All About PCPs

### What do I need to bring with me to the Doctor's appointments?

You must take your DCHP ID card with you when you go to the doctor. If your child is going for shots, don't forget your child's shot records.

### What is a Primary Care Physician (PCP)

The PCP you chose is considered your child's "medical home". He or she will help you with all medical care. Your PCP will get to know you and your child. He or she will do regular check-ups and treat your children when they are sick. Your PCP will prescribe medicines and medical supplies for your children and send them to a specialist if needed.

It is important to follow the PCP's advice. Take part in decisions about your child's health care. Your PCP may ask us to assign you to another PCP if you do not follow his or her advice. It may also happen if you and the PCP do not get along. The PCP must notify us if this occurs. We will contact you and ask that you select another PCP.

Call your PCP during office hours when you can. If possible, do not wait until evening to call to take care of a medical problem. Most illnesses tend to get worse as the day goes on. Call early.

There may be times when DCHP may allow a Specialist to be your child's PCP. This is for Children with Special Health Care Needs (CSHCN). Call DCHP Member Services at 1-877-451-5598 for more information.

You must only see the PCP listed on your ID Card. If you see another PCP, you will have to pay the bill.

### **Can a Clinic be my PCP?**

You or your child may select a clinic as your PCP. This can be a Federally Qualified Health Center (FQHC), or a Rural Health Clinic (RHC). If you have questions call Member Services at **1-877-451-5598**.

### **How can I change my PCP?**

You may want to change to another PCP if:

- You are not happy with your PCP's care
- You need a different kind of doctor to take care of your child
- You move farther away from your PCP
- Your PCP is no longer a part of DCHP's network

You can change your PCP by calling toll-free at 1-877-451-5598. You may only ask to change your PCP four (4) times a year. The *DCHP Provider Directory* lists all PCPs.

You may only change your PCP at the beginning of the month. If you call after the fifth day of the month, the PCP will not change until the first of the next month. If you see the new PCP before the change, you will have to pay the bill.

You will get a new ID card that shows the date your new PCP can begin to care for your child. The new card will show the new PCP's name and phone number. Changing your PCP will not stop you from getting care. If you need care before your new PCP is effective, call the PCP on your current card.

To give you the best care possible, your PCP needs to know your child's medical history. Your medical records are private and confidential. Only you, your PCP, and other approved providers have a right to see them. If you change doctors, be sure to give your new PCP any information needed about your medical history.

### **How many times can I change my PCP?**

You may change your or your child's PCP up to four (4) times every year.

### **When will my PCP change become effective?**

You may change your PCP at anytime. If you call **BEFORE** the 5<sup>th</sup> of the month, the change will become effective immediately. If you call **AFTER** the 5<sup>th</sup> of the month, the PCP will not change until the first of the next month. If you see the new PCP before the change, you will have to pay the bill.

### **Are there any reasons why my request to change PCP may be denied?**

You may not be able to have the PCP you chose if:

- The PCP you picked is not seeing new patients
- The PCP you picked is no longer a part of DCHP
- You have already changed PCPs more than four (4) times in one year

### **Can my PCP request that I be changed to another PCP for non-compliance?**

It is important to follow the PCP's advice. Take part in decisions about your or your child's health care. Your PCP may ask us to assign you or your child to another PCP if you do not follow his or her advice. It may also happen if you and the PCP do not get along or you miss visits without calling to tell the PCP why you weren't there. The PCP must notify us if this occurs. We will contact you and ask that you select another PCP.

### **What if I choose to go to another doctor who is not my PCP?**

You may go to any provider who is part of DCHP, if you need:

- 24-hour emergency care from an emergency room
- OB/GYN provider

If you need mental health or substance abuse services you should call the Behavioral Health Hotline at **1-877-330-3312**. Behavioral Health Services are very private so you do not need the permission from your PCP to get these services.

If you need a routine vision exam, you do not need permission from your PCP to get these services. But if you have an eye problem you will need a referral from your PCP. For questions about vision services, call **1-888-268-2334**.

For all other care, you must only see the PCP listed on your ID Card. If you see another PCP, you may have to pay the bill.

### **How do I get medical care after my PCP's office is closed?**

If you or your child gets sick at night or on a weekend and cannot wait to get medical care, call your PCP for advice. Your PCP or another doctor is available by phone 24 hours a day, 7 days a week. If you or your child has a fever or a sore throat and you are not sure what to do, call your PCP's office.

## **Changing Health Plans**

### **What if I want to change health plans?**

Families can change plans only once per year.

### **Who do I call?**

For more information, call CHIP toll-free at **1-800-647-6558**.

## Health Care and Other Services

### What is routine medical care?

Routine medical care may be when your child is seeing the PCP for a well-child visit. Routine medical care may also be your first visit with your PCP. You should expect your PCP to give you an appointment within 2 weeks for your first visit or for any other routine care.

### What is urgent medical care?

Urgent medical care is when your child is sick or hurt and needs treatment as soon as possible to keep your child from getting worse. These are situations when you need to call your PCP first:

- Earache
- Toothache or baby teething
- Rash
- Colds, cough, sore throat, flu or sinus problems
- Minor sun burn
- Minor cooking burn
- Chronic back pain
- Minor headache
- Broken cast
- Stitches needing to be removed
- Medication refills

Your PCP is available, directly or through other doctors helping to cover the office, 24 hours a day, 7 days a week. You can expect to be seen for urgent medical care within 24 hours.

## Emergency Care

### What is emergency medical care?

Emergency care is a covered CHIP service. “Emergency” and “emergency condition” means a medical condition of recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the child’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- placing the child’s health in serious jeopardy;
- serious impairment to bodily functions;

- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

“Emergency services” and “emergency care” means health care services provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency condition exists.

**If your child has an emergency, go to the closest Emergency Room right away or call 9-1-1.**

Examples of when to go to the emergency room are:

- Someone may die.
- Someone has bad chest pains.
- Someone cannot breathe or is choking
- Someone has passed out or is having a seizure.
- Someone is sick from poison or a drug overdose
- Someone has a broken bone.
- Someone is bleeding a lot.
- Someone has been attacked (raped, stabbed, shot, beaten).
- Someone is about to deliver a baby.
- Someone has a serious injury to the arm, leg, hand, foot, or head.
- Someone has a severe burn.
- Someone has a severe allergic reaction or has an animal bite.
- Someone has trouble controlling behavior and without treatment is dangerous to self or others.

Go to the nearest hospital if you think you have any of these problems. You may call 9-1-1 for help in getting to the hospital emergency room. Emergency care is available 24 hours a day, 7 days a week.

A cold, cough, rash, small cuts, minor burns or bruises are **not** good reasons to go to the Emergency Room.

**If you go to the ER, be sure to call you PCP within 24 hours, or as soon as your child is medically stable.**

### **Getting care at night or on weekends**

If your child gets sick at night or on a weekend and cannot wait to get medical care, call your PCP for advice. Your PCP or another doctor is available by phone 24 hours a day, 7 days a week. If your child has a fever or a sore throat and you are not sure what to do, call your PCP's office.

### **What if your child becomes sick when out of town or traveling?**

If your child gets sick while you are out of town or out of state, call your PCP at the phone number listed on the front of your DCHIP CHIP ID card. You may also call Member Services at the number on the back of your ID card. If your child has an emergency while you are out of town or out of state, take your child to the nearest ER.

When your child will be temporarily away from home, you should contact your PCP ahead of time to schedule appointments or obtain prescriptions to last for the duration of your child's stay. If your child gets sick while he or she is out of town—**and it is not an emergency**—he or she will still remain under the care of your PCP. With the exception of emergency care, if your child sees an out-of-town doctor you may have to pay. If your child leaves the Driscoll Children's Health Plan service area for an extended period of time, your child may be disqualified from CHIP or have to enroll in a health plan covering another area within the state of Texas.

CHIP does not cover any care outside of the country.

Keep your child's DCHIP ID card with you at all times.

## **ATTENTION FEMALE MEMBERS**

### **What if my child needs OB/GYN care?**

You have the right to select an OB/GYN for your child without a referral from your PCP. The access to health care services of an OB/GYN doctor includes:

- One well-woman check-up per year;
- Care related to pregnancy;
- Care for any female medical condition; and
- Referral to special doctor (specialist) within the network.

Driscoll Children's Health Plan has limited your selection of an OB/GYN to the same network as your child's PCP. Choose an OB/GYN provider from your *DCHIP Provider Directory*. If you select an OB/GYN who is not on the DCHIP Provider Directory list, you may have to pay.

You are not required to have an OB/GYN doctor for these services. Your PCP can provide these services for you.

If you have questions about OB/GYN services, call DCHP Member Services at **1-877-451-5598**.

### **How soon can my child be seen after contacting the OB/GYN for an appointment?**

You should be able to get an appointment within 2 weeks of calling for an appointment.

### **Can I stay with my OB/GYN if he or she is not with Driscoll Children's Health Plan?**

If your daughter is already seeing an OB/GYN who is not with Driscoll Children's Health Plan, you need to contact DCHP Member Services at **1-877-451-5598**. Ask for a Case Manager who can help you with continuing the care.

### **What if my daughter is pregnant? Who do I call?**

It is very important that you call Driscoll Children's Health Plan to tell us your daughter is pregnant and what doctors she is seeing. Call Member Services at **1-877-451-5598**. It is very important for her to start prenatal care immediately. You should be able to get an appointment within two weeks of your request. Pregnant women will receive case management and health education. A nurse case manager will:

- Contact you by phone;
- Contact you by mail;
- Provide education about your daughter's pregnancy; and
- Help you find an OB/GYN doctor for your daughter.

## **Services available from DCHP CHIP**

This list shows some of the services you get from DCHP. Please follow your child's PCP's advice. Office visits, prescriptions and going to the emergency room may require co-payments as shown on the front of your DCHP ID Card.

- Doctor's office visits
- Hospital care
- Laboratory and x-ray services
- Immunizations
- Preventive care such as well baby and well child care
- Laboratory testing
- 24-hour emergency care
- Surgery as an outpatient
- Speech, physical and occupational therapy
- Allergy testing
- Diabetic supplies

- Hearing screening and hearing aids
- Home health agency services
- Ambulances (for emergencies only)
- Dialysis for kidney problems
- Major organ transplants

For a full list of services see pages 25-38. To get these services, call your PCP.

### **What benefits are not covered?**

A list of benefits not covered by CHIP are on page 39 of this Member Handbook.

## **Behavioral (Mental) Health Services**

### **How do I get help if I have behavioral (mental) health or drug problems?**

You can get help for behavioral (mental) health problems and/or substance (drug) abuse. You can go to a mental health provider without a referral from your PCP. The provider you pick must be a provider with Driscoll Children's Health Plan's Behavioral Health network. Call the Behavioral Health Hotline on your ID card for help. The phone number is **1-877-330-3312**. You can call anytime 24 hours a day, seven (7) days a week. Behavioral health services are very private so you do not need permission of your child's PCP.

If your child has an emergency related to mental health problems or drug or alcohol abuse, go to the nearest hospital emergency room or call 911 for an ambulance.

## **Prescription Coverage**

### **How Do I Get My Prescriptions?**

Driscoll Children's Health Plan does not provide your prescription drugs. These drugs are covered by the CHIP Prescription Drug Benefit (PDB).

You can take your child's prescription to any pharmacy taking part in the CHIP PDB. Try to always use the same pharmacy to get more personal service.

Take your child's Driscoll Children's Health Plan CHIP ID card with you when you go to the pharmacy. The pharmacy can make sure your child is a CHIP member. The pharmacy may ask for the ID card.

You may have to pay a co-payment for the prescription. A prescription for a generic drug may cost you nothing or cost very little. The co-payment for a brand name drug will be higher. If your doctor prescribes a drug for a whole month, you will make one co-

payment for a 34-day supply. In most cases, you cannot get more than a 34-day supply. The CHIP PDB does not offer drugs by mail order.

The CHIP PDB does not cover:

- Over-the-counter drugs
- Birth control medications prescribed only for birth control purposes
- Nutritional products
- Medical supplies or equipment, except for insulin syringes
- Drugs that must be given in a physician's office or health care facility.

Call CHIP toll free if you need help finding a pharmacy. Their number is **1-800-647-6558**. Call the CHIP Prescription Hotline if you have problems getting prescriptions filled. Their number is **1-866-274-9154**.

## Other Health Coverage and Services

### What Health Education classes does DCHP offer?

DCHP has education for members on many different health subjects. There is no charge for DCHP's health education. Health education may include information on:

- Immunizations
- Special diets for diabetes
- Asthma care
- Bicycle safety
- Wellness programs and health fairs

If you need health education materials in another language, or in another format, call Member Services at **1-877-451-5598**.

### How do I get eye care services?

Eye care services include one examination by an eye doctor per year. One pair of eyeglasses is also available each year. For more information about eye exams or glasses, call our eye care vendor at **1-888-268-2334**.

### How do I get dental services?

Dental checkups can be received every 6 months beginning at 12 months of age. If the dentist finds a problem, he/she can also treat the problem in a follow-up visit. If the dentist has to do needed dental treatment at the hospital or some place other than his/her office, you will need to contact Driscoll Children's Health Plan before the service is done. Call Delta Dental for information about dental treatment at **1-866-561-5892**. Visit the Delta Dental web page at [www.deltadentalca.org/gov/](http://www.deltadentalca.org/gov/).

## Interpreter

### Can someone interpret for me when I talk with my doctor?

Yes. Call Member Services at **1-877-451-5598**. We will arrange for an interpreter to help you during your visit.

### How far in advance do I need to call?

You will need to call at least 48 hours in advance of your appointment.

### How can I get a face-to-face interpreter in the provider's office?

The interpreter we arrange for you can be someone that comes to the office. This interpreter will be in the doctor's office with you. Let us know if this is what you want.

**Se Habla Español** – DCHP has people to help you who speak both Spanish and English. We also have member handouts in Spanish.

## Costs of Your DCHP CHIP Insurance

### What are Co-Payments? How much are they and when do they apply?

The following table lists the CHIP co-payment schedule according to family income. Co-payments for medical services or prescription drugs are paid to the doctor's office or pharmacy at the time of service. No co-payments are paid for preventive care such as well-child or well-baby visits or immunizations.

Your child's health plan ID card lists the co-payments that apply to your family. Present your ID card when you receive office visit or emergency room services or have a prescription filled.

Federal Poverty Levels	Office Visits	Emergency Room Visits	Inpatient Hospitalizations	Prescription Generic Drugs	Prescription Brand Drugs	Annual Reporting Caps
<b>Native Americans</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>At or Below 100%</b>	\$3	\$3	\$10	\$0	\$3	1.25% cap of family annual income
<b>101%-150%</b>	\$5	\$5	\$25	\$0	\$5	1.25% cap of family annual income
<b>151%-185%</b>	\$7	\$50	\$50	\$5	\$20	2.5% cap of family annual net income
<b>186%-200%</b>	\$10	\$50	\$100	\$5	\$20	2.5% cap of family annual net income

## What Extra Benefits does a Member of Driscoll Children's Health Plan get?

All eligible Driscoll Children's Health Plan members will receive the following Extra Benefits (Value Added services):

- Eyeglasses with a retail value up to \$100 every 12 months;
- Provide transportation services for members who have special health care needs, and do not have transportation to their PCP, or Specialist Physician.
- Temporary Cell Telephones are available for members who meet medical criteria.
- Home visits to new mothers within the first 6 months after the baby's birth. This could be up to six home visits. The home visit will include:
  - Breastfeeding and nutrition advice
  - Child development and anticipatory guidance
  - Assistance with access to other services, i.e. WIC, etc.
  - Assistance with newborn care questions

## How can I get these Value Added services?

For eyeglasses, contact our vision vendor at **1-888-268-2334**.

If you need transportation services to your doctor, call Member Services at 1-877-451-5598 to arrange these services. You will need to call 48 hours in advance of your doctor's appointment to arrange these services. Services may be available in the evenings or on weekends. Extra time may be needed to arrange for these services. Operation hours are 8:00 a.m. to 5:00 p.m.

For temporary cell phones, contact Member Services at **1-877-451-5598**.

To arrange for home visit after giving birth, you will be contacted by our case manager. If you have questions of the case manager, contact Member Services at **1-877-451-5598**.

## CHIP Cost-Sharing Caps

When you enrolled in CHIP you received a form that you should use to track your CHIP expenses. To ensure that you do not exceed your cost-sharing limit, please keep track of your CHIP-related expenses on this form. The CHIP welcome letter tells you exactly what your cost-sharing cap is, based on your family's income. If you have misplaced this letter, please call CHIP hotline at **1-800-647-6558** and they will tell you what your annual limit is.

When you reach your annual cap, please send the form to CHIP and we will issue a new member ID card within several weeks. This new card will indicate that no co-payments are due when your child receives services.

### **What if I get a bill from my Doctor?**

Except for co-payments, you should never get a bill from your PCP or DCHP doctor.

Your co-payments and costs are shown on the front of your child's ID Card. Co-payments usually have to be paid before your child receives health care or gets a prescription.

If you get a bill from your PCP or other doctor, call DCHP Member Services at **1-877-451-5598**, and someone will call the provider's office. We will help explain your benefits and co-payments. When you call us, please have your child's ID card and the provider's bill available. DCHP Member Services will need this information to help you.

### **What do I have to do if I move?**

If you move, you need to call Member Services at **1-877-451-5598**. They will change your address in our system and notify CHIP central office. If you move outside of the DCHP service area, you will need to call CHIP central office to change your health plan. The CHIP hotline number is **1-800-647-6558**.

## **Referrals to Specialists**

### **What is a Referral?**

A referral is when your PCP sends you to another doctor or service for care.

### **What if my child needs to see a special doctor (specialist)?**

Your PCP will tell you if your child needs to see a specialist. Your PCP will make sure that your child gets the special care needed. In general, you cannot go to another doctor or get a special service if your PCP does not agree to make a referral. You should expect the specialist to give you an appointment within 2 weeks for non-urgent care or within 24 hours for urgent care.

### **Who do I call if my child has special health care needs?**

Your child may need more health and other services because of a complex or chronic conditions. There may be times when DCHP may allow a special doctor (Specialist) to be your child's PCP.

Call Member Services at **1-877-451-5598** for more information on special services that DCHP has for your special needs child.

## What Services do not need a referral?

You can get some services without going to your PCP first. These include:

- Emergency care
- OB/GYN Care
- Behavioral Health Services

It is good to let your PCP know when you receive other care, but you are not required to. This lets your PCP know all of your child's needs.

## Services That Require Prior Authorization

The following services require that your PCP or other provider contact DCHP for approval for the service before given:

- All admissions to a hospital (except in an emergency situation, where notifying DCHP within 24 hours of admission is required)
- Admissions required prior to the day of surgery
- Admission to an observation program for 23 hours
- Admission to a rehabilitation center
- Outpatient ambulatory / surgical procedure
- Surgical assistants for outpatient / ambulatory surgical procedure
- Non-emergency request for a surgeon to assist with a surgery
- Rehabilitation therapy (physical therapy, speech therapy and occupational therapy)
- Home health services, including home intravenous therapy
- Referral to a Specialist physician other than an OB/GYN physician
- Chronic pain medications / pain clinic treatments
- Sleep studies / sleep labs
- Pneumogram
- Radiological procedures which require admission for observation
- Durable Medical Equipment services that cost over \$300
- Use of ambulance for medical transportation (not emergency transport)
- Request for services by a provider who does not have a contract with DCHP
- Out of area / out of network services
- Bio-feedback treatment
- Injectable drugs that cost over \$300
- Temporal Mandibular Joint (TMJ) treatment
- Organ transplant evaluation
- Other forms of medical treatment (such as hypnosis, massage therapy)

To call for authorization, you or your physician may call the Member Services number **1-877-451-5598**, Monday through Friday, 8:00 a.m. until 5:00 p.m., CST. If there is no authorization for the service, you may have to pay for it.

You have a right to know the cost of any service before your child receives that service. If you agree to get services that DCHP does not cover or authorize, you may have to pay for them.

Your child's hospital stay is reviewed everyday. Services may be reviewed after they are delivered or paid.

### **How will I be notified if services are denied?**

There may be times when the DCHP Medical Director denies these services. You will be sent a letter telling you of the denial of services.

### **What can I do if Driscoll Children's Health Plan denies or limits my doctor's request for a covered service?**

When this occurs, you may appeal this decision. To appeal these medical decisions, call Member Services at **1-877-451-5598**. If you need help filing this appeal, ask Member Services to help you.

You have ten (10) days from the date on the denial letter or the date of requested service to send us an appeal. You or your provider may appeal verbally or in writing. If a request for an appeal is received verbally, you or your provider will need to put the appeal in writing. If you need more than ten (10) days to appeal, you may ask for more time. You may have fourteen (14) more days to file the appeal.

We will send you a letter within five (5) days of receiving your appeal, to let you know that we did receive it. We will complete the appeal review within thirty (30) days. If we need more time to review the appeal, we will send you a letter telling you why we need more time.

If you wish to appeal a denial of a service that is not a covered benefit, then you will need to file a complaint. See page 20 to see how to file a complaint.

## **Expedited Appeal**

### **What is an Expedited Appeal?**

An expedited appeal is when the HMO is required to make a decision quickly based on your health status and taking the time for a standard appeal could jeopardize your child's life or health.

### **How do I request an Expedited Appeal?**

You need to call Member Services at **1-877-451-5598** to request an expedited appeal. Your request does not have to be in writing. You or your doctor may request this type of

appeal. Your request will be reviewed and a response given to you and your doctor within one day of making the request. If you need help with filing this appeal, contact Member Services at **1-877-451-5598**.

### **What happens if we deny your request for an expedited appeal?**

You may discuss your request for an expedited appeal with the Medical Director if there are questions. Requests for expedited appeal are very serious. We want to make sure you or your child receive the care that is medically necessary.

## **Independent Review Organization (IRO) Process**

### **What is an Independent Review Organization?**

An Independent Review Organization is an organization that the Texas Department of Insurance (TDI) selects to review appeals for health plans. When a member or doctor is not happy with the health plan response, TDI will help make a decision through this organization.

### **How do I request an IRO review?**

If you are not happy with the results of the DCHP appeal, contact us. Forms will be sent to you to complete for this review. We will send your request to TDI right away. TDI will arrange for an Independent Review Organization (IRO) to review your appeal within one (1) business day after they receive the request. The IRO will review your case. They will make a decision about the service within fifteen (15) days, but no longer than twenty (20) days after they receive the request. DCHP will follow the IRO decision. We will pay for the IRO process. We will also pay for the service if the IRO decision is to provide the service.

If your child is in the hospital or needs an appeal decision quickly due to his/her condition, contact DCHP right away. We will send your request to TDI right away. The IRO will make a decision about your child's care within five (5) days, but no longer than eight (8) days after they receive the request. DCHP will follow the IRO decision. We will pay for the IRO process.

To request a review by an Independent Review Organization, call DCHP at **1-877-451-5598**. Complete the IRO form obtained from DCHP and fax it to us at **361-882-4520**. You may also mail it to us at:

Driscoll Children's Health Plan  
**ATT: Appeals Coordinator**  
 P.O. Box 6609  
 Corpus Christi, Texas 78466-6609

## Complaints

### What should I do if I have a complaint?

We want to help. If you have a problem, we want to know. Please call our Member Services Department at **361-904-0955** or toll-free at **1-877-451-5598**. A Member Services Representative can help you with filing a complaint. We will send you a letter to let you know we received the complaint. This letter will be sent within five (5) days of receiving your complaint. We will send you a form to complete and mail to us. We will not follow-up on your complaint unless you put it in writing. We will not punish you for filing a complaint.

Your doctor may file a complaint for you. We will not punish you or your doctor for filing a complaint.

Most of the time, we can help you right away or at the most within a few days. At the most, we will respond with an answer to your complaint within thirty (30) days of receipt. If you are not happy with the way we help you, you can call us and appeal.

Driscoll Children's Health Plan wants to help you get the best healthcare for your family. If you have questions about how to file a complaint, an appeal, or need additional help, call us toll-free at **1-877-451-5598**. We will be glad to help.

Call us: Driscoll Children's Health Plan  
DCHP Member Services  
**1-877-451-5598**

Write to us: Driscoll Children's Health Plan  
**ATT: Executive Director of QI**  
615 N Upper Broadway, Suite 1621  
Corpus Christi, TX 78401

All complaints are reviewed to make sure that there is follow-up. They are also reviewed to make sure that timely answers are given.

### If I am not satisfied with the outcome, who else can I contact?

You may file an appeal if you are not happy with our answer to your complaint. Your doctor may also file an appeal for you. To appeal, call Member Services. The number is **1-877-451-5598**. They will explain how to appeal the complaint. You may also call the Texas Department of Insurance. Their number is 1-800-252-3439. TDI will explain what to do to appeal our answer. We will not punish you or your doctor for filing an appeal.

You also have the right to meet with a Complaints Appeal Panel. This panel is made up of doctors and others who will hear your complaint and make a decision.

## Abuse of the CHIP program

### Provider or Recipient Waste, Abuse or Fraud in CHIP

If you suspect a client (a person who receives benefits) or a provider (e.g. doctor, dentist, counselor, etc.) has committed waste, abuse or fraud you have a responsibility and a right to report it.

### Reporting Provider/Clients Waste, Abuse or Fraud

You can report provider / clients directly to your health plan at:

Driscoll Children's Health Plan  
**ATT: Compliance Officer**  
 615 N Upper Broadway, Suite 1621  
 Corpus Christi, Texas 78401  
**Phone – 1-877-324-7543**

Or – If you have access to the Internet go to the HHSC Inspector General website at:

<http://www.hhs.state.tx.us>

and select “Reporting Waste, Abuse and Fraud”. The site provides information on the types of waste, abuse and fraud to report. If you do not have Internet access and prefer to talk to a person, call the Office of Inspector General (OIG) Fraud Hotline at 1-800-436-6184, or you may send a written statement to the following OIG addresses:

### **To report providers, use this address:      To report clients, use this address:**

Office of Inspector General  
 Medicaid Provider Integrity/Mail Code  
 1361  
 P.O. Box 85200  
 Austin, TX 78708-5200

Office of Inspector General  
 General Investigations/Mail Code  
 1362  
 P.O. Box 85200  
 Austin, TX 78708-5200

- When reporting a provider (e.g., doctor, dentist, counselor, etc.) provide the following:
  - Name, address, and phone number of provider;
  - Name and address of the facility (hospital, nursing home, home health agency, etc.);
  - Medicaid number of the provider and facility is helpful;
  - Type of provider (physician, physical therapist, pharmacist, etc.);
  - Names and the number of other witnesses who can aide in the investigation;
  - Dates of events; and

- Summary of what happened.
- When reporting a client (a person who receives benefits) provide the following:
  - The person's name;
  - The person's date of birth, social security number, or case number if available;
  - The city where the person resides; and
  - Specific details about the waste, abuse or fraud.

## Member Rights and Responsibilities

As a member of DCHIP CHIP, you have rights and responsibilities. If you have any questions or concerns, please call us. We are here to help. You can call us toll-free at **1-877-451-5598**.

### Members have a right to:

1. Get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. Meaning, you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network".
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know what those payments are and how they work.
4. You have a right to know how the health plan decides about whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If your child is confirmed to have special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.

8. Children who are confirmed to have special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. You have a right to emergency services when you need them if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a few dollars depending on your income. This is called a "co-payment".
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right speak for your child in all treatment choices.
14. You may have a right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

**Member Responsibilities:**

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. Try to follow healthy habits, such as, encourage your child to exercise, to stay away from tobacco, and to eat a healthy diet.
2. Become involved in the doctor's decisions about your child's treatments.
3. Work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, try to first resolve it using the health plan's complaint process.
5. Learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. To pay your doctor and other providers co-payments that you owe them.
8. Report misuse of the CHIP program by health care providers, other CHIP members, or CHIP health plans.

## DCHIP CHIP Scope of Benefits

Covered CHIP services must meet the CHIP definition of "medically necessary."  
"Medically necessary" health services are:

Health care services that are:

- Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
- provided at appropriate facilities and at the appropriate levels of care for the treatment of Members' medical conditions;
- consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
- consistent with the diagnoses of the conditions;
- no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- are not experimental or investigative; and
- are not primarily for the convenience of the Member or Provider; and

Behavioral Health Services that:

- are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder or to improve, maintain, or prevent deterioration of function resulting from the disorder;
- are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
- are the most appropriate level or supply of service that can safely be provided;
- could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;
- are not experimental or investigative; and
- are not primarily for the convenience of the Member or Provider.

Type of Benefit	Description of Benefit	Limitations	Co-Pay
<b>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</b>	<p>Medically necessary services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Hospital-provided physician or provider services</li> <li>▪ Semi-private room and board (or private if medically necessary as certified by attending)</li> <li>▪ General nursing care</li> <li>▪ ICU and services</li> <li>▪ Patient meals and special diets</li> <li>▪ Operating, recovery and other treatment rooms</li> <li>▪ Anesthesia and administration_(facility technical component)</li> <li>▪ Surgically implanted devices</li> <li>▪ Surgical dressings, trays, casts, splints</li> <li>▪ Drugs, medications and biologicals</li> <li>▪ blood or blood products not provided free-of-charge to the patient and their administration</li> <li>▪ X-rays, imaging and other radiological tests (facility technical component)</li> <li>▪ Laboratory and pathology services (facility technical component)</li> <li>▪ Machine diagnostic tests (EEGs, EKGs, etc)</li> <li>▪ Oxygen services and inhalation therapy</li> <li>▪ Radiation and chemotherapy</li> <li>▪ Access to DSHS-designated Level III perinatal centers or</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency care and following stabilization of an emergency condition</li> <li>▪ Requires authorization for in-network or out-of-network facility and physicians 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</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of inpatient co-pay applies</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	<p>hospitals meeting equivalent levels of care</p> <ul style="list-style-type: none"> <li>▪ In-network or out-of-network facility 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</li> <li>▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care</li> <li>▪ Surgical implants</li> <li>▪ Other artificial aids including surgical implants</li> <li>▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.</li> </ul>		
<p><b>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</b></p>	<p>Medically necessary services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Semi-private room and board</li> <li>▪ Regular nursing services</li> <li>▪ Rehabilitation services</li> <li>▪ Medical supplies and use of appliances and equipment furnished by the facility</li> </ul>	<ul style="list-style-type: none"> <li>• Requires authorization and physician prescription</li> <li>▪ 60 days per 12-month period limit</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
<p><b>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center</b></p>	<p>Medically necessary services include, but are not limited to, the following services provided in a hospital clinic, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> <li>▪ X-ray, imaging, and radiological tests (technical component)</li> <li>▪ Laboratory and pathology services (technical component)</li> <li>▪ Machine diagnostic tests</li> <li>▪ Ambulatory surgical facility services</li> <li>▪ Surgically implanted devices</li> <li>▪ Drugs, medications and biologicals</li> <li>▪ Casts, splints, dressings</li> <li>▪ Preventive health services</li> <li>▪ Physical, occupational and speech therapy</li> <li>▪ Renal dialysis</li> <li>▪ Respiratory Services</li> <li>▪ Radiation and chemotherapy</li> <li>▪ Blood or blood products not provided free-of-charge to the patient and the administration of these products</li> <li>▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.</li> <li>▪ Surgical implants</li> <li>▪ Other artificial aids</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require prior authorization and physician prescription</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to prescription drug services</li> <li>▪ Co-pays do not apply to preventive services</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	<p>including surgical implants</p> <ul style="list-style-type: none"> <li>▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit</li> </ul>		
<p><b>Physician / Physician Extender Professional Services</b></p>	<p>Medically necessary services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)</li> <li>▪ Physician office visits, inpatient and outpatient services</li> <li>▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</li> <li>▪ Medications, biologicals and materials administered in physician's office</li> <li>▪ Allergy testing, serum and injections</li> <li>▪ Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> <li>• Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care</li> <li>• Administration of</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ May require authorization for specialty services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits</li> <li>▪ Co-pays do not apply to preventive visits or to prenatal visits after the first visit</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	<p>anesthesia by physician (other than surgeon) or CRNA</p> <ul style="list-style-type: none"> <li>• Second surgical opinions</li> <li>• Same-day surgery performed in a hospital without an over-night stay</li> <li>• Invasive diagnostic procedures such as endoscopic examination</li> </ul> <ul style="list-style-type: none"> <li>▪ Hospital-based physician services (including physician-performed technical and interpretative components)</li> <li>▪ 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</li> <li>▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.</li> </ul>		
<p><b>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</b></p>	<p>Covered 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,</p>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization and physician prescription</li> <li>▪ \$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	<p>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"> <li>▪ Orthotic braces and orthotics</li> <li>▪ Prosthetic devices such as artificial eyes, limbs and braces</li> <li>▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease</li> <li>▪ Hearing aids</li> <li>▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements</li> </ul>	<p>equipment are not counted against this cap)</p>	
<p><b>Home and Community Health Services</b></p>	<p>Medically necessary services are provided in the home and community and include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Home infusion</li> <li>▪ Respiratory therapy</li> <li>▪ Visits for private duty nursing (R.N., L.V.N.)</li> <li>▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).</li> <li>▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved</li> <li>▪ Speech, physical and</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization and physician prescription</li> <li>▪ Services are not intended to replace the child's caretaker or to provide relief for the caretaker</li> <li>▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services</li> <li>▪ Services are not intended to replace</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	occupational therapies.	24-hour inpatient or skilled nursing facility services	
<b>Inpatient Mental Health Services</b>	<p>Medically necessary services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Neuropsychological and psychological testing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency services</li> <li>▪ Does not require PCP referral.</li> <li>▪ Inpatient mental health services are limited to: <ul style="list-style-type: none"> <li>▪ 45 days 12-month period inpatient limit</li> <li>▪ Includes inpatient psychiatric services, up to 12-month period limit, 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. 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.</li> </ul> </li> <li>▪ 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of inpatient co-pay applies</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		<p>treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost</p> <ul style="list-style-type: none"> <li>▪ 20 of the inpatient days must be held in reserve for inpatient use only</li> </ul>	
<p><b>Outpatient Mental Health Services</b></p>	<ul style="list-style-type: none"> <li>▪ Medically necessary services include, but are not limited to, mental health services, including for serious mental illness, provided on an outpatient basis.</li> <li>▪ Medication management visits do not count against the outpatient visit limit.</li> <li>▪ Neuropsychological and psychological testing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization.</li> <li>▪ Does not require PCP referral.</li> <li>▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.</li> <li>▪ Up to 60 days 12-month period limit for rehabilitative day treatment.</li> <li>▪ 60 outpatient visits 12-month period limit</li> <li>▪ 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost.</li> <li>▪ 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost.</li> <li>▪ Includes outpatient psychiatric services, up to 12-month</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits.</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		<p>period limit, 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. 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.</p> <ul style="list-style-type: none"> <li>▪ Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits.</li> <li>▪ A Qualified Mental Health Professional (QMHP), as defined by and credentialed through the Texas Department of State Health Services (DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of a DSHS entity and be supervised by a licensed mental health professional or physician. QMHPs</li> </ul>	

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		<p>are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHPs. 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.</p>	
<p><b>Inpatient Substance Abuse Treatment Services</b></p>	<ul style="list-style-type: none"> <li>▪ Medically necessary 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.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency services</li> <li>▪ Does not require PCP referral.</li> <li>▪ Medically necessary detoxification/stabilization services, limited to <u>14 days per 12-month period</u>.</li> <li>▪ 24-hour residential rehabilitation programs, or the equivalent, up to <u>60 days per 12-month period</u>.</li> <li>▪ 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost.</li> <li>▪ 30 days must be held in reserve for inpatient use only.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of inpatient co-pay applies</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
<p><b>Outpatient Substance Abuse Treatment Services</b></p>	<ul style="list-style-type: none"> <li>▪ Medically necessary outpatient substance abuse treatment services include, but are not limited to, prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.</li> <li>▪ 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.</li> <li>▪ 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.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization.</li> <li>▪ Does not require PCP referral.</li> <li>▪ Outpatient treatment services up to a maximum of:</li> <li>▪ Intensive outpatient program (up to 12 weeks per 12-month period).</li> <li>▪ Outpatient services (up to six-months per 12-month period)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits.</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
<b>Rehabilitation Services</b>	<ul style="list-style-type: none"> <li>▪ Medically necessary 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:</li> <li>▪ Physical, occupational and speech therapy</li> <li>▪ Developmental assessment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization and physician prescription</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>
<b>Hospice Care Services</b>	<p>Medically necessary hospice services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ 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</li> <li>▪ Treatment for unrelated conditions is unaffected</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization and physician prescription</li> <li>▪ Services apply to the hospice diagnosis</li> <li>▪ Up to a maximum of 120 days with a 6 month life expectancy</li> <li>▪ Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
<p><b>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</b></p>	<p>Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Medically necessary covered services include:</p> <ul style="list-style-type: none"> <li>▪ Emergency services based on prudent lay person definition of emergency health condition</li> <li>▪ 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</li> <li>▪ Medical screening examination</li> <li>▪ Stabilization services</li> <li>▪ Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services</li> <li>▪ Emergency ground, air or water transportation</li> <li>▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require authorization for post-stabilization services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable co-pays apply to emergency room visits (facility only)</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
<b>Transplants</b>	<p>Medically necessary services include:</p> <ul style="list-style-type: none"> <li>▪ 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</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>
<b>Vision Benefit</b>	<p>Medically necessary services include:</p> <ul style="list-style-type: none"> <li>▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</li> <li>▪ One pair of non-prosthetic eyewear per 12-month period</li> </ul>	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <ul style="list-style-type: none"> <li>▪ Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits billed for refractive exam</li> </ul>
<b>Chiropractic Services</b>	<p>Medically necessary services do not require physician prescription and are limited to spinal subluxation</p>	<ul style="list-style-type: none"> <li>• Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit)</li> <li>• Requires authorization for additional visits.</li> </ul>	<ul style="list-style-type: none"> <li>• Applicable level of co-pay applies to chiropractic office visits</li> </ul>
<b>Tobacco Cessation Programs</b>	<ul style="list-style-type: none"> <li>▪ Covered up to \$100 for a 12-month period limit for a plan- approved program</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization</li> <li>▪ Health Plan defines plan-approved program.</li> <li>▪ May be subject to formulary requirements.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

Type of Benefit	Description of Benefit	Limitations	Co-Pay
<b>Case Management Services and Service Management for Children with Complex Special Health Care Needs (CCSHCN)</b>	<ul style="list-style-type: none"> <li>▪ Medically necessary case management services above and beyond those normally provided to all members are covered. These covered services include outreach, informing, intensive case management, care coordination and community referral.</li> </ul>	<ul style="list-style-type: none"> <li>▪ None</li> </ul>	<ul style="list-style-type: none"> <li>▪ None</li> </ul>

## 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
- 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 which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- 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
- 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
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- 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
- 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, which 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

### 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	
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	X		Eligible for coverage only if receiving covered home care for

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Supplies/Decubitus			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 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: <ul style="list-style-type: none"> <li>•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</li> </ul> Does not include formula: <ul style="list-style-type: none"> <li>•For members who could be sustained on an age-appropriate diet.</li> <li>•Traditionally used for infant feeding</li> <li>•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)</li> <li>•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.</li> </ul> Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are <i>not</i> 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, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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 parenteral nutrition has been authorized by the Health Plan.
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.
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 catheterization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.