urac ACCREDITED Health Plan Expires 04/01/2024

El Paso Health

HEALTH PLANS FOR EL PASOANS.
BY EL PASOANS.

CHIP Perinatal Member Handbook

CALL **915 532-3778**

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

CHIP | TEXAS Health and Human Services

EPHM4062109

09/2021

A Great Health Plan Comes With Healthy Rewards.

HEALTHY REWARDS*	MEDICAID MEMBER	CHIP MEMBER
FIRSTCALL MEDICAL ADVICE INFOLINE CALL 1-844-549-2826 — Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual medical advice info line staffed by nurses, pharmacists, and a medical director on call.	✓	✓
TAXI — A free ride service to help you get to medical appointments or health education classes.	✓	✓
Readers Today. Leaders Tomorrow. by El Paso Health — Two free books from the EPH Literacy Program for members in speech therapy.	✓	✓
Pregnant members 21 or older can receive up to $500 each year for dental checkups, x-rays, routine cleaning, fillings, and extractions.	✓	✓
Members 20 and younger. For contact lenses and glasses (lenses and frames), members receive up to $125 above the Medicaid/CHIP benefit.	✓	✓
Members 21 years and older. For contact lenses and glasses (lenses and frames), members receive up to $150 above the Medicaid benefit, once every 24 months.	✓	
GIFT CARD $10 — $25 gift packet which includes a first aid kit and a $10 Walmart gift card for health related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	✓	✓
Members between the ages of 4 and 18 can get a free sports physical each year.	✓	✓
One allergy-free pillow case for members who are enrolled in the Asthma Disease Management Program.	✓	✓
VIRTUAL-CONNECT BY EL PASO HEALTH — "Virtual Connect by El Paso Health" is a service that provides face to face virtual visits for members with social determinants of health or complex conditions such as high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.	✓	✓
GIFT CARD $15 — A $15 gift card for members ages 3 to 19 who get a check-up when due.		✓

HEALTHY REWARDS*	MEDICAID MEMBER	CHIP MEMBER
GIFT CARD $25 — 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. • $20 - 3rd prenatal visit. • $20 - 6th prenatal visit. • $20 - 9th prenatal visit. • $20 - flu shot during pregnancy. • $25 -a timely postpartum visit within 7 to 60 days of delivery.	✓	✓
NUTRITION ADVICE — Medicaid members age 20 or younger and CHIP members age 18 or younger can receive four addition nutritional/ obesity counseling services above the Medicaid/CHIP benefit.	✓	✓
Food from the Heart — A free "EPH Food from the Heart" food basket for new members after completing a new member orientation with El Paso Health.	✓	✓
STAY SAFE KIT by El Paso Health — A free "EPH Stay Safe kit" that includes 2 washable and reusable cloth masks, 2 mask covers, 4 disposable masks, gloves, hand sanitizers, thermometer, healthy tips on hand washing, and sanitizing wipes.	✓	✓
GIFT CARD $20 — A $20 gift card is offered to members ages 21 and older who get an annual preventative wellness exam.	✓	
GIFT CARD $10 — A $10 gift card for members 20 and younger who complete a Texas Health Steps check up on time.	✓	
GIFT CARD $10 — A $10 Walmart gift card for members 20 and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one gift card per year.	✓	✓
the YMCA — Up to $35 discount for any sport, swim, or camp registration fee at participating YMCA's; once every 12 months.	✓	✓

For questions or doctor information: **877-532-3778**
TTY line for people with a hearing or speech disability: **855-532-3740**
Help for mental health, drug, or alcohol problems: **877-377-6184**
For prescription or medicine information: **877-532-3778**

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

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www.elpasohealth.com

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El Paso Health
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IMPORTANT NOTICE

To obtain information or make a complaint:

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

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

You may also write to El Paso Health at:

1145 Westmoreland Dr.
El Paso, TX 79925

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

You may write the Texas Department of Insurance:

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

PREMIUM OR CLAIM DISPUTES:

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

ATTACH THIS NOTICE TO YOUR POLICY:

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

AVISO IMPORTANTE

Para obtener información o para someter una queja:

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

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

Usted también puede escribir a El Paso Health a:

1145 Westmoreland Dr.
El Paso, TX 79925

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

Puede escribir al Departamento de Seguros de Texas:

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

DISPUTAS SOBRE PRIMAS O RECLAMOS:

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

UNA ESTE AVISO A SU POLIZA:

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

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IMPORTANT NOTICE TO MEMBERS

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

AVISO A LOS MIEMBROS

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

GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

Grievance – A complaint to your health insurer or plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INTRODUCTION

THANK YOU FOR CHOOSING EL PASO HEALTH

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

El Paso Health is a Health Maintenance Organization that provides services and benefits to people eligible for the CHIP Perinate 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 CHIP is a managed care program that includes CHIP Perinate. Managed care allows you to choose your child's primary care provider (PCP). 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." References to "you," "my", or "I" apply if you are a CHIP Member.

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. You have a doctor who will give you the information you need to make good choices about your treatments.

IMPORTANT TELEPHONE NUMBERS

Our Address

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

Member Services

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

Our Member Services Department can:

- Explain what services are covered, and help you get the services you need.
- Help you choose a Primary Care Provider if you do not have one.
- Help you find a doctor close to your home.
- Help you change your primary care provider.
- Help send new ID cards.
- Inform you of what to do when you move out of the area.
- We will transfer members to 211 to change your address or phone number.
- Explain how to get transportation services.
- Act as your patient advocate and listen to your complaints and concerns.
- Tell you about classes, health fairs, and other special events in your area.

Stay Connected with El Paso Health's Mobile App!

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

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

After Hours Answering Service

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

Interpreter Services

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

Other Numbers

CHIP Help Line **1-800-647-6558**
Prescription Drugs **915-532-3778** or **1-877-532-3778**

Member Handbook

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

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

TTY Line for the Hearing Impaired

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

Transportation

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

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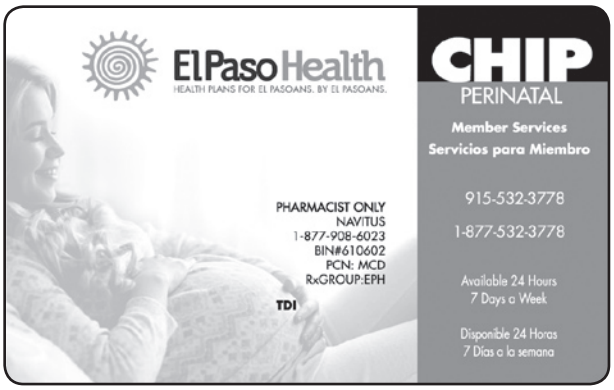
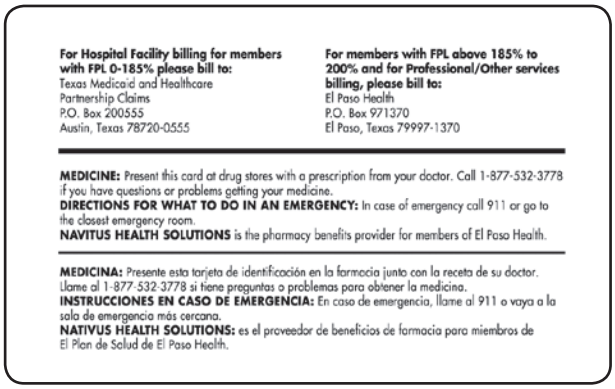
EL PASO HEALTH IDENTIFICATION (ID) CARD

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





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

Printed on the El Paso Health card are:

- The plan ID number, your name and date of birth.
- The name, address and phone number of your doctor (Primary Care Provider).
- The phone number for the 24-hour El Paso Health Member Service Line. You can call this number whenever you have a question or a problem—**915-532-3778** or **1-877-532-3778.**
- The phone number in case there is a question regarding your medicine benefits.
- The date in which your coverage begins.
- The number you can call if you are having a crisis.

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

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

NIGHT CLINICS

When your child has:

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

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

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

NIGHT CLINICS

CENTRAL PEDIATRIC NIGHT CLINIC
7888 Gateway East
El Paso, TX 79915
(915) 593-6444
Will be open in August 2021

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

NORTHEAST PEDIATRIC NIGHT CLINIC PA
10755 Kenworthy Dr
El Paso, TX 79924
(915) 821-2300
Mon-Sat 6pm-9pm

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

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

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PROVIDERS FOR CHIP PERINATE PREGNANT MEMBERS

WHAT DO I NEED TO BRING TO A PERINATAL PROVIDER'S APPOINTMENT?

When you need to see your doctor, call his or her office ahead of time and make an appointment for a visit. You will not have to wait long if you do this.

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

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

If you have a medical problem that needs attention the same day, call your doctor immediately. Your doctor will tell you what you need to do.

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

CAN A CLINIC BE A PERINATAL PROVIDER?

A Primary Care Provider can be a family practice doctor, a pediatrician (children's doctor), or a doctor of internal medicine (doctor for adults). It can also be a clinic or a Federal Qualified Health Center (FQHC). If you need help choosing a clinic, El Paso Health can help you. Call El Paso Health Member Services at **915-532-3778** or **1-877-532-3778.**

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

- Check-ups that help you stay healthy
- Treatment for common health problems
- Make arrangements for you to get medical tests or treatment when needed

Your doctor is the first person to call when you have a health problem or you have a question about your health. Your doctor will provide the care you need or direct you to someone else who can help you.

HOW DO I GET AFTER HOURS CARE?

Your doctor is available 24 hours a day either in person or by telephone. If your doctor is not available he or she will arrange for another doctor to be available for you to include weekends and holidays.

If you need to speak to your doctor and it is not during regular "office hours," you should still call. Remember your doctor's phone number is printed on your member identification card. If an answering service answers your call, you can request a doctor to call you back. Give the answering service the information requested, and a doctor will call you back within 30 minutes.

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CHANGING HEALTH PLANS

FOR CHIP PERINATAL MEMBERS

- **ATTENTION:** If you meet certain income requirements, your baby will be moved to Medicaid and get 12 months of continuous Medicaid coverage from date of birth.
- Your baby will continue to receive services through the CHIP Program if you meet the CHIP Perinatal requirements. Your baby will get 12 months of continuous CHIP Perinatal coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

WHAT IF I WANT TO CHANGE HEALTH PLANS?

- Once you pick a health plan for your unborn child, the child must stay in this health plan until the child's CHIP Perinatal coverage ends. The 12-month CHIP Perinatal coverage begins when your unborn child is enrolled in CHIP Perinatal and continues after your child is born.
- If you do not pick a plan within 15 days of getting the enrollment packet, HHSC will pick a health plan for your unborn child and send you information about that health plan. If HHSC picks a health plan for your unborn child, you will have 90 days from your effective date of coverage to pick another health plan if you are not happy with the plan HHSC chooses.
- The children must remain with the same health plan until the end of the CHIP Perinatal Member's enrollment period, or the end of the other children's enrollment period, whichever happens last. At that point, you can pick a different health plan for the children.
- You can ask to change health plans:
  — for any reason within 90 days of enrollment in CHIP Perinatal;
  — if you move into a different service delivery area; and
  — for cause at any time.

Who do I call?

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

How many times can I change health plans?

You may request to change health plans for exceptional reasons or good cause. For more information please call CHIP at **1-800-647-6558.**

When will my health plan change become effective?

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

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

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

- You let someone else use your El Paso Health ID card.
- You do not follow the advice that your doctor gives you.
- You keep going to the emergency room when it is not a true emergency.
- You cause problems at the doctor's office.
- You make it difficult for your doctor to help you or other people.
- You no longer live or reside in the Service Area.

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

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

- You are no longer eligible for coverage.
- You have other health insurance.
- You move out of the El Paso Health service area.

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

CONCURRENT ENROLLMENT IN CHIP AND CHIP PERINATAL

If your children are enrolled in CHIP, they will remain in CHIP but will be placed with the health plan providing CHIP Perinatal coverage. Co-payments, cost-sharing, and enrollment fees still apply for children enrolled in CHIP.

An unborn child who is enrolled in CHIP Perinatal will be moved to Medicaid for 12 months of continuous Medicaid coverage, beginning on the date of birth, if the child lives in a family with an income at or below 185% of the FPL.

An unborn child will continue to receive coverage through CHIP Perinatal after birth, if the child is born to a family with an income above 185% to 200% FPL.

If you have any questions please contact the Member Services Department at **915-532-3778** or **1-877-532-3778.**

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BENEFITS FOR CHIP PERINATE PREGNANT MEMBERS

BENEFITS FOR CHIP PERINATE PREGNANT MEMBERS

WHAT ARE MY UNBORN CHILD'S CHIP PERINATAL BENEFITS? (FOR PREGNANT MEMBERS)

How do I get these services?

El Paso Health can help you receive these services.

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

Covered Benefit	Limitations
Inpatient General Acute Services include: Covered medically necessary Hospital-provided services • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services associated with labor related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes above 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges with delivery until birth.

Covered Benefit	Limitations
Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	• May require prior authorization and physician prescription Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. Ultrasound of the pregnant uterus is a covered benefit of CHIP Perinatal when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of CHIP Perinatal with an appropriate diagnosis. Laboratory tests for CHIP Perinatal are limitited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gesta-

	tional diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.
Covered Benefit	**Limitations**
Physician/Physician Extender Professional Services Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. • Physician office visits, in-patient and out-patient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation • Medically necessary medications, biologicals and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: – Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. – Administration of anesthesia by Physician (other than surgeon) or CRNA – Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. – Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Hospital-based Physician services (including Physician-performed technical and interpretive components)	Requires authorization for scheduled specialty services. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT. Authorization is required after 4 ultrasounds have been performed.

- Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.

Covered Benefit	Limitations
Prenatal Care and Pre-pregnancy Family Services and Supplies Covered services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: One visit every four weeks for the first 28 weeks of pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.	Does not require prior authorization. Limit of 20 prenatal visits and 2 postpartum visits of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).

Covered Benefit	Limitations
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services El Paso Health cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. • Emergency services based on prudent lay person definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor and delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. • Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

Covered Benefit	Limitations
Case Management Services Case management services are a covered benefit for the Unborn Child.	These covered services include outreach informing, case management, care coordination and community referral.

Covered Benefit	Limitations
Care Coordination Services Care coordination services are a covered benefit for the Unborn Child.	

WHAT BENEFITS ARE NOT COVERED?

CHIP PERINATAL EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and
  other articles that are not required for the specific treatment related to labor and delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.

- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by El Paso Health except for emergency care related to the labor and delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Corrective orthopedic shoes.
- Convenience items.
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse that do not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico,
- U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

WILL I HAVE TO PAY FOR SERVICES THAT ARE NOT COVERED BENEFITS?

El Paso Health will not pay for services that are not covered. You will be responsible to stay within the El Paso Health Network. If you go outside the CHIP Perinatal Network you will be responsible to pay for these services.

HOW MUCH DO I HAVE TO PAY FOR MY UNBORN CHILD'S HEALTH CARE UNDER CHIP PERINATAL?

There are no co-payments for CHIP Perinate Members no cost-sharing on benefits for well-baby or pregnancy-related assistance.

WHAT ARE MY UNBORN CHILD'S PRESCRIPTION DRUG BENEFITS?

El Paso Health will pay for most of the medicine your doctor says you need. Some medicine is not in the El Paso Health Pharmacy Formulary.

Your doctor will write a prescription so you can take it to a drug store that is in the El Paso Health Pharmacy Network.

WHAT EXTRA BENEFITS DOES A MEMBER OF EL PASO HEALTH GET? HOW CAN I GET THESE BENEFITS?

As of September 1, 2021, CHIP Perinate Pregnant Members can receive the following Value Added Services:

Value-added Service	Limitations or Restrictions
A free transportation service that helps members be able to attend their doctor visits or health education classes.	None
Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual Medical Advice Infoline staffed by nurses, pharmacists, and a Medical Director on call.	None
$25 gift which includes a first aid kit and a $10 gift card for health related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	Members are eligible to receive this packet every 12 months.
One allergy-free pillow case is given to members who are enrolled in the Asthma Disease Management Program.	Once a year, Members will be eligible to receive one allergy-free pillow case when enrolled in the Asthma Disease Management Program at El Paso Health.

Pregnant Members 21 or older can receive up to $500 each year for dental checkups, x-rays, routine cleaning, fillings, and extractions.	Members will be eligible to receive dental service by scheduling an appointment at the Project Vida or Centro San Vicente Dental Clinics. Only available for Pregnant Members over 21 years of age, once every 12 months.
Pregnant members can receive: • A free convertible car seat after attending a baby shower at El Paso Health.	CHIP Perinate Pregnant Members must complete one baby shower (pregnancy class) at El Paso Health to receive a free convertible car seat. Limited to one free convertible car seat per pregnancy.
• 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, — $20 – 3rd prenatal visit, — $20 – 6th prenatal visit, — $20 – 9th prenatal visit, — $20 – flu shot during pregnancy, — $25 – a timely postpartum visit within 7-60 days of delivery.	CHIP Perinate Pregnant members can receive gift cards for completing prenatal visits, following confirmation of the visits. For the 1st, 3rd, 6th, and 9th prenatal visit, members must notify us that they are pregnant prior to having the baby by calling us or submitting a completed Notification of Pregnancy (NOP) form. Prenatal visit count begins after we notified of the pregnancy. To earn the reward for the first visit, the visit must be completed within 42 days of enrollment in El Paso Health. The postpartum doctor visit must complete between 7-60 days after delivery. For the annual flu vaccine, it is limited to one per flu season from September to April.

• A First-Steps Baby Shower including a diaper bag, a starter supply of diapers, and other items for the baby.	CHIP Perinate pregnant Members must complete one pregnancy class (baby shower) at El Paso Health to receive a diaper bag, starter supply of diapers and other items, such as baby lotion and baby wipes. The diaper bag, starter supply of diapers and other items are limited per pregnancy.
"Virtual Connect by El Paso Health" is a service that provides face-to-face virtual home visits for members with social determinants of health or complex conditions such as high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.	Available to members with social determinants of health or complex conditions to include high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.
A $10 gift card is offered to members 18 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one gift card per year.	For members 18 years and younger who complete a follow-up psychiatrist visit visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one movie gift card per year.
A free "EPH Food from the Heart" food basket for new members aftercompleting a new member orientation with El Paso Health.	The new member orientation class must be completed within 90 days of enrollment to be eligible to receive an EPH Food from the Heart food basket. Every 12 months Members are eligible to receive one EPH Food from the Heart food basket per household.
A free "EPH Stay Safe kit" that includes 2 reusable cloth masks, 4 disposable masks, gloves, hand sanitizers, thermometer, healthy tips on hand washing, and sanitizing wipes.	EPH high-risk Members must complete a wellness class within 90 days of enrollment to be eligible to receive an EPH Stay Safe kit. Every 12 months Members are eligible to receive one kit per household.

HOW CAN I GET THESE BENEFITS FOR MY UNBORN CHILD?

Whenever you have a question about your health care service, call El Paso Health's Member Services Department at **915-532-3778** or **1-877-532-3778,** anytime between 7 a.m. to 5 p.m., Mountain Time. An El Paso Health Representative will always be available to help you.

WHAT HEALTH EDUCATION CLASSES DOES EL PASO HEALTH OFFER?

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

HEALTH CARE AND OTHER SERVICES FOR CHIP PERINATE PREGNANT MEMBERS

WHAT DOES "MEDICALLY NECESSARY" MEAN?

FOR CHIP MEMBERS AND CHIP PERINATAL MEMBERS

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

***Medically Necessary* means:**

1. Health Care Services that are:
   a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
   b. provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
   c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
   d. consistent with the member's diagnoses;
   e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   f. not experimental or investigative; and
   g. not primarily for the convenience of the member or provider; and
2. Behavioral Health Services that:
   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 doctor and treatment by him or her when you are sick. During these regular visits, your doctor can give you prescriptions for medicine, and send you to a special doctor if you need one.

It is important that you do what your doctor 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 choose someone else to make them for you.

When you need to see your doctor, call the doctor at the number on your El Paso Health ID card. Someone in the doctor'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 have 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 arrange for another doctor to be available for him/her. This includes weekends and holidays.

When you need to see your doctor, call ahead of time and make an appointment for a visit.

How soon can I expect to be seen?

Your Primary Care Provider will see you or your child within two weeks. If you have a condition that needs medical attention the same day, your doctor can arrange for that. Please be on time for your appointments. If you need to cancel an appointment, please call the doctor's office as far in advance as possible.

WHAT IS URGENT MEDICAL CARE?

Urgent care involves the treatment of a medical problem that is not an emergency but needs attention the same day.

How soon can I expect to be seen?

The doctor will see you within 24 hours (usually the same day). If you have a problem that is not an emergency, you should call your doctor. Some good reasons to call your doctor are:

- You need more medicine
- You have a rash that does not get better
- You have a cold
- You have the flu
- You have some stitches to be removed
- You have aches and pains in your back

WHAT IS EMERGENCY MEDICAL CARE?

FOR CHIP PERINATE MEMBERS

What is an Emergency and an Emergency Medical Condition?

A CHIP Perinate Member is defined as an unborn child. Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth. Emergency care is provided for the following Emergency Medical Conditions:

- Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child;
- Stabilization services related to the labor with delivery of the covered unborn child;
- Emergency ground, air and water transportation for labor and threatened labor is a covered benefit;
- Emergency ground, air, and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.

Benefit Limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

What is Emergency Services or Emergency Care?

"Emergency Services" or **"Emergency Care"** are 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, including post-stabilization care services related to labor and delivery of the unborn child.

How soon can I expect to be seen?

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

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

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

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 **1-877-532-3778** and we will help you find a doctor.

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

What if I am out of the state?

The El Paso Health service area includes the El Paso county only. When you are not in these counties, or in the state of Texas you are outside of the service area.

Your identification card has the El Paso Health number that you and the hospital may call if there are questions about your coverage.

What if I am out of the country?

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

WHAT IS A REFERRAL?

Your doctor may give you a form to take a special doctor. This form is called a "referral."

What services do not need a referral?

You do not need a referral for freedom-of-choice services.

These services are called "freedom-of-choice" services:

- OB/GYN (doctor for women's health

WHAT IF I NEED SERVICES THAT ARE NOT COVERED BY CHIP PERINATAL?

El Paso Health Outreach/Promotoras will try to help you find help within your community such as faith based organizations, or community clinics. Call El Paso Health Member Services Department at **915-532-3778** or **1-877-532-3778.**

HOW DO I GET MY MEDICATIONS?

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

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

How do I find a network drug store?

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

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

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

What do I bring with me to the drug store?

You must take your El Paso Health ID card.

What if I need my 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?

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

What if I can't get my doctor's order 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 **1-877-532-3778** for help with your medications and refills.

What if I lose my medication?

Please call El Paso Health at **1-877-532-3778.** Call El Paso Health at for help with your medications and refills.

What if I need an over-the-counter medication?

The pharmacy cannot give you an over-the-counter medication as part of your CHIP Perinate benefit. If you need an over-the-counter medication, you will have to pay for it.

CAN SOMEONE INTERPRET FOR ME WHEN I TALK WITH MY PERINATAL PROVIDER?

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

Who do I call for an interpreter?

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

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

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

How far in advance do I need to call?

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

We also have interpreters who know sign language to help with doctor visits. Let us know at least two days before your child's visit if you need this service. El Paso Health's telephone staff speaks English and Spanish. We can also mail information to you in other languages. If you need help hearing, El Paso Health has a TDD line. For TDD help, call toll free **1-855-532-3740** or **915-532-3740.**

HOW DO I CHOOSE A PERINATAL PROVIDER?

El Paso Health has a list of specialized doctors that you can choose from our limited network, which includes University Medical Center, University Medical Center Clinics, and Texas Tech. When you need to see your doctor, call his or her office ahead of time and make an appointment for a visit. You will not have to wait long if you do this. You will probably be seen within 2 weeks of your request.

El Paso Health will not cover any providers who are not part of the CHIP Perinatal network.

Will I need a referral?

You do not need a referral from your primary care provider for this service.

How soon can I be seen after contacting a perinatal provider for an appointment?

When you need to see your doctor call his or her office ahead of time and make an appointment for a visit. You will not have to wait long if you do this. You will probably be seen within 2 weeks.

When you call, be ready to tell the receptionist about your health problem or questions.

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

If you have a medical problem that needs attention the same day, please call your doctor immediately. Your doctor will tell you what you need to do.

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

Can I stay with my perinatal provider if they are not with El Paso Health?

You will need to select a doctor who is part of El Paso Health. If you are at least six months pregnant when you join El Paso Health you may keep seeing the doctor who is already caring for you. However, you will need to contact a Nurse Case Manager at **915-532-3778** if you are in El Paso or **1-877-532-3778.**

WHAT IF I GET A BILL FROM A PERINATAL PROVIDER?

Who do I call?

If you get a bill from your doctor, you should call El Paso Health at **915-532-3778** or **1-877-532-3778** if outside of the calling area. A Member Services Representative will be happy to help you.

What information will they need?

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

WHAT DO I HAVE TO DO IF I MOVE?

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

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

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

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

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

There are two types of Advance Directives:

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

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

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

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

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

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

Examples of things that help you live longer are:

- Cardiopulmonary Resuscitation (CPR): used to give back breathing and/or heartbeat.
- Intravenous (IV) Therapy: used to give food and water to you if you cannot eat or drink.
- Feeding Tubes: these are tubes put through your nose or throat to provide you with food if you cannot eat.
- Respirators: these are machines that help you breathe if you cannot breathe on your own.

- Dialysis: this is a machine that cleans your blood if your kidneys do not work.
- Medications: these are medicines that will be used to help keep you alive.
- Restraints: these are used to keep you from hurting yourself.

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

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

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

Other facts:

- A terminal illness is any illness that is not curable.
- The doctor who gives services in the Advance Directive is protected from lawsuits, unless the doctor acts badly.
- The Advance Directive does not become effective until 2 doctors decide that you have a terminal condition and that life-sustaining procedures are the only way to keep you alive.
- The doctor's statement of terminal illness must be written in your medical records.
- Life sustaining procedures mean mechanical or other "artificial means" of keeping a person alive. This does not include medications or procedures to make you comfortable or to make pain go away.
- The Advance Directive is not good if you are pregnant at the time it is to be carried out. For example, your Advance Directive will not be followed if you are pregnant and suffer an accident that leaves you unable to make your own medical decisions.
- If the doctor follows your Advance Directive, and you tell him you do not want life sustaining procedures, it is not to be considered euthanasia or "mercy killing." The Advance Directive is a legal paper accepted by Texas law that allows a doctor to give or not give medical treatment depending on what you tell him to do.

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

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

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

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

  1. The person you pick as your agent;
  2. Your doctor;
  3. An employee of your doctor;
  4. An employee of the facility where you live;
  5. Your spouse;
  6. Your family or beneficiaries named in your will or a deed; or,
  7. Creditors or persons who have a claim against you.

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

WHAT ARE MY RIGHTS AND RESPONSIBILITES?

FOR CHIP PERINATE MEMBERS

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. You must talk to your provider about your medications that are prescribed.

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

WHEN DOES MY COVERAGE UNDER CHIP PERINATAL END?

Coverage for CHIP Perinate pregnant members will end the last day of the month the baby is born. The CHIP Perinate Newborn's coverage will end at the end of the 12 months of coverage from the month eligibility was determined.

Will the state send me anything when my CHIP Perinatal coverage ends?

Near the end of CHIP Perinatal, the state will send you a letter telling you that you no longer have these benefits and will also send you information telling you what programs your child may be eligible to receive. Please be sure to complete and mail back any forms you receive in the mail.

HOW DOES RENEWAL WORK?

In the 10th month of coverage, you will receive a CHIP renewal package from CHIP. Once you complete the renewal package and you are eligible for CHIP, then you will become a traditional CHIP member. Once you are eligible for CHIP the 90 day waiting period doesn't apply. Copay and premiums do apply once you are a CHIP member.

DOES MY BABY RECEIVE BENEFITS AT BIRTH?

Yes, your baby will receive the same benefits provided under traditional CHIP for duration of the CHIP Perinatal coverage period.

CAN I CHOOSE MY BABY'S PRIMARY CARE PROVIDER BEFORE THE BABY IS BORN?

Who do I call?

Before or after your baby is born, please call El Paso Health, at **915-532-3778** or **1-877-532-3778,** to choose a Primary Care Provider for your baby.

What information do they need?

Please provide our Member Services Representative the name and address of the Primary Care Provider you have selected from the El Paso Health CHIP Perinatal Provider Directory. If you called to choose your baby's Primary Care Provider before your baby is born, you do not need to call again. If you do not choose a Primary Care Provider, one will be chosen for your baby.

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

To change your Primary Care Provider call El Paso Health Member Services Line at **915-532-3778** if you are in El Paso, or **1-877-532-3778.** A Member Customer 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 Service Representative will also tell you when you can start seeing your new PCP.

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

COMPLAINT PROCESS

WHAT SHOULD I DO IF I HAVE A COMPLAINT?

Who do I call?

We want to help. If you have a complaint, please call us toll-free at **1-877-532-3778** to tell us about your problem. An El Paso Health Member Services Advocate can help you file a complaint. Just call **1-877-532-3778.** Most of the time, we can help you right away or at the most within a few days. El Paso Health cannot take any action against you as a result of your filing a complaint.

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

If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll-free to **1-800-252-3439,** Fax **1-512-490-1007.** If you would like to make your request in writing send it to:

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

If you can get on the Internet, you can send your complaint in an e-mail to
ConsumerProtection@tdi.texas.gov

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

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

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

HOW LONG WILL IT TAKE TO PROCESS MY COMPLAINT?

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

WHAT ARE THE REQUIREMENTS AND TIMEFRAMES FOR FILING A COMPLAINT?

Your complaint will be processed and resolved within 30 days of when we receive your oral or written complaint form. In the event a complaint is related to an emergency or a denial of continued hospitalization, the HMO must investigate and resolve the complaint concerning an emergency or a denial of continued hospitalization in accordance with the medical or dental immediacy of the case; and no later than 1 business day after the El Paso Health receives the complaint. You may file a formal complaint by calling **915-532-3778** or **1-877-532-3778,** or by writing to El Paso Health. Mail your formal complaint letter to:

El Paso Health
Attn: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, Texas 79925

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

You can contact the Texas Department of Insurance by calling toll-free to **1-800-252-3439,** Fax **1-512-490-1007.** If you would like to make your request in writing send it to:

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

If you can get on the Internet, you can send your complaint in an email to **ConsumerProtection@tdi.texas.gov**

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

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

APPEALS TO THE HEALTH PLAN

1. If the Complaint is not resolved to YOUR satisfaction, YOU have the right either to appear in person before a CAP where YOU normally receive health care services, unless another site is agreed to by YOU, or to address a written appeal to the Complaint appeal panel. WE shall complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for appeal.
2. WE shall send an acknowledgment letter to YOU not later the fifth day after the date of receipt of the request of the appeal.

3. WE shall appoint members to the CAP, which shall advise US on the resolution of the dispute. A complaint appeal panel shall be composed of an equal number of El Paso Health staff members, physicians or other providers, and enrollees. A member of a complaint appeal panel may not have been previously involved in the disputed decision.
4. The physicians in the CAP shall have experience in the area of care in dispute and shall be independent of any physician or provider who made any previous determination. If a specialty care is in dispute, the CAP will include a specialist in that field of care.
5. Not later than the fifth business day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:
   a. Any documentation to be presented to the panel by OUR staff;
   b. The specialization of any Physicians or Providers consulted during the investigation; and
   c. The name and affiliation of each of OUR representatives on the panel.
6. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:
   a. Appear in person before the CAP;
   b. Present alternative expert testimony; and
   c. Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.
7. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed one business day after YOUR request for appeal.

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

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

El Paso Health
Attn: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, Texas 79925

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PROCESS TO APPEAL A CHIP ADVERSE DETERMINATION

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

You, and the health care provider or facility who rendered your services, if different from your attending physician, can appeal to El Paso Health. You will need to appeal within sixty (60) days from when you receive your notice that your covered service(s) was denied or limited. If you choose a person to act on your behalf, you will need to let El Paso Health know in writing who your authorized representative will be. You will need to appeal within sixty (60) days from the date on your notice that your covered service(s) was denied or limited.

You or your authorized representative may submit your appeal to:

El Paso Health
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Tel: 915-532-3778
Toll Free: 877-532-3778
Fax No.: 915-298-7872
Toll Free Fax: 844-298-7872
Online: http://www.elpasohealth.com

HOW WILL I FIND OUT IF SERVICES ARE DENIED?

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

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

What are the timeframes for the appeal process?

You will receive an acknowledgement letter from El Paso Health within five days from the day your appeal is received. El Paso Health will give you a decision on your appeal within 30 days from the date we receive your appeal.

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

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

Does my request have to be in writing?

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

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

If you appeal by phone, El Paso Health will send a one-page appeal form along with the letter of acknowledgement. The appealing party does not have to return the appeal form, but El Paso Health encourages the appealing party to do so along with the documents listed in the letter of acknowledgement needed for your appeal.

Please send the documents to the following:

El Paso Health
Attn: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, Texas 79925

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 at **915-532-3778** or **1-877-532-3778.**

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EXPEDITED EL PASO HEALTH APPEAL

WHAT IS AN EXPEDITED APPEAL?

An Expedited Appeal is when the health plan 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 EXPEDITED APPEAL?

You, the person acting on your behalf, your provider of record, and the health care provider or facility who rendered your services, if different from your attending physician, can request an expedited appeal orally or in writing. If you want to request the expedited appeal orally, please call **915-532-3778** or Toll Free at **1-877-532-3778** and ask for a Member Services Advocate. If you want to submit your request in writing, please send it to:

El Paso Health
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925

DOES MY REQUEST HAVE TO BE IN WRITING?

No, you can request an expedited appeal to El Paso Health orally or in writing. To submit your appeal in writing, send your request to:

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

You may also call El Paso Health at **915-532-3778** or Toll Free at **1-877-532-3778.**

WHAT ARE THE TIMEFRAMES FOR AN EXPEDITED APPEAL?

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

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

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

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

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

SPECIALTY REVIEW

WHO CAN ASSIST ME IN FILING A SPECIALTY REVIEW?

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

WHAT ARE THE TIMEFRAMES FOR THE SPECIALTY REVIEW?

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

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INDEPENDENT REVIEW ORGANIZATION (IRO) PROCESS

WHAT IS AN INDEPENDENT REVIEW ORGANIZATION?

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

HOW DO I ASK FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION?

To request an IRO, you, the person acting on your behalf, your provider of record, and the health care provider or facility who rendered your services, if different from your attending physician must complete the HHS Federal External Review Request Form which El Paso Health includes along with your notice of denied services.

If the form is not signed, the IRO cannot receive the medical records. Return the completed and signed form to MAXIMUS External Review by fax, mail, or online at:

Fax: **1-888-866-6190**

Mail: **MAXIMUS Federal Services**
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Online Portal: **externalappeal.com.gov**

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

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

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

WHAT ARE THE TIMEFRAMES FOR THIS PROCESS?

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

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

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

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

WHO CAN ASSIST ME IN FILING AN APPEAL?

Please call our Member Services Department at **915-532-3778** or **1-877-532-3778** and we will direct you to our Member Advocate.

REPORT CHIP WASTE, ABUSE OR FRAUD

HOW DO I REPORT SOMEONE WHO IS MISUSING/ ABUSING THE CHIP PROGRAM OR SERVICES?

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit **https://oig.hhsc.state.tx.us/** and click the red "Report Fraud" box to complete the online form; or
- You can report directly to your health plan:

  EL PASO HEALTH
  1145 Westmoreland
  El Paso, TX 79925
  1-877-532-3778

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

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

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

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STATEMENT OF NON-DISCRIMINATION

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

El Paso Health:

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

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

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

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

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

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

SPANISH

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

VIETNAMESE

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

CHINESE

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

KOREAN

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

ARABIC

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

URDU

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

TAGALOG–FILIPINO

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

FRENCH

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

HINDI

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

PORTUGUESE

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

GERMAN

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

GUJARATI

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

RUSSIAN

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

JAPANESE

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

LAO

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

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