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ACCREDITED
Medicaid Health Plan
Expires: 05/01/2027

El Paso Health

HEALTH PLANS FOR EL PASOANS.
BY EL PASOANS.

CHIP Member Handbook

CALL **915 532-3778**

CALL TOLL FREE **1 877 532-3778**

CHIP

TEXAS
Health and Human Services

EPHM11542507

09/2025

A Great Health Plan Comes With Healthy Rewards 2025-26.

HEALTHY REWARDS*	MEDICAID MEMBER	CHIP MEMBER
FIRSTCALL MEDICAL ADVICE INFOLINE — Members have 24-hour, 7-days-a-week access to FIRSTCALL, an El Paso based bilingual medical advice line staffed by local nurses, pharmacists, and an on-call medical director.	✓	✓
A free ride service to help you get to medical appointments, health education classes or Member Advisory Group meetings that are not covered under the Non-Emergency Medical Transportation (NEMT) benefit.	✓	✓
Members 20 and younger. Up to $125 above the CHIP/Medicaid vision benefit for contact lenses and glasses (lenses and frames). *For members under 21 years old for Medicaid	✓	✓
A free annual sports physical for members aged 4 through 18.	✓	✓
One allergy-free pillow case for members who are enrolled in the Asthma Disease Management Program.	✓	✓
A Calming Kit with calming strips, pop-it fidgets, clickers, and fidget spinners for members age 6 through 12 with ADHD after a follow-up visit within 30 days of filling an initial ADHD prescription.	✓	✓
A $25 "EPH Food from the Heart" gift card for new members after completing a new member orientation with El Paso Health.	✓	✓
Members 18 or younger can receive four additional nutritional/obesity counseling and meal planning services above the CHIP benefit.		✓
Members 20 or younger can receive four additional nutritional/obesity counseling and meal planning services above the Medicaid benefit.	✓	
A $15 gift card for members age 6 months to 2 years who get a flu shot when due.	✓	✓
A $15 gift card for members age 16-24 who receive a qualifying risk-based screening, as recommended by their PCP or OB/GYN provider. Limit one per year.	✓	✓
A $15 gift card for members 20 and younger who complete a Texas Health Steps check up on time.	✓	
A $15 gift card for members ages 3 to 19 who get a check-up when due.		✓
A $20 gift card is offered to members ages 21 and older who get an annual preventative wellness exam.	✓	

HEALTHY REWARDS*	MEDICAID MEMBER	CHIP MEMBER
Blood pressure cuffs for pregnant members diagnosed with hypertension or pre-eclampsia.	✓	✓
STAR Members must complete one Growing Together Postpartum class at El Paso Health to receive a baby-proofing home safety kit. The safety kit is limited to one time per pregnancy.	✓	
Pregnant members can receive: • A free convertible car seat after attending a baby shower at El Paso Health. • A First-Steps Baby Shower including a diaper bag, a starter supply of diapers, and other items for the baby. **Gift cards for completing prenatal visits and after confirmation of those visits for:** • $25 - Prenatal visit within 42 days of enrollment. • $25 - 3rd prenatal visit. • $25 - 6th prenatal visit. • $25 - 9th prenatal visit. • $25 - flu shot during pregnancy. • $25 - a timely postpartum visit within 7 to 84 days of delivery.	✓	✓
A $25 gift card for healthy food related items for pregnant CHIP Perinatal Members age 19 or older who complete four nutritional counseling/ meal planning services		✓
A $25 gift card for healthy food related items for pregnant STAR Members age 21 or older who complete four nutritional counseling/meal planning services	✓	
Up to $500 each year for dental checkups, x-rays, routine cleaning, fillings, and extractions for pregnant members 21 or older.	✓	✓
In-home breastfeeding counseling support visits for postpartum members with high-risk pregnancies that require specialized intervention	✓	✓
A $25 gift card each year for Diabetic Members who complete a Diabetic eye exam. One per year.	✓	
A $25 gift card for members ages 18-75 years with a diagnosis of diabetes who complete an HbA1c blood test each year.	✓	
New members can receive a gift packet which includes a $25 gift card for health-related items and a free first aid kit.	✓	✓
A $25 gift card is offered to members 18 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay.		✓
A $25 gift card is offered to members 20 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay.	✓	
the YMCA — Up to $35 discount for any sport, swim, or camp registration fee at participating YMCA's; once every 12 months.	✓	✓

For questions or doctor information: **877-532-3778**

TTY line for people with a hearing or speech disability: **855-532-3740**

Help for mental health, drug, or alcohol problems: **877-377-6184**

For prescription or medicine information: **877-532-3778**

El Paso Health
HEALTH PLANS FOR EL PASOANS BY EL PASOANS

www.elpasohealth.com

Healthy Rewards are El Paso Health's Value Added Services. Terms and limitations may apply.

EPHM11482507

TABLE OF CONTENTS

EPHM11542507

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

HEALTH CARE AND OTHER SERVICES FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact your Compliance Director at **915-532-3778.**

You may call El Paso Health "toll-free" telephone number for information or to make a complaint at: **1-877-532-3778**

You may also write to El Paso Health at:

1145 Westmoreland Dr.
El Paso, TX 79925

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: **1-800-252-3439**

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail:
ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact El Paso Health first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Puede comunicarse con el Compliance Director al **915-532-3778.**

Puede llamar al número de teléfono gratis de El Paso Health para más información o para someter una queja al: **1-877-532-3778**

Usted también puede escribir a El Paso Health a:

1145 Westmoreland Dr.
El Paso, TX 79925

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de companias, coberturas, derechos o quejas al: **1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: 1-(512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail:
ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con El Paso Health primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjun.

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

IMPORTANT NOTICE TO MEMBERS

If you have any questions or need help, please call our Member Services Department at **915-532-3778** or toll free at **1-877-532-3778** from 7 A.M. to 5 P.M. Mountain Time, Monday thru Friday. Our toll free TTY phone number for the hearing impaired is **1-855-532-3740.** We can provide you with written or oral interpretation of the services provided. Call us toll free at **1-877-532-3778** to receive support aids and services, including this material in another format.

AVISO A LOS MIEMBROS

Si tiene alguna pregunta o necesita ayuda, llame a nuestro Departamento de Servicios para Miembros al **915-532-3778** o al número gratuito **1-877-532-3778** de 7 A.M. a 5 P.M. horario de la montaña, de lunes a viernes. Nuestro número de teléfono TTY gratuito para personas con discapacidad auditiva es **1-855-532-3740.** Podemos proporcionar una interpretación escrita u oral de los servicios brindados. Llámenos sin cargo al **1-877-532-3778** para asistencia técnica y servicios, incluyendo material en otro formato.

GLOSSARY OF TERMS

Appeal – A request for your managed care organization to review a denial or a grievance again.

Complaint – A grievance that you communicate to your health insurer or plan.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Durable Medical Equipment (DME) – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Emergency Medical Condition – An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.

Emergency Medical Transportation – Ground or air ambulance services for an emergency medical condition.

Emergency Room Care – Emergency services you get in an emergency room.

Emergency Services – Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services – Health care services that your health insurance or plan doesn't pay for or cover.

Grievance – A complaint to your health insurer or plan.

Habilitation Services and Devices – Health care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.

Health Insurance – A contract that requires your health insurer to pay your covered health care costs in exchange for a premium.

Home Health Care – Health care services a person receives in a home.

Hospice Services – Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization – Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care – Care in a hospital that usually doesn't require an overnight stay.

Medically Necessary – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network – The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-participating Provider – A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider, instead of a participating provider. In limited cases such as there are no other providers, your health insurer can contract to pay a non-participating provider.

Participating Provider – A Provider who has a contract with your health insurer or plan to provide covered services to you.

Physician Services – Health care services a licensed medical physician (M.D.–Medical Doctor or D.O.–Doctor of Osteopathic Medicine) provides or coordinates.

Plan – A benefit, like Medicaid, to pay for your health care services.

Pre-authorization – A decision by your health insurer or plan before you receive it that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or pre-certification. Pre-authorization isn't a promise your health insurance or plan will cover the cost.

Premium – The amount that must be paid for your health insurance or plan.

Prescription Drug Coverage – Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs – Drugs and medications that by law require a prescription.

Primary Care Physician – A physician (M.D.–Medical Doctor or D.O.–Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider – A physician (M.D.–Medical Doctor or D.O.–Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.

Provider – A physician (M.D.–Medical Doctor or D.O.–Doctor of Osteopathic Medicine), health care professional, or health care facility licensed, certified, or accredited as required by state law.

Rehabilitation Services and Devices – Health care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

Skilled Nursing Care – Services from licensed nurses in your own home or in a nursing home.

Specialist – A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

INTRODUCTION

THANK YOU FOR CHOOSING EL PASO HEALTH!

El Paso Health is happy to welcome you to our CHIP family. Your child will receive covered benefits and services from doctors, hospitals and other medical care providers who are part of the El Paso Health network of providers.

El Paso Health is a Health Maintenance Organization that provides services and benefits to people eligible for CHIP. El Paso Health will provide or arrange for covered services to be available to members enrolling in the health plan.

ABOUT MANAGED CARE

El Paso Health CHIP is a managed health care program. Managed care allows you to choose your child's primary care provider. This primary care provider could be a doctor, nurse practitioner or a physician assistant. For this handbook, we may refer to the primary care provider as "doctor or primary care provider." References to "you," "my," or "I" apply if you are a CHIP Member. References to "my child" apply if your child is a CHIP Member or a CHIP Perinate Newborn Member.

The biggest advantage of managed care is that your child will have his/her own doctor. This doctor makes sure your child gets all the health care he/she needs. Your doctor will give you the information you need to make good choices about your child's treatment.

IMPORTANT TELEPHONE NUMBERS

Our Address

EL PASO HEALTH–CHIP
1145 Westmoreland Dr.
El Paso, Texas 79925
915-532-3778 or "Toll-Free" **1-877-532-3778**
Monday-Friday, during regular business hours 8 a.m. to 5 p.m., Mountain Time excluding state approved holidays. Call center hours of operation are 7 a.m. to 5 p.m.

Member Services

Our Member Services staff consists of highly qualified and trained individuals, fluent in both English and Spanish. You can reach our Member Services Department at **915-532-3778** or "Toll-Free" **1-877-532-3778.**

Our Member Services Department can:

- Explain what services are covered, and help you get the services you need.
- Help you choose a Primary Care Provider for your child if he/she does not have one.
- Help you find a doctor for your child close to your home.
- Help you change your child's primary care provider.
- Help send new ID cards.
- Inform you of what to do when you move out of the area.
- We will transfer members to 211 to change your address or phone number.

- Explain how to get transportation services.
- Act as your patient advocate and listen to your complaints and concerns.
- Tell you about classes, health fairs, and other special events in your area.

Stay Connected with El Paso Health's Mobile App!

The El Paso Health App is convenient and secure. It can help you manage your health care information. You can create a free account that will allow you to:

- View and print a temporary ID
- View eligibility information
- Find a Provider
- Request a PCP change
- View wellness information
- View authorizations
- View claims
- Ask a Question

After Hours Answering Service

If you call after regular business, weekend, and holiday hours, El Paso Health will still answer your phone call. We have bilingual staff working during the evening hours that can give you the information you need, or take your message and have someone from our Member Services Department call you the next working day. Our phone number is **915-532-3778** or **1-877-532-3778.**

Behavioral Health Services Hotline

El Paso Health also has behavioral health services. If you need help or have an emergency, please call our 24 hours day/7 days a week, crisis hotline at **1-877-377-6184** or call **911.** A trained bilingual representative will be there to help you. Interpreter services are also available.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

Interpreter Services

Interpreter services are available through our Member Services Department. Call **915-532-3778** or **1-877-532-3778** if outside the service area.

Other Numbers

Eye Care: **915-532-3778** or **1-877-532-3778**
CHIP Help Line: **1-800-647-6558**
For questions about Dental Services call:
DentaQuest **1-800-516-0165** / MCNA Dental **1-800-494-6262** /
United HealthCare **1-877-901-7321**
Prescription Drugs: **915-532-3778** or **1-877-532-3778**

Member Handbook

If you need help understanding or reading this Member Handbook, just call the Member Services Helpline at **915-532-3778** or **1-877-532-3778**. This number is available 24 hours a day, 7 days a week. You can speak to a Member Services Representative in English or Spanish. They will gladly help you understand this manual.

If you need the Member Handbook in audio, larger print, Braille, or another language, just call the El Paso Health Member Helpline at **915-532-3778** or **1-877-532-3778**, to request it.

TTY Line for the Hearing Impaired

Our Toll Free TTY phone number is **1-855-532-3740** or **915-532-3740.**

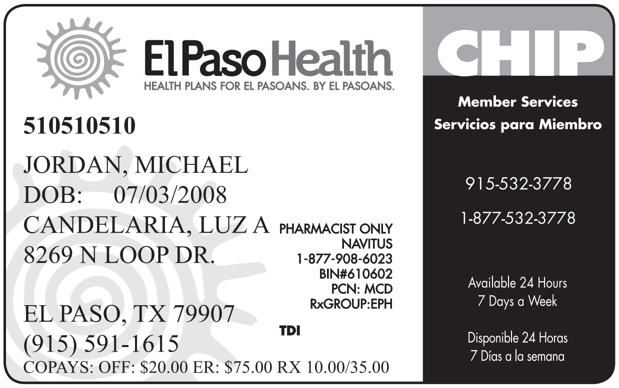
Transportation

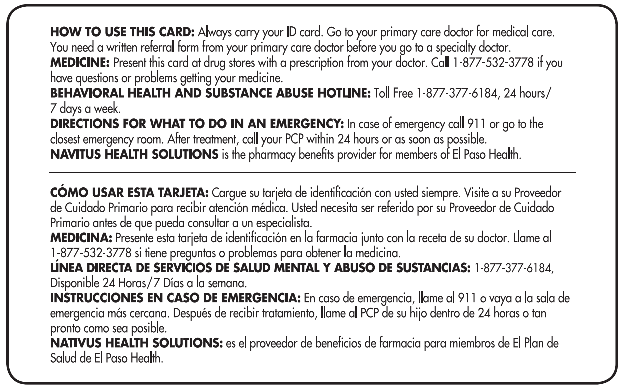
For transportation to a doctor's appointment, call the El Paso Health Member Services Line at **915-532-3778** or **1-877-532-3778**.

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

EL PASO HEALTH IDENTIFICATION (ID) CARD

We will give your child an identification card that looks similar to the one below:





This is how you will show that your child is an El Paso Health member. Always carry this card with you in your wallet or purse. This will assure that you have it in the event of an emergency.

Printed on your child's El Paso Health card are:

- The plan ID number and the name and date of birth of your child.
- The name, address and phone number of your child's doctor (Primary Care Provider).
- The phone number for the 24-hour/7 days a week El Paso Health Member Services line. You can call this number whenever you have a question or a problem **915-532-3778** or **1-877-532-3778.**
- The phone number in case there is a question regarding your prescription benefits.
- The phone number where you can call regarding Behavioral Health and Substance Abuse.
- The date in which your child's coverage begins.
- The number you can call if you are having a crisis.

If your child's card is lost or stolen, call the Member Services Line at **915-532-3778** or **1-877-532-3778.** A Member Services Representative will send out a new card to your home.

PRIMARY CARE PROVIDERS FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

WHAT DO I NEED TO BRING WITH ME TO MY CHILD'S DOCTOR'S APPOINTMENT?

When your child needs to see their primary care provider, call his or her office ahead of time and make an appointment for a visit. You will not have to wait long if you do this.

When you call, be ready to tell the receptionist about your child's health problem or question.

It is important that you be on time to your child's appointments. If you need to cancel an appointment with your child's primary care provider, please call the primary care provider's office as far in advance as possible.

If your child has a medical problem that needs attention the same day, call his/her primary care provider immediately. Your child's primary care provider will tell you what you need to do.

Always take your child's El Paso Health ID card with you to your appointments. At the doctor's office, you will be asked to show that your child is covered by a health care plan. You do this by showing your child's ID card.

WHAT IS A PRIMARY CARE PROVIDER?

A primary care provider is the person who gives your child the health care he/she needs when he/she needs it. It is a person who wants to keep your child from getting sick and help you take better care of him/her. A primary care provider can be a family practice doctor, a pediatrician (children's doctor), or a doctor of internal medicine (doctor for adults). Your primary care provider can also be a clinic.

CAN A CLINIC BE MY CHILD'S PRIMARY CARE PROVIDER?

Yes, if you need help choosing a clinic El Paso Health can help you. Call El Paso Health Member Services at **915-532-3778** or **1-877-532-3778.**

The following are some examples of the services your Primary Care Provider can provide for your child:

- Check-ups that help your child stay healthy
- Vaccines that prevent disease
- Treatment for common health problems
- Make arrangements for your child to get medical tests or treatment when needed
- Make arrangements for your child to see a specialist (special doctor) when needed
- Help you make decisions about your child's health care, such as whether or not he/she should have an operation

Your child's Primary Care Provider is the first person to call when your child has a health problem or you have a question about his/her health. Your child's Primary Care Provider will provide the care your child needs or direct you to someone else who can help you. Your child's Primary Care Provider can also be a Rural Health Center or Federally Qualified Health Center. If you decide later that the primary care provider you chose for your child does not meet your needs, you may choose a different one.

HOW CAN I CHANGE MY/MY CHILD'S PRIMARY CARE PROVIDER?

To change your child's primary care provider, call the El Paso Health Member Services Line at **915-532-3778** or **1-877-532-3778.** A Member Services Representative will help you make the change. We will do everything we can to help you find a doctor that is right for your child.

Our Member Services Representative will also tell you when your child can start seeing his/her new primary care provider.

Please do not change to a new primary care provider without telling El Paso Health. If you take your child to a new primary care provider without telling us, the services may not be covered.

If your child's primary care provider decides to leave El Paso Health and your child is under treatment, we will arrange for your child's continued treatment with his/her primary care provider until his/her treatment is complete or you have selected a new primary care provider that is qualified to treat your child's condition and is acceptable to you.

HOW MANY TIMES CAN I CHANGE MY/MY CHILD'S PRIMARY CARE PROVIDER?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us toll-free at **1-877-532-3778** or writing to:

EL PASO HEALTH
Member Services / Enrollment
1145 Westmoreland Dr.
El Paso, Texas 79925

WHEN WILL A PRIMARY CARE PROVIDER CHANGE BECOME EFFECTIVE?

If you call on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, the change will take place on May 1.
- If you call after April 15, the change will take place on June 1.

Are there any reasons why my request to change a Primary Care Provider may be denied?

Your request to change a Primary Care Provide may be denied if:

- The primary care provider you want for your child is not taking new patients.
- The primary care provider you want to change to is not part of the El Paso Health Network.

CAN A PRIMARY CARE PROVIDER REQUEST THAT MY CHILD BE CHANGED TO ANOTHER PRIMARY CARE PROVIDER FOR NON-COMPLIANCE?

Yes. A provider may ask that you choose another primary care provider if:

- You often miss visits without calling your child's primary care provider to say you won't be there.
- You don't follow the primary care provider's advice.
- You and your child's doctor do not get along.

If your child's primary care provider requests a change, you will get a letter in the mail. You will be able to choose a new primary care provider for your child. If you do not choose a new primary care provider, we will pick one for your child.

Remember that in order for your child to get the best health care, his/her primary care provider needs to know his/her medical information. Your child's medical information is private. Only you, your child's primary care provider, and other official people can see it. If you change your child's primary care provider, be sure to give the new primary care provider any information about your child's health that is important so that your child can continue to get the best care possible.

Please do not change to a new primary care provider without telling El Paso Health. If you go to a new primary care provider without telling us, the services may not be covered.

WHAT IF I CHOOSE TO GO TO ANOTHER DOCTOR WHO IS NOT MY CHILD'S PRIMARY CARE PROVIDER?

It is very important that you stay with the same doctor. Your doctor has your child's medical records and knows what medications they are using and is responsible for making sure they are getting good medical service.

If you take your child to another doctor that is not their assigned primary care provider, El Paso Health will not pay the other doctor and this may cause you to get billed for the services.

HOW DO I GET MEDICAL CARE AFTER MY PRIMARY CARE PROVIDER'S OFFICE IS CLOSED?

Your child's doctor is available 24 hours a day either in person or by telephone. If your child's doctor is not avail-able, he or she will arrange for another doctor to be available for your child. This includes weekends and holidays. If you need to speak to your child's primary care provider, you can still contact him/her if it is after regular "office hours". The answering service will be ready to take your concerns and have a doctor call you back within 30 minutes. Remember that your child's primary care provider's phone number is on your member ID card.

How do I get after hours care?

You can visit one of our Night Clinics. Our Night Clinics are open from 6:00 p.m. to 12:00 a.m., seven days a week. All you pay is your co-payment. For more information about our Night Clinics, please call Member Services at **915-532-3778** or **1-877-532-3778.**

DON'T GO TO THE EMERGENCY ROOM WHEN IT'S NOT AN EMERGENCY!

NIGHT CLINICS

When your child has:

• Fever • Diarrhea • Vomiting • Constipation • Or any other illness

...take your child to one of the convenient night clinics. You will avoid a long emergency room visit and your child will get quality medical treatment. For more information, please call **915-532-3778** or **1-877-532-3778.**

During the COVID -19 Pandemic clinic hours of operation may vary, call ahead of time to ensure they are open.

NIGHT CLINICS

MONTANA PEDIATRIC NIGHT CLINIC PA
11800 Montana Ave
El Paso, TX 79936
(915) 546-4140
Mon-Fri 6pm-9pm
Sat 8:30am-12pm
Sun 6pm-9pm

SALUD Y VIDA PA
6974 Gateway Blvd East, Ste F
El Paso, TX 79915
(915) 774-8850
Mon-Thurs 6pm-10pm
Fri 6pm-8pm
Sat 9am-7pm
Closed Sunday

SOUTHWEST PEDIATRIC NIGHT CLINIC
2325 Pershing
El Paso, TX 79903
(915) 633-9280
Mon-Sun 6pm-10pm

PHYSICIAN INCENTIVE PLANS

The MCO cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members.

El Paso Health cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. You have the right to know if you/your child's primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call **1-877-532-3778** to learn more about this.

CHANGING HEALTH PLANS

WHAT IF I WANT TO CHANGE HEALTH PLANS?

You are allowed to make health plan changes:

- For any reason within 90 days of enrollment in CHIP;
- for cause at any time;
- if you move to a different service delivery area; and
- during your annual CHIP re-enrollment period.

Who do I call?

For more information, call CHIP toll-free at **1-800-964-2777.**

How many times can I change health plans?

There is no limit on how many times you can change health plans.

When will my health plan change become effective?

The health plan change will become effective the following month after you requested the change. Some changes may take up to 45 days, depending on the date that you requested the change.

Can El Paso Health ask that I get dropped from their health plan for non-compliance, etc.?

El Paso Health may request that your child be disenrolled from the plan if:

- You let someone else use your child's El Paso Health ID card.
- You do not follow the advice that your child's doctor gives you.
- You keep taking your child to the emergency room when he/she does not have a true emergency.
- You cause problems at the doctor's office.
- You make it difficult for your child's doctor to help you or other people.
- Your child no longer lives or resides in the Service Area.

If there are any changes in your health plan, you will be sent a letter. If you decide to leave El Paso Health, you should call CHIP toll-free at **1-800-647-6558** or **2-1-1.**

There are situations that may cause your child to leave El Paso Health. The following are some examples:

- Your child is no longer eligible for coverage.
- Your child has other health insurance.
- Your child moves out of the El Paso Health service area.

If your child is facing one of these situations and you have questions, you should call our Member Services Department at **915-532-3778** or **1-877-532-3778.**

CONCURRENT ENROLLMENT OF FAMILY MEMBERS IN CHIP AND CHIP PERINATAL, AND MEDICAID COVERAGE FOR CERTAIN NEWBORNS

Newborn children who are enrolled in CHIP will stay in the CHIP Program but they will be enrolled in the MCO providing the CHIP Perinatal coverage for their mom. Copayments, cost-sharing, and enrollment fees still apply for those children enrolled in the CHIP Program.

An unborn child who is enrolled in CHIP Perinatal will be moved to Medicaid for 12 months of continuous Medicaid coverage, beginning on the date of birth, if the child lives in a family with an income at or below the Medicaid eligibility threshold.

An unborn child will continue to receive coverage through the CHIP Program as a "CHIP Perinate Newborn" after birth if the child is born to a family with an income above the Medicaid eligibility threshold.

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

BENEFITS FOR CHIP MEMBERS

WHAT ARE MY CHIP BENEFITS?

Your child's Primary Care Provider together with El Paso Health can help you receive these services.

The following is a brief summary of important services covered by CHIP:

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	• Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. • Requires authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.	Applicable level of inpatient co-pay applies

- In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Hospital, physician and related medical services, such as anesthesia, associated with dental care.
- Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  - dilation and curettage (D&C) procedures;
  - appropriate provider-administered medications;
  - ultrasounds; 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 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

Covered Benefit	Limitations	Co-payments
Skilled Nursing Facilities (Includes Rehabilitation Hospital) 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 authorization and physician prescription • 60 days per 12-month per period limit	Co-pays do not apply

Covered Benefit	Limitations	Co-payments
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings	• May require prior authorization and physician prescription services Co-pays do not apply to preventive services	Applicable level of co-pay applies to prescription drug

- 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
  - 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		

Covered Benefit	Limitations	Co-payments
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 component and/or professional interpretation • Medications, biologicals and materials administered in Physician's office	• May require authorization for specialty services	Applicable level of co-pay. Applies to office visits. Co-pays do not apply to preventative visits or to prenatal visits after the first visits.

- 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 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
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Covered services include DME (equip-ment 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	• May require prior authorization and physician prescription • $20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).	Co-pays do not apply

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 12-month period limit.
• Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.

Covered Benefit	Limitations	Co-payments
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 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	Co-pays do not apply

Covered Benefit	Limitations	Co-payments
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 prior authorization for non-emergency services • Does not require PCP referral • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Applicable level of inpatient co-payment

Covered Benefit	Limitations	Co-payments
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 (partial hospitaliza tion or rehabilitative day treatment)	• May require prior authorization applies to office visits. • 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 bind ing determination of medical necessity. Any modifica-	Applicable level of co-pay

• Skills training (psycho-educational skill development)	tion or termination of services must be presented to the court with jurisdiction over the matter for determination. • A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	

Covered Benefit	Limitations	Co-payments
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 prior authorization for non-emergency services • Does not require PCP referral	Applicable level of inpatient co-pay applies

Covered Benefit	Limitations	Co-payments
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 • 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.	• Requires prior authorization • Does not require PCP referral	Co-payment for office visit applies

Covered Benefit	Limitations	Co-payments
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 prior authorization and physician prescription	Co-pays do not apply

Covered Benefit	Limitations	Co-payments
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 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 may cancel this election at anytime	Co-pays do not apply

Covered Benefit	Limitations	Co-payments
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for Emergency Conditions 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	• Does not require authorization for post-stabilization services	Applicable co-pays apply to emergency room visits (facility only)

Covered Benefit	Limitations	Co-payments
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 authorization	Co-pays do not apply

Covered Benefit	Limitations	Co-payments
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 authorization • One pair of non-prosthetic eyewear per 12-month period	The health plan may reasonably limit the cost of the frames/lenses. • May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	Applicable level of co-pay applies to office visits billed for refractive exam

Covered Benefit	Limitations	Co-payments
Chiropractic Services Covered services do not require physician prescription visits and are limited to spinal subluxation.	• Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modal ities provided in one visit) • Requires authorization for additional visits.	Applicable level of co-pay applies to chiropractic office

Covered Benefit	Limitations	Co-payments
Tobacco Cessation Program Covered up to $100 for a 12-month period for a plan-approved program	• May require authorization • Health Plan defines plan-approved program. • May be subject to formulary requirements.	Co-pays do not apply

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

Covered Benefit	Limitations	Co-payments
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center. Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.		None

Covered Benefit	Limitations	Co-payments
Physician/Physician Extender Professional Services		Applicable co-payment for office visit.

WHAT BENEFITS ARE NOT COVERED?

CHIP Exclusions from Covered Services

- 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
- Elective Abortions
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarean 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)
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- 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").
- Medications prescribed for weight loss or gain
- Over-the-counter medications
- 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 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, 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

CHIP 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 neces-sary 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.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for 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 which 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.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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: • 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.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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.
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		

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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.*
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.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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.*

WHAT ARE MY PRESCRIPTION DRUG BENEFITS?

Co-payment applies for generic and brand name drugs.

El Paso Health will pay a portion for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to a drug store that is in the El Paso Health Pharmacy Network.

To learn more about your prescription drug benefits, visit **http://www.txvendordrug.com/formulary/formulary-search.asp** or call our Member Services Department at **915-532-3778** or toll-free **1-877-532-3778.**

HOW DO I GET THESE SERVICES FOR MY CHILD?

The Primary Care Provider will always be there to help you or your child get the services needed. If your Primary Care Provider cannot help you, he or she will refer you or your child to a specialist. You can always call Member Services **915-532-3778** or **1-877-532-3778.**

WHAT ARE CO-PAYMENTS? HOW MUCH ARE THEY AND WHEN DO I HAVE TO PAY THEM?

Co-payments for medical services or prescription drugs are paid to the health care provider at the time of service. CHIP Perinatal members and CHIP members who are Native American or Alaskan Native are exempt from all cost-sharing obligations, including enrollment fees and co-pays. Additionally, for all CHIP Members there is no cost-sharing on benefits for well-baby and well-child services, preventive services, or pregnancy-related assistance.

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

Federal Poverty Levels	Office Visit	Non-Emergency ER	Prescription Generic Drugs	Prescription Brand Name Drugs	Facility Co-pay, Inpatient (per admission)	Annual Co-pay Maximum
Native Americans	$0	$0	$0	$0	$0	None
At or below 151%	$5	$5	$0	$5	$35	5% of family's income
Above 151% up to and including 186%	$20	$75	$10	$35	$75	5% of family's income
Above 186% up to and including 201%	$25	$75	$10	$35	$125	5% of family's income

It is important that you keep track of your CHIP related expenses. This will help you know when you have reached your cap. When you reach your annual cap, please contact HHSC. HHSC will contact us, El Paso Health, and we will issue you a new ID card. This new card will show that no co-payments are due when your child receives services.

You may also have to pay a premium, unless you are a Native American or you are at or below the 100% Federal Poverty Level. If you need to pay a premium, you will receive a bill from HHSC with the amount you need to send. If you have any questions regarding your premium, contact HHSC at **1-800-647-6558.**

If you get a bill from your child's doctor, you should call El Paso Health at **915-532-3778** or **1-877-532-3778.** A Member Services Representative will be happy to help. Please have your El Paso Health ID card and the bill ready.

WHAT EXTRA BENEFITS DOES A MEMBER OF EL PASO HEALTH GET?

As of September 1, 2025, CHIP Members can receive the following Value Added Services:

Value-added Service	Limitations or Restrictions
Members have 24-hour, 7-days-a-week access to FIRSTCALL, an El Paso based bilingual medical advice line staffed by local nurses, pharmacists, and an on-call medical director.	None
A free ride service to help you get to doctor visits or health education classes.	None
Members 18 or younger can receive four additional nutritional/obesity counseling and meal planning services above the CHIP benefit. A Calming Kit with calming strips, pop-it fidgets, clickers, and fidget spinners for members age 6 through 12 with ADHD after a follow-up visit within 30 days of filling an initial ADHD prescription.	Only available for CHIP Members age 0 through 18. For members age 6 through 12 years with a new prescription dispensed for ADHD medication and who complete a follow-up visit with a practitioner with prescribing authority within 30 days. Members can receive one Calming Kit per year.
Up to $125 above the CHIP vision benefit for contact lenses and glasses (lenses and frames).	None.
New members can receive a gift packet which includes a $25 gift card for health-related items and a free first aid kit.	New members are eligible to receive this VAS every 12 months (rolling year) from the day of utilization.
A free annual sports physical for members aged 4 through 18.	Limited to 1 sport physical a year for Members ages 4 through 18.
One allergy-free pillow case for members who are enrolled in the Asthma Disease Management Program.	Once a year, Members will be eligible to receive one allergy-free pillowcase when enrolled in the Asthma Disease Management Program at El Paso Health.

A $25 “EPH Food from the Heart” gift card for new members after completing a new member orientation with El Paso Health.	The new member orientation class must be completed within 90 days of enrollment to be eligible to receive an EPH Food from the Heart $25 gift card. Every 12 months Members are eligible to receive one EPH Food from the Heart gift card per household.
Up to $35 discount for any sport, swim, or camp registration fee at participating YMCA’s; once every 12 months.	Up to $35 discount for any sport, swim, or camp registration fee at participating YMCA’s; once every 12 months.
A $15 gift card for members age 6 months to 2 years who get a flu shot when due. A $15 gift card for members ages 3 to 19 who get a check-up when due. A $15 gift card for members age 16-24 who receive a qualifying risk-based screening, as recommended by their PCP or OB/GYN provider. Limit one per year.	For El Paso Health CHIP Members age 6 months through 2 years of age only. For El Paso Health CHIP Members only. Limited to CHIP and CHIP Perinatal Members age 16-24. Must receive a chlamydia screening. Limit one per year.
A $25 gift card is offered to members 18 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay.	For members 18 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one Walmart gift card per year.

How can I get these benefits/how can I get these benefits for my child?

Please call the Member Services Helpline at **915-532-3778** or **1-877-532-3778,** for more information about these value-added services.

El Paso Health will try to help you and your child get other services you may need such as, but not limited to:

- Living arrangements
- Employment
- Job training
- Access to adequate food
- Access to affordable food
- Access to public schools

Member Services Representatives work with others at El Paso Health and the community to help each member connect with services from the many community agencies in El Paso. For more information, please contact Member Services at **915-532-3778** or **1-877-532-3778.** You can also call **2-1-1.**

TRANSPORTATION

El Paso Health covers ambulance services in emergency situations for all members. Severely disabled members, whose condition requires ambulance services, will also be covered.

If you and your child need a ride to a doctor's office, you can get help from El Paso Health. Please call our member service line as soon as you know you will need a ride. Call at least 48 hours in at **915-532-3778** or **1-877-532-3778.** El Paso Health will provide transportation through bus tokens or their contracted transportation provider. El Paso Health does not reimburse anyone for mileage.

WHAT HEALTH EDUCATION CLASSES DOES EL PASO HEALTH OFFER?

Free access to health education classes. Our health education classes are prepared with your family's health in mind. If your child has asthma or diabetes, our health educator will be happy to register you and your child in some of our classes. For information about our health education classes, please call Member Services at **915-532-3778** or **1-877-532-3778.**

HEALTH CARE AND OTHER SERVICES FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

Covered services for CHIP and CHIP Perinate Newborn Members must meet the CHIP definition of "Medically Necessary."

WHAT IS ROUTINE MEDICAL CARE?

Routine medical care involves regular checkups by your child's primary care provider and treatment by him or her when your child is sick. During these regular visits, your child's primary care provider can give you prescriptions for medicine, and send your child to a special doctor (specialist) if he/she needs one.

It is important that you do what your child's primary care provider says and that you take part in decisions made about your child's health care. If you cannot make a decision about your child's health care, you can choose someone else to make them for you.

When you need to see your child's primary care provider, call the primary care provider at the number on your child's CHIP ID card. Someone in the primary care provider's office will set a time for you. It is very important that you keep your appointment. Call early to set up office visits, and call back if you have to cancel. If more than one member of your family needs to see the doctor, you need an appointment for each person.

Your child's doctor is available 24 hours a day either in person or by telephone. If your child's doctor is not available, he or she will arrange for another doctor to be available for him/her. This includes weekends and holidays.

HOW SOON CAN I EXPECT TO BE SEEN/ HOW SOON CAN I EXPECT MY CHILD TO BE SEEN?

Your Primary Care Provider will see you or your child within 14 days for routine primary care services.

When you need to see your child's primary care provider, call ahead of time and make an appointment for a visit. If your child has a condition that needs medical attention the same day, your child's primary care provider can arrange for that. Please be on time for your appointments. If you need to cancel an appointment, please call the primary care provider's office as far in advance as possible.

WHAT IS URGENT MEDICAL CARE AND HOW SOON CAN I EXPECT TO BE SEEN?

Urgent medical care involves the treatment of a medical problem that is not an emergency but needs attention the same day. Your child can be seen within 24 hours. If your child has a problem that is not an emergency, you should call his/her primary care provider. If your child's primary care provider feels you need to go to an emergency room, he or she will tell you to go to a hospital close to you. Some good reasons to call your child's primary care provider are:

- Your child needs more medicine
- Your child has a rash that does not get better
- Your child has a cold
- Your child has the flu
- Your child's cast breaks
- Your child has some stitches to be removed
- Your child has aches and pains in his/her back

FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

WHAT IS AN EMERGENCY, AN EMERGENCY MEDICAL CONDITION, AND AN EMERGENCY BEHAVIORAL HEALTH CONDITION?

FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

Emergency care is a covered service. Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions. "Emergency Medical Condition" is a medical condition characterized by sudden acute symptoms, severe enough (including severe pain), that would lead an individual with average knowledge of health and medicine, to expect that the absence of immediate medical care could result in:

- placing the member'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 CHIP member, serious jeopardy to the health of the CHIP member or her unborn child

"Emergency Behavioral Health Condition" means any condition, without regard to the nature or cause of the condition, which in the opinion of an individual, possessing average knowledge of health and medicine:

- requires immediate intervention or medical attention without which the member would present an immediate danger to himself/herself or others;
- or renders the member incapable of controlling, knowing, or understanding the consequences of his/her actions.

WHAT IS EMERGENCY SERVICES OR EMERGENCY CARE?

"Emergency Services" and "Emergency Care" mean health care services provided in an in-network or out-of-network hospital emergency department, free-standing emergency medical facility, or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize Emergency Medical Conditions or Emergency Behavioral Health Conditions. Emergency services also include any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency Medical Condition or an Emergency Behavioral Health Condition exists.

How soon can I expect to be seen / how soon can I expect my child to be seen?

Emergency services are provided and available through the closest hospital, 24 hours a day, 7 days a week.

In a life-or-death situation, go to the nearest hospital emergency room, or call 911 for an ambulance. Emergency room doctors will handle a true emergency immediately. They will continue treatment until the patient is out of danger.

If you go to a hospital emergency room for a true emergency, you must call your child's doctor, clinic, or El Paso Health at **915-532-3778** or **1-877-532-3778,** as soon as you can. If you are not able to make the phone call, a family member or friend may call for you. You must also show your child's El Paso Health Identification Card. If the nearest hospital is not an El Paso Health contracted hospital, your child may be moved to an El Paso Health contracted hospital when strong enough.

When people who are not in serious danger go to an emergency room, they often have to wait a long time for treatment. In most cases they can get the treatment they need more quickly at their doctor's office or at one of El Paso Health's Night Clinics. El Paso Health pays for all visits to your primary care provider and to our Night Clinics. For more information about our Night Clinics, please call our Member Services Department at **915-532-3778** or **1-877-532-3778.** ***Remember that Non-emergency treatment in an emergency room is not a covered benefit.*** Only true emergency treatments in an emergency room are covered.

Examples of when not to go the emergency room:

- Ear ache
- Toothache or baby teething
- Rash
- Colds, cough, sore throat, flu, or sinus problems
- Minor sunburn
- Minor cooking burn
- Chronic back pain
- Minor headache
- Broken cast
- Stitches that need to be removed
- Prescription refills

WHAT IF I GET SICK WHEN I AM OUT OF TOWN OR TRAVELING/WHAT IF MY CHILD GETS SICK WHEN HE OR SHE IS OUT OF TOWN OR TRAVELING?

If you/your child needs medical care when traveling, call us toll-free at **1-877-532-3778** and we will help you find a doctor.

If you/your child needs emergency services while travelling, go to a nearby hospital, then call us toll-free at **1-877-532-3778.**

WHAT IF I AM/MY CHILD IS OUT OF THE STATE?

If your child has an emergency situation outside the state of Texas, go to the closest hospital. Then call your child's primary care provider and El Paso Health as soon as possible. El Paso Health will cover your child's emergency room treatment outside of the state as long as it is a true emergency.

WHAT IF I AM/MY CHILD IS OUT OF THE COUNTRY?

Medical services performed out of the country are not covered by CHIP.

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

WHAT DOES MEDICALLY NECESSARY MEAN?

FOR CHIP MEMBERS

Covered services for CHIP Members, CHIP Perinate Newborn Members, and CHIP Perinate Members must meet the CHIP definition of "Medically Necessary." A CHIP Perinate Member is an unborn child.

***Medically Necessary* means:**

1. Health Care Services that are:
    a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
    b. provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
    c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
    d. consistent with the member's diagnoses;
    e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
    f. not experimental or investigative; and
    g. not primarily for the convenience of the member or provider; and
2. Behavioral Health Services that are:
    a. reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
    b. in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
    c. furnished in the most appropriate and least restrictive setting in which services can be safely provided;
    d. the most appropriate level or supply of service that can safely be provided;
    e. could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
    f. not experimental or investigative; and
    g. not primarily for the convenience of the member or provider.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and 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 child's physical health and/or the quality of care provided.

Services provided outside of the United States are not covered benefits.

WHAT IS A REFERRAL?

Your primary care provider may give you a form to take to a special doctor. This form is called a "referral." Please take it with you when you go see the special doctor. You do not need a referral for freedom-of-choice services.

WHAT SERVICES DO NOT NEED A REFERRAL?

These services are called "freedom-of-choice" services. You can visit:

- Night Clinics or 24-hour emergency room care
- Behavioral (mental) Health and substance abuse services
- OB/GYN (doctor for women's health)
- Eye doctor (routine vision exam)

HOW CAN I ASK FOR A SECOND OPINION?

You have the right to get a second opinion from another doctor. If you need help please call us at **1-877-532-3778** and we will help you find a doctor.

Do I need a referral for this?

You do not need a referral from your primary care provider for these services

HOW DO I GET MY/MY CHILD'S MEDICATIONS?

CHIP covers most of the medicine your/your child's doctor says you need. Your/your child's doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription to the drug store for you.

Exclusions include: contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain. You may have to pay a co-payment for each prescription filled depending on your income.

There are no co-payments required for CHIP Perinate Newborn Members.

How do I find a network drug store?

El Paso Health will provide you with a list of all the pharmacies that are in network.

What if I go to a drug store not in the network?

Please call El Paso Health for help in finding a drug store that is network. You might be responsible for the retail cost of the medications, if the drug store you go to, is not in network.

What do I bring with me to the drug store?

You must take your El Paso Health ID card.

What if I need my/my child's medications delivered to me?

Call our Member Services Department at **1-877-532-3778** and they will help you find a drug store that delivers medications.

Who do I call if I have problems getting my/my child's medications?

If you have problems getting your medications, please call our Member Services Department at **1-877-532-3778** and a Member Service representative will assist you.

What if I can't get my/my child's prescription approved?

If your/your child's doctor cannot be reached to approve a prescription, you/your child may be able to get a three-day emergency supply of your/your child's medication.

Call El Paso Health at **1-877-532-3778** for help with your/your child's medications and refills.

What if I lose my medication(s)?

Please call El Paso Health at **1-877-532-3778.**

What if I need/my child needs an over the counter medication?

The pharmacy cannot give you an over the counter medication as part of your/your child's CHIP benefit. If you need/your child needs an over the counter medication, you will have to pay for it.

What if I need/my child needs birth control pills?

The pharmacy cannot give you/your child birth control pills to prevent pregnancy. You/your child can only get birth control pills if they are needed to treat a medical condition.

WHAT IF MY CHILD NEEDS TO SEE A SPECIAL DOCTOR (SPECIALIST)?

Your child's primary care provider will arrange for him/her to see a specialist when he or she finds it necessary. This is called a referral.

For most health care services, your child's primary care provider will be the only one he/she will need to see. If your child has a special health condition, your child's primary care provider may arrange for him/her to see another doctor who has the special skills needed to treat him/her. In that case, your child's primary care provider will give you a form called a referral. You can call the specialist to make an appointment once you have a referral from your child's primary care provider. Be sure to take the referral form with you when you go see the specialist. You will need to give the referral form to him or her.

Please be on time to your appointments with a specialist. If you need to cancel an appointment, please call the specialist's office as far in advance as possible.

HOW SOON CAN I EXPECT TO BE SEEN BY A SPECIALIST/ HOW SOON CAN I EXPECT MY CHILD TO BE SEEN BY A SPECIALIST?

The specialist may be able see you on the next day and no later than the 14th day.

Some specialists include:

- Cardiologist – heart doctor
- Dermatologist – skin doctor
- Gynecologist – a doctor who specializes in women's health
- Obstetrician – a doctor who takes care of pregnant women and delivers babies
- Orthopedist – a doctor for the skeleton (bones)
- Hematologist – a doctor for blood problems

The referral is good for a limited number of days. If the specialist says your child will need more visits or another referral, the specialist should contact your child's primary care physician or El Paso Health to make sure the added care will be covered.

Your child can get certain types of services without a referral from his/her primary care provider. The following is a list of health care providers that you can visit without a referral. Please refer to our El Paso Health Provider Directory for specific doctors. You may contact these doctors on your own:

- An obstetrician for your child's first visit when she's pregnant, and
- Wellness and preventive services for children.

If you have questions, or need help to make an appointment, you can call Member Services at **915-532-3778** or **1-877-532-3778.**

HOW DO I REQUEST AUTHORIZATION FOR SPECIALTY MEDICAL SERVICES FOR MY CHILD?

If authorization is required for a specialty medical service your doctor must fax the request to the Health Services Department at El Paso Health to request an authorization before this service can be provided.

Decisions related to medically necessary and service coverage are made in compliance with the time frames established by Medicaid guidelines. These decisions will not take more than 3 business days after the Health Services Department receives all the required information.

Answers to authorization requests for out-of-network services will be given within 3 working days after the Health Services Department receives all the required information.

HOW DO I GET HELP IF I HAVE/MY CHILD HAS BEHAVIORAL (MENTAL) HEALTH OR ALCOHOL OR DRUG PROBLEMS?

You can get help for mental health problems and drug abuse. You can also go to a mental health doctor without a note from your primary care provider. A group of doctors developed by El Paso Health provides these services. Call us for help. Our number is **915-532-3778** or **1-877-532-3778.**

Mental health services are very private. You do not need a referral from your primary care provider for these services. You may call El Paso Health anytime you need:

- Help with family problems or other problems that are upsetting in your life, or
- Help for drug or alcohol abuse.

Sometimes you might need help with a personal or family problem. If you have a problem and you need help, please call our crisis line at **1-877-377-6184.** A trained person will be there to help you.

HOW DO I GET EYE CARE SERVICES/ HOW DO I GET EYE CARE SERVICES FOR MY CHILD?

Eye care services include one examination by an eye doctor per year. You or your child may get one pair of eyeglasses each year. To learn more about eye exams or glasses, please call our Member Services Department if you need an eye exam or glasses at **915-532-3778** or toll-free at **1-877-532-3778.**

WHAT IS EARLY CHILDHOOD INTERVENTION (ECI)?

ECI is a statewide Texas program for families with children, birth to three, with disabilities and developmental delays. ECI supports families to help their children reach their potential through developmental services.

ECI services feature:

- Individualized Planning Process
- Family-Centered Services
- Case Management
- Familiar Settings
- Professional Providers
- Plans for Continuing Services

Do I need a referral?

You do not need a referral from your Primary Care Provider.

Where do I find an ECI Provider?

For help in locating ECI services, please call the ECI toll-free number **1-800-628-5115** or search for an ECI provider online: **https://dmzweb.dars.state.tx.us/prd/citysearch**

HOW DO I GET DENTAL SERVICES FOR MY CHILD?

El Paso Health will pay for some emergency dental services in a hospital or ambulatory surgical center. El Paso Health will pay for the following:

- Treatment of a dislocated jaw.
- Treatment of traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment and devices for craniofacial anomalies.

El Paso Health covers hospital, physician and related medical services for the above conditions. This includes services from the doctor and other services your child might need, like anesthesia or other drugs.

The CHIP medical benefit provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for craniofacial anomalies; and drugs.

Your child's CHIP dental plan provides all other dental services, including services that help prevent tooth decay and services that fix dental problems. Call your child's CHIP dental plan to learn more about the dental services they offer.

WHAT DO I DO IF I NEED/MY CHILD NEEDS EMERGENCY DENTAL CARE?

During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, call us toll-free at **1-877-532-3778.**

WHAT IS POST STABILIZATION?

Post-stabilization care services are services covered by CHIP that keep the Member's condition stable following emergency medical care.

CAN SOMEONE INTERPRET FOR ME WHEN I TALK WITH MY/MY CHILD'S DOCTOR?

El Paso Health provides translation services for members who speak languages other than English.

Who do I call for an interpreter?

Call our Member Services Department at **915-532-3778** or **1-877-532-3778.** We will arrange for an interpreter to help you during your visit.

HOW CAN I GET A FACE-TO-FACE INTERPRETER IN THE PROVIDER'S OFFICE?

El Paso Health can get an interpreter to be present with you at the doctor's office.

How far in advance do I need to call?

For this service, please call the Member Helpline at least 24 hours in advance at **915-532-3778** or **1-877-532-3778.**

We also have interpreters who know sign language to help with doctor visits. Let us know at least two days before your child's visit if you need this service.

El Paso Health's telephone staff speaks English and Spanish. We can also mail information to you in other languages. If you need help hearing, El Paso Health has a TDD line. For TDD help, call toll free **1-855-532-3740** or **915-532-3740.**

WHAT IF I NEED/MY DAUGHTER NEEDS OB/GYN CARE?

You have the right to pick an OB/GYN for yourself/your daughter without a referral from your/your daughter's Primary Care Provider. An OB/GYN can give you:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to special doctor (specialist) within the network.

El Paso Health allows you/your daughter to pick an OB/GYN for you/your daughter but this doctor must be in the same network as your/your daughter's Primary Care Provider.

You have the right to select an OB/GYN for your child without a referral from your child's primary care provider. These services are called "freedom-of-choice" services.

To choose an OB/GYN as your child's primary care provider, just call our Member Helpline at **915-532-3778** or **1-877-532-3778,** and let us know who you want to choose as your child's OB/GYN. Remember that you have to choose from the OB/GYN providers listed in the El Paso Health Provider Directory.

You also have direct access to an OB/GYN. You are not required to choose an OB/GYN as your child's primary care provider, but if your child is pregnant, you should choose an OB/GYN to take care of her.

If your child has already been seen by an OB/GYN who is not part of the El Paso Health Network, she may be able to continue seeing that OB/GYN. However, you will need to contact a Nurse Case Manager at **915-532-3778** or **1-877-532-3778.**

WHAT IF I AM PREGNANT/WHAT IF MY DAUGHTER IS PREGNANT?

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

- one well-woman check-up per year;
- care related to pregnancy
- care for any female medical condition; and
- referral to a special doctor (specialist) within the network.

If your daughter becomes pregnant call El Paso Health's Member Services Department at **915-532-3778** or **1-877-532-3778,** as soon as you know your daughter is pregnant.

HOW SOON CAN I/MY DAUGHTER BE SEEN AFTER CONTACTING AN OB/GYN FOR AN APPOINTMENT?

You/your daughter should be able to get an appointment within 14 days of calling for an appointment. If you/your daughter are 7 months pregnant or more and a new member, you/your daughter should be able to get an appointment within 5 days, or immediately if there is an emergency.

Your daughter may also be able to receive WIC assistance. WIC is a program for pregnant women and mothers of children younger than five that provides certain free foods, such as milk, cereal, juice, eggs, and cheese. To apply for WIC, call **771-5850** to make an appointment.

For more information about the program, call WIC at **1-800-942-3678** or call the El Paso Health Member Services Department at **915-532-3778** or **1-877-532-3778.**

What other services/activities/education does El Paso Health offer pregnant women?

El Paso Health offers a gift card for health-related items for pregnant Members that complete a prenatal visit and attend a prenatal class.

WHO DO I CALL IF I HAVE/MY CHILD HAS SPECIAL HEALTH CARE NEEDS AND I NEED SOMEONE TO HELP ME?

In certain cases, your child's doctor or another provider or healthcare professional might decide that your child has a special need.

If your child's primary care provider decides that he/she needs a special medical service or special medical equipment, and you agree, El Paso Health will help make the arrangements for your child to receive the help that he/she needs.

If your child has a special health care need, contact our Member Services Department at **915-532-3778** or **1-877-532-3778** for help.

If you get a bill from your doctor, you should call El Paso Health at **915-532-3778** or **1-877-532-3778.** A Member Services Representative will be happy to help you. Have your El Paso Health ID card and the bill ready.

WHAT IF I GET A BILL FROM MY/MY CHILD'S DOCTOR?

If you get a bill from your doctor, you should call El Paso Health at **915-532-3778** or **1-877-532-3778.** A Member Services Representative will be happy to help. Have your El Paso Health ID card and the bill ready.

WHAT DO I HAVE TO DO IF I MOVE/MY CHILD MOVES?

As soon as you have your new address, give it to HHSC by calling **2-1-1** or updating your account on **YourTexasBenefits.com** and call the El Paso Health Member Services Department at **1-877-532-3778.** Before you get CHIP services in your new area, you must call El Paso Health unless you need emergency services. You will continue to get care through El Paso Health until HHSC changes your address.

WHAT IF I AM TOO SICK TO MAKE A DECISION ABOUT MY MEDICAL CARE?

Sometimes people are too sick to make decisions about their health care. If this happens, how will a doctor know what you want? You can make an **Advance Directive.** An Advance Directive is a letter that tells people what you want to happen if you get very sick. One kind of Advance Directive is a **Living Will.** A will tells your doctor what to do if you are too sick to tell him or her. The other kind is a **Durable Power of Attorney.** A Durable Power of Attorney lets a friend or family member (who you choose) make decisions for you. Any Advance Directive you make starts when you get very sick. It will last until you change or cancel it.

Congress made a law that protects your right to make decisions about your health care if you become very sick. An Advance Directive lets you tell your doctor about your future health care.

An Advance Directive can be helpful to you, your family, and your doctor. It is your right to accept or refuse health care. You can protect this right even if you become mentally ill. You can also protect it if you become physically unable to make decisions about your health care. An Advance Directive helps your family by not making them decide how to care for you if you cannot make your own medical decisions. It helps your doctor by providing the guidelines for your care.

There are two types of Advance Directives:

1. **Living Will:** This lets you tell your doctor about your future health care in case you cannot make your own decisions because you are sick. Your doctor has to follow anything you write about how to provide your health care. This becomes active only if you are unable to make your own decisions.
2. **Durable Power of Attorney:** You can name another person to make decisions for you if you are ever not able to make decisions for yourself. This person can start making decisions for you when you are unable to make your own medical decisions due to any illness or injury (not only life threatening ones).

It is a good idea for you to complete both of these documents. As a patient, you have certain rights. These are:

- You have the right to privacy of your medical records and medical information.
- You have the right to an "Informed Consent." Your doctor must tell you about both the good things and bad things of any procedure, test, or treatment.
- You have the right to turn down any treatment.
- You have the right to know about your health condition, any treatments, and your chances of getting better.
- In most cases, your doctor will explain Advance Directives and your rights as a patient.

Here are some examples of when you might need to use your Advance Directive:

- Irreversible Brain Damage
- Permanent Coma or any other unconscious state
- Terminal Illness

An Advance Directive can also limit things that help you live longer. It will tell the doctor whether or not to give you these services if you have little chance to get better.

Examples of things that help you live longer are:

- Cardiopulmonary Resuscitation (CPR): used to give back breathing and/or heartbeat.
- Intravenous (IV) Therapy: used to give food and water to you if you cannot eat or drink.
- Feeding Tubes: these are tubes put through your nose or throat to provide you with food if you cannot eat.
- Respirators: these are machines that help you breathe if you cannot breathe on your own.
- Dialysis: this is a machine that cleans your blood if your kidneys do not work.
- Medications: these are medicines that will be used to help keep you alive.
- Restraints: these are used to keep you from hurting yourself.

Advance Directives are only good until they are canceled. If you want to change your health care decisions or if you want to cancel it, inform your doctor.

If you do not cancel your Advance Directive, your doctor will follow your instructions.

Once you give your Advance Directive to your doctor, he must make sure that it is legal before it is good. The law says a "qualified patient" is someone diagnosed and certified in writing to have a terminal illness by 2 doctors. One of these doctors must be your Primary Care Provider. Your Primary Care Provider must personally examine you before you are considered terminally ill.

Other facts:

- A terminal illness is any illness that is not curable.
- The doctor who gives services in the Advance Directive is protected from lawsuits, unless the doctor acts badly.
- The Advance Directive does not become effective until 2 doctors decide that you have a terminal condition and that life-sustaining procedures are the only way to keep you alive.
- The doctor's statement of terminal illness must be written in your medical records.

- Life sustaining procedures mean mechanical or other "artificial means" of keeping a person alive. This does not include medications or procedures to make you comfortable or to make pain go away.
- The Advance Directive is not good if you are pregnant at the time it is to be carried out. For example, your Advance Directive will not be followed if you are pregnant and suffer an accident that leaves you unable to make your own medical decisions.
- If the doctor follows your Advance Directive, and you tell him you do not want life sustaining procedures, it is not to be considered euthanasia or "mercy killing." The Advance Directive is a legal paper accepted by Texas law that allows a doctor to give or not give medical treatment depending on what you tell him to do.

You can call the Member Services Helpline at **915-532-3778** or **1-877-532-3778** to get an Advance Directive form.

The Durable Power of Attorney for Health Care is an important legal paper. It is very important that you understand what it says before you sign a Durable Power of Attorney for Health Care.

Unless you specifically state otherwise, this paper gives all medical decision-making powers to the person you pick regardless of your religious or moral beliefs. The person you pick is called your "agent." Your agent has power over all medical decisions made for you while you are not able to make these decisions for yourself.

- Your agent gets power to make medical decisions for you when your doctor decides that you are unable to make decisions on your own.
- Your agent must follow your instructions to make the decisions that you want.
- Your agent has the power to make any decisions that you do not specifically write about.
- You should talk to your doctor about this paper before you sign it.
- The person you pick, as your agent should be someone you know and trust. This person should be over 18 years old. If you pick your doctor, an employee of a home health agency, or an employee of a nursing home, that person has to pick between being your health care provider or your agent. Your agent and your health care provider cannot be the same person.
- You need to tell your agent that you have chosen him/her as your agent.
- Even after you sign this paper, you are able to make medical decisions for yourself until you cannot physically make decisions anymore.
- You may cancel the powers of your agent at any time by telling your agent or doctor, or by signing a new Durable Power of Attorney for Health Care.
- If you pick your spouse as your agent, the Durable Power of Attorney for Health Care is canceled if you get divorced.
- You may not make changes to a Durable Power of Attorney for Health Care. If you want to change any part of it, you must sign another form.
- You have the right to pick a different agent to make your decisions for you if something happens to your first agent.
- You must sign the form in front of 2 or more witnesses over the age of 18.
- The following people may not be witnesses:

  1. The person you pick as your agent;
  2. Your doctor;
  3. An employee of your doctor;

4. An employee of the facility where you live;
5. Your spouse;
6. Your family or beneficiaries named in your will or a deed; or,
7. Creditors or persons who have a claim against you.

The person you pick may not make medical decisions for you that have to do with voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion.

WHAT DO I HAVE TO DO IF I NEED HELP WITH COMPLETING MY RENEWAL APPLICATION?

Families must renew their CHIP or Children's Medicaid coverage every year. In the months before a child's coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family's income and cost deductions. The family needs to:

- Look over the information on the renewal application.
- Fix any information that is not correct.
- Sign and date the application.
- Look at the health plan options, if Medicaid health plans are available.
- Return the renewal application and documents of proof by the due date.

Once HHSC receives the renewal application and documents of proof, staff checks to see if the children in the family still qualify for their current program or if they qualify for a different program. If a child is referred to another program (Medicaid or CHIP), HHSC sends the family a letter telling them about the referral and then looks to see if the child can get benefits in the other program. If the child qualifies, the coverage in the new program (Medicaid or CHIP) begins the month following the last month of the other program's coverage. During renewal, the family can pick new medical and dental plans by calling the CHIP/Children's Medicaid call center at **1-800-964-2777.**

Completing the Renewal Process

When children still qualify for coverage in their current program (CHIP or Medicaid), HHSC will send the family a letter showing the start date for the new coverage period. If the children qualify for CHIP and an enrollment fee is due, the family must pay the enrollment fee by the due date or risk losing the coverage.

CHIP renewal is complete when the family:

- Pays any enrollment fee due by the due date.
- If the family changes their medical or dental plan, then they must sign and send the appropriate Enrollment/Transfer Form to HHSC showing the change.

If HHSC receives and processes the CHIP enrollment fee before the cutoff in the 12th month of coverage, then new coverage begins without interruption on the first day of the following month. If HHSC does not get the enrollment fee in time, then new coverage will not begin until the first day of the following month.

Medicaid renewal is complete when the family signs and sends to HHSC the appropriate Enrollment/ Transfer Form if the family picks a new medical or dental plan.

RIGHTS AND RESPONSIBILITIES

WHAT ARE MY RIGHTS AND RESPONSIBILITES?
FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBERS HAVE THE RIGHT TO:

1. You have the right to 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. "Limited provider network" means 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 about what those payments are and how they work.
4. You have a right to know how the health plan decides 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. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. If a doctor says your child has 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.
9. Children who are diagnosed with special health care needs or a disability have the right to special care.
10. 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.
11. 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.

12. Your child has the right to emergency services 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 copayment depending on your income.
    Copayments do not apply to CHIP Perinatal Members.
13. You have the right and responsibility to take part in all the choices about your child's health care.
14. You have the right to speak for your child in all treatment choices.
15. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
16. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.
17. 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.
18. 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.
19. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
20. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

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. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must 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, you must try first to resolve it using the health plan's complaint process.

5. You must 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, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. You must talk to your provider about your medications that are prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at **1-800-368-1019.** You also can view information concerning the HHS Office of Civil Rights online at **www.hhs.gov/ocr.**

COMPLAINT PROCESS

WHAT SHOULD I DO IF I HAVE A COMPLAINT?

We want to help. If you have a complaint, please call us at **915-532-3778** or toll-free at **1-877-532-3778** to tell us about your problem. An El Paso Health Member Services Advocate can help you file a complaint. Just call **915-532-3778** or toll-free at **1-877-532-3778.** Most of the time, we can help you right away or at the most within a few days.

El Paso Health cannot take any action against you as a result of your filing a complaint.

IF I AM NOT SATISFIED WITH THE OUTCOME, WHO ELSE CAN I CONTACT?

If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll-free to **1-800-252-3439.** If you would like to make your request in writing send it to:

Texas Department of Insurance
Consumer Protection
P.O Box 149091
Austin, Texas 78714-9091

If you can get on the Internet, you can send your complaint in an email to
http://www.tdi.texas.gov/consumer/complfrm.html

CAN SOMEONE FROM EL PASO HEALTH HELP ME FILE A COMPLAINT?

A member may request a complaint orally or in writing. A Member Services Advocate will be assigned to help you. This person will try to solve your concern quickly, possibly while you are waiting on the phone. If your concern cannot be resolved on the phone, El Paso Health will send you a one page complaint form that must be returned to us for quick resolution of your complaint.

If you are unable to complete the Complaint form, a Member Services Advocate will complete the form on your behalf and explain our complaint process, if necessary. The Complaint Process involves a series of steps you can take when you are not satisfied with the solution to your concern.

HOW LONG WILL IT TAKE TO PROCESS MY COMPLAINT?

Within (5) five business days of receipt of your complaint El Paso Health will send you a letter acknowledging your complaint. We shall complete the resolution of your complaint within (30) thirty calendar days after the receipt of your complaint. El Paso Health will reach a decision about your complaint and inform you in writing of the decision. You will get a letter that tells you what was found out about your complaint and what El Paso Health will do to solve the problem.

WHAT ARE THE REQUIREMENTS AND TIMEFRAMES FOR FILING A COMPLAINT?

Your complaint will be processed and resolved within thirty (30) calendar days of when we receive your oral or written complaint form.

If the complaint is related to an emergency or a denial of continued hospitalization no later than within one (1) business day of receipt, El Paso Health will investigate and resolve the complaint.

You may file a formal complaint by calling **915-532-3778** or **1-877-532-3778,** or by writing to El Paso Health. Mail your formal complaint letter to:

EL PASO HEALTH
Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, Texas 79925

DO I HAVE THE RIGHT TO MEET WITH A COMPLAINT APPEAL PANEL?

If you are not satisfied with the solution to your complaint, you may "appeal" by asking for a hearing with the internal Complaint Appeal Panel (CAP). The CAP is a group of people, including people who, like you, are members of El Paso Health, and people who work on the El Paso Health team.

APPEALS TO THE HEALTH PLAN

1. If the Complaint is not resolved to YOUR satisfaction, YOU have the right either to appear in person before a CAP where YOU normally receive health care services, unless another site is agreed to by YOU, or to address a written appeal to the Complaint appeal panel. WE shall complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for appeal.
2. WE shall send an acknowledgment letter to YOU not later the fifth day after the date of receipt of the request of the appeal.
3. WE shall appoint members to the CAP, which shall advise US on the resolution of the dispute. A complaint appeal panel shall be composed of an equal number of El Paso Health staff members, physicians or other providers, and enrollees. A member of a complaint appeal panel may not have been previously involved in the disputed decision.
4. The physicians in the CAP shall have experience in the area of care in dispute and shall be independent of any physician or provider who made any previous determination. If a specialty care is in dispute, the CAP will include a specialist in that field of care.

5. Not later than the fifth business day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:
   a. Any documentation to be presented to the panel by OUR staff;
   b. The specialization of any Physicians or Providers consulted during the investigation; and
   c. The name and affiliation of each of OUR representatives on the panel.
6. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:
   a. Appear in person before the CAP;
   b. Present alternative expert testimony; and
   c. Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.
7. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed one business day after YOUR request for appeal.

   Due to the ongoing Emergency or continued Hospital stay, and at YOUR request, WE shall provide, in lieu of a CAP, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal. The provider reviewing the appeal may interview the Member or the Member's representative and shall decide the appeal. This decision can be made orally and a written decision must be mailed not later than the third day after the date of the decision.
8. Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. YOU may request that the resolution of an emergency care appeal be reviewed by a CAP.

A Member Service Advocate will help you set-up a meeting to meet with the CAP or we can mail you an appeal form. You can also request a CAP by writing to:

EL PASO HEALTH
Attention: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, Texas 79925

PROCESS TO APPEAL A CHIP ADVERSE DETERMINATION

WHAT CAN I DO IF MY DOCTOR ASKS FOR A SERVICE OR MEDICINE FOR ME THAT'S COVERED BUT EL PASO HEALTH DENIES OR LIMITS?

You, the person acting on your behalf, your provider of record, and the health care provider or facility who rendered your services, if different from your attending physician, can appeal El Paso Health's decision to deny or limit a service or medicine that is a covered benefit. You will need to appeal within sixty (60) days from the date on your notice that your covered service(s) was denied or limited.

You may submit your appeal in writing, by phone, or fax at the following:

EL PASO HEALTH
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Tel: 915-532-3778
Toll Free: 877-532-3778
Fax No.: 915-298-7872

HOW WILL I FIND OUT IF SERVICES ARE DENIED?

You will receive a notice by letter from El Paso Health. The letter will include:

- The specific dental, medical, contractual reasons for the resolution;
- Clinical basis for the decision;
- The description of or the source of the screening criteria used in making the determination;
- The professional specialty of the physician who made the determination;
- The notice of the appealing party's physician right to seek a Specialty Review;
- The notice of the appealing party's right to seek review by a TDI approved Interal Review Organization and procedures for obtaining that review.
- A copy of the request for IRO Forms
- Procedures for filing a complaint to TDI

WHAT ARE THE TIMEFRAMES FOR THE APPEAL PROCESS?

El Paso Health will respond to your appeal as soon as practical, but no later than thirty (30) days from the date El Paso Health receives the appeal. The timeframe for the appeal may be extended up to fourteen (14) calendar days if you or your representative requests an extension, or El Paso Health shows that there is a need for additional information and how the delay is in your best interest. If the timeframe is extended by El Paso Health, you will receive a written notice of the reason for the delay.

WHEN DO I HAVE THE RIGHT TO REQUEST AN APPEAL?

You may request an appeal if you are not in agreement with a decision made on your covered medical services and medicines.

DOES MY REQUEST FOR AN APPEAL HAVE TO BE IN WRITING?

No, you may submit your appeal in writing, by phone, or fax at the following:

EL PASO HEALTH
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Tel: 915-532-3778
Toll Free: 877-532-3778
Fax No.: 915-298-7872

If you appeal by phone, you will receive a one-page appeal form along with a letter of acknowledgement. The appealing party does not have to return the appeal form, but El Paso Health will encourage the appealing party to do so along with any additional information that will help with the appeal. You can return the form to:

EL PASO HEALTH
Attention: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, Texas 79925

You, the person acting on your behalf, your provider of record, and the health care provider or facility who rendered your services, if different from your attending physician, will receive a letter from El Paso Health within (5) five calendar days acknowledging receipt of your appeal. The acknowledgment letter will include El Paso Health's appeal process and your right to request an IRO.

CAN SOMEONE FROM EL PASO HEALTH ASSIST ME IN FILING AN APPEAL?

Yes, if necessary, a Member Services Advocate will help you fill out your appeal form and explain the appeal process. Please call our Member Services Department at **915-532-3778** or **1-877-532-3778.**

EXPEDITED APPEAL

WHAT IS AN EXPEDITED APPEAL?

An expedited appeal is available for a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits and for denied step therapy protocol exception requests.

HOW DO I REQUEST AN EXPEDITED APPEAL?

You, the person acting on your behalf, your provider of record, and the health care provider or facility who rendered your services, if different from your attending physician, can request an expedited appeal orally or in writing. If you want to request the expedited appeal orally, please call **915-532-3778** or Toll Free at **877-532-3778** and ask for the Health Services representative that can assist you with filing the appeal. If you want to submit your request in writing, please send it to:

EL PASO HEALTH
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925

DOES MY REQUEST HAVE TO BE IN WRITING?

No, you can request an expedited appeal to El Paso Health orally or in writing.

To submit your appeal in writing, send your request to:

EL PASO HEALTH
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Fax No.: 915-298-7872

You may also call El Paso Health at **915-532-3778** or Toll Free at **877-532-3778.**

WHAT IS THE TIMEFRAME FOR AN EXPEDITED APPEAL?

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review. The resolution of the appeal may not exceed one (1) working day from the date all information necessary to complete the appeal is received.

Expedited appeal determinations will be provided by telephone or electronic transmission and will be followed with a letter within three (3) working days of the initial telephonic or electronic notification and will contain:

- A statement of the dental, medical, contractual reasons for resolution;
- The clinical or contractual basis for the decision;
- The description of or the source of the screening criteria that were utilized in making the determination;
- The professional specialty of the physician who made the determination;
- The notice of the appealing party's right to seek review by a Texas Department of Insurance (TDI) approved Independent Review Organization (IRO) and procedures for obtaining that review.
- A copy of a request for a review by an IRO Form
- Procedures for filing a complaint to TDI

WHAT HAPPENS IF EL PASO HEALTH DENIES THE REQUEST FOR AN EXPEDITED APPEAL?

The expedited appeal would be treated as a normal appeal and will be resolved in the thirty (30) day time frame.

SPECIALTY REVIEW

WHO CAN ASSIST ME IN FILING A SPECIALTY REVIEW?

Please call our Member Services Department at **915-532-3778** or toll-free at **1-877-532-3778** and we will direct you to a Member Advocate that can assist you with the specialty review.

WHAT ARE THE TIMEFRAMES FOR THE SPECIALTY REVIEW?

The provider of record may request a specialty appeal, which requests that a specific type of specialty provider review the case. A specialty review may be requested for the appeal of El Paso Health's original decision or the denial of the first appeal. The provider must request this type of appeal within 10 working days from the date the appeal was requested or denied. We will complete the specialty appeal and send our written decision to the enrollee or the person acting on the enrollee's behalf and the provider within 15 working days of receipt of the request for the specialty appeal.

INDEPENDENT REVIEW ORGANIZATION PROCESS

WHAT IS AN INDEPENDENT REVIEW ORGANIZATION?

An independent review organization (IRO) is an independent third party certified by the Texas Department of Insurance to review the medical necessity and appropriateness of health care services provided or proposed to be provided to the member.

HOW DO I ASK FOR A REVIEW BY AN IRO?

To request an IRO, you, the person acting on your behalf, your provider of record, and the health care provider or facility who rendered your services, if different from your attending physician must complete the HHS Federal External Review Request Form which El Paso Health includes along with your notice of denied services. If the form is not signed, the IRO cannot receive the medical records. Return the completed and signed form to MAXIMUS External Review by fax, mail, or online at:

Fax: **1-888-866-6190**
Mail: **MAXIMUS Federal Services**
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Online Portal: **externalappeal.com.gov**

An authorized representative may ask for an external review on your behalf. You and your authorized representative must complete and sign an *HHS Federal External Review Process Appointment of Representative (AOR) Form*. You may access the form by visiting: **externalappeal.cms.gov/ferpportal/#/forms** If you have questions about your external review or would like to request an AOR Form, please call **1-888-866-6205.**

You will have to go through El Paso Health's appeal's process first. El Paso Health will not require that you go through their internal appeals process first if El Paso Health fails to meet internal appeal process timeframes or for life-threatening circumstances.

There is no cost to you, El Paso Health will pay for the IRO.

WHAT ARE THE TIMEFRAMES FOR THIS PROCESS?

For a standard IRO review, you or someone acting for you may request an external review within four months of receiving the denial notice.

For an expedited IRO review, if you believe your situation is urgent you may request an expedited external review by calling **1-888-866-6205** immediately to begin the process.

MAXIMUS will send you, or someone acting for you a letter of their final review decision as soon as possible, but no later than forty-five (45) days after they receive your request for an external review.

If your child is in the hospital or has a condition that jeopardizes your child's life or health you do not have to go through the regular process. You can ask for an expedited review. MAXIMUS will notify you of their decision by phone as quickly as medical condition requires, but no later than seventy-two (72) hours of receiving the request. MAXIMUS will also send you a letter with their decision within 48 hours of the phone call.

WHO CAN ASSIST ME IN FILING AN IRO?

Please call our Member Services Department at **915-532-3778** or **1-877-532-3778** and you will be directed to a Member Advocate that will be able to assist you.

REPORT CHIP WASTE, ABUSE OR FRAUD

DO YOU WANT TO REPORT CHIP WASTE, ABUSE, OR FRAUD?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care provider, or a person getting CHIP benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for CHIP services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a CHIP ID.
- Using someone else's CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184;**
- Visit **https://oig.hhsc.state.tx.us/** Under the box labeled "I WANT TO," click "Report Fraud, Waste, or Abuse" to complete the online form; or
- You can report directly to your health plan:

  EL PASO HEALTH
  1145 Westmoreland Dr.
  El Paso, Texas 79925
  1-877-532-3778 (Toll Free)

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - 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, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse or fraud

EL PASO HEALTH HAS YOU COVERED
915-532-3778 or "TOLL FREE" 1-877-532-3778

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

STATEMENT OF NON-DISCRIMINATION

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

El Paso Health:

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

If you need these services, contact El Paso Health at **1-877-532-3778** (TTY **1-855-532-3740).**

If you believe that El Paso Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: El Paso Health, 1145 Westmoreland, El Paso, TX 79925, **1-877-532-3778** (TTY **1-855-532-3740),** Fax **915-532-2286** or **FileGrievance@elpasohealth.com.** You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, El Paso Health is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

SPANISH

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

VIETNAMESE

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).。

KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740) 번으로 전화해 주십시오.

ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-532-3778 (رقم هاتف الصم والبكم: (TTY: 1-855-532-3740 or 915-532-3740).

URDU

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

TAGALOG–FILIPINO

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

FRENCH

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-532-3778 (ATS: 1-855-532-3740 or 915-532-3740).

HINDI

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740) पर कॉल करें।

PORTUGUESE

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

GERMAN

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

GUJARATI

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-532-3778 (телетайп: 1-855-532-3740 or 915-532-3740).

JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-532-3778（TTY: 1-855-532-3740 or 915-532-3740）まで、お電話にてご連絡ください。

LAO

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

El Paso Health

HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

09/2025