El Paso Health

STAR+PLUS Member Handbook

CALL TOLL FREE
1-833-742-3127

TEXAS STAR PLUS Your Health Plan ★ Your Choice

TEXAS Health and Human Services

urac ACCREDITED Medicaid Health Plan Expires: 05/01/2027

08/2025

El Paso Health STAR+PLUS Value Added Services 2024

	At Home		Nursing Facilities	
	Medicaid Only	Dual	Medicaid Only	Dual
Help Getting a Ride A free ride service to help you get to appointments, health education classes, non-medical drivers of health locations, or Member Advisory Group meetings that are not covered under the NEMT benefit.	✓	✓	N/A	N/A
Dental Services Dual eligible members receive up to $2,000 each year for dental check-ups, x-rays, cleanings, filling and simple tooth extractions for members 21 and older for STAR+PLUS non-HCBS waiver members. Medicaid only members receive up to $600 each year for dental check-ups, x-rays, and cleanings (no extractions) for members 21 and older.	✓ **$600** allowance	✓ **$2,000** allowance	✓ **$600** allowance	✓ **$2,000** allowance
Extra Vision Services Medicaid only members get $150 allowance every two years to be used on one pair of eyeglasses (lenses and frames) or contact lenses and get one routine eye exam every two years. Dual eligible members receive a $300 yearly allowance and get one routine eye exam per year.	✓ **$150** biennial allowance	✓ **$300** annual allowance	✓ **$150** biennial allowance	✓ **$300** annual allowance
Extra Foot Doctor (Podiatry) Services Additional routine foot doctor (podiatry) visits each year.	N/A	✓ **12 visits**	✓ **4 visits**	✓ **12 visits**
Discount Pharmacy / Over-the-Counter Benefits Up to $140 once a year: $35 gift card every three months for over-the-counter medicines and other medical or health-related supplies not covered by Medicaid, upon request.	✓	✓	N/A	N/A
Temporary Phone Help El Paso Health Members ages 18 years and older eligible for the Federal Lifeline Program is offered at no cost to the member the exclusive El Paso Health Unlimited Plan that includes: An Android Smartphone, Unlimited Calling, Unlimited Text, Unlimited Data.	✓	✓	✓	✓
Emergency Response Services (ERS) Emergency response services for STAR+PLUS non-HCBS waiver members age 21 and older.	✓	✓	N/A	N/A
Home Visits Up to an extra 40 hours respite services for STAR+PLUS non-HCBS waiver members age 21 and older.	✓	✓	N/A	N/A

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Restrictions and limitations may apply

El Paso Health STAR+PLUS Value Added Services 2024

	At Home		Nursing Facilities	
	Medicaid Only	Dual	Medicaid Only	Dual
Extra Hearing Services Hearing aid allowance limited to $2,000 every year.	N/A	✓	N/A	✓
Healthy Eats Program Diabetic STAR+PLUS Non-HCBS waiver members can participate in the Healthy Eats Program and receive a $50 gift card each quarter to obtain nutritious food.	✓	✓	✓	N/A
Delivered Meals Receive up to 14 healthy meals delivered to their home after being discharged from a hospital or nursing facility for STAR+PLUS non-HCBS waiver members 21 and older.	✓	✓	N/A	N/A
Meal Planning Four additional nutritional counseling/meal planning services for diabetic STAR+PLUS non-HCBS waiver members 21 and older.	✓	✓	N/A	N/A
Health Get Fit Program or a Home Fitness Kit STAR+PLUS Non-HCBS waiver members have a choice of the El Paso Health Get Fit Program at the YMCA or a home fitness kit, or both.	N/A	✓	N/A	✓
Care Kit Receive a free personal blanket, skid proof socks, an accessory tote bag, and a large print digital clock.	N/A	N/A	N/A	✓
Gift Programs Members are eligible to receive a $25 gift card as a Thank You from El Paso Health for completing the following Preventative Screenings:	✓	✓	✓	✓

- $25 gift card for members after completing an annual wellness exam each year.
- $25 gift card for members that get an annual flu shot and COVID-19 vaccine.
- $25 gift card for members who have a follow-up doctor visit within 30 days of getting out of the hospital once a year.
- $25 gift card for members after completing an HbA1c blood test each year.
- $25 gift card for members after completing a diabetic eye exam each year.
- $25 gift card for female members ages 21-64 who get a recommended cervical cancer screening once every three years.
- $25 gift card for members that complete a doctor follow-up visit within 30 days of hospital discharge for a mental illness condition. Limit one gift card every 30 days.

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IMPORTANT NOTICE TO MEMBERS

If you have any questions or need help, please call our Member Services Department at **1-833-742-3127** from 8 A.M. to 5 P.M. Mountain Time, Monday thru Friday. For the hearing impaired (TTY), dial 711. We can provide you with written or oral interpretation of the services provided. Call us toll free at **1-833- 742-3127** 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 **1-833-742-3127** de 8 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 **1-833-742-3127** para asistencia técnica y servicios, incluyendo material en otro formato.

MEMBER HANDBOOK

Introduction to El Paso Health's STAR+PLUS Program

Thank you for choosing El Paso Health!

El Paso Health is happy to welcome you to our El Paso Health family. You will get 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 and El Paso Health STAR+PLUS Program, work in partnership with you to provide for you and your families' health care needs.

El Paso Health is a Health Maintenance Organization that provides services to people eligible for the health plan. 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 is a managed health care program. Managed care allows you to pick your primary care provider. This primary care provider could be a doctor, nurse practitioner, or a physician assistant. For this handbook, we will call the primary care provider "doctor or primary care provider (PCP)."

The biggest advantage of managed care is that you will have your own doctor. This doctor makes sure you get all the health care you need. It is not up to you to find the services and arrange for those services. You have a doctor who will give you the information you need to make good choices about your treatment.

Important Telephone Numbers and Information

Our Address

EL PASO HEALTH
1145 Westmoreland Dr.
El Paso, Texas 79925
"Toll-Free" **1-833-742-3127**
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 8 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 **1-833-742-3127**.

The Member Handbook will be made available in audio, larger print, braille, and other languages. Please contact Member Services if you need it in one of these formats.

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 you or your child if you/he/she does not have one.
- Help you find a doctor close to your home.
- Help you change you or 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.
- Inform you of what to do in case of an emergency.
- You can also call **1-833-742-3127** to learn more about Service Coordination

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

What should I do if I have an emergency?

Call 911 or go to your nearest hospital/emergency facility, if you think you need emergency care. You can call 911 for help in getting to the hospital emergency room. If you receive emergency services, call your doctor to schedule a follow-up visit as soon as possible. Remember to call El Paso Health at **1-833-742-3127** and let us know of the emergency care you/your child received. El Paso Health defines an emergency as a condition in which you think you/your child has a serious medical condition, or not getting medical care right away will be a threat to you/your child's life, limb or sight.

After Hours Answering Service

If you call after regular business, weekend, and holiday hours, your phone call will still be answered. We have bilingual staff working during the evening hours that can give you information, or take your message and have someone from our Member Services Department call you the next working day. Our phone number is **1-833-742-3127**.

Behavioral Health Services Hot-line

El Paso Health also has Behavioral Health Services. These services are for an emotional, alcohol, or drug problem. If you need help accessing these services or have an emergency/crisis, please call our 24 hour day/7 days a week, crisis hot-line at **1-877-377-2950** or call **911**. A trained representative, fluent in both English and Spanish will be there to help you. Interpreter services are also available. You do not need a referral to get help for Behavioral Health Services.

24-hour Nurse Line

You can call our toll-free 24-hour Nurse Line 24 hours a day, 7 days a week at 1-844-549-2826 (TTY 711). The line is staffed with healthcare professionals who are bilingual. Interpreter services are available for other languages. They will help you decide what kind of care you need and recommend that you do one or more of the following:

- Stay at home
- Go see your doctor the next day
- Go to an after-hours/night clinic or urgent care
- Go to the emergency room
- Call 911

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 **1-833-742-3127**.

TTY Line for the Hearing Impaired (information on the availability of Service Coordination (STAR+PLUS)

For the hearing impaired, dial **711** (TTY)Transportation.

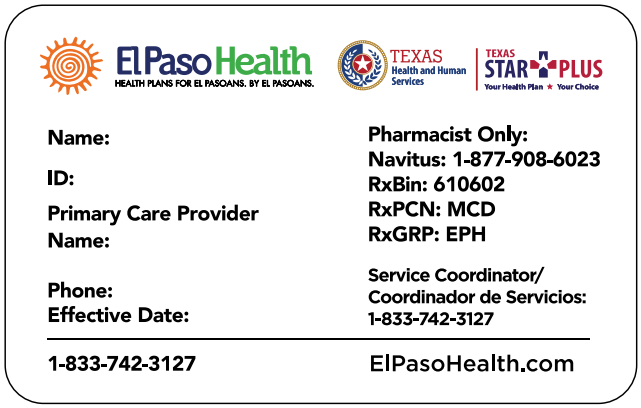
Non-Emergency Medical Transportation (NEMT) Services and "Where's My Ride?"

- NEMT and Where's My Ride? services are available 24 hours a day, 7 days a week and 365 days a year.
- Members can access NEMT services by calling Access2Care at **1-855-584-3530** to schedule a transportation appointment.
- Access2Care Call Center Representatives consists of highly qualified and trained individuals, fluent in both English and Spanish. You can reach Access2Care representatives for information toll-free at **1-855-584-3530**.
- Access2Care interpreter services are available at **1-855-584-3530**.
- Access2Care toll free TTY phone number is **711**.

Other helpful numbers:

- The STAR+PLUS Program Helpline number is **1-800-964-2777.**
- For Non-Emergency Medical Transportation (NEMT) Services call Access2Care at **1-855-584-3530.**
- For Where's My Ride call **1-855-584-3530**.
- For questions regarding Eye Care Services, please call **1-833-742-3127**.
- Ombudsman Managed Care Assistance Team **1-866-566-8989**;
- Medicaid Managed Care Helpline TDD# **1-866-222-4306**.
- For pharmacy information, please call El Paso Health at **1-833-742-3127**.
- For questions about Dental Services call:
  Liberty Dental **1-866-975-2435**
- United Health Care **1-877-901-7321**
- Finding Help in Texas, please call **2-1-1**. (STAR=PLUS Help line)

El Paso Health Identification Card



When you become a member of El Paso Health, you will get an El Paso Health ID card. This card will show important information about you, and the name and phone number of your primary care provider (PCP). Carry your ID card and the Your Texas Benefits Medicaid Card with you at all times. You must show both when you get medical care or medicine.

You will not get a new El Paso Health ID card every month. El Paso Health will mail you a new ID card when:

- You change your Primary Care Provider
- Your Primary Care Provider's address or phone number changes
- You get a new address or phone number

If you lose your ID card, you will need to ask for a new one. Call El Paso Health Member Services Helpline at **1-833-742-3127**.

Your El Paso Health ID card shows:

- The Name of the Health Plan – El Paso Health
- Member Name – This is your name
- Member Number – This is your Medicaid ID Number
- DOB – This is your birth date
- Name, address, and phone number of your Primary Care Provider – This is your Primary Care Provider's information. You should call your Primary Care Provider for all medical needs.
- The back of the ID card has important information for you and your Primary Care Provider. Remember to call the Primary Care Provider listed on the front of your card for appointments. Call your Primary Care Provider before going to a special doctor (specialist). It also has information on Behavioral (mental) Health and Substance Abuse Helpline **1-877-377-2950**. You can call this number 24 hours a day if you have questions or problems about behavioral (mental) health and substance abuse (such as alcohol or drugs) and it also tells you what to do in an emergency. Be sure to read the back of your card. There is important information which will be used by your Primary Care Provider and other health care providers.
- The front of the ID card also has some important phone numbers. Member Services Helpline (**1-833-742-3127**) – You can call this number 24 hours a day if you have questions or problems about El Paso Health. Call this number if you want to change your Primary Care Provider.

Remember to show the Your Texas Benefits Medicaid Card and El Paso Health ID card whenever you go to the doctor or get any other health care.

If you lose your card or did not get one, call El Paso Health Member Services Helpline right away. Call **1-833-742-3127** to get a new ID card.

Your Texas Benefits (YTB) Medicaid Card

When you are approved for Medicaid, you will get a YTB Medicaid Card. This plastic card will be your everyday Medicaid card. You should carry and protect it just like your driver's license or a credit card. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.

You will be issued only one card and will receive a new card only if your card is lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free **1-800-252- 8263**, or by going on-line to order or print a temporary card at **www.YourTexasBenefits.com**.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at **1-800- 252-8263**. You can also call 2-1-1. First pick a language and then pick option 2.

Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your medical and dental information through the secure on-line network, call toll-free at **1-800-252-8263** or opt out of sharing your health information at **www.YourTexasBenefits.com**.

The YTB Medicaid card has these facts printed on the front:

- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - — Medicare (QMB, MQMB)
  - — Healthy Texas Women Program (HTW)
  - — Hospice
  - — STAR Health
  - — Emergency Medicaid, or
  - — Presumptive Eligibility for Pregnant Women (PE).
- Facts your drug store will need to bill Medicaid.
- The name of your doctor and drug store if you're in the Medicaid Lock-in program.

The back of the YTB Medicaid card has a website you can visit **(www.YourTexasBenefits.com)** and a phone number you can call toll-free **(1-800-252-8263)** if you have questions about the new card.

If you forget your card, your doctor, dentist, or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

The YourTexasBenefits.com Medicaid Client Portal

You can use the Medicaid Client Portal to do all of the following for yourself or anyone whose medical or dental information you are allowed to access:

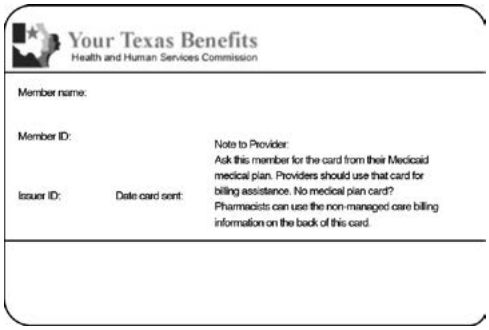
- View, print, and order a YTB Medicaid card
- See your medical and dental plans
- See your benefit information
- See STAR and STAR Kids Texas Health Steps alerts
- See broadcast alerts
- See diagnoses and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see your available medical and dental information

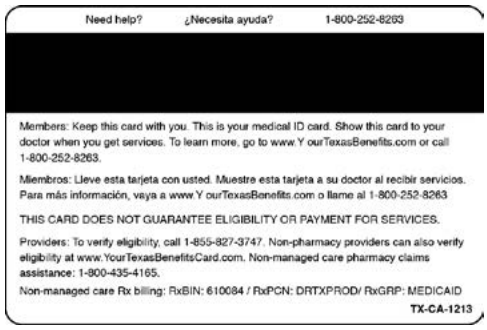
To access the portal, go to **www.YourTexasBenefits.com**.

- Click **Log In**.
- Enter your User name and Password. If you don't have an account,
- click **Create a new account**.
- Click **Manage**.
- Go to the "Quick links" section.
- Click **Medicaid & CHIP Services**.
- Click **View services and available health information**.

Note: The **YourTexasBenefits.com** Medicaid Client Portal displays information for active clients only. A Legally Authorized Representative may view the information of anyone who is a part of their case.

Your Texas Benefits Medicaid ID Card





Front of the card:

This is where your name appears.

This is your Medicaid ID number.

This is HHSC's agency ID number. Doctors and other providers need this number.

This is the date the card was sent to you.

Back of the card:

This message is for you.

This reminds your doctor to make sure you are still in the Medicaid program before giving you services.

These messages help doctors and providers get paid for the Medicaid services they give you.

Information on how to obtain a temporary verification form when the YTB Medicaid ID card is lost or stolen—Form 1027-A

The HHSC form 1027-A is called the Temporary Verification Form. It is to provide members who are eligible or may be eligible for Medicaid with a document verifying their eligibility. This form is only issued out when one of the following situations occurs:

- Has had his or her Medicaid eligibility related to foster care/adoption
- Has not had a Medicaid client number assigned
- His or her current Medicaid card has not been issued
- Has been lost or not accessible

Texas Department of Human Services/Form1027-A/1-2000

MEDICAID ELIGIBILITY VERIFICATION
CONFIRMACIÓN DE ELEGIBILIDAD PARA MEDICAID

	Name of Doctor/Nombre del Doctor	**Name of Pharmacy**/Nombre de la Farmacia

THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.
ESTA FORMA ES VÁLIDA SOLAMENTE EN LAS FECHAS INDICADAS ABAJO. NO ES VÁLIDA NI ANTES NI DESPUÉS DE ESTAS FECHAS.

☐ **Each person listed below has applied for and is eligible for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacist have 90 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filling deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.**

☐ **Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid identification form is lost or late. The client number must appear on all claims for health services.**

Date Eligibility Verified	**Verification Method** ☐ **Local DCU** ☐ **SAVERR Direct Inquiry** ☐ **Regional Procedure** ☐ **S.O DCU (A & D Staff Only)**	**BIN** 610098

CLIENT NAME NOMBRE DEL CLIENTE	**DATE OF BIRTH** FECHA DE NACIMIENTO	**CLIENT NO.** CLIENTE NÚM.	**ELIGIBILITY DATES** PERIODO DE ELEGIBILIDAD		**MEDICARE CLAIM NO.** NÚM. DE RECLAMO DE MEDICARE	**STAR/STAR+PLUS HEALTH PLAN INFORMATION** INFORMACIÓN DEL PLAN DE SALUD STAR/STAR+PLUS **Plan name and Member Services Toll-Free Telephone No.** Nombre del Plan y el Teléfono de Servicios para Miembros para Llarmar Gratis
			From/Desde	**Through**/Hasta		

I hereby certified, under penalty or perjury and/ are fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid identific d/or by imprisonment.
CAUTION: If you accept Medicaid benefits (services or supplies), you give an assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Por este medio certifico, bajo pena perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la Identificación para Medicaid (Forma 3087) del corriente mes. Solicité y recibí esta Confirmación de Elegibilidad Médica (Forma 1027-A) para comprobar nuestra elegibilidad para Medicaid durante el período cubierto específico arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude es castigable por una multa y/o la cárcel.

ADVERTENCIA: Si usted acepta beneficios de Mary Kate (servicios o artículos) otorga y concede al estado de Texas el derecho a recibir pagos por los servicios o artículos de otras compañías de seguros y otras fuentes responsables, hasta completar la cantidad que se requiere para cubrir lo que haya gastado Medicaid

Signature-Client or Representative/Firm-Cliente o Representate **Date**/Fecha

Office Address and Telephone No./Oficina y Teléfono

Name of Worker (type)/Nombre del Trabajador	**Worker BJN**	**WORKER SIGNATURE** X	**Date** ▸
Name of Supervisor* (type)/Nombre del Supervisor*	**Supervisor* BJN**	**SUPERVISOR SIGNATURE** X	**Date** ▸

***or Authorized Lead Worker**/*o Trabajador Encargado

Medicaid clients do not have to pay bills that Medicaid should pay. It is very important that you tell your doctor, hospital, drug store, and other healthcare providers right away that you have Medicaid. If you do not tell them that you have Medicaid you may have to pay these bills. If you get a bill from the doctor, hospital, or other healthcare provider, ask the provider why they are billing you. If you still get a bill call the Medicaid hotline at 1-800-252-8263 for help. If Medicaid will not pay the bill or if Medicaid benefits (services and supplies) are denied, you may request a fair hearing by writing to the address or calling the telephone number listed on the letter you get.

NOTE: Family planning clinics and other providers give free physical exams, lab test, birth control methods (including sterilization), and contraceptive conseling.

El cliente de medicate no tiene que pagar cuentas médicas que medicate debe pagar. Es muy importante que usted diga inmediatamente a su médico, al hospital, a la farmacia, y a otros proveedores de servicio médicos que usted tiene Medicaid. Si no les dice que tiene Medicaid ,puede que usted tenga que pagar estas cuentas. Si usted recibe una cuenta de un doctor, un hospital, u otro proveedor de servicios médicos, pregunte por qué le mandó la cuenta. Si todavía le mandan una cuenta, llame al número directo de Medicaid al 1-800-252-8263 para pedir ayuda. Si Medicaid no va a pagar la cuenta o si se niegan los beneficios de Medicaid (los servicios o los artículos), usted puede pedir por escrito una audiencia imparcial. La dirección y el número de teléfono aparece en la carta que recibió.

NOTA: Las clínicas de planificación familiar y los otros proveedores ofrecen gratis exámenes físicos, análisis de laboratorio, métodos anticonceptivos (inclusive la esterilización) y consejería sobre los anticonceptivos.

PROVIDER INFORMATION/INFORMACION PARA EL PROVEEDOR

Only those people listed under "CLIENT NAME" have Medicaid coverage. Payment is allowed ONLY for services received during the eligibility dates reflected on the front of this form.

PLEASE NOTE: Payment of Family Planning Services is available without the consent of the client's parent or spouse. Confidentiality is required. Family planning drugs, supplies, and services are exempt from the prescription drug and LIMITED restrictions.

Key to the terms that may appear on this form:

LIMITED—Except for the family planning services, and for Texas Health Steps (EPSDT), medical screening, dental, and hearing aid services, the client is limited to seeing the doctor **and/or** limited to using the pharmacy name on the form for drugs obtain through the Vendor Drug Program. In the event of an emergency medical conditions as defined below the "LIMITED" restriction does not apply.

EMERGENCY—The client is limited to coverage for an emergency medical condition. This means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (who possesses an average knowledge of health and medicine) would think that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health and serious jeopardy, (2) serious impairing to bodily functions, or (3) serious dysfunction of any bodily organ or part.

HOSPICE—The client is in hospice and waives the right to receive services related to the terminal condition through other Medicaid programs. If a client claims to have canceled hospice, call the local hospice agency or DHS to verify.

QMB—The Medicaid agency is providing coverage of Medicare premiums, deductibles, and coinsurance liabilities, but the client is not eligible for regular Medicaid benefits.

MQMB—the Medicaid agency is providing regular Medicaid coverage as well as coverage of Medicare premiums, deductibles, and coinsurance liabilities.

PE—Medicaid coverage only family planning and medically necessary outpatient services.

STAR/STAR+PLUS HEALTH PLAN—The client is enrolled in the Medicaid Managed Care program and is assigned to the health plan named on the form.

NOTE TO PHARMACY: Medicaid will pay more than three prescriptions each month for any Medicaid client who is under age 21, or lives in a nursing facility, or has the STAR/STAR+PLUS Health Plan, or get services through the Community Living Assistance and Support Services (CLASS), Community-Based Alternatives (CBA) and other non-SSI community-based waiver programs. Clients with Medicare who are enrolled in the STAR+PLUS may be limited to three prescriptions per month.

PRIMARY CARE PROVIDERS

What do I need to bring with me to my doctor's appointment?

When you need to see your Primary Care Provider, call his or her office ahead of time and make an appointment for a visit.

When you call, be ready to tell the receptionist about your health problem or question. It is important that you be on time to your 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 has a medical problem that needs attention the same day, call your Primary Care Provider immediately. Your Primary Care Provider will tell you what you need to do. You must take the **Your Texas Benefits Medicaid Card** and your **El Paso Health ID Card** with you when you get any healthcare services.

What is a Primary Care Provider?

Your main health care provider in non-emergency situations

Your Primary Care Provider is the first person to call when you have a health problem or you have a question about your health. Your Primary Care Provider will provide the care you need or direct you to someone else who can help you. STAR+PLUS Members who are covered by Medicare, no Primary Care Provider will be assigned.

Your Primary Care Provider's role is to:

- Provide preventive care and teach healthy lifestyle choices
- Identify and treat common medical conditions
- Make referrals to medical specialists when necessary

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

How can I change my Primary Care Provider?

If you decide later that the Primary Care Provider you chose for yourself or for your child does not meet your needs, you may call anytime to pick a different one.

To change your Primary Care Provider, call the El Paso Health Member Services Line at **1-833-742-3127**. 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 you. Our Member Services Representative will also tell you when you can start seeing your new Primary Care Provider.

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.

If your Primary Care Provider decides to leave El Paso Health and you are under treatment, we will arrange for your continued treatment with your Primary Care Provider until your treatment is complete or you have chosen a new Primary Care Provider that is qualified to treat your condition and is acceptable to you.

Can a specialist ever be considered a Primary Care Provider?

Yes! If you are a woman, you may pick an obstetrician (OB) or gynecologist (GYN) as your Primary Care Provider. Call El Paso Health at **1-833-742-3127** to find an OB/GYN Provider that is also a Primary Care Provider.

You will need to pick a Primary Care Provider for each eligible family Member. You can pick from:

- Pediatricians (they only see children)
- General/family practice (they see all ages)
- Internal medicine (they usually see adults)
- OB/GYNs (they see women)
- Federally Qualified Health Centers/ Rural Health Clinics (RHC/FQHC)

Can a clinic (RHC/FQHC) be my Primary Care Provider?

Yes! El Paso Health lets you pick a clinic as your Primary Care Provider. If you have any questions, call El Paso Health at **1-833-742-3127**.

How do I pick a new Primary Care Provider?

To pick a new Primary Care Provider, follow these simple steps:

- Look at the El Paso Health Primary Care Provider Directory.
- See who speaks your language.
- See who has an office in your neighborhood or if the Primary Care Provider's office is close enough for you to travel to.
- Pick your Primary Care Provider.

Once you pick a Primary Care Provider, call El Paso Health Member Services Helpline at **1-833-742-3127**. An El Paso Health ID card will be sent to you with the name and phone number of your Primary Care Provider.

Remember if you do not pick a Primary Care Provider, a Primary Care Provider will be picked for you. You can always call and pick a new Primary Care Provider if you don't want the one we selected for you.

Be sure to keep your El Paso Health Provider Directory. If you lose it, you may call the El Paso

Health Member Services Helpline at **1-833-742-3127**, to get a new copy.

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 **1-833-742-3127** or writing to:

El Paso Health
Member Services / Enrollment
1145 Westmoreland Dr.
El Paso, Texas 79925

When will my Primary Care Provider change become effective?

If you call to change your Primary Care Provider, the change will happen the day you call to make the change. Once you have changed you/your child's doctor, you will get a new El Paso Health Member ID card with their name and phone number on it.

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

- The Primary Care Provider you want is not taking new patients.
- The Primary Care Provider you want to change to is not part of El Paso Health.

Can my Primary Care Provider move me to another Primary Care Provider for non-compliance?

A provider may ask that you pick another Primary Care Provider if:

- You often miss visits without calling your Primary Care Provider to say you won't be there.
- You don't follow your Primary Care Provider's advice.
- You and the provider do not get along.
- You miss a lot of appointments.

If your Primary Care Provider requests a change, you will get a letter in the mail. You will be able to pick a new Primary Care Provider. If you do not pick a new Primary Care Provider, one will be picked for you.

Remember, for you to get the best health care, your Primary Care Provider needs to know your medical information. Your medical information is private: only you, your Primary Care Provider, and other authorized people can see them. If you change your Primary Care Provider, be sure to give your new Primary Care Provider any information so you can get the best care possible.

What if I choose to go to another doctor who is not my Primary Care Provider?

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.

But, you may go to any provider who takes Medicaid if you need:

- 24-hour emergency care from an emergency room
- Texas Health Steps
- Family Planning services and supplies

If you need mental health or substance abuse services you should call the Behavioral Health number on your ID card. That number is **1-877-377-2950**. Behavioral Health Services are very private so you do not need the permission of your Primary Care Provider to get these services.

If you need a routine vision exam, you do not need a referral. But if you have an eye problem, get a referral from your Primary Care Provider. Pick a Vision Provider from the El Paso Health Provider Directory. You must pick a provider from El Paso Health Directory.

If your Primary Care Provider sends you to another Primary Care Provider, he/she must give you medical care. If you see another doctor that your Primary Care Provider didn't send you to, you may have to pay your medical bills yourself. If you have questions about what providers you can see call the Member Services Helpline. The number is **1-833-742-3127**.

What is the Medicaid Lock-in Program?

You may be put in the Lock-in Program if you do not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same. Changing to a different MCO will not change the Lock-In status.

To avoid being put in the Medicaid Lock-in Program:

- Pick one drug store at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more, call El Paso Health at our toll-free number at **1-833-742-3127** or in case of an emergency.

PHYSICIAN INCENTIVE PLAN INFORMATION

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 your 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 **1-833-742-3127** to learn more about this.

CHANGING HEALTH PLANS

What if I want to change health plans?

You can change your health plan by calling the Texas STAR, STAR Kids, or STAR+PLUS Program Helpline at **1-800-964-2777**. You can change health plans as often as you want.

If you call to change your health plan 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, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

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

You may have to leave El Paso Health if:

- You let someone else use your El Paso Health card;
- You let someone else use Your Texas Benefits Medicaid Card;
- You don't follow your doctor's advice;
- You keep going to the emergency room when you do not have a true emergency;
- You cause problems at the doctor's office; or,
- You make it difficult for your doctor to help you or other people.

If there are any changes in your health plan, you will be sent a letter.

BENEFITS

What are my Medicaid Health Care Benefits?

El Paso Health gives you every covered service that you are entitled to get through Medicaid and sometimes more!

You get:

- 24-hour emergency care from an emergency room;
- ABA (Autism Services) for clients who are 20 years of age or younger when criteria is met.
- A checkup every year;
- Behavioral (mental) health services;
- Birthing center services;
- Chiropractic (back doctor) services;
- Dialysis (help from a machine) for kidney problems;
- Durable medical equipment and supplies (wheelchairs);
- Ear doctor visits and hearing aids;

- Family planning services and supplies (such as birth control);
- Foot doctor services;
- Help with substance abuse (such as alcohol or drugs);
- Home health services (health care at home);
- Hospital care with an "OK" from El Paso Health;
- Human Papillomavirus (HPV) vaccine is a benefit for males who are 9 through 45 years of age;
- Laboratory services;
- Mastectomy and breast reconstruction procedures;
- Needed medical care for adults and children;
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age;
- Prenatal care;
- Primary care services to help you stay well;
- Shots for children under 21 years old;
- Specialty physician services;
- Surgery without staying in the hospital overnight;
- The use of an ambulance, if you need it;
- Telehealth/Telemedicine
- Therapies – physical, speech, and occupational;
- Transplantation of organs and tissues (such as heart or kidney);
- Vision (eye exams and glasses);
- X-ray services.

How do I get these services?

Your Primary Care Provider together with El Paso Health can help you receive these services. Whenever you have a question about your health care services, call El Paso Health Member Services Department at **1-833-742-3127** , anytime between 8 a.m. to 5 p.m., Mountain Time. An El Paso Health Representative will always be ready to help you.

Are there any limits to any covered service?

Some services may require prior authorizations. For information on services that require prior authorization please call El Paso Health Member Services Department at **1-833-742-3127** .

What are my Long-Term Services and Supports (LTSS) benefits? STAR+PLUS information.

LTSS are services that are to help STAR+PLUS members that need help with everyday tasks like getting dressed, preparing meals, light housekeeping or personal care. The kind of care that you can get depends on the Medicaid eligibility category you're in:

- Other Community Care (OCC)
- Community First Choice (CFC)
- HCBS STAR+PLUS Waiver (SPW)

Some of the LTSS services include:

- Primary home care/personal assistance services
- Day activity and health services (DAHS)
- Minor home modifications
- Adaptive aids
- Adult foster care/personal home care
- Home delivered meals
- Assisted living

- Transition assistance services (for members leaving a nursing facility)
- Respite
- Supported employment

Will my STAR+PLUS benefits change if I am in a Nursing Facility?

- Yes. If you live in a nursing facility, most of your care will come from the nursing facility.

What number do I call to find out about these services?

- You can call El Paso Health Member Services department at 1-833-742-3127 anytime between 8 a.m. to 5 p.m. Mountain time for questions regarding Long-Term Services and Supports (LTSS) benefits available to you.

What are my acute care benefits?

Your Primary Care Provider together with El Paso Health can help you receive these services. Acute care benefits include:

- Routine doctor visits
- Preventive and specialist care
- Hospital care-
- Prescriptions
- Behavioral health services (inpatient or outpatient)
- Cancer screenings, diagnosis and treatment
- Dialysis
- Birthing services
- Audiology services
- Chiropractic services
- Family planning

You can call El Paso Health Member Services department at **1-833-742-3127** anytime between 8 a.m. to 5 p.m. Mountain time for questions regarding all acute care benefits available to you.

How do I get these services?

- You must first meet with your Service Coordinator to talk about what kind of help you need and qualify for. Call **1-833-742-3127** to find out more about these services.

What services are Not Covered by Medicaid?

There are health services that are not covered by Medicaid. The following are some examples:

- Any service that you don't need to have (is not medically necessary):
- Any service that your Primary Care Provider does not say is "OK"; or,
- Any service you get outside of the United States.
- Artificial insemination;
- Autopsies;
- Biofeedback therapy;
- Cosmetic surgery (such as a face-lift);
- Dentures or endosteal implants for adults;
- Ear piercing;
- Experimental medicines or procedures;
- Hair transplant;
- Healing using needles and pins (Acupuncture);
- Hospital bereavement;
- Hypnosis;
- Infertility treatment;

- Intersex surgery;
- Intragastric balloon for obesity;
- In-vitro fertilization;
- Marital counseling;
- Mastectomy for diagnosis of fibrocystic disease in the absence of documented risk factors;
- Medical documents and reports;
- Penile implant;
- Respite care;
- Reversal of sterilization;
- Non-authorized services.

What are my prescription drug benefits?

You get unlimited prescriptions through your Medicaid coverage if you go to a pharmacy in the El Paso Health network. There are some medications that may not be covered through Medicaid. An El Paso Health pharmacy can let you know which medications are not covered, or help you find another medication that is covered. You can also ask your doctor or clinic about what medications are covered, and what is best for you.

If you would like a copy of the drug formulary mailed to you, please call Member Services at **1- 833-742-3127**. Please note that there is no charge for the copy and drug formularies are updated every January and July.

What extra benefits do I get as a Member of El Paso Health?

As of September 1, 2024, STAR+PLUS Members can receive the following Value Added Services:

Value-added Service

Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual medical advice infoline staffed by nurses, pharmacists, and a Medical.

A free ride service to help you get to appointments, health education classes, non-medical drivers of health locations, or Member Advisory Group meetings that are not covered under the NEMT benefit.

Dental check-ups, x- rays, cleanings, fillings and simple tooth extractions for members 21 and older for STAR+PLUS non-HCBS waiver members.

- **Dual eligible members** receive up to $2,000 each year for dental check-ups, x-rays, cleanings, fillings and simple tooth extractions for members 21 and older for STAR+PLUS non-HCBS waiver members.
- **Medicaid only members** receive up to $600 each year for dental check-ups, x-rays and cleanings (no extractions) for members 21 and older.

Eyewear allowance every year, includes one pair of eyeglasses (lenses and frames) or contact lenses. One routine eye exam per year.

- **Medicaid only members** get $150 allowance every two years to be used on one pair of eyeglasses (lenses and frames) or contact lenses and get one routine eye exam every two years
- **Dual eligible members receive** a $300 yearly allowance and get one routine eye exam per year.

Twelve (12) additional routine foot doctor (podiatry) visits each year. Dual coverage members receive 12 additional routine foot doctor (podiatry) visits per year.

Up to $140 once a year: $35 gift card every three months for over-the-counter medicines and other medical or health-related supplies not covered by Medicaid, upon request.

El Paso Health Members ages 18 years and older eligible for the Federal Lifeline Program and Affordable Connectivity Program are offered at no cost to the member the exclusive El Paso Health Unlimited Plan.

Emergency response services for STAR+PLUS non-HCBS waiver members age 21 and older.

Up to an extra 40 hours respite services for STAR+PLUS non-HCBS waiver members age 21 and older.

Hearing aid allowance limited to $2,000 every year. Dual coverage members can receive a hearing aid allowance limited to $2,000 every year.

Diabetic STAR+PLUS Non-HCBS waiver members can participate in the Healthy Eats Program and receive a $50 gift card each quarter to obtain nutritious food.

Receive up to 14 healthy meals delivered to their home after being discharged from a hospital for STAR+PLUS non-HCBS waiver members 21 and older.

Four additional nutritional counseling/meal planning services for diabetic STAR+PLUS non-HCBS waiver members 21 and older.

STAR+PLUS Non-HCBS waiver members have a choice of the El Paso Health Get Fit Program at the YMCA or a home fitness kit, or both, for members with dual coverage only.

$25 gift card for members after completing an annual wellness exam each year.

$25 gift card for members that get an annual flu shot and COVID-19 vaccine.

$25 gift card for members who have a follow-up doctor visit within 30 days of getting out of the hospital once a year.

$25 gift card for members after completing an HbA1c blood test each year.

$25 gift card for members after completing a diabetic eye exam each year.

$25 gift card for female members ages 21-64 who get a recommended cervical cancer screening once every three years.

$25 gift card for members that complete a doctor follow-up visit within 30 days of hospital discharge for a mental illness condition. Limit one gift card every 30 days.

How do I get these benefits?

For more information on how to get these benefits please call the El Paso Health Member Services Help Line at **1-833-742-3127**.

What health education classes does El Paso Health offer?

Our health education classes are prepared with your family's health in mind. If you or your child has asthma, diabetes or you are pregnant, one of our nurse case managers 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 **1-833-742-3127**

What other services can El Paso Health help me with?

El Paso Health wants to link you to quality healthcare and social services. This is the goal of the El Paso Health Outreach Coordinators/Promotoras. The El Paso Health Outreach Coordinators/ Promotoras teach you how to use El Paso Health services. They can visit you at home, talk to you on the phone or send you information by mail. They can help you with things like:

- How to pick a Primary Care Provider
- Transportation Services
- How to use El Paso Health Services
- How to use your Member Handbook
- Texas Health Steps
- DSHS Case Management for Children and Pregnant Women / DSHS Targeted

Case Management

- Preventive, Urgent and Emergent Care
- Visits to Specialists
- Complaint and Appeal Procedures
- Disenrollment Procedures

El Paso Health Outreach Coordinators/Promotoras can provide you with resources to help you get food, housing, clothing and utility services.

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

- Living arrangements
- Employment
- Job training
- Food
- Access to public schools

For more information, please call Member Services at **1-833-742-3127** .

We also invite our members to visit our office located at 1145 Westmoreland Dr., El Paso, TX 79925. Our Resource Center is inside our office—we have a selection of health information brochures and applications. You can also call our Member Services Department to request an application or health information by mail.

Please call the Member Services Department at **1-833-742-3127**, for more information about any of these value-added services.

HEALTH CARE AND OTHER SERVICES

What does "Medically Necessary" mean?

***Medically Necessary* means:**

(1) For Members birth through age 20, the following Texas Health Steps services:
  (a) screening, vision, and hearing services; and
  (b) other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
    (i) must comply with the requirements of the Alberto N., et al. v. Traylor, et al. partial settlement agreements; and
    (ii) may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.

(2) For Members over age 20, non-behavioral health related 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 handicap, 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 diagnoses of the conditions;
  (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

(3) For Members over age 20, behavioral health services that:
  (a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
  (b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
  (c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
  (d) are 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) are not experimental or investigative; and
  (g) are not primarily for the convenience of the member or provider.

What is Routine Medical Care?

Routine medical care involves regular checkups by your Primary Care Provider and treatment by him or her when you are sick. During these regular visits, your Primary Care Provider can give you prescriptions for medicine, and send you to a special doctor (specialist) if you need one.

It is important that you do what your Primary Care Provider says and that you take part in decisions made about your health care. If you cannot make a decision about your health care, you can pick someone else to do it for you.

How soon can I expect to be seen?

When you need to see your Primary Care Provider, call the Primary Care Provider at the number on your El Paso Health 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 visits, and call back if you need to cancel. If more than one member of your family needs to see the doctor, you need an appointment for each person.

Your doctor is available 24 hours a day either in person or by telephone. If your doctor is not available, he or she will have another doctor available for you. This includes weekends and holidays. For routine medical care, your Primary Care Provider should see you within two weeks. If you have a condition that needs medical attention the same day, your Primary Care Provider can help you with that.

What is Urgent Medical Care?

Another type of care is urgent care. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

- Minor burns or cuts
- Earaches
- Sore throat
- Muscle sprains/strains

What should I do if my child or I need urgent medical care?

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes El Paso Health Medicaid. For help, call at **1-833-742-3127**.

If you want to speak with a healthcare professional to help you decide if you or your child need urgent medical care, you can call El Paso Health's Nurse Line (First Call) at **1-844-549-2826** 24-hours a day, 7 days a week.

How soon can I expect to be seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take El Paso Health Medicaid.

What is Emergency Medical Care?

Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

<u>Emergency Medical Condition</u> means:

A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

(1) placing the patient's health in serious jeopardy;
(2) serious impairment to bodily functions;
(3) serious dysfunction of any bodily organ or part;
(4) serious disfigurement; or
(5) in the case of a pregnant women, serious jeopardy to the health of a woman 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 a prudent layperson, possessing average knowledge of medicine and health:

(1) requires immediate intervention and/or medical attention without which the Member would present an immediate danger to themselves or others; or
(2) which renders the Member incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Services and Emergency Care means:

Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or Emergency Behavioral Health Condition, including post-stabilization care services.

You have an **EMERGENCY** medical need if you think your condition is life threatening, if you have serious pain or if serious harm could come to you without immediate medical attention.

Examples of when to go to the emergency room are:

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

How soon can I expect to be seen?

Go to the nearest hospital if you think you have any of these problems. You may call **911** for assistance in getting to the hospital emergency room. **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 **1-833-742-3127** , as soon as you can. If you are not able to make the phone call, a family member or friend may call for you. If the nearest hospital is not an El Paso Health contracted hospital, you 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 **1-833-742-3127** .

If you have an emergency when you are traveling outside the service area, you are still covered for emergency care, even when you are outside of the state of Texas. If you have an emergency situation outside the state of Texas, go to the closest hospital. Then call your Primary Care Provider and El Paso Health as soon as possible. El Paso Health will cover your emergency room treatment outside of the state as long as it is a true emergency.

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

Most medical problems do not need emergency care. You should call your Primary Care Provider whenever you have one of the following problems.

- 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

Are emergency dental services covered by the health plan?

El Paso Health covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

- Treatment for dislocated jaw.
- Treatment for traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Hospital, physician, and related medical services such as drugs for any of the above conditions.

What do I do if 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 **1-833-742-3127** or call **911**.

What is post-stabilization?

Post-stabilization care services are services covered by Medicaid that keep your condition stable following emergency medical care.

How do I get medical care after my Primary Care Provider's office is closed?

Go to your Primary Care Provider during office hours when you can. Do not wait until evening to call. Most illnesses get worse as the day goes on. If you get sick at night or on a weekend,and you feel you cannot wait to get health care, call your Primary Care Provider. Your Primary Care Provider or another provider that your Primary Care Provider works with is ready to help you 24 hours a day, 7 days a week. This person will talk to you and tell you what to do.

What if I get sick when I am out of town or traveling?

If you need medical care when traveling, call us toll-free at **1-833-742-3127** and we will help you find a doctor. If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-833-742-3127**.

What if I am out of state?

If you get sick while you are out of state, call your Primary Care Provider or the Member Services Helpline at **1-833-742-3127** . If you have a true emergency, go to the closest emergency room or provider to get health care right away.

What if I am out of the country?

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

What if I need to see a special doctor (specialist)?

For most healthcare services, your Primary Care Provider will be the only one you will need to see. But if you have a special health condition, your Primary Care Provider may arrange for you to see a special doctor (specialist). This is a doctor who has the special skills needed to treat you. In that case, your Primary Care Provider will give you a form (referral) to take to the specialist.

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."

How soon can I expect to be seen by a specialist?

Call the specialist to make an appointment. If you have an urgent situation, the specialist should see you within 24 hours. For routine care, the specialist should see you within two weeks.

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.

Some specialists include:

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

REMEMBER that the specialist can give you only those services requested by your Primary Care Provider on the referral form.

The referral is good for a limited number of days. If the specialist says you will need more visits or another referral, the specialist should call your Primary Care Provider or El Paso Health to make sure the added care will be covered.

What services do not need a referral?

You can get certain types of services without a referral from your Primary Care Provider. Please refer to our El Paso Health Provider Directory for specific doctors.

- 24-hour emergency room care from an emergency room
- Family planning services and supplies
- Behavioral (mental) health and substance abuse services
- OB/GYN care

If you have questions, or need help to make an appointment, you can call Member Services at **1-833-742-3127** .

How can I request a second opinion?

You may go back to your Primary Care Provider or clinic and request to be referred to another doctor for a second opinion or you can reach El Paso Health at **1-833-742-3127** and a Member Services Representative will help you.

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

El Paso Health can help you get help for mental health problems and drug abuse. You can also go to a mental health doctor without a referral from your Primary Care Provider. A group of doctors developed by El Paso Health provides these services. Call us for help. Our number is **1-833-742-3127** .

Do I need a referral for this?

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.

The 24-hour toll free number is **1-877-377-2950**. You will not get a recording. A trained person will answer the phone and arrange treatment, no matter what time of day or night you call.

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 **1-877-377-2950**. A trained person will be there to help you.

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

What are mental health rehabilitation services and mental health targeted case management?

These are services provided to members with serious emotional disturbance or severe and persistent mental illnesses that can benefit from medication management, skills training, and targeted case management.

How do I get these services?

No referral is needed for these services. Behavioral Health providers are listed in the Provider Directory or contact your local mental health authority—Emergence Health Network at **915-887-3410.**

How do I get my medications?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

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 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 the Your Texas Benefits Medicaid Card and your El Paso Health ID card.

What if I need my medications delivered to me?

El Paso Health Members may choose to have maintenance drugs sent to their homes instead of filling prescriptions at a local retail drug store.

Who do I call if I have problems getting my medications?

Please call El Paso Health, and we will gladly help you.

What if I can't get the medication my doctor ordered approved?

If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication. Call El Paso Health at **1-833-742-3127** for help with your medications and refills.

What if I lose my medication(s)?

Please call El Paso Health, and we will gladly help you.

What if I also have Medicare?

If you have Medicare prescription drug benefits, your Medicare plan will provide your prescriptions. If they do not cover your medicine, Medicaid may pay for it.

How do I get my medications if I am in a Nursing Facility?

Most of the medications prescribed by your physician will be paid by Medicaid. Your doctor will send your prescription to the nursing facility and they will give it to you as prescribed. (If you have Medicare prescription drug benefits, your Medicare plan will pay for your prescriptions).

What if I need durable medical equipment (DME) or other products normally found in a pharmacy?

Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all members, El Paso Health pays for nebulizers, ostomy supplies, andother covered supplies and equipment if they are medically necessary. For children (birth through age 20), El Paso Health also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call El Paso Health Member Services Department at **1-833-742-3127** for more information about these benefits.

How do I get family planning services?

Family planning services (such as birth control and counseling) are very private. Call a family planning provider to get these services.

Do I need a referral for this?

You do not need to ask your Primary Care Provider for a referral to get these services or supplies. You can go to any provider who takes Medicaid. If you are under 21, you do not have to ask your parents before getting help.

Where do I find a family planning services provider?

You can find the locations of family planning providers near you on-line at **http://www.dshs.state.tx.us/famplan/default.shtm**, or you can call El Paso Health Member Services Help line at **1-833-742-3127** for help in finding a family planning provider.

What is Case Management for Children and Pregnant Women (CPW)?

Case Management for Children and Pregnant Women (CPW) is a case management program that provides health related case management services to Medicaid eligible children with a health condition or health risk and high-risk pregnant women.

Case Management for Children and Pregnant Women

Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- Have health problems, or
- Are at a high risk for getting health problems.

What do case managers do?

A case manager will visit with you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?

Case managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you get a case manager?

Contact El Paso Health for more information or call Texas Health Steps at **1-877-847-8377**(toll free). Monday to Friday 8 a.m. to 8 p.m.

- El Paso Health **1-833-742-3127** Hours: 8 a.m. to 5:00 p.m.
- **http://www.elpasohealth.com/**

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**

What is Case Management for Members with Special Health are Needs (MSHCN)?

Case Management is a collaborative process of assessment, planning, facilitation, care coordination,evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. (Case Management Society of America)

What will a Case Manager do for me?

El Paso Health case managers will assist members with coordination of services that includes but is not limited to:

- identification of needs, including physical and mental health services;
- development of a Service Plan to address identified needs;
- provide assistance to ensure timely and coordinated access to an array of providers and Covered Services;
- attention to addressing unique needs of Members;
- coordination of Covered Services and Non-capitated Services, as necessary and appropriate; and,
- collaborating with Primary Care Providers and specialist to ensure appropriate and timely coordination of care is provided.

How can I talk to a Case Manager?

Members can speak to a Case Manager by calling El Paso Health at **1-833-742-3127**.

What is Service Coordination?

Service Coordination is a team that may include doctors, nurses, counselors or other health professional that will help you get the care you need.

What will a Service Coordinator do for me?

Your Service Coordinator will help you manage all your providers and services to make sure you get the services and care you need.

How can I talk with a service Coordinator?

Call the Service Coordination line at **1-833-742-3127** or **711**(TTY) Monday -Friday from 8 a.m. to 5 p.m. MST.

How can I get Service Coordination?

When you enroll in El Paso health, you will be assigned a Service Coordinator. They will arrange your service coordination.

Does my doctor have to be part of the El Paso Health network?

Your child may go to any Medicaid provider for Texas Health Steps services. Most of the El Paso Health Primary Care Providers who work with children are also able to offer Texas Health Steps services. You may want to talk to your child's Primary Care Provider first. Also, don't forget to show your El Paso Health ID card and the Your Texas Benefits Medicaid Card to the provider. Call first to make an appointment for each family member who needs to be seen. Call if you cannot make your appointment. Some Primary Care Providers ask patients to call at least 24hours before their appointment so that another patient can use that time slot.

Do I have to have a referral?

You do not need a referral from your primary care provider for any texas health steps services.

What if I need to cancel an appointment?

If you need to cancel an appointment with your doctor, please call the doctor's office as far in advance as possible. Please make sure to re-schedule your appointment as soon as possible. It is important to keep your children up-to-date on their check-ups.

What if I am out of town and my child is due for a Texas Health Steps exam?

If you are out of town or you moved you may also go to any Texas Medicaid Provider in the area for Texas Health Steps Services.

What if I am a Migrant Farmworker?

You can get your checkup sooner if you are leaving the area.

A migrant worker is a person who works on farms in fields or as a food packer during certain times of the year. Migrant workers usually move to different places to follow the crops. El Paso Health can help migrant families to:

- Learn about their benefits
- Get the health care services they need
- Get Texas Health Steps Dental and Physical Exams

Please call El Paso Health Member Services at **1-833-742-3127**.

What Non-Emergency Medical Transportation (NEMT) Services are available to me?

Non-Emergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provide transportation to non-emergency health care appointments for members who have no other transportation options. These trips include rides to the doctor, dentist,hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

What services are part of NEMT Services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.(Based on medical necessity)
- Demand response transportation services, which is curb-to-curb transportation: in private buses, vans, or sedans, including wheelchair-accessible vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) to a covered healthcare service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor. (ITP packet must be completed 30 days prior to request)
- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day, per person.
- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services.

If you need an attendant to travel to your appointment with you, NEMT services will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years old must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adults on file to travel alone. Parental consent is not required if the health care service is confidential in nature.

How to get a ride?

Your MCO will provide you with information on how to request NEMT services. You should request NEMT Services as early as possible, and at least 48 hours before you need the NEMT service. In certain circumstances you may request the NEMT service with less than 48 hours' notice. These circumstances include being picked up after being discharged from a hospital;trips to the pharmacy to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

If your medical appointment is canceled or rescheduled, please call 1-855-584-3530 to cancel or change transportation arrangements.

If your Primary Care Provider made an appointment for you out of town and you need transportation assistance, it must be approved by the health plan. If approved, call to make arrangements at least 5 days before your appointment.

If you do not call within these time frames, you may be asked to reschedule your appointment

How do I get eye care services?

You have eye care benefits. You don't need a referral from your doctor for these benefits. Please call Member Services at 1-833-742-3127 for help finding an eye doctor (optometrist) in the plan near you. Young adults age 18–20 get coverage for a vision exam once every 12 months and medically necessary frames and lenses or contact lenses once every 24 months, or when otherwise medically necessary. Adult members ages 21 years and older get coverage for a vision exam and medically necessary frames and lenses or contact lenses every 24 months.

YOU DO NOT NEED A REFERRAL FROM YOUR PRIMARY CARE PROVIDER

FOR ANY TEXAS HEALTH STEPS SERVICES.

What dental services does El Paso Health cover for children?

El Paso Health covers emergency dental services in a hospital or ambulatory surgical center,including, but not limited to, payment for the following:

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

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

El Paso Health is also responsible for paying for treatment and devices for craniofacial anomalies.

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

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

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

Who do I call for an interpreter?

For this service, please call the Member Services Helpline, at least 24 hours in advance, at **1-833-742-3127**.

How far in advance do I need to call?

Please call and schedule this service at least 24 hours in advance.

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

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

What if I need OB/GYN care?

ATTENTION FEMALE MEMBERS

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

You have the right to pick an OB/GYN without a referral from your 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 within the network.

How do I pick an OB/GYN?

To pick an OB/GYN as your Primary Care Provider, just call our Member Services Helpline **1-833-742-3127**, and let us know who you want to pick as your OB/GYN. Remember that you have to pick from the OB/GYN providers listed in the El Paso Health Provider Directory.

If I do not choose an OB/GYN, do I have direct access?

Yes, you can have direct access. You don't have to pick an OB/GYN as your Primary Care Provider,but if you are pregnant, you should pick an OB/GYN to take care of you and your unborn baby.

How soon can I be seen after contacting my OB/GYN for an appointment?

El Paso Health will help you get the prenatal care that you need within two weeks of your request.

Will I need a referral?

Again, you have direct access to an OB/GYN without a referral from your Primary Care Provider. If you need help, call El Paso Health at **1-833-742-3127**.

Can I stay with my OB/GYN if they aren't with El Paso Health?

If you have already been seen by an OB/GYN who is not part of the El Paso Health, you may be able to continue seeing that OB/GYN. If you are at least six months pregnant when you join El Paso Health you may keep seeing the OB/GYN who is already caring for you. You will not need to get a referral from your Primary Care Provider to keep seeing him or her. However, you will need to call a Nurse Case Manager at **1-833-742-3127**.

What if I am pregnant?

It is very important that you call El Paso Health to tell us you are pregnant and what doctors you are seeing (such as your OB/GYN). The number is **1-833-742-3127**. El Paso Health will help you get the prenatal care that you need within two weeks of your request.

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

El Paso Health offers pregnant member our First Steps Program. It offers:

- A nurse who helps with pregnancy-related questions
- A nurse and/or social worker who can help coordinate prenatal care
- A nurse and/or social worker who can help coordinate social services, mental health services, and provides referrals to community agencies
- Home visits by a nurse or social worker, if necessary
- A Monthly Prenatal Class/Baby Shower

As part of our Healthy Rewards, 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 in the first trimester or 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.

Where can I find a list of birthing centers?

To find a birthing center close to you, call Member Services at **1-833-742-3127**.

What services will El Paso Health provide me and my baby when I deliver?

El Paso Health must provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean delivery. El Paso Health must provide neonatal care for its newborn Members until the time of discharge.

El Paso Health cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services,regardless of when the emergency condition arises.

Can I pick a Primary Care Provider before my baby is born?

You may pick your baby's Primary Care Provider from the El Paso Health Primary Care Provider and Hospital List before your baby is born.

How and when can I switch my baby's Primary Care Provider?

After your baby is born, you will receive the Your Texas Benefits Medicaid Card. Your baby will be enrolled in El Paso Health for at least 90 days from the date of birth. Call us at **1-833-742-3127**to pick a Primary Care Provider for the baby. (If you called to choose your baby's Primary Care Provider before your baby was born, you do not need to call again.) If you do not pick a Primary Care Provider, one will be chosen for your baby.

If you decide later that the Primary Care Provider you pick for yourself or for your baby does not meet your needs, you may call anytime to pick a different one.

To change your Primary Care Provider, call the El Paso Health Member Services Line at **1-833-742-3127**. 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 you. Our Member Services Representative will also tell you when you can start seeing your new Primary Care Provider. Please do not change to a new Primary Care Provider without telling El Paso Health. If you goto a new Primary Care Provider without telling us, the services may not be covered.

Can I switch my baby's health plan?

For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at **1-800-964-2777**. You cannot change health plans while your baby is in the hospital.

If you call to change your health plan 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, your change will take place on May 1.
- If you call after April 15, your change will take on June 1.

How do I sign up my newborn baby?

When your baby is born, or as soon as possible, call your Health and Human Services caseworker so your baby can get Medicaid. It is important that you also call the El Paso Health Member Services Helpline at **1-833-742-3127**. Pick your baby's Primary Care Provider from the El Paso Health Primary Care Provider and Hospital List before your baby is born.

How and when do I tell my health plan?

Remember to call El Paso Health as soon as you can to report the birth of your baby. We will need to get information about your baby. We can help you pick a primary care provider for your newborn if you have not already done so.

How and when do I tell my caseworker?

After you have your baby, call 2-1-1 or your HHSC caseworker to tell them your baby was born.

How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)?

After your baby is born you may lose Medicaid coverage. You may be able to get some healthcare services through the Healthy Texas Women's Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

Healthy Texas Women Program

The Healthy Texas Women Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.

To learn more about services available through the Healthy Texas Women Program, write, call, or visit the program's website:

Healthy Texas Women Program
P.O. Box 14000
Midland, TX 79711-9902
Phone: 1-800-335-8957
Website: www.texaswomenshealth.org/
Fax: (toll-free) 1-866-993-9971

DSHS Primary Health Care Program

The DSHS Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program,a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a co-payment, but no one is turned down for services because of a lack of money. Primary Health Care focuses on prevention of disease, early detection and early intervention of health problems. The main services provided are:

- Diagnosis and treatment
- Emergency services
- Family planning
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home healthcare, dental care, rides to medical visits, medicines your doctor orders (prescription drugs),durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at **http://txclinics.com/**.

To learn more about services you can get through the Primary Health Care program, email, call,or visit the program's website:

Website: **www.dshs.state.tx.us/phc/**

Phone: 512-776-7796

Email: PPCU@dshs.state.tx.us

DSHS Expanded Primary Health Care Program

The Expanded Primary Health Care program provides primary, preventive, and screening services to women age 18 and above whose income is at or below the program's income limits(200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breast feeding.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/. To learn more about services you can get through the DSHS Expanded Primary Health Care program, visit the program's website, call, or email:

Website: **www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx**

Phone: **512-776-7796**

Fax: 512-776-7203

Email: PPCU@dshs.state.tx.us

DSHS Family Planning Program

The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men.

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at **http://txclinics.com/**.

To learn more about services you can get through the Family Planning program, visit the program's website, call, or email:

Website: **www.dshs.state.tx.us/famplan/**

Phone: **512-776-7796**

Fax: 512-776-7203

Email: PPCU@dshs.state.tx.us

Who do I call if I have special health care needs and need someone to help me?

If you have a special health care need, call our Member Services Department for help at **1-833-742-3127**.

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**.

What are advance directives?

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 healthcare.

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 healthcare 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.

How do I get an advance directive?

You can call the Member Services Helpline at **1-833-742-3127** 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 notable 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, psycho surgery, or abortion.

What do I have to do if I need help with completing my renewal application?

Don't lose your health care benefits. You could lose your benefits even if you still qualify.

Every 12 months, you'll need to renew your benefits. The Health and Human Services Commission (HHSC) will send you a packet about 60 days before the due date telling you it's time to renew your Medicaid benefits. The packet will have instructions to tell you how to renew. If you don't renew by the due date, you'll lose your health care benefits.

You can apply for and renew benefits on-line at YourTexasBenefits.com. Select Manage your account or applications and set up an account to get easy access to the status of your benefits. If you have any questions, you can call 2-1-1, pick a language and then select option 2 or visit the HHSC benefits office near you.

To find the office nearest your home, call 2-1-1 or you can go to YourTexasBenefits.com and select Find an Office at the bottom of the page.

El Paso Health can assist with applications and renewals at our office located at 1145 Westmoreland, El Paso, TX 79925. Call **1-833-742-3127** if you would like to schedule an appointment for us to help you.

You can also renew or update your information on YourTexasBenefits.com and select Manage your account or applications. Follow the directions there to renew.

We want you to keep getting your health care benefits from us if you still qualify.

Completing the Renewal Process

When children still qualify for coverage in their current program (Medicaid), HHSC will send the family a letter showing the start date for the new coverage period.

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.

What happens if I lose my Medicaid coverage?

If you lose Medicaid coverage but get it back again within six (6) months you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same Primary Care Provider you had before.

You may lose your membership in El Paso Health for one of these reasons:

- You move out of El Paso or Hudspeth Counties, or
- You are no longer eligible for Medicaid

You must tell your Health and Human Services caseworker about any changes that affect your eligibility. Examples are changes in income, an address change, or other insurance coverage.

What if I get a bill from my doctor?

Who do I call?

If you get a bill from your doctor, you should call El Paso Health at **1-833-742-3127**. A Member Services Representative will be happy to help.

What information will they need?

Have your El Paso Health ID card and the bill ready.

Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid?

You cannot be billed for Medicare "cost-sharing," which includes deductibles, coinsurance, and co-payments that are covered by Medicaid.

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and El Paso Health Member Services Department at 1-833-742-3127. Before you get Medicaid 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. You will need to chose a plan in your new area.

What if I have other insurance in addition to Medicaid?

Medicaid and Private Insurance

You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hot-line and update your Medicaid case file if:

- Your private health insurance is canceled.
- You get new insurance coverage.
- You have general questions about third party insurance.

You can call the hot-line toll-free at **1-800-846-7307**.

If you have other insurance you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.48 Rights and Responsibilities.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.
   c. Be given information about your health, plan, services, and providers.
   d. Be told about your rights and responsibilities.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and State Fair Hearings.
   a. Make a Complaint to your health plan or to the state Medicaid program about your health care, your Provider, or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.

b. Get medical care in a timely manner.
c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

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. You have a right to know that doctors, hospitals, and others who care for you can advise you about your 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.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay co-payments or any other amounts for covered services.
10. You have a right to make recommendations to your health plan's member rights and responsibilities.

Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:a.
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a primary care provider quickly.
   c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.

Additional Member Responsibilities while using NEMT Transportation Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights on-line 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 toll-free at **1-833-742-3127** to tell us about your problem. An El Paso Health Member Services Advocate can help you file a complaint. Just call **1-833-742-3127**. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the El Paso Health complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission

Ombudsman Managed Care Assistance Team

P.O. Box 13247

Austin, Texas 78711-3247

If you can get on the Internet, you can submit your complaint at:

hhs.texas.gov/managed-care-help

What are the requirements and time frames for filing a Complaint?

There are no time frames to filing a complaint. You or your authorized representative may file a co plaint either verbally or in writing.

How long will it take to process my complaint?

Within (5) five business days of receiving your verbal or written complaint, we will send you an acknowledgment letter. The letter will confirm the day we received your complaint. El Paso Health will review the facts and will reach a decision within thirty (30) calendar days of receiving your complaint. A resolution letter will be sent to you.

Can someone from El Paso Health help me file a complaint?

If needed, El Paso Health Member Services Department will also help you with the formal complaint process. The complaint process involves a series of steps you can take when you are not happy with the solution to your concern. The Member Services Department can help you understand the complaint process, and then they can also help you go through the process,if you wish.

PROCESS TO APPEAL A STAR MEDICAID 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 it or limits it?

You or a representative can appeal El Paso Health's decision to deny or limit a service or medicine that is a covered benefit, or if El Paso Health fails to process your request within the time frames set forth by the state. You may request an appeal for denial of payment for services in whole or in part.

How will I find out if services are denied?

We will send you a letter.

Time frames for the appeals process.

El Paso Health must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a Member; or El Paso Health shows that there is a need for more information and how the delay is in the Member's interest. If El Paso Health needs to extend, the Member must receive written notice of the reason for delay.

Can I continue to receive my medical services that El Paso Health has already approved?

If El Paso Health already approved services for you, and you want to continue to get these services, you need to file your appeal on or before the later of: ten (10) Days following El Paso Health's mailing of the notice of the Action or the intended effective date of the proposed Action.

When do I have the right to ask for an Appeal?

You can request an appeal due to lack of medical necessity or for denial of payment for services in whole or in part.

Can someone from El Paso Health help me file 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 toll free at **1-833-742-3127**.

A Member has the right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination. Such information includes, but is not limited to, medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. For Expedited El Paso Health Internal Appeals the Member's case file will be provided to the Member within two Business Days upon El Paso Health receiving the Expedited El Paso Health

Internal Appeal request. A Member's case file will be provided to the Member within five Business Days upon El Paso Health's receipt of an internal El Paso Health appeals request that is not expedited.

You, your authorized representative or your Legally Authorized Representative (LAR) has the option to request and External Medical Review and State Fair Hearing no later than 120 days after the date El Paso Health mails the appeal decision notice. You also have the option to request only a State Fair Hearing Review no later than 120 Days after El Paso Health mails the appeal decision notice.

Can I have someone else file the appeal for me?

Yes. Your authorized representative or your Legally Authorized Representative can contact El Paso Health to file an appeal for you.

Is there a timeline for filing the appeal?

You will need to appeal within 60 days from when you receive your notice that your covered service(s) have been denied or limited.

How do I file the appeal?

You, your authorized representative or your Legally Authorized Representative (LAR) can submit your appeal in writing, by phone, fax or on-line at the following:

El Paso Health

Attention: Complaints and Appeals Department

1145 Westmoreland Drive

El Paso, TX 79925

Toll Free: **1-833-742-3127**

Fax No.: 915-298-7872

Online: **www.elpasohealth.com**

Appeals will be accepted orally or in writing by you, your authorized representative or your Legally Authorized Representative (LAR).

For written appeals you will need to give us the following information:

- A letter letting us know the reason you want to appeal
- A copy of the denial letter you received from El Paso Health
- Any new information that will help with your case

Who will review my appeal?

A doctor or dentist who has not looked at your request before will review your appeal.

What are the time frames for the appeal process?

We will let you know in writing in five (5) Days or less, that we received your appeal. The letter will tell you:

- The date we received the appeal.
- If we need any more information; which may lead to a different decision.

EMERGENCY EL PASO HEALTH INTERNAL APPEAL

What is an Emergency El Paso Health Internal Appeal?

An Emergency Appeal is when El Paso Health has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an Emergency El Paso Health Internal Appeal?

You can submit your Emergency 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

Toll Free: **1-833-742-3127**
Fax No.: 915-298-7872
Online: **www.elpasohealth.com**

Does my request have to be in writing?

No, El Paso Health will accept your request orally or in writing.

What are the time frames for an Emergency El Paso Health Internal Appeal?

An Emergency Appeal will be resolved within three (3) business days and if the appeal is for an ongoing emergency or you will remain in the hospital, it will take one (1) business day or less to make a decision. El Paso Health will need all the information for our Emergency Appeal.

What happens if El Paso Health denies the request for an Emergency El Paso Health Internal Appeal?

El Paso Health will let you know if we can treat your request as an Emergency Appeal or not.

If El Paso Health decides that your request should be treated as a Standard Appeal instead of an Emergency Appeal, we will let you know in two (2) days or less that your request will be treated as a Standard Appeal and the decision on a Standard Appeal will be made within thirty (30)days from the date of your appeal request.

El Paso Health will give your appeal to a doctor or dentist who has not looked at your request before, and knows the condition or disease you are appealing.

Who can help me file an Emergency El Paso Health Internal Appeal?

You can contact the Member Advocate or the Member Services Department at **1-833-742-3127**.

How will I find out if my appeal was denied?

We will let you know in writing. A letter will be mailed to you letting you know why we did not approve the services, what information we used, and what type of doctor reviewed your appeal. We will let you know as soon as possible, but no longer than thirty (30) Days from when we receive your appeal. The letter will let you know the reason for the decision and what information we used in making the decision.

- The reason for the decision
- What information we used in making the decision
- What type of doctor reviewed your appeal
- Your right to seek a Specialty Review
- Your right to ask for a State Fair Hearing
- What you need to do to request a State Fair Hearing
- What forms you need to file the State Fair Hearing
- How you can file a complaint to Health and Human Services Commission (HHSC)

You can ask for more time for your appeal. You can ask for up to fourteen (14) Days or if El Paso Health shows that there is a need for more information and how the delay is in your best interest. If El Paso Health needs to use the extension, we will send you a written notice of the reason for the delay.

You can request a State Fair Hearing only after exhausting El Paso Health's internal appeals process.

STATE FAIR HEARING

Can I ask for a State Fair Hearing?

If you, as a Member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter with the internal appeal decision. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the health plan at 1145 Westmoreland Dr. El Paso, Tx 79925 or call 1-833-742-3127.

You have the right to keep getting any service the health plan denied or reduced, based on previously authorized services, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of: (1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or (2) the day the health plan's internal appeal decision letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped. If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Can I ask for an emergency State Fair Hearing?

If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling El Paso Health. To qualify for an emergency State Fair Hearing through HHSC, you must first complete El Paso Health's internal appeals process.

EXTERNAL MEDICAL REVIEW INFORMATION

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed before the State Fair Hearing occurs. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to <MCO name> by using the address or fax number at the top of the form.;
- Call the MCO at **1-833-742-3127**;
- Email the MCO at **Complaints&Appeals Team@elpasohealth.com** or;

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling El Paso Health. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete El Paso Health's internal appeals process.

REPORTING ABUSE, NEGLECT, AND EXPLOITATION

FRAUD AND ABUSE

How do I report suspected abuse, neglect, or exploitation?

You have the right to respect and dignity, including freedom from Abuse, Neglect, and Exploitation.

What are Abuse, Neglect, and Exploitation?

Abuse is mental, emotional, physical, or sexual injury, or failure to prevent such injury. Neglect results in starvation, dehydration, over medicating or under medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care, and personal hygiene.

Exploitation is misusing the resources of another person for personal or monetary gain. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Reporting Abuse, Neglect, and Exploitation

The law requires that you report suspected Abuse, Neglect, or Exploitation, including unapproved use of restraints or isolation that is committed by a provider.

Call 9-1-1 for life-threatening or emergency situations. Report by Phone (non-emergency) 24 hours a day, 7 days a week, toll-free.

Report to the Department of Aging and Disability Services (DADS) by calling **1-800-647-7418** if the person being abused, neglected, or exploited lives in or receives services from a:

- Nursing Facility;
- Assisted living facility;
- Adult day care center;
- Licensed adult foster care provider; or
- Home and Community Support Services Agency (HCSSA) or home health agency.

Suspected Abuse, Neglect or Exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

Report all other suspected abuse, neglect, or exploitation to DFPS by calling 1-800-252-5400.

Report Electronically (non-emergency)

Go to https://txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

Helpful Information for Filing a Report

When reporting abuse, neglect, or exploitation, it is helpful to have the names, ages, addresses, and phone numbers of everyone involved.

FRAUD AND ABUSE

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers,or a person getting 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 services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid 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 Hot-line at 1-800-436-6184;
- Visit **https://oig.hhs.texas.gov/**
  Click "Report Fraud" to complete the on-line form;
- You can report directly to your health plan:

El Paso Health

1145 Westmoreland Dr.

El Paso, TX 79925

1-833-742-3127 (Toll Free)

1-866-356-8395 (Toll Free waste, abuse, and fraud hot-line)

To report waste, abuse, or fraud, gather as much information as possible. You can remain anonymous when reporting.

- 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

INFORMATION THAT MUST BE AVAILABLE ON A YEARLY BASIS

As a member of El Paso Health you can ask for and get the following information each year:

- Information about network providers—at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:

  - What makes up emergency medical conditions, emergency services and post stabilization services.
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- El Paso Health's practice guidelines.

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 **1-833-742-3127** (TTY **711**).

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, **1-833-742-3127** (TTY **711**), 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**.

Please call **1-833-742-3127.**

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.

E**mergency 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. Preauthorization 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.

NOTES

El Paso Health

HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

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