BlueCross BlueShield of Texas

CHIP | TEXAS Health and Human Services

Travis Service Area



CHIP Member Handbook

Customer Advocate Department: **1-888-657-6061**; TTY: **711**

www.bcbstx.com/medicaid

Effective September 2026

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Welcome!

Welcome to Blue Cross and Blue Shield of Texas (BCBSTX). Thank you for choosing our health plan. As a valued member of BCBSTX, this handbook has information you need to help you get the most from your health plan. It is our goal to provide care to all members in a culturally competent manner regardless of gender, sexual orientation or gender identity.

If you need this book in another format or language such as audio CD, large print, Braille or in a language other than English or Spanish, please contact the Customer Advocate Department toll-free at **1-888-657-6061**. If you need a printed copy of our member handbook, provider directory or other materials that will help you better understand your benefits, please call a Customer Advocate. Requests in English and Spanish will be fulfilled at no cost within five business days. Fulfillment of materials in other languages may need additional time for translation.

Please read this handbook to learn how your plan works. You must have an OK* from us before some types of specialty care will be covered.

Make sure you use providers in the BCBSTX network. If we do not have a provider in our network that can give you the care you need, your primary care provider (PCP) will get an OK from us to send you to a provider that is not in the network. If you get non-emergency care from a provider that is not in the network before you get the required OK from us, you may have to pay the Children's Health Insurance Program (CHIP) for that service.

You do not need an OK for in-network PCPs or to get emergency or urgent care. You do not need an OK from us for a referral** from your PCP to see a family planning care provider.

In this handbook, references to 'you,' 'my' or 'I' apply if you are a CHIP member. References to 'my child' or "my daughter" applies if your child is a CHIP member or a CHIP Perinate newborn member.

Your member ID card has been sent to you as a separate item. Your ID card lists your PCP. If you want to change your PCP, choose one from the BCBSTX Provider Directory. You can log into Blue Access for Members℠ to make a PCP change or a Customer Advocate can help you with this by calling **1-888-657-6061** or TTY **711**.

The phone numbers for the Customer Advocate Department and the 24/7 Nurse Advice Line are available at the bottom of every page of this book.

We look forward to serving you.

*Throughout this book we use the term 'OK' to mean prior authorization.

**Throughout this book when we use the term 'referral,' it is defining a process that one provider uses to recommend a member to see another provider or specialist. BCBSTX does not require documentation of these referrals.

Table of Contents

BCBSTX Service Area 1

Part 1

How to Use This Book 2

Important Things to Do 2

Important Phone Numbers 3

Part 2

BCBSTX Member ID Card 6

How to Use Your Member ID Card 6

How to Replace a BCBSTX ID Card If It Is Lost: 6

How to Read Your ID Card 6

Part 3

How to Choose a Provider 8

Choosing a Primary Care Provider (PCP) 8

Part 4

How to Use Your Health Plan with BCBSTX 8

Making an Appointment with Your Child's Doctor (PCP) 8

First Well Child Checkup 9

Blue Access for Members 9

Physician Incentive Plans 9

Changing Your/Your Child's PCP 9

Provider Directory/Provider Finder® 10

Part 5

Your Perinatal Provider for CHIP Perinate 11

Choosing a Perinatal Provider 11

Part 6

Access to Care – CHIP and CHIP Perinate Newborn 12

Enrollment 12

Specialty Care 12

Referrals 13

Prior Authorizations 13

Second Opinions 13

Renewing Your Benefits 14

Changing Health Plans 14

Part 7

Access to Care – CHIP Perinate 15

Enrollment and Eligibility 15

When Your Eligibility Ends 15

Changing Health Plans 16

Out-of-Town Care 17

Part 8

Routine, Urgent and Emergency Services 17

Medically Necessary 17

Routine Medical Care 18

Urgent Medical Care 18

Emergency Medical Care 18

For CHIP and CHIP Perinate Newborn . 18

For CHIP Perinate 19

What to Do in an Emergency 20

Post-Stabilization 20

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

Part 9

Covered Services – CHIP and CHIP Perinate Newborn 20

- Covered Services 22
- Well Child Visits 24
- Service Coordination 24
- Behavioral Health Services for CHIP members 25
- Emergency and Crisis Support 25
- Tobacco Cessation Program 25
- Dental Services 25
- Early Childhood Intervention 26
- Women's Health Care Services 26
- Pregnancy Care 27
- Will I need a referral? 27
- Vision Services 28
- Copayments and Cost-Sharing 28

Part 10

Covered Services – CHIP Perinate . 31

- What Are My Unborn Child's CHIP Perinatal Benefits? 31

Part 11

Value-Added Services 32

- Extra Help Getting a Ride 33
- 24/7 Nurse Advice Line 34
- Gift Card for Child and Adolescent Checkups 35
- Human Papillomavirus (HPV) Vaccine Gift Card Incentive 35
- Enhanced Eyewear for Kids 35
- Sports and Camp Physicals 36
- Health and Wellness Activity Reward ... 36
- Online Prenatal, Postpartum and Grief Classes 36
- Prenatal Visit Gift Card 37
- Breastfeeding Education through our Special Beginnings® Program 37
- Postpartum Visit Gift Card 37
- In-Home Meal Delivery Services after a Hospital Discharge 37
- Dental Services for Adult Members 38
- Blue365® Health and Wellness Program 38
- Learn to Live: Online Behavioral Health Platform 38

Part 12

Prescriptions and Pharmacy Benefits 39

- For CHIP Members and CHIP Perinate Newborn Members 39
- For CHIP Perinate Members 39
- Preferred Drug List 39
- Limited Home Health Supplies 40
- Finding a Network Pharmacy 40
- Transportation to the Pharmacy 41
- Mail Order Pharmacy 41

Part 13
Programs to Help Keep You Well .. 41
Service Coordination 41
What Other Services Can BCBSTX Help Me Get? 42
How to Get Other Services 43

Part 14
Help with Special Services 43
Help in Other Languages 43
Help for Members with Hearing or Vision Loss 44
Americans with Disabilities Act 44
Members with Special Health Care Needs 44

Part 15
How to Resolve a Problem 44
Complaints 44
Appeals 46
Pharmacy Appeals 47
Expedited Appeals 47
Independent Review Organization 48

Part 16
Other Things You May Need to Know 49
If We Can No Longer Serve You 49
What If I Get a Bill from My/My Child's Doctor? What if I get a bill from a perinatal provider? 49
If You Have Other Insurance 50
New Medical Treatments 50
Quality Improvement 50
Evidence of Coverage 50
Privacy Policies 50
Your Child's Medical Records 51
Advance Directives ('Living Will') 51
Program Changes 51
Report CHIP Waste, Abuse or Fraud 51
HIPAA Notice of Privacy Practices 52
State Notice of Privacy Practices 55

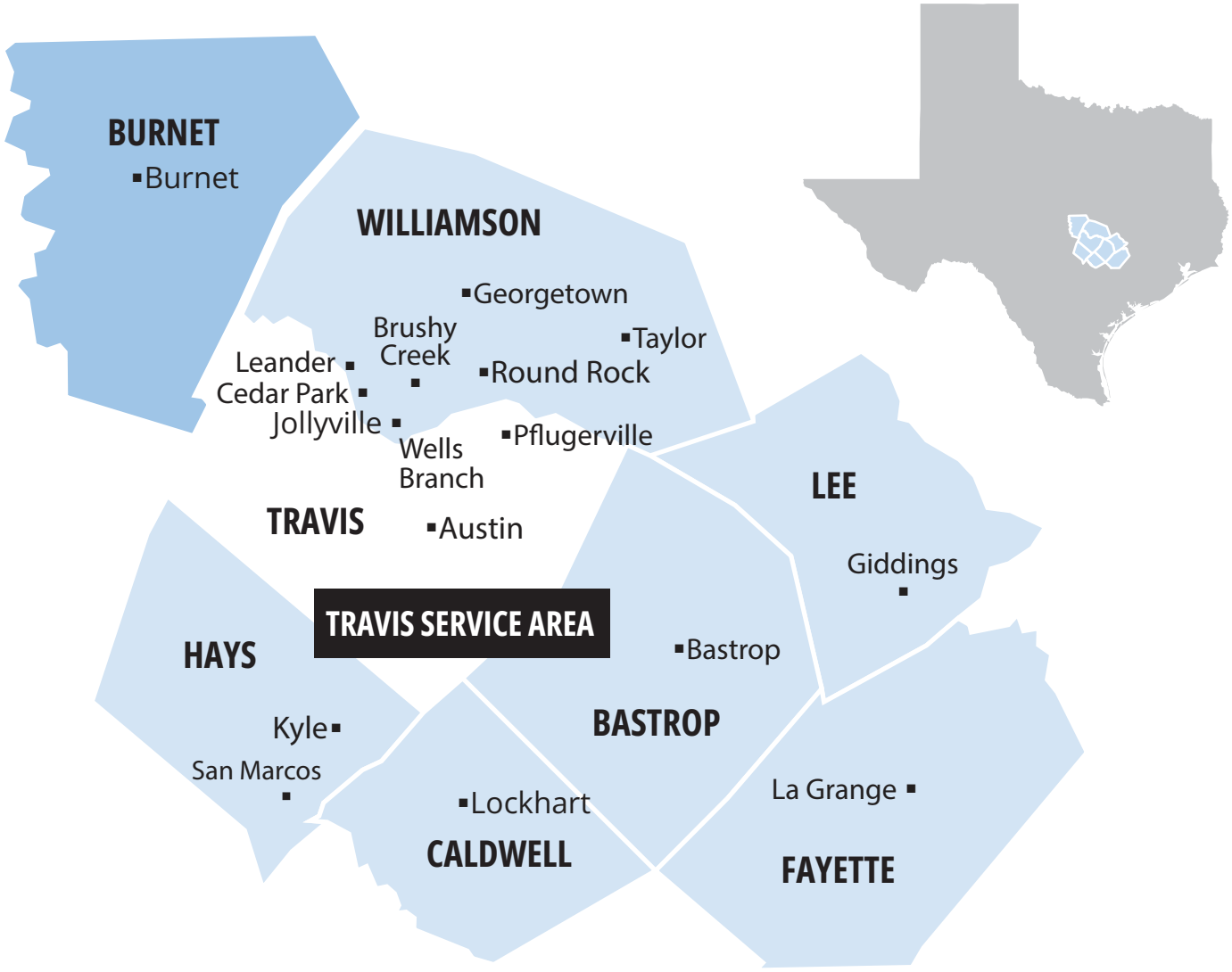
Part 17
Your Health Care Rights and Responsibilities 56
Member Rights 56
Member Responsibilities 58
For CHIP Perinate Members 59

Part 18
Definitions 60

Part 19
Details about CHIP Covered Services 65

BCBSTX Service Area

You may be eligible to enroll with BCBSTX in the CHIP Program if you live in one of these counties: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson counties.



Part 1

How to Use This Book

Important Things to Do

Choose a Primary Care Provider (PCP)

A primary care provider (PCP) is your main health care provider. Your BCBSTX Member ID card will list the name of your/your child's PCP. If you want a different PCP, call the Customer Advocate Department.

Make an Appointment

- Set up a Well Child Checkup exam with your PCP right away. Your child should be seen by a doctor within 90 days after joining BCBSTX for a Well Child Checkup. A newborn should be seen by a doctor within 14 days after birth.
- CHIP Perinate members should set up an initial visit with an OB/GYN provider within 42 days of joining the plan or within your first 12 weeks of being pregnant.

If there is an Emergency

- If you or your child has an emergency, get help right away. Call **911** or go to the nearest emergency room for medical care. You will be covered for emergency services even if the provider is not part of the BCBSTX network.
- If you have a health problem or question that is not an emergency, you can call the 24/7 Nurse Advice Line toll-free at **1-844-971-8906**. Have your BCBSTX ID card ready when you call. The nurse will ask for your ID card number. They will help you get the care you need.

Register for Blue Access for Members

Our secure member portal allows you to order a new ID card, view your covered benefits, find doctors and hospitals and more. Visit **www.bcbstx.com/medicaid** to register.

You are important to us. We want to help you get the health care you need. Thank you for choosing BCBSTX.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

Important Phone Numbers

211 Texas

211

Information and referral line for State of Texas services: food, housing, senior services, health care, SNAP, Medicaid and CHIP

24/7 Nurse Advice Line

1-844-971-8906 (TTY*: **711**)

Customer Advocate Department

1-888-657-6061

Hours: Monday – Friday, 8 a.m. to 5 p.m. Central time, excluding state-approved holidays.

After hours and on weekends, if you have a non-urgent question, you may leave a message. Your call will be returned the next business day. Help is offered in English and Spanish. Interpreter services are available.

In an emergency, call **911**.

Customer Advocate Department TTY: **711** (After hours and on weekends, call Texas Relay at the number on page 4.)

CHIP Member Advocate

1-877-375-9097 (TTY: **711**)

CHIP Program Help Line

1-800-964-2777

Dental Contractors for CHIP Members and CHIP Perinate Newborn Members

DentaQuest

1-800-516-0165

MCNA Dental

1-800-494-6262

Department of Assistive and Rehabilitative Services (DARS)

1-800-628-5115

Disease Management Services

1-877-214-5630

Extra Help Getting a Ride (MTM Health)

1-866-824-1565 (TTY: **711**)

Behavioral Health and Substance Use Crisis Line

1-888-657-6061

This line is available in English and Spanish, 24 hours a day, seven days a week. Interpreter services are available. In an emergency, call **911**. TTY: **711**

Maximus Enrollment Broker

1-800-964-2777

*TTY lines are only for members with hearing or speech loss.

National Maternal Mental Health Hotline

1-833-TLC-MAMA (**1-833-852-6262**) TTY: **711**

Call or text to receive support from a professional counselor before, during or after pregnancy if you are feeling overwhelmed or depressed. The hotline is available 24/7 and they can provide resources, referrals and other information.

National Poison Control Center

1-800-222-1222

Calls are routed to the office closest to you.

Special Beginnings

1-888-421-7781

Texas Health and Human Services Commission

1-866-566-8989

Texas Department of State Health Services

Maternal and Child Health

1-512-776-7373

Texas Immunization Registry Help Desk

1-800-348-9158

Immunization Division

1-800-252-9152

Texas Relay Service or 711*

1-800-735-2989

Tobacco Cessation Program

1-877-937-7848 (TTY: **711**)

Call to join the Tobacco Cessation Program if you need help to quit smoking. Support, advice and education are provided throughout the program.

Vision (Eye Care)

1-888-657-6061

Women, Infants and Children Program

1-800-942-3678

Your Texas Benefits Medicaid Card

1-855-827-3748 or **211**

www.yourtexasbenefits.com

Suicide & Crisis Lifeline

988

Call or text **988** to receive support for anyone experiencing a mental health or substance use crisis. A trained crisis counselor is available 24/7 to provide free, confidential support.

*TTY lines are only for members with hearing or speech loss.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

Blue365 is a discount program only for BCBSTX members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Members should check their benefit booklet or call the Customer Service number on the back of their ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors that take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSTX reserves the right to stop or change this program at anytime without notice. The relationship between the Blue365 vendors and BCBSTX is that of independent contractors.

DentaQuest is an independent company that provides dental benefits for Blue Cross and Blue Shield of Texas plans.

Findhelp, formerly Aunt Bertha, is an independent company that provides community resource listings and discount programs for BCBSTX members.

Learn to Live provides educational behavioral health programs. Members considering further medical treatment should consult with a physician. Learn to Live, Inc. is an independent company that provides online behavioral health programs and tools for members with coverage through Blue Cross and Blue Shield of Texas.

MTM Health is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide transportation services for members with coverage through BCBSTX.

Hearing services are provided by Start Hearing, BeltoneTM, HearUSA and TruHearing®. Vision services are provided by ContactsDirect ®, Croakies, Davis VisionSM, EyeMed Vision Care, Glasses.com, Jonathan Paul Fitovers, and LasikPlus®.

Walgreens Mail Service is a separate and independent central specialty and home delivery pharmacy.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

BCBSTX complies with all applicable federal and state laws.

Part 2

BCBSTX Member ID Card

How to Use Your Member ID Card

Show your child's BCBSTX ID card to the doctor, hospital or other provider when you go or take your child for health care services.

Always carry the BCBSTX ID card with you in case of an emergency. Only the person whose name is on the card can get services under this BCBSTX ID card number. If you let someone else use the card, you/your child could lose CHIP plan coverage.

If you/your child need a new ID card or if you did not get an ID card, call the Customer Advocate Department at the number below. Members with hearing or speech loss may call our TTY line.

You will get a new BCBSTX ID card if:

- You change your PCP.
- The address or phone number for the PCP changes.
- The ID card gets lost.

How to Replace a BCBSTX ID Card If It Is Lost:

If you/your child needs a new BCBSTX ID card or did not get a BCBSTX ID card, call the Customer Advocate Department at the number below. Members with hearing or speech loss may call our TTY line. You can also request a new BCBSTX ID card and print a temporary card by logging into BAM℠, secure member portal for BCBSTX. To access BAM, visit **www.bcbstx.com/medicaid** and click the 'Log In' button at the top right of the page.

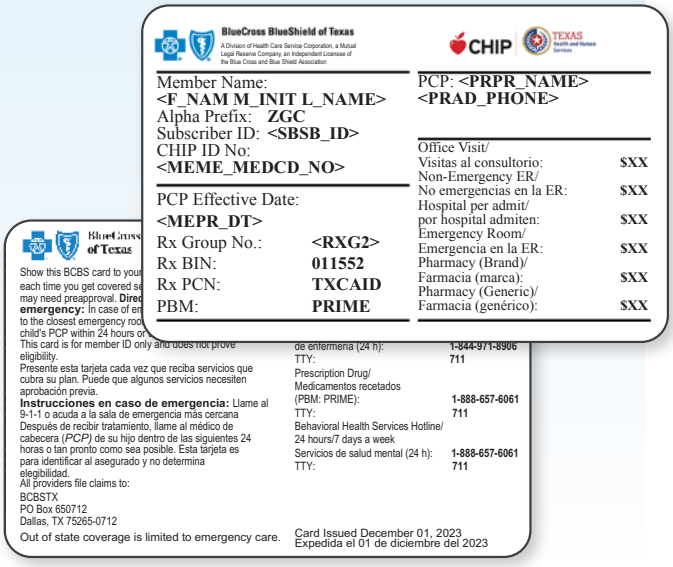
How to Read Your ID Card

The BCBSTX ID Card has these important details:

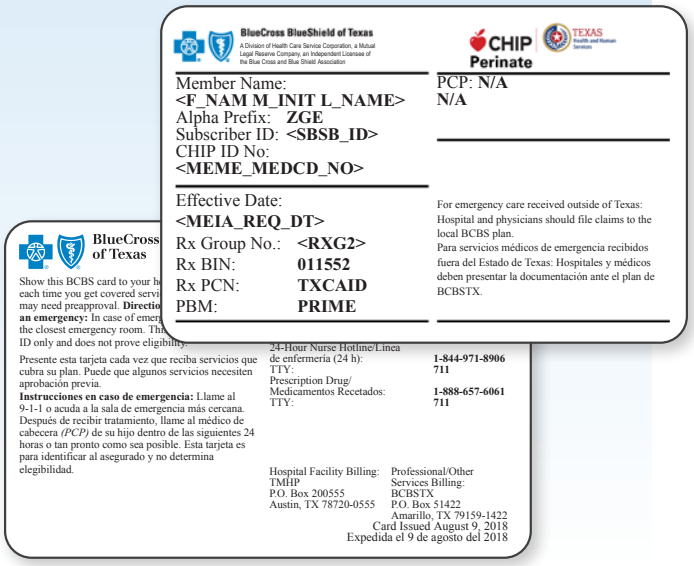
- Name
- Member ID number
- Subscriber ID number
- Effective date
- PCP name and phone number
- Copay information (if there is a copay)
- BCBSTX name and address
- Important phone numbers such as the Customer Advocate Department and TTY numbers, 24/7 Nurse Advice Line, behavioral health and pharmacy
- What to do in an emergency
- Instructions for help in Spanish

Below is a sample of what the card will look like.

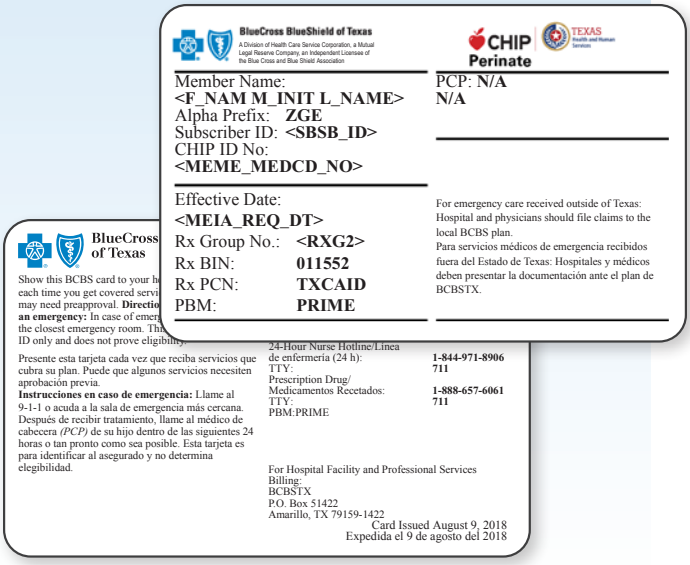
BCBSTX CHIP ID card



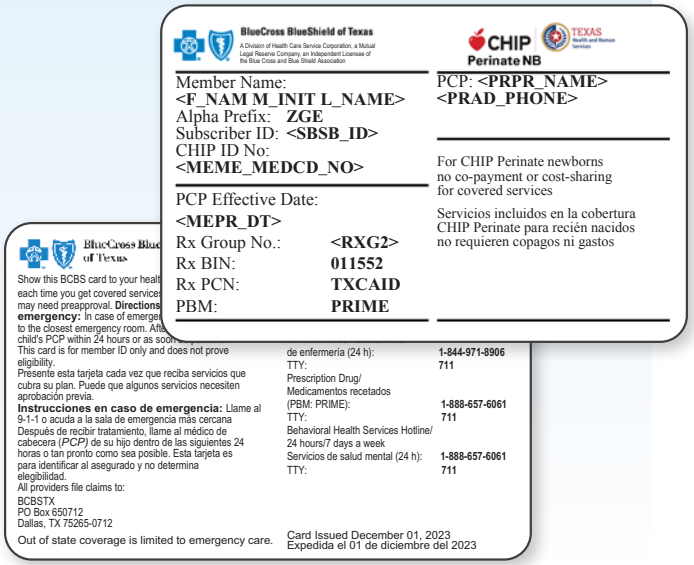
CHIP Perinatal ID card - under 185% FPL



CHIP Perinatal ID card - over 185% FPL



CHIP Perinatal ID card- Newborn



Part 3

How to Choose a Provider

Choosing a Primary Care Provider (PCP)

What is a Primary Care Provider?

A PCP is your/your child's main health care provider. Your/your child's BCBSTX ID card will have the name and phone number of the PCP you chose or the PCP assigned to you/your child, if you did not choose one.

A PCP can be a:

- Pediatrician
- Family or general practitioner
- Internist
- Obstetrician/gynecologist (OB/GYN)
- Nurse Practitioner (NP) or Physician Assistant (PA)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)

Can a clinic be my/my child's PCP?

Clinics such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHC) can also be PCPs.

Can I choose my baby's PCP before the baby is born? Who do I call? What information do they need?

You can choose a PCP for your baby before or after the baby is born. Call the Customer Advocate Department to choose your baby's PCP. You will be asked to provide your name and member ID number. You can find your ID number on your BCBSTX ID card. If you do not choose a PCP, we will choose one for you.

Part 4

How to Use Your Health Plan with BCBSTX

Making an Appointment with Your Child's Doctor (PCP)

Call your child's PCP for an appointment. Tell the doctor that your child is a CHIP member. Have your BCBSTX ID card with you when you call. You may be asked for the ID number on the card. If you need a ride to the appointment, call the Customer Advocate Department.

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

Make sure to take your child's BCBSTX ID card with you to the doctor's appointment. Be on time for appointments. Call the doctor's office as soon as possible if:

- You will be late.
- You cannot keep your child's appointment.

This will shorten everyone's time in the waiting room. The PCP may not be able to see your child if you are late.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

First Well Child Checkup

The first meeting with your child's new PCP is important. It is a time for you to get to know each other and talk about your child's health.

The doctor will:

- Get to know your child and talk about your child's health.
- Help you understand your child's medical needs.
- Teach you ways to make your child's health better or help keep him or her healthy.

We ask all new members to see their PCP as soon as possible but no later than 90 days after joining BCBSTX. Call your child's PCP to make an appointment today. Newborns should see their PCP within 14 days of joining BCBSTX and they should have at least six visits within the first 15 months of life.

What if I need to cancel an appointment?

If you need to cancel your appointment, call the PCP's office and they will help you set up a new appointment.

How do I get medical care after the PCP's office is closed?

Call your child's PCP before he or she gets any medical care, unless it is an emergency. You can call the PCP's office 24 hours a day at the number on your child's BCBSTX ID card. After regular business hours, leave a voicemail with your name and phone number. Either the PCP or an on-call doctor will call you back. If you have an emergency, call **911** or go to the nearest emergency room (ER). You can also call the 24/7 Nurse Advice Line.

Blue Access for Members

BAM is a secure member portal where you can:

- Print a temporary ID card or order a new card.
- Find doctors and hospitals under the 'Doctors and Hospitals' tab.
- View your covered benefits.
- See a list of your prescription drugs.
- View your care profile.
- Set up text message alerts.
- Get information on health and wellness.

It is easy to get started

1. Go to **www.bcbstx.com/medicaid**.
2. Click the 'Log In' button at the top of the page.
3. Then, click the 'Register Now' link to create an account.

Physician Incentive Plans

BCBSTX cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit medically necessary covered services to members. Right now, BCBSTX does not have a physician incentive plan.

Changing Your/Your Child's PCP

How can I change my/my child's PCP?

Call the Customer Advocate Department. It is important to know that when you change PCPs often, your health care may not be as good as it could be. If you choose to change, have your medical records sent to your new PCP.

How many times can I change my/my child's PCP?

There is no limit on how many times you can change primary care providers. You can change primary care providers by calling us toll-free at **1-888-657-6061** (TTY: **711**) or by writing to:

Blue Cross and Blue Shield of Texas
PO Box 201166
Austin, Texas 78720-9919

Are there any reasons why a request to change a PCP may be denied?

Your request to change your PCP may be denied if:

- You choose a PCP who is not taking new patients
- The PCP is not in our network
- The PCP is outside your service area

Can a PCP move me or my child to another PCP for noncompliance?

Yes. BCBSTX or a PCP, may ask you to change your/your child's PCP if:

- BCBSTX no longer works with that PCP.
- You keep missing appointments or you are often late to appointments.
- You or your child is rude, abusive or disrupts the PCP's office.

When will the PCP change become effective?

- Your/your child's PCP change will be effective on the date the change is made and you can schedule an appointment that same day.
- You will get a new ID card with the new PCP's name and contact details on it in about seven to 10 days.

What if I choose to go to another doctor who is not my/my child's PCP?

If you choose to go to a doctor who is not your/your child's PCP, call the Customer Advocate Department first. If you see a doctor who is not your PCP without an OK from us first, you may have to pay for the services you get.

Provider Directory/Provider Finder®

Look in the Provider Directory or on Provider Finder at **www.bcbstx.com/medicaid** to:

- Choose a PCP for your child under 'Family Practice,' 'Pediatrics' or 'General Practice' or 'FQHCs'.
- Choose a provider for a pregnant member under 'Family Practice', 'Obstetrics and Gynecology' or 'General Practice' or 'FQHCs'.

It is important to find the right PCP for your child. When choosing a PCP, you may have questions such as:

- What language does the PCP speak?
- Is the PCP's office open on weekends?

You can find these details in the Provider Directory or on Provider Finder. As a member of BCBSTX, you will get a new directory if you ask for one within five business days at no cost. To request a Provider Directory or to get help choosing a PCP, call the Customer Advocate Department.

If you would like to learn more about a PCP or a specialist, such as the doctor's specialty, medical school, residency training or board certification, visit these websites:

- American Medical Association **www.ama-assn.org**
- The Texas Medical Board **www.tmb.state.tx.us**

Our providers are given guidelines to help ensure you receive quality care based on evidence-based practice guidelines. These are clinical practice and preventive care guidelines. Guidelines are available to members upon request. Call the Customer Advocate Department if you would like a copy.

Part 5

Your Perinatal Provider for CHIP Perinate

Choosing a Perinatal Provider

How do I choose a perinatal provider?

Look in the Provider Directory or on Provider Finder at **www.bcbstx.com/medicaid**. If you need help finding a perinatal provider, call the Customer Advocate Department. You should have an initial visit with your OB/GYN within 42 days of joining the plan or within your first 12 weeks of being pregnant.

Will I need a referral?

No, you will not need a referral for a perinatal provider.

Can a clinic be a perinatal provider?

Yes, clinics such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHC) can also be perinatal providers.

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

Your perinatal provider should schedule an appointment within two weeks of your call to request an appointment.

What do I need to bring to my perinatal provider's appointment?

Make sure to take your BCBSTX CHIP Perinate ID card with you to the doctor's appointment. You should carry your card with you at all times in case of an emergency.

How do I get after hours care?

After regular business hours, call your perinatal provider and leave a voicemail with your name and phone number. Either your provider or an on-call doctor will call you back. If you have an emergency, call **911** or go to the nearest emergency room (ER). You can also call the 24/7 Nurse Advice Line.

Can I stay with my perinatal provider if they are not with BCBSTX?

Call the Customer Advocate Department if your perinatal provider is not with BCBSTX. We can help you find a new provider or we can work with your current doctor to keep seeing you. Pregnant members with 12 weeks or less remaining before the expected delivery date can continue seeing their current perinatal provider through the postpartum checkup, even if the provider is or becomes, out-of-network.

Can I choose my baby's PCP before the baby is born? Who do I call? What information do they need?

You can choose a PCP for your baby before or after the baby is born. Call the Customer Advocate Department to choose your baby's PCP. You will be asked to provide your name and member ID number. You can find your ID number on your BCBSTX ID card. If you do not choose a PCP, we will choose one for you.

Part 6

Access to Care – CHIP and CHIP Perinate Newborn

Enrollment

Concurrent Enrollment of Family Members in CHIP and CHIP Perinate

Children enrolled in CHIP will remain in the CHIP program, but will be moved to the managed care organizations that are providing the CHIP Perinatal coverage. Copayments, cost-sharing and enrollment fees still apply for those children enrolled in the CHIP Program.

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

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

How long is my baby covered? How does renewal work? (CHIP Perinate Newborn only)

Your baby will be covered for 12 months under the CHIP Perinate Newborn Program.

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

If you/your child need medical care when traveling, call us toll-free at **1-888-657-6061** and we will help you find a doctor. If you/your child need emergency services while travelling, go to a nearby hospital, then call the Customer Advocate Department.

What if I/my child is out of state?

If you/your child need medical care while you are out of the state, call the Customer Advocate Department.

What if I/my child is out of the country?

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

Specialty Care

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

The PCP may send you/your child to a different provider, including a specialist, for special care or treatment.

- The PCP's office can help you make the appointment.
- Tell the PCP as much as you can about your child's health, so you both can decide what is best for your child.
- The PCP will help you choose a specialist who will give your child the care he or she needs.
- The PCP must send an OK to a specialist before services are given.
- A specialist may treat your child for as long as he or she thinks treatment is needed.

How soon can my child expect to be seen by a specialist?

You will get your child's referral within 30 days of the request.

Who do I call if I/my child has special health care needs and I need someone to help me?

BCBSTX allows members with special health care needs to have direct access to the right specialists for their conditions and identified needs. This includes a standing referral to a specialty doctor. These services are at no extra cost and include:

- Service Coordination to help you get the health services you need
- Your specialist can act as your PCP

If you would like to speak to a service coordinator, please call **1-877-214-5630** between 8 a.m. and 5 p.m., Central time, Monday through Friday.

Referrals

What is a referral?

A referral is when one provider recommends a member see another provider or specialist.

What services do not need a referral?

Several types of care do not need an OK from your child's PCP:

- OB/GYN services (You must choose doctors in the BCBSTX network.)
- Family planning services
- Emergency care
- Well Child Checkups
- Behavioral health and substance use services. (You must choose doctors in the BCBSTX network.)
- Vision services

Prior Authorizations

Some services may require your child's PCP to get an OK from BCBSTX to make sure they are covered. This means that both BCBSTX and your child's PCP (or specialist) agree that the services are medically necessary. 'Medically necessary' generally refers to services that:

- Protect life.
- Keep your child from getting seriously ill or disabled.
- Reduce severe pain through the diagnosis or treatment of disease, illness or injury.

For more information about medically necessary services, see **Part 8: Routine, Urgent and Emergency Services**.

We may ask your child's PCP why he or she needs special care. We may not OK the service you or your child's PCP asks for. We will send the PCP a letter to explain why we would not cover the service. It will tell you how to appeal our decision. You or the PCP can call the Customer Advocate Department.

You may also write to us at:

Blue Cross and Blue Shield of Texas
PO Box 201166
Austin, Texas 78720-9919

Second Opinions

You might have questions about care your child's doctor says is needed. You may want a second opinion to:

- Diagnose an illness.
- Make sure the treatment plan is right for your child.

How can I ask for a second opinion?

You should speak to your child's doctor if you want a second opinion. Your child's doctor will send you to a doctor who works in the same field as your PCP or the specialist you saw first.

If we do not have an in-network provider that meets your child's needs, your PCP may refer you to an out-of-network provider at no extra cost. You must get an OK to see an out-of-network provider.

If you need help getting a second opinion or want to learn more, you can call the Customer Advocate Department or the 24/7 Nurse Advice Line.

If you are denied a second opinion, you may appeal. See **Part 15: How to Resolve a Problem** to file a complaint.

Renewing Your Benefits

It is important to renew your CHIP/children's Medicaid coverage on time or your child's coverage could end. You will get a renewal letter in the mail at least two months before your child's coverage is due to end.

Go online at **www.YourTexasBenefits.com** and choose 'Manage Your Account' to log in or create an account. You will then be able to complete your renewal application online. If you have questions or would like a paper copy of the application, call **211**. Our CHIP member advocate can also help you understand your application.

What do I have to do if I/my child move?

As soon as you have your new address, give it to the Health and Human Services Commission (HHSC) by calling **211** or updating your account on **YourTexasBenefits.com** and call the Customer Advocate Department at **1-888-657-6061** or TTY **711**. Before you get CHIP services in your new area, you must call BCBSTX, unless you need emergency services. You will continue to get care through BCBSTX until HHSC changes your address.

You will still get benefits through BCBSTX until your new address is changed by HHSC and you pick a new plan. We will assist you in finding doctors near your new home until you select a local plan. If you have any questions, please call the Customer Advocate Department. If you leave the state, you will no longer be eligible for benefits.

Changing Health Plans

What if I want to change health plans?

You are allowed to make health plan changes:

- For any reason within 90 days of enrollment in CHIP;
- For cause at anytime;
- If you move to a different service delivery area;
- During the annual CHIP re-enrollment period.

Who do I call?

For more information, call the Customer Advocate Department or Maximus, the enrollment broker, at **1-800-964-2777**.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

How many times can I change health plans? When will my health plan change become effective?

You can only change your health plan once per year if it is after the first 90 days of enrollment in CHIP. If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

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

Can BCBSTX ask that I get dropped from their health plan for non-compliance?

Yes. BCBSTX may ask you to change your health plan if you:

- Make it a habit to use the emergency room for non-emergency care.
- Keep making appointments and do not show up for them.
- Are often late for your appointments.
- Misrepresent yourself.
- Negatively affect BCBSTX's ability to give or arrange services for you or other members.
- Negatively impact a provider's ability to give services to other patients.

If you have a complaint about BCBSTX's request to disenroll you, see **Part 15: How to Resolve a Problem**.

Part 7

Access to Care – CHIP Perinate

Enrollment and Eligibility

If you are a CHIP Perinate member who has children concurrently enrolled with another CHIP managed care plan, your other CHIP children will be moved to BCBSTX to help us better manage your family's care. Copayments, cost-sharing and enrollment fees still apply for those children enrolled in the CHIP Program.

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

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

When Your Eligibility Ends

When does CHIP Perinatal coverage end?

Your CHIP Perinatal benefits will continue until you deliver your baby. After delivery, BCBSTX will cover two postpartum visits before your coverage ends.

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

Yes. You will get a letter in the mail from the state telling you that you no longer have these benefits.

How does renewal work?

Once you have your baby, you are no longer eligible for the CHIP Perinate program and cannot renew your benefits.

Changing Health Plans

How will my baby be covered after it's born?

- 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
  - for cause at anytime

Who do I call?

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

How many times can I change health plans? When will my health plan change become effective?

You can change your health plan once per year. If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

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

Can BCBSTX ask that I get dropped from their health plan for non-compliance?

Yes. BCBSTX may ask you to change your health plan if you:

- Make it a habit to use the emergency room for non-emergency care.
- Keep making appointments and don't show up for them.
- Are often late for your appointments.
- Misrepresent yourself.
- Negatively affect BCBSTX's ability to give or arrange services for you or other members.
- Negatively impact a provider's ability to give services to other patients.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

If you have a complaint about BCBSTX's request to disenroll you, see **Part 15: How to Resolve a Problem** with BCBSTX.

Out-of-Town Care

What if I get sick when I am traveling?

If you need medical care when traveling, call us toll-free at **1-888-657-6061** and we will help you find a doctor.

If you need emergency services while travelling, go to a nearby hospital, then call the Customer Advocate Department.

What if I am out of state?

If you need medical care while you are out of the state, call the Customer Advocate Department.

What if I am out of the country?

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

Part 8

Routine, Urgent and Emergency Services

Medically Necessary

What does Medically Necessary mean?

1 Health Care Services that are:

- **a** reasonable and necessary to prevent illnesses or medical conditions or provide early screenings, 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 substance use 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.

Routine Medical Care

What is routine medical care?

Routine care is the regular care you get from your PCP to help keep you healthy, such as regular checkups. You can call your PCP to make an appointment for routine care.

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

Your child should be able to see their PCP within 14 days from the date you call to make the appointment.

Do not use the ER for routine care. If you do so, you will have to pay for these services. We do not cover ER visits for routine care.

Urgent Medical Care

What is urgent medical care?

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

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

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

For urgent care, you should call your child's PCP, even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes BCBSTX CHIP. For help, call the Customer Advocate Department or the 24/7 Nurse Advice Line.

How soon can I/my child expect to be seen for an urgent care appointment?

You should be able to see your child's PCP within 24 hours for an urgent care appointment.

Emergency Medical Care

What is emergency medical care?

Emergency medical care is provided for emergency medical conditions and emergency behavioral health conditions.

For CHIP and CHIP Perinate Newborn

What is an Emergency, an Emergency Medical Condition and an Emergency Behavioral Health Condition?

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

- placing the member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or

- in the case of a pregnant CHIP member, serious jeopardy to the health of the CHIP member or her unborn child.

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

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

Call **988** if you or someone you know is having a mental health or substance use crisis.

What is Emergency Services or Emergency Care?

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

For CHIP Perinate

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.

What to Do in an Emergency

Call **911** or go to the nearest ER for emergency medical care. You should go to the ER if you/your child:

- May die
- Have chest pains
- Cannot breathe or are choking
- Have passed out or are having a seizure
- Are sick from poison or a drug overdose
- Have a broken bone
- Are bleeding a lot
- Are about to deliver a baby
- Have a serious or severe injury, burn or allergic reaction
- Have an animal bite
- Feel you are a danger to yourself or others

You may call **911** for help getting to the ER. You do not need an approval from BCBSTX for transport to the ER. If you need help deciding if you should call your doctor, visit urgent care or the ER, call the 24/7 Nurse Advice Line.

How soon can I expect to be seen?

Your child will be seen as soon as possible. Your child will be covered for emergency services even if the provider is not part of our network

Post-Stabilization

What is post-stabilization?

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

Part 9

Covered Services – CHIP and CHIP Perinate Newborn

What are my CHIP benefits? What are the CHIP Perinate Newborn benefits?

BCBSTX offers health care benefits and access to care to help you stay well. You can find a summary of covered services on the next page. You can also go to **Part 19: Details about CHIP Covered Services** for more information about your CHIP benefits.

What benefits does my baby receive at birth?

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

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

How do I/my child get these services?

Your child's PCP will order any medically necessary services. We will only pay for covered services. Some covered services need an OK from BCBSTX first. If you have questions about a covered service and whether it needs an OK first, call the Customer Advocate Department.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

Are there any limits to covered services?

Yes, covered services for CHIP and CHIP Perinate Newborn members must be medically necessary and may have limits. For more information about what medically necessary means, see **Part 8: Routine, Urgent and Emergency Services**.

What services are not covered?

We will only pay for those services we OK and that are considered medically necessary. If you are unsure if your treatment options are a covered benefit, call the Customer Advocate Department. Services not covered include, but are not limited to:

- Services, supplies and medical equipment that are not medically necessary
- Procedures that are new or still being tested
- Cosmetic surgeries that are not medically necessary
- Weight loss drugs or diet aids
- Any services received outside of the United States

How can I get Evidence of Coverage (EOC)?

See **Chapter 16: Other Things You May Need to Know** to learn how to access EOC.

How does BCBSTX evaluate new technology for inclusion as a covered benefit?

New technologies for inclusion as a covered benefit are reviewed and evaluated by the Medical Policy Review Committee at BCBSTX. Decisions are based on what treatment types are considered medically necessary. For more information on what medically necessary means, see **Part 8: Routine, Urgent and Emergency Services**.

Covered Services

The chart below tells you about the benefits and services covered by this plan. All services must be medically necessary.

Covered Service or Benefit	Details and/or Limitations
Behavioral Health for CHIP members only (not a covered benefit for CHIP Perinate members)	• Inpatient mental health services • Inpatient and residential substance use treatment services • Outpatient mental health or substance use services • Intensive outpatient services for substance use • Partial Hospitalization for substance use • Substance use disorders
Chiropractic Services	• Covers services that help keep the spine and other body structures straight. Services are limited to spinal subluxation (bones in the spine are out of place). • Needs an OK from us
Durable Medical Equipment (DME) and Supplies Thrown Away After Use	• Must be medically necessary • Within the limits of what is covered by Medicaid • Needs an OK from us
Early Childhood Intervention	• No referral needed
Emergency Services	• Emergency room • Ambulance services • An OK ahead of time is not needed
Home Health Services	• Nursing services • Personal care services
Hospice Care	• Covered services for members who are not likely to live for more than six months • Needs an OK from us
Inpatient Hospital Services	• Hospital room with more than two beds • Operating room • Anesthesia • Nursing care • Surgery • Needs an OK from us

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

Covered Service or Benefit	Details and/or Limitations
Lab Services	• All lab services ordered by your child's provider and done in a proper setting
OB/GYN Services	• Prenatal care • Care for any OB/GYN-related medical condition • One well-care checkup per year
Orthotics and Prosthetics	• Parts needed such as manmade arms or legs and the parts needed to attach them • Orthotic braces, splints or ankle and foot supports • Covered when medically necessary • Need an OK from us
Outpatient Hospital Services	• Emergency room use • Dialysis • Giving you someone else's blood • Needs an OK from us
Physician Services	• Visits to doctors, specialists and other providers • Well exams
Pregnancy and Maternity Care	• Pregnancy • After-delivery care when medically necessary • Newborn exams
Prescription Drugs	• BCBSTX uses a preferred drug list • Some drugs need an OK from BCBSTX
Preventive Care Services	• Well Child exams and preventive services (including but not limited to, vision and hearing screenings and immunizations)
Radiology Services	• X-rays, CT scans, MRIs, PET scans
Rehabilitation Services	• Includes physical, occupational and speech therapies • Must get an OK from us
Skilled Nursing Facilities (SNFs)	• Routine nursing • Rehab • Medical supplies • Use of appliances and equipment given by SNFs

Covered Service or Benefit	Details and/or Limitations
Smoking Cessation Programs (to stop smoking)	• Up to $100 annually for a program approved by BCBSTX
Transplants	• Human organ and tissue transplants that are not still being tested • All corneal, bone marrow and peripheral stem cell transplants that are not still being tested • Includes donor medical costs
Vision Services	• Annual vision exam • One pair of non-prosthetic eyewear annually

Well Child Visits

Well Child visits are for children ages 18 and under. These services follow the American Academy of Pediatrics Child Health and Disability Prevention program rules. We ask doctors to schedule these visits within 14 calendar days of the time you call. Your child may go to any CHIP provider for a Well Child care visit. During these visits:

- The doctor checks the child's physical health, hearing, vision and teeth.
- Your child will get vaccines (shots).
- You should ask the doctor when to bring your child in for the next visit.

We will send you a letter to remind you of your child's yearly Well Child visit.

BCBSTX provides its doctors with information about their childhood obesity program to teach parents about exercise and good eating habits for children.

Service Coordination

What is Service Coordination?

Service Coordination is a benefit offered to members with special health care needs.

BCBSTX Service Coordinators will work with you to make a service plan that will coordinate services between your PCP, specialty care providers and any non-medical providers. If you have special health care needs, Service Coordination can help you get access to available services and supports and teach you how to use the services correctly.

If you have a chronic illness, our Service Coordination team may be able to help you manage your health condition. To learn more, see **Part 13: Programs to Help Keep You Well**.

How can I get Service Coordination?

If you would like Service Coordination, call **1-877-214-5630** from 8 a.m. to 5 p.m., Central time, Monday through Friday.

Behavioral Health Services for CHIP members

How do I get help if I/my child have behavioral (mental) health, alcohol or drug problems? Do I need a referral for this?

You do not need a referral from your PCP for behavioral health or substance use disorder treatment services but you may want to talk to your PCP about the issue.

These providers can help members who have:

- Mental disorders
- Emotional disorders
- Substance use disorders

We cover inpatient and outpatient mental health and substance abuse services. Sometimes, members with mental health or substance abuse issues need 24-hour care in the hospital or a place like home. Services may include:

- Medicine
- Counseling
- Working with other family members

You must get an OK from BCBSTX for all hospital care. BCBSTX needs an OK from a doctor for inpatient psychiatric care or drug/alcohol treatment. Call Service Coordination at **1-877-214-5630** or the Customer Advocate Department at **1-888-657-6061** (TTY:**711**) for help finding treatment services or for discharge planning.

Emergency and Crisis Support

In addition, BCBSTX offers emergency and crisis support. If, at anytime, you/your child is acting in a way that you think might lead to a mental health emergency situation, call the BCBSTX Behavioral Health and Substance Abuse Crisis Line at **1-888-657-6061** (TTY: **711**).

You may call at anytime of day or night and on any day of the week. You will be able to talk to a mental health professional.

Tobacco Cessation Program

A Service Coordinator can connect you with resources to help you stop smoking. Call the Tobacco Cessation Line at **1-877-262-2674** (TTY **711**).

Dental Services

How do I get dental services for my child?

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

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

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

The CHIP medical benefit provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth and removal

of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for craniofacial anomalies and drugs.

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

What do I do if I need/my child needs emergency dental care?

During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call us toll-free at **1-888-657-6061** (TTY **711**).

Early Childhood Intervention

What is Early Childhood Intervention?

Early Childhood Intervention (ECI) is a statewide program that helps children from birth to age three with disabilities or developmental problems. You do not need an OK from your doctor but you should talk to your child's PCP about ECI so your child can get the best care. To learn more call **1-800-628-5115** or visit the ECI website at **https://hhs.texas.gov/services/disability/early-childhood-intervention-services**.

Do I need a referral for this?

No, you do not need a referral from your doctor for the ECI program.

Where do I find an ECI provider?

You can search for the ECI program in your area by using the ECI program tool at **https://citysearch.hhsc.state.tx.us** or call the HHSC Office of the Ombudsman at **1-877-787-8999**, select the language and choose option 3.

Women's Health Care Services

What if I/my daughter needs OB/GYN care? Do I have the right to choose an OB/GYN? (Does not apply to CHIP Perinate Newborn members)

Attention Members

- You have the right to pick an OB/GYN for yourself/your daughter without a referral from your/your daughter's PCP. An OB/GYN can give you:
- One Well Woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to special doctor (specialist) within the network.

BCBSTX allows you/your daughter to pick any OB/GYN, for you/your daughter but this doctor must be in the same network as your/your daughter's PCP.

How do I choose an OB/GYN?

You can look in the Provider Directory or Provider Finder to choose an OB/GYN.

If you are pregnant, call the Customer Advocate Department. We can help you get the care you need and help you choose a PCP for your baby.

If I don't choose an OB/GYN, do I have direct access or will I need a referral?

If you do not choose an OB/GYN as your PCP, you will be allowed direct access to OB/GYN services in the network without a referral from your PCP.

Can I/my daughter stay with an OB/GYN who is not with BCBSTX?

The OB/GYN must be in the same network as the PCP. No referral is needed to see an OB/GYN. A pregnant member with 12 weeks or less remaining before the expected delivery date may remain under her current

OB/GYN's care through the postpartum checkup, even if the OB/GYN doctor is or becomes, out-of-network.

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

You should be seen within 14 calendar days from the date you call to schedule your appointment.

Pregnancy Care

What if I/my daughter is pregnant? Who do I need to call?

If you/your child is pregnant, call our Customer Advocate Department number. We can help you find an OB/GYN and a hospital that is in network. We can also talk to you about programs, resources and Value-Added Services available during pregnancy and after delivery.

Also, call your Health and Human Services Commission (HHSC) caseworker and tell him or her that you or your child is pregnant.

If you have not already called us to choose a PCP for your child's baby, you can call after the baby is born. Call the Customer Advocate Department to choose the baby's PCP. Members with hearing or speech loss may call the TTY line at **711**.

If you do not choose a PCP, we will choose one for you. The parent of the newborn may ask that the newborn's health plan coverage be changed to another health plan during the first 90 days after the baby is born. Call the CHIP enrollment broker, Maximus, at **1-800-964-2777**.

When should I get an appointment with my PCP? How soon can I be seen after contacting my OB/GYN for an appointment?

You need to set up your first prenatal care visit:

- As soon as possible, but no later than 42 days after enrollment in the plan or the first trimester (the first three months) of your pregnancy
- The doctor should see you within 14 calendar days from the date you call if you are in your first three months of pregnancy.
- The doctor should see you within seven calendar days from the date you call if you are in the second trimester of pregnancy.
- The doctor should see you within five business days from the date you call if you are in the last trimester (the last three months) of pregnancy

Will I need a referral?

No. You will not need a referral or prior-authorization to see an in-network OB/GYN.

Call your OB/GYN and ask to set up an appointment right away if you have an emergency. Also, call your OB/GYN if you think you have a high-risk condition that has to do with pregnancy.

CHIP members who become pregnant may qualify for Medicaid, but you must apply. If you are eligible for Medicaid, you will be disenrolled from CHIP once you are enrolled in the Medicaid program. If you or your child are not eligible for Medicaid, you may be eligible for CHIP Perinate. If your health plan changes, we will coordinate your Medicaid coverage to avoid gaps in care.

If we are not aware of the member's pregnancy until delivery, CHIP will cover the delivery. The baby will be automatically enrolled in the mother's CHIP plan at birth and follows the same time frame as the mother to re-enroll and remain eligible. The member is covered until the date the coverage ends or through the end of the second full month after the month of the infant's birth, if that date is later.

What other services/activities/education does BCBSTX offer pregnant women?

We can provide you information about:

- Caring for yourself and your new baby
- Perinatal and breastfeeding news
- How to choose a PCP for your baby

As part of our Value-Added Services for pregnant members, we offer prenatal classes to help you learn how to care for yourself and for your baby. These classes are available at no cost to you. See **Part 11: Value-Added Services** for more information.

Vision Services

How do I get eye care services for myself/my child?

Call the Customer Advocate Department.

Copayments and Cost-Sharing

What are copayments (copays)?

A copay is the part of the cost you pay when you get care from a doctor. Cost-sharing is the total amount you will spend out of pocket based on your household income in the benefit year. Each family member pays a copay when getting health care until the family's cost-sharing limit is reached.

There is no lifetime limit on benefits, but lifetime limits do apply to some services. If services with a 12-month per year limit are all used in one six-month time frame, these services are not offered in the second six months in that same 12-month time frame.

How much do I have to pay for my child's health care?

Each family has its own cost-sharing limit. This means you pay a copayment for each service until you reach the cost-sharing limit. Once your family's cost-sharing limit is reached, you will not have to pay another copay in the benefit year.

When you go to your PCP, fill a prescription or have to go to a hospital, ask for a receipt and keep your receipts until you reach your cost-sharing cap. Once you have met your cost-sharing cap, contact Maximus, the enrollment broker. How much are copays and when do they apply?

The tables below show your plan's copays and when they apply. Your copays will be included on your BCBSTX member identification card.

If you have questions, call the Customer Advocate Department.

CHIP Cost-Sharing	Effective July 1, 2022
Enrollment Fees (for 12-month enrollment period):	
	Charge
At or below 151% of FPL* or otherwise exempt from cost- sharing.	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50

CHIP Cost-Sharing	Effective July 1, 2022
Copays (per visit):	
At or below 151% FPL	**Charge**
Office Visit (non-preventive) No Copay is applied for MH/SUD Office Visits.	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Copay, Inpatient (per admission) No Copay is applied for MH/SUD residential treatment services.	$35
Cost-sharing Cap	5% (of family's income)**

CHIP Cost-Sharing	Effective July 1, 2022
Copays (per visit):	
Above 151% up to and including 186% FPL	**Charge**
Office Visit (non-preventive) No Copay is applied for MH/SUD Office Visits.	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***

CHIP Cost-Sharing	Effective July 1, 2022
Facility C opay, Inpatient (per admission) No copay is applied for MH/SUD residential treatment services.	$75
Cost-sharing Cap	5% (of family's income)**

CHIP Cost-Sharing	Effective July 1, 2022
Copays (per visit):	
Above 186% up to and including 201% FPL	**Charge**
Office Visit (non-preventive) No Copay is applied for MH/SUD Office Visits.	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Copay, Inpatient (per admission) No copay is applied for MH/SUD residential treatment services.	$125
Cost-sharing Cap	5% (of family's income)**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.

**Per 12-month term of coverage.

***Copays for insulin cannot exceed $25 per prescription for a 30-day supply, in accordance with Section 1358.103 of the Texas Insurance Code.

If the member's card shows a copay requirement and the member is Native American or Alaskan Native, the member should call the Customer Advocate Department at **1-888-657-6061**. Members with hearing or speech loss can call the TTY Line at **711** to have this corrected.

All CHIP Members are exempt from copays on benefits for well-baby and Well Child services, preventive services or pregnancy-related assistance.

Members receiving the CHIP Perinatal benefit are exempt from all cost- sharing obligations, including enrollment fees and copays.

Part 10

Covered Services – CHIP Perinate

What Are My Unborn Child's CHIP Perinatal Benefits?

Please see **Part 19: Details about CHIP Covered Services** for more information on covered services.

CHIP Perinatal benefits include:

- Regular checkups and office visits including two postpartum visits for the mother after delivery
- Hospital care and services, including emergency services
- Prenatal care and pre-pregnancy family services and supplies
- Labor and delivery
- Birthing center services
- Prescription drug benefits
- Service Coordination (care coordination)

How do I get these services?

You will get these services from your perinatal provider.

What services are not covered?

For more information about what is not covered, see **Part 19**. We will only pay for those services we OK and that are considered medically necessary. If you are unsure if your treatment options are a covered benefit, call the Customer Advocate Department. Services not covered include, but are not limited to:

- Inpatient and outpatient treatments other than:
  - Prenatal care
  - Labor and delivery
  - Services that have to do with miscarriage and a nonviable pregnancy
  - Care after childbirth that has to do with the covered unborn child until birth
  - Inpatient and outpatient mental health services
- Services, supplies and medical equipment that are not deemed medically necessary
- Procedures that are new or still being tested
- Cosmetic surgeries that are not medically necessary
- Weight loss drugs or diet aids
- Any services received outside of the U.S.

How much do I have to pay for my unborn child's health under CHIP Perinatal?

There are no copayments or cost-sharing for your child under CHIP Perinatal.

What if I need services not covered by CHIP Perinatal? Will I have to pay for services that are not covered benefits?

BCBSTX will only pay for covered services. If you need services that are not covered by CHIP Perinatal, call to speak to a Service Coordinator at **1-877-214-5630**. We will help you find community resources that may be able to help you get these services.

How can I get Evidence of Coverage (EOC)?

See **Chapter 16: Other Things You May Need to Know** to learn how to access EOC.

Part 11

Value-Added Services

What extra benefits does a member of BCBSTX get?

BCBSTX offers many Value-Added Services (VAS) to help you stay healthy. These services are offered at no cost to you. Read each section to learn more about each VAS.

- Free rides to non-emergency doctor visits, therapy, pharmacy and classes
- 24/7 Nurse Advice Line
- Infant Well Child Checkup Gift Card
- Child and Adolescent Checkup Gift Card
- Human Papillomavirus (HPV) Vaccine Gift Card
- Upgrade to Eyewear or Contact Lenses for Kids
- Sports and Camp Physicals
- Health and Wellness Activity Reward
- Online Prenatal, Postpartum and Grief Classes
- Prenatal Visit Gift Card
- Breastfeeding Education
- Postpartum Visit Gift Card
- In-Home Meal Delivery Services after a Qualifying Hospitalization
- Dental Services for Adult Members
- Online Behavioral Health (BH) Resources
- Blue365 Health and Wellness Program

How do I/my child/my unborn child get these benefits?

Call our toll-free the Customer Advocate Department number at **1-888-657-6061**. If you have hearing or speech loss, you may call the Customer Advocate Department TTY line at **711**.

Value-Added Services may have restrictions and limitations.



How do I get my reward if I've earned a gift card as a VAS?

When you earn a gift card reward as a VAS for making a healthy choice, you will need to register for Healthy Rewards℠. You will need your member ID card, date of birth and email address to set up your account at **BCBSTX.com/WellnessRewards**. You can also call us at **1-877-860-2837** (TTY/TDD: **711**) for help signing up for Healthy Rewards.

Once registered, you will receive an email letting you know that your account is set up. Then you're ready to start earning rewards!

What are the gift card restrictions?

These restrictions apply to ALL gift card VAS. You must be an active member on the plan and the member/parent/guardian must register through the Wellness Rewards gift card program portal to receive the gift card. The gift card will not automatically be mailed if the member is not registered.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

Gift card awards are based on claims your doctor will send to BCBSTX after the checkup is completed. Once your doctor sends BCBSTX the claim, it could take up to two months for you to get the gift card after the required health action is completed.

The gift card will be sent to the address you have listed as your mailing address with HHSC. If you have moved, be sure to update your address with HHSC within 10 days. Gift cards will not be re-issued if the mailing address is listed incorrectly with HHSC.

Extra Help Getting a Ride

How do I get transportation benefits?

CHIP and CHIP Perinate members can call our VAS transportation vendor, MTM Health at **1-866-824-1565** (TTY: **711**) to schedule free rides to scheduled health care appointments, the pharmacy, health classes and therapy.

It's easy to schedule a ride on your phone! Search and download 'MTM Link Member mobile app' in the app store on your smart phone and create an account. You must have an email address to create an account. Book your ride through the app at least two business days before your appointment. You can also make changes, cancel and track your ride through the app.

Out-of-Area Rides

CHIP members can also get extra help with non-emergency rides to doctor visits over 75 miles away from home. Rides over 75 miles away are considered out-of-area. For help with out-of-area rides, hotel stays and food, you must ask for approval at least five business days before the scheduled appointment. CHIP Perinate members cannot use the out-of-area portion of the VAS transportation benefit.

Please have this information ready when you book your appointment over the phone or through the app:

- Your full name, current address and phone number
- Your member ID number
- The date you want to ride
- The name, address and phone number of where you are going
- What kind of appointment you are going to
- If you will need a wheelchair van or some other kind of help during your trip

MTM Link Member Mobile App

As a member, you can also download the MTM Link Member mobile app to schedule medical rides. All you need to do is search 'MTM Link Member' on either Google Play® or the Apple App Store® to download. Make sure to have an email address handy to create your account.

The MTM Link Member mobile app gives you access to:

- Booking, changing or cancelling rides
- Live ride tracking
- Driver's real-time location and estimated time of arrival
- Text or calling the driver to ensure trips aren't missed
- Support contact within the app to talk to a live agent

Limitations: This VAS is for CHIP members for medical services, WIC appointments, health education classes, MCO meetings and events.

Members can get free rides to approved services such as non-emergency doctor visits, therapy, pharmacy, WIC visits, BCBSTX member events and meetings, approved health classes or for covered services where the parent needs to bring more than one child.

Approved transportation in the service area and less than 75 miles apply to CHIP and CHIP Perinate members and requires authorization. VAS Transportation greater than 75 miles including Lodging and Food allowances are limited to CHIP members. CHIP Perinate is excluded from this VAS greater than 75 miles.

This VAS requires two business days advance scheduling. BCBSTX may approve rides with less notice on a case-by-case basis. Lodging and food allowances are limited to CHIP members and one parent, guardian or authorized caregiver only. Lodging and food do not apply to CHIP Perinate members. All lodging and meals expenses for CHIP members will require five business days' prior approval. Requests for overnight lodging and transport may be approved in less than five business days on a case-by-case basis. Travel, food and lodging greater than 75 miles from the members' home will only be approved for prior approved medical appointments. This service does not include emergency transportation benefits.

How do I get reimbursement for transportation costs?

You can get reimbursement for approved appointments through our VAS transportation vendor, MTM Health. You must complete an Individual Transportation Participant (ITP) Agreement. You can download a copy from **https://www.mtm-inc.net/texas/members/** or call MTM Health to ask for the packet at **1-866-824-1565** (TTY: **711**) between 8 a.m. and 5 p.m. Central time, Monday through Friday. Return the completed documents by mail, fax or email to the following:

Mail: MTM Health ITP Claims
16 Hawk Ridge Circle
Lake St. Louis, MO 63367

Email: TXPayee@mtm-inc.net

Fax: 1-844-239-5971

Limitations: To get reimbursed, BCBSTX must approve the trip and the driver before the trip is taken. You must call at least two business days before the scheduled visit. CHIP and CHIP Perinate members are eligible.

24/7 Nurse Advice Line

Members can call the 24/7 Nurse Advice Line anytime, day or night, to get general health management information. Our nurses can give you information about health issues and help you decide if you should call your doctor, visit the ER or urgent care or treat the problem yourself. Call toll free **1-844-971-8906** (TTY: **711**) and get answers to your health questions.

Teens may also call the 24/7 Nurse Advice Line and speak to a nurse in private about teen health issues.

Learn about hundreds of other health topics we have stored in our audio tape library on topics such as:

- Pregnancy
- Diabetes
- Children's health
- High blood pressure
- Sexually transmitted diseases such as HIV/AIDS

The 24/7 Nurse Advice Line offers interpreter services if you need to speak to someone in your own language.

Limitations: There are no limitations. Members may access the Nurse Advice Line at anytime. CHIP and CHIP Perinate members are eligible.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.



Gift Card for Child and Adolescent Checkups

CHIP members ages 2 to 18 can earn a $25 gift card when they visit their PCP or OB/GYN for a yearly Well Child checkup.

Limitations: Parents or guardians of child members ages 2 through 18 years must ensure their child completes their well child checks by the defined criteria. Members must be active on the plan and register on BCBSTX Wellness Rewards to qualify for and receive the $25 gift card. Checkups must be performed by an in-network PCP. Members are eligible for one gift card award each calendar year. We will not replace gift cards that were sent to the wrong address due to incorrect information provided by the member upon online registration.



Human Papillomavirus (HPV) Vaccine Gift Card Incentive

CHIP members ages 9 to 13 are eligible to earn a $25 gift card when they receive all of their age required doses of the HPV vaccine.

Limitations: Adolescent CHIP members ages 9 through 13 can earn a $25 gift card when they receive all their age required doses of the HPV Vaccine. Members must be active on the plan and register on BCBSTX Wellness Rewards website to qualify for the gift card and to receive the $25 gift card. Members can request their gift card after receiving their last dose. Check-ups must be performed by an in-network PCP. The visit must be completed prior to end of calendar year (December 31) to receive the gift card reward. Full vaccination series must be completed to qualify for gift card.

Enhanced Eyewear for Kids

CHIP members ages 18 and under can get one upgrade to eyewear such as:

- One pair of stylish frames (upgraded from basic frames)
- Upgraded lenses
- Contact lenses
- Extra pair of glasses

Children must complete an eye exam before using this VAS. The value of the upgrade cannot be over $150. Call the Customer Advocate Department for more information.

Limitations: CHIP members ages 0 through 18 will be eligible to receive one upgrade to eyewear such as one pair of stylish frames (upgraded from basic), an upgrade to lenses, contact lenses or an additional pair of glasses every year after the completion of an eye exam. The maximum value of the benefit will not exceed $150.

This benefit is restricted to CHIP members. The enhanced eyewear does not apply to CHIP Perinate.

This VAS applies after coverage has been provided by primary and secondary insurances.

This benefit is only applicable to routine and specialty eyewear, upgrades to eyewear and lenses, an additional pair of eyewear, and cannot be converted to cash. Vanity contact lenses are not covered. The VAS prescription must be fulfilled by an in-network Davis Vision Provider.

The member will receive the VAS when the request is made by the provider, and the member appointment is completed. The member will still receive the VAS benefit if they are still enrolled on the date of service on which the request was made

Sports and Camp Physicals

Members ages 3 through 18 can get one free sports and camp physical each calendar year.

Limitations: Sports and camp physicals will be available from contracted providers. This VAS is limited to one physical each calendar year for members ages 3 through 18.

Health and Wellness Activity Reward

CHIP members ages 7 through 18 can earn a $40 gift card reward for completing a health and wellness class or activity. This includes, but is not limited to a sport, swimming, music or camp of the member's choice. The activity does not need to be approved prior to enrolling. The member is responsible for submitting a receipt for reimbursement for this VAS.

Online Prenatal, Postpartum and Grief Classes

What health education classes does BCBSTX offer CHIP and CHIP Perinate members?

BCBSTX offers online prenatal, breastfeeding, diet and nutrition, how to make a birth plan, postpartum care and grief classes to pregnant CHIP and CHIP Perinate members, at no cost. Classes are available in English and 15 other languages. Visit the CHIP member website at **www.bcbstx.com/medicaid** to find out more about online classes and other resources for pregnant members.

Call Special Beginnings to register for an online class.

Limitations: You must be an active CHIP or CHIP Perinate member and be pregnant to begin classes.

What will you learn?

Pregnancy

- How your body changes
- How baby grows and changes
- Taking care of yourself
- Aches and pains of pregnancy
- Your checkups and tests
- Knowing signs of early labor

Labor and Birth

- Your birth plan
- Birthing choices
- Breathing and pushing skills
- C-section birth
- Pain relief choices
- Recovery and postpartum care
- How to deal with grief after loss

Baby Care and Breastfeeding

- New baby care and safety
- Umbilical cord and circumcision care
- Choosing your baby's doctor
- How to know if your baby is sick
- Vaccines your baby needs
- Breastfeeding
  - Feeding positions
  - Expressing and storing milk
  - Going back to work

Guide to Grief

- Grief support
- Maternal infant health resources
- Information about local support groups and resources

Limitations: CHIP and CHIP Perinate members must be pregnant to be eligible to begin prenatal classes. Classes are available online by computer or mobile app in English and 17 other languages. Suggested classes include, but are not limited to: prenatal, breastfeeding, postpartum, emotional changes and grief. Classes are available to pregnant members and post-partum up to 30 days after the

expected due date. Members must remain active on the plan during the 30 days following the expected due date.



Prenatal Visit Gift Card

Pregnant members are eligible to receive a $50 gift card when they complete their first prenatal visit within the first trimester of pregnancy or within 42 days of enrollment with BCBSTX.

Limitations: Pregnant members must complete their first prenatal visit by the timelines listed above. We will not replace gift cards that were sent to the wrong address due to incorrect information provided by the member upon online registration. Review the, 'What are the gift card restrictions?' section.

Breastfeeding Education through our Special Beginnings® Program

Members who register for the Special Beginnings maternity program will have access to breastfeeding education information provided by Special Beginnings nurses.

The Special Beginnings maternity program can help you better understand and manage your pregnancy. When you register for Special Beginnings, you will get a Special Beginnings Service Coordinator. Your service coordinator is a specially trained nurse who will talk to you about how you and your baby are doing and will continue to call you up to six weeks after your baby is born.

They can teach you how to make healthy choices for you and your baby, find pregnancy-related resources if you need them and work with your doctor if you have any special health needs during your pregnancy. If you are pregnant and would like to register for Special Beginnings, call us toll-free at **1-888-421-7781** (TTY **711**) or email Special Beginnings at **TXSBMedicaid@bcbstx.com**.

Limitations: Members must join the Special Beginnings program to receive access to assistance from Special Beginnings nurses about breastfeeding, and maternal health education support all the way from the start of the member's pregnancy until six weeks after the child is born.



Postpartum Visit Gift Card

CHIP members can earn a $25 gift card for completing a postpartum visit within seven to 84 days after having a baby.

Limitations: Members who have recently delivered a baby must complete a postpartum visit within seven to 84 days after delivery and be active on the BCBSTX plan when the visit is completed. We will not replace gift cards that were sent to the wrong address due to incorrect information provided by the member upon online registration. Review the, 'What are the gift card restrictions?' section.

In-Home Meal Delivery Services after a Hospital Discharge

CHIP members who have been discharged from the hospital after a qualifying medical or mental health inpatient stay, while on our plan, can qualify to receive up to 14 meals delivered to their home. Meal choices are delivered frozen, and include lunch and dinner. You can order up to 14 meals from the meal services provider for one incident per year.

Limitations: CHIP members, who have been discharged from the hospital with a date of service while effective on our plan, may order up to 14 prepared meals from the meal services provider. In-home meal delivery will only be available for one hospitalization per year for a maximum of 14 meals per year. Parents or LARs must work through their Service Coordinator to determine eligibility and to order the meals via online registration. Meals will be shipped to the address provided to the vendor

at time of order. The request for meals must be made within 30 days of discharge. Meals will not be replaced due to incorrect address.

Dental Services for Adult Members

We offer dental services to adult CHIP Perinate members age 19 and older. This VAS includes dental exams and cleanings, X-rays, cavity fillings and tooth extractions up to $250 per year. Call our dental partner, DentaQuest, toll-free at **1-800-205-4715**, 8 a.m. to 6 p.m., Central time, Monday through Friday to get help finding an in-network provider or to get an OK for dental services.

Limitations: CHIP Perinate members ages 19 through 64 must be enrolled with BCBSTX at the time of the request and receipt of the VAS. Services must be received by a contracted DentaQuest dental provider. Services for pre-existing issues will be approved on a case-by-case basis, if the member's eligibility has already expired. The maximum amount covered is $250 per year.

Blue365® Health and Wellness Program

Our Blue365 program offers discounts on a variety of health and wellness related services and items. The program is available to all CHIP and CHIP Perinate members at **www.blue365deals.com/BCBSTX/**. Discount types include:

- Apparel and Footwear
- Fitness
- Hearing and Vision
- Home and Family
- Nutrition
- Personal Care

This VAS excludes benefits covered by CHIP.

Limitations: Members ages 0 through 64 get free membership to Blue365, a program which offers discounts for health and wellness products and services.

Members who have limited or no access to the internet, those who have vision impairment or members who have questions about how to access information on Blue365, can call Member Outreach or their Member Advocate for assistance in locating resources and information on Blue365.

Members must register on the Blue365deals.com site for Texas. The information required for the registration process includes name, email, password, ZIP code, member ID number and the alpha prefix, TXS.

Learn to Live: Online Behavioral Health Platform

Learn to Live is a no cost online health program. It is offered to members 13 and older and their caregivers. Learn to Live gives self-paced mental health solutions, plus, access to 24/7 member coaches. It can help with common challenges like stress, anxiety, depression, insomnia and substance use. To start, register at **https://www.learntolive.com/welcome/BCBSTXMedicaid**.

Limitations: Members must be aged 13 through 64 to use this VAS. Members must have login information to utilize this service as provided by Case Management and are in control of the frequency of their utilization and selecting the tools provided. Input the Access Code: **TXMED** to use the tool. This service is available to CHIP and CHIP Perinate members.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

Part 12

Prescriptions and Pharmacy Benefits

For CHIP Members and CHIP Perinate Newborn Members

What are my prescription drug benefits?

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

Exclusions include:
Contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain.

You may have to pay a copayment for each prescription filled depending on your income. There are no copayments required for CHIP Perinate Newborn Members.

For CHIP Perinate Members

What are my unborn child's prescription drug benefits?/How do I get my medications?

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

There are no copayments required for CHIP Perinate Members.

Preferred Drug List

BCBSTX uses Vendor Drug Program (VDP) Preferred Drug Lists to help your doctor choose which drugs to give you. Certain drugs on this list need an OK. Your doctor will request approval before these drugs can be prescribed. Without approval, the drugs are not covered. Some drugs may have limits on the amount that is covered. You can find out if your drug has any conditions or limits by looking at the Drug List. To find out more about a drug, call the Customer Advocate Department or visit **www.bcbstx.com/medicaid** and go to the Prescription Drugs section of the website.

If your doctor thinks you need to take a drug that is not on the list, your doctor can request approval for that drug. We will let your doctor know if we OK the request within 24 hours. If the request is after hours, we will let your doctor know on the next business day. Your pharmacist can ask for a 72-hour emergency supply of the drug. If we say no to your request, you will get a letter that tells you the medical reasons why.

Some drugs can hurt you if you take them at the same time. To protect your health and keep you safe, we will let your doctor and pharmacist know if we have a concern about the drugs you take.

How do I get my/my child's medications?

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

Exclusions include:
Contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain.

You may have to pay a copayment for each prescription filled depending on your income. There are no copayments required for CHIP Perinate Newborn Members.

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

Call the Customer Advocate Department.

Limited Home Health Supplies

CHIP members can now get some home health supplies from BCBSTX pharmacies. Many standard diabetic supplies are included, like insulin syringes and needles, lancets, blood glucose monitors, test strips and more. OneTouch® products are the preferred diabetes monitor. If you need a new monitor, your doctor can write a prescription. Other home health goods, like aerosol holding chambers oral electrolytes and saline solutions are also available.

Most CHIP members will be able to get these services through a pharmacy or a durable medical equipment (DME) provider. If you have questions, ask your pharmacist or call the Customer Advocate Department.

What if I/my child needs an over-the-counter medication for CHIP?

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

What if I/my child needs birth control pills?

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

Finding a Network Pharmacy

How do I find a network drugstore?

Prescriptions can be filled at more than 4,400 retail pharmacies in Texas. You can find local pharmacies on the BCBSTX website or you may call the Customer Advocate Department at **1-888-657-6061** or TTY at **711**.

What if I go to a drugstore not in the network?

If you go to a drugstore that is not in the network, call the Customer Advocate Department. We can help you find an in-network pharmacy. If you get your prescriptions filled at a pharmacy that is not in network, you will have to pay for those medications.

What do I need to bring with me to the drugstore?

Make sure to take your child's BCBSTX ID card and the prescription to the drugstore.

Transportation to the Pharmacy

BCBSTX may give you a ride to your pharmacy visits that are not emergencies. BCBSTX will arrange a ride through its transportation VAS if you have:

- No other way to get a ride to services that are medically necessary.
- An OK ahead of time from BCBSTX.

See the Value-Added Services chapter for more information about our transportation VAS.

Mail Order Pharmacy

What if I need my medications delivered to me?

Walgreens Mail Service offer home delivery at no cost to you. You can get a 90-day supply of your long-term medical drugs delivered to your home. Long-term medical drugs are the types of drugs you take for chronic conditions such as asthma, high cholesterol, high blood pressure, depression or anxiety. Call Walgreens Mail Service toll-free at **1-877-357-7463** (TTY: **711**) or visit **walgreensmailservice.com**.

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

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

Call BCBSTX at **1-888-657-6061** for help with your/your child's medications and refills. Members with hearing or speech loss may call the TTY line at **711**.

Can I file an appeal for an medication or DME that was not approved?

You can file an appeal by calling the Customer Advocate Department. Learn more about filing an appeal in Part 13: How to Resolve a Problem with BCBSTX.

What if I lose my/my child's medication?

If you lose your medication, call your drugstore and ask the staff to call the Customer Advocate Department.

Part 13

Programs to Help Keep You Well

Each member has special needs at every stage of life. We have programs to help you stay healthy and manage your illness. You do not have to pay to join these programs. We give them at no cost to our members. You can call the Customer Advocate Department to learn more. We hope you and your family will use them. We want you to be well and stay that way.

Service Coordination

Our Service Coordination staff can help you manage your specific health care needs while being sensitive to any cultural needs you may have.

A CHIP Service Coordinator can help with specific chronic health concerns, prevention and wellness at no cost. Services include:

- Managing your treatment plan to help control chronic illnesses, such as asthma, diabetes or other complex conditions related to mental health and substance use
- Education on how to improve heart health and how to control high blood pressure and cholesterol
- Care coordination with your PCP or other medical specialist
- Help with tobacco cessation
- Information on how to maintain good nutrition, exercise and weight management

To learn more about Service Coordination, please call toll-free at **1-877-214-5630**, 8 a.m. to 5 p.m., Central time, Monday through Friday. If you have hearing or speech loss, you can call the TTY line at **711**. You can opt out of these services at anytime by calling the Service Coordination phone number listed above.

What Other Services Can BCBSTX Help Me Get?

Special Beginnings

Special Beginnings is a maternity program, offered by BCBSTX, that can help you better understand and manage your pregnancy. You will get the support you need through every stage of pregnancy. To help achieve good health for you and your baby, you should register for Special Beginnings as soon as you know you are pregnant. We keep all of your information confidential. When you register, you will get:

- Two pregnancy risk interviews. These may help us to find out if your pregnancy is high risk.
- Information and materials about nutrition and healthy life choices before and after your baby is born. You will also receive information on how your unborn baby is growing, newborn care and well child information that is helpful for new parents.
- Personal phone calls from a specially trained nurse, who will serve as your Special Beginnings Service Coordinator. Your Service Coordinator will talk to you about how you and your baby are doing and will continue to call you up to six weeks after your baby is born.
- 24-hour, toll-free access to a telephone hotline staffed by experienced registered nurses and maternity nurses (**1-844-971-8906**). The 24/7 Nurse Advice Line includes access to an audio library with health information.

Personal, Confidential Help

Your personal Special Beginnings Service Coordinator will call you regularly to ask questions about your health and activities. The service coordinator will also help you find more pregnancy-related resources if you need them. Through your entire pregnancy, our specially trained nurses will:

- Assess your health, lifestyle and possible pregnancy problems
- Teach you to avoid problems that can happen when you are pregnant
- Check in on you regularly to talk about how you and your baby are doing
- Encourage you to make healthy changes
- Talk to you about your OB provider's treatment plans
- Help if you develop diabetes or high blood pressure while you are pregnant
- Teach you about prenatal, postpartum and newborn care

If you are pregnant and would like to register for Special Beginnings or to ask questions, please call us toll-free at **1-888-421-7781** (TTY/TDD: **711**) or email Special Beginnings at **TXSBMedicaid@bcbstx.com**.

Women, Infants and Children Program

The Women Infants and Children (WIC) Program is a Texas Health and Human Services program that gives healthy food and other services to pregnant women and mothers of young children. WIC also gives free news about foods that are good for you. If you have questions about WIC services, call **1-800-942-3678**.

How to Get Other Services

You may want services that BCBSTX does not cover. Call to speak to a service coordinator at **1-877-214-5630** to ask for help with other services.

Part 14

Help with Special Services

Need help with languages or other communications? BCBSTX offers services and programs that meet many language and cultural needs and give you access to quality care.

Help in Other Languages

Can someone interpret for me when I talk with my/my child's doctor?

BCBSTX ensures interpreter services are available for you when you call our Customer Advocate Department, visit your child's PCP and more.

BCBSTX does not encourage the use of family, friends or children to serve as interpreters due to the different words used for medical information. If you need help with interpreters or need any of our member materials in a different language, please call the Customer Advocate Department. We offer:

- Health education materials in English and Spanish
- Customer Advocate Department staff who can speak English and Spanish
- 24-hour phone interpreter services
- Sign language and face-to-face interpreter services
- Providers who speak more than one language
- A multilingual interpreter service for more than 140 languages if you do not speak English or Spanish

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

If you need help in a language other than English during your visit (one your doctor does not speak), you can ask for a face-to-face or phone interpreter to help you at no cost. The CHIP Provider Directory tells you what languages the doctors speak. Also, BCBSTX offers interpretation via telephone and video conferencing.

Who do I call for an interpreter?

Call the Customer Advocate Department.

How far in advance do I need to call?

If you need someone to interpret for you while you are at your child's PCP's office, ask your child's PCP to call us at least 72 hours (three days) in advance. We will be glad to help.

Help for Members with Hearing or Vision Loss

BCBSTX has a toll-free number for members who do not hear well or are deaf. Call the Customer Advocate Department TTY line at **711** from 8 a.m. to 5 p.m., Monday through Friday, excluding state-approved holidays. For help after hours and on weekends, call the Texas Relay Service at **1-800-735-2989** or dial **711** to get the help you need.

How do I get these materials in other languages and formats?

We offer this book and other important information in other languages and formats, including Braille, large print and audio for members with vision or hearing loss. Call the Customer Advocate Department for more information.

Americans with Disabilities Act

We follow the rules of the Americans with Disabilities Act (ADA) of 1990. This law protects your child from being treated in a different way by us because of a disability. If you feel your child has been treated in a different way because of a disability, call the Customer Advocate Department.

Members with Special Health Care Needs

BCBSTX offers special services for members with special needs at no cost. These services are:

- Service Coordination to help you get the health services you need
- Your specialist can act as your PCP

If you would like to speak to a Service Coordinator, please call **1-877-214-5630** between 8 a.m. and 5 p.m., Central time, Monday through Friday.

Part 15

How to Resolve a Problem

We want to help. If you are unhappy with care or service you received from BCBSTX, a doctor or hospital, you can file a complaint. If you have a complaint, call us toll free at **1-888-657-6061**. You may also write to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 660717
Dallas, Texas 75266-0717

Complaints

What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call the Customer Advocate Department to tell us about your problem. A CHIP Member Advocate can help you file a complaint. Most of the time, we can help you right away or at the most within a few days. BCBSTX cannot take any action against you as a result of your filing a complaint.

Can someone from BCBSTX help me file a complaint?

A Member Advocate can help you file a complaint. You can reach a Member Advocate at **1-877-375-9097** or call the TTY line: **711**. If you do not speak English, we can get someone to translate for you. No member will be treated differently for filing a complaint.

What information do I need to file a complaint?

If you want to file the complaint for any reason, fill out a complaint form located in the Member Resources section on the CHIP website at **www.bcbstx.com/medicaid** or write a letter to tell us about the problem. Clearly state who is involved in the complaint, what happened, when and where it happened and why you are not happy with your health care services. Attach any documents that will help us look into the problem. Send your completed complaint form or letter to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 660717
Dallas, Texas 75266-0717

How long will it take to process my complaint?

BCBSTX will respond with a decision on your appeal no later than 30 calendar days after we receive your complaint.

What are the requirements and timeframes for filing a complaint?

Once we receive your complaint, we will send you an acknowledgment letter within five days. You will get a complaint resolution letter within 30 calendar days of the date we get your complaint. The letter will:

- Describe your complaint.
- Tell you what will be done to solve your problem.
- Tell you how to ask for a second review of your complaint with BCBSTX.
- Tell you how to ask for an internal appeal of our decision.

If I am not satisfied with the outcome, what else can I do?

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

Texas Department of Insurance
Consumer Protection
PO Box 149091
Austin, Texas 78714-9091

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

Do I have the right to meet with a complaint appeal panel?

Yes. You or your child has a right to appear in person before a complaint appeal panel. You can also mail a written complaint appeal to the complaint appeal panel. You can give us proof or any claims of fact or law that support your appeal, in person or in writing. You may also show proof to the complaint appeal panel. We will send you a letter that tells you the final decision of the complaint appeal panel within 30 days of your request.

Appeals

What can I do if my doctor asks for a service for me that's covered but BCBSTX denies or limits it? How will I find out if services are denied?

If we deny or limit coverage for a service or medicine your doctor requests, we will send your doctor a letter to explain the reason for our denial. You will also get a letter that explains the reason for our denial. The letter, which is called a Notice of Action letter, will also tell you how you can appeal the decision to deny or limit services. You or your child's doctor, can appeal a denial of medical service or payment for service. Call the Customer Advocate Department at **1-888-657-6061** to learn more. Members with hearing or speech loss may call the TTY line at **711**.

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

You may ask for an appeal for reasons such as:

- A denial of a claim in whole or in part
- A limited authorization
- The type or level of service and the denial

Does my request have to be in writing?

You can file an appeal by calling the Customer Advocate Department or by sending us a written appeal request. There is an Appeal Request Form located at **www.bcbstx.com/medicaid** in the 'Member Resources' section under 'Complaints and Appeals.' You can write to:

Blue Cross and Blue Shield of Texas
C/O Complaints and Appeals Department
PO Box 660717
Dallas, Texas 75266

Can someone from BCBSTX help me file an appeal?

A Member Advocate can help you file an appeal. You can reach a Member Advocate at **1-877-375-9097**.

What are the timeframes for an appeal?

You must file your appeal with BCBSTX no later than 60 calendar days from the date on your Notice of Action letter that explains the reason for the denial or limit of coverage for a medical service.

We will send you a letter within five business days to let you know that we got your appeal request. If the time frame will be longer, we must give you written notice of the reason for the delay (unless you asked for the delay). You can give us proof or any claims of fact or law that support your appeal, in person or in writing. We will let you know when to do so. You will get a letter that will explain the final decision of our internal review within 30 days of your request.

Pharmacy Appeals

To request a pharmacy appeal you can:

- Call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**), Monday through Friday, 8 a.m. to 5 p.m., Central Time.
- Mail a written appeal to:

  BCBSTX Appeals
  C/O Processing
  2900 Ames Crossing Road
  Eagan, MN 55121

- Fax a written appeal to **1-855-212-8110**.
- Have your doctor submit online at **MyPrime.com** or **CoverMyMeds.com**.

Expedited Appeals

What is an expedited appeal?

An expedited appeal is when the health plan has to decide quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

If your request for an expedited appeal is denied, your appeal will go through the standard appeal process. We will try as much as we can to tell you the decision verbally.

You have the right to give written comments, documents or other information for your appeal by phone or in writing.

Does my request have to be in writing?

We will take an oral or written request for an appeal. If you file your appeal request orally, you must also send it to us in writing.

How do I ask for an expedited appeal?

You can ask for an expedited appeal orally or in writing.

Who can help me in filing an expedited appeal?

A Member Advocate can help you file your expedited appeal.

What are the timeframes for an expedited appeal?

We will review your expedited appeal the earlier of one working day from the date we receive all of the information we need to complete the appeal or 72 hours after we receive the appeal request. We will call you to tell you our decision and we will also send a letter. If your request for a faster appeal is about an emergency that keeps occurring or denial of a hospital stay while you are still in the hospital, we will look at your case and tell you our decision within one working day. You will get a call about our decision and follow up with a letter within three calendar days.

What happens if BCBSTX denies the request for an expedited appeal?

If we do not approve the expedited appeal after we look at your case, then your appeal will go through the standard appeal steps.

What can I do if I disagree with the appeal decision?

If you still do not agree with the decision, you or your doctor can ask for a review by an Independent Review Organization (IRO). You may ask for an IRO review at anytime during the appeal process.

Independent Review Organization

What is an Independent Review Organization (IRO)?

An IRO is a system for a final review to decide if members can get the right health care services that they need for medical reasons (medically necessary). You can ask for a review of the denial by using the IRO process. There is no cost to the member to have an IRO review.

How do I ask for a review by an IRO?

You or someone you trust can send a written request to BCBSTX at this address:

Blue Cross and Blue Shield of Texas
C/O Complaints and Appeals Department
PO Box 660717
Dallas, Texas 75266
Fax: **1-855-235-1055**

The person submitting the request must also sign the consent to release medical information to the IRO. You, your provider or someone that you trust can also send a request for an external medical review directly BCBSTX at the address above or to Maximus:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax number: **1-888-866-6190**

You can find copies of the appeals request and MAXIMUS Federal Services IRO request form on at **www.bcbstx.com/medicaid**.

This form will be attached to the appeal decision letter sent to you.

What are the timeframes for this process?

We will send a copy of the IRO request form that you filled out, medical records and the information needed for an IRO review to the IRO that was chosen to review your case. The IRO must get the information within three business days from the date of the review request. The IRO must make a decision:

- Within 20 days from the date it was assigned your case to decide whether your plan must pay for the denied treatment.
- Within three days for cases involving life-threatening conditions.
- When there is a condition that puts your/your child's life at risk, the IRO must reach a decision:
  - Within three days after it gets the information needed.
  - No later than eight days after the IRO gets its assignment.

You cannot always get an IRO review. It can only be used if we decide that the covered service or treatment is not medically necessary.

You cannot ask for an IRO review if the service you asked for is not a covered benefit.

Part 16

Other Things You May Need to Know

If We Can No Longer Serve You

We may not cover you if you:

- Move out of the BCBSTX service area permanently
- Are no longer eligible for CHIP benefits
- Disenroll from the CHIP program

Your BCBSTX coverage is effective as of the date shown on the front of your BCBSTX ID card. It ends on the date given to BCBSTX by the HHSC. HHSC decides:

- The eligibility and enrollment for health plan members.
- If a member is kept out of or disenrolled from, the plan.

Except as stated in this agreement, we may ask to disenroll your child from our health plan if:

- You or your child is no longer eligible.
- You or your child let someone else use your child's BCBSTX ID card.
- You or your child make it a habit to use the emergency room (ER) for non-emergency reasons.
- You or your child commit fraud.
- You misrepresent yourself or your child.

BCBSTX may no longer cover your child if he or she acts in such a way that affects the ability of:

- The health plan to give or set up services for your child or other members.
- A provider to give care to other patients.

If you have a complaint about a BCBSTX request to disenroll your child, see **Part 15: How to Resolve a Problem**.

Contact our enrollment broker, Maximus, to request disenrollment at **1-800-964-2777**. You can also contact a Customer Advocate to discuss a complaint or to request to disenroll.

What If I Get a Bill from My/My Child's Doctor? What if I get a bill from a perinatal provider?

You may have to pay a premium to HHSC for your child's CHIP coverage and copays to your child's doctors. In most other cases, you should not get a bill from a BCBSTX provider. You may have to pay for charges if:

- You agree to pay for services that are not covered or OK'd by BCBSTX.
- You agree to pay for services from a provider who does not work with BCBSTX.

Who do I call?

If you get a bill and do not think you should have to pay the charges, call the Customer Advocate Department.

What information will they need?

Have the bill with you when you call us. Sometimes a provider may send you a 'statement' that is not a 'bill.' We will tell you if you have to pay it. You will need to let us know:

- Date of service.
- Amount you were charged.
- Why you were billed.

How to submit a claim?

In the rare chance that you are asked to pay for health care or medical supplies, you will need to send written documentation

to BCBSTX. You will also need to tell us in writing why you had to pay for the item or service. We will then check your claim for repayment. Call the Customer Advocate Department to ask for a claim form or to learn more. Members with hearing or speech loss may call our TTY line at **711**.

If You Have Other Insurance

If your child is covered by another health insurance plan, you must tell us. You must also call your HHSC caseworker. This helps us and your providers decide who should pay the bill. We have the right to get information from anyone who gives your child care. We need this information so we can pay for your health care. This information is only shared with your health care provider and us or as the law allows.

New Medical Treatments

BCBSTX reviews new medical treatments. A group of PCPs, specialists and medical directors decides if the treatment:

- Has been approved by the government.
- Has shown how it affects patients in a reliable study.
- Will help patients as much as or more than, treatments we use now.
- Will improve a patient's health.

The review group looks at all of this information and then decides if the treatment is medically necessary.

If your doctor asks us about a treatment that the review group has not looked at yet, the reviewers will learn about the treatment and make a decision. They will let your doctor know if the treatment is medically necessary and approved by us for payment.

Quality Improvement

At BCBSTX, we want to make your health plan better. To do this, we have a Quality Improvement (QI) program which outlines the processes, goals & outcomes as they relate to member care and services.. Through this program, we:

- Track how happy you are with your doctor.
- Conduct surveys of how happy you are with us.
- Use the information we learn to make a plan to improve our services.
- Put our plan into action to make your health care services better.

For details about our QI program, call the Customer Advocate Department or download a copy of the report from the CHIP member website under the forms and documents section..

Evidence of Coverage

Upon request, we will give you an evidence of coverage (EOC) to show the time you were covered by the plan. The EOC is posted on our member website in the Member Resources section, under 'Forms and Documents.' You can also access it here: **https://www.bcbstx.com/medicaid/pdf/tx_chip_evidence_of_coverage.pdf**.

If you do not have access to a computer and would like us to mail you a copy, please call the Customer Advocate Department.

Privacy Policies

We have the right to get information from anyone giving you/your child care. We use this information so we can pay for and manage your child's health care. We keep this information private between you, your child's health care provider and

us, except as the law allows. Refer to the Notice of Privacy Practices at the end of this chapter to read about your right to privacy. This notice was in your new member packet from BCBSTX. If you would like another copy of the notice, please call the Customer Advocate Department.

Your Child's Medical Records

Federal and state laws allow you to see your child's medical records. Ask your child's PCP for the records first. If you have a problem getting your child's medical records from his or her PCP, call the Customer Advocate Department.

Advance Directives ('Living Will')

An Advance Directive is a legal document that states how your child wants to be treated if he or she cannot talk or make decisions. This applies to members 18 years of age or older.

Your child may also want to list the types of care he or she does or does not want. For instance, some people do not want to be put on life support machines if they go into a coma. Your child's PCP will note the living will in the child's medical records. That way, the doctor will know what your child wants.

Your child has the right to set up papers with this information for the PCP and other health care providers to use. These are called 'advance directives for health care.' Your child can talk to family members, the PCP or someone he or she trusts to help fill out the papers. You may change or take back your advance directive at anytime.

You can find the forms you need at office supply stores and pharmacies. You may find them at a lawyer's office as well. If you have more questions about living wills, call the Customer Advocate Department or go to the website: **https://hhs.texas.gov/formas/advance-directives**.

Program Changes

BCBSTX services can change without your agreement. If you have questions about program changes, call the Customer Advocate Department.

Report CHIP Waste, Abuse or Fraud

How do I report someone who is misusing/abusing the program or service?

Let us know if you think a doctor, dentist, pharmacist, 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 Office of the Inspector General (OIG) Hotline at **1-800-436-6184**
- Visit **https://oig.hhs.texas.gov/reportfraud** to report fraud, waste or abuse
- Report directly to your health plan:

  Blue Cross and Blue Shield of Texas
  PO Box 201166
  Austin, Texas 78720-9919

- Call the Customer Advocate Department.

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 providers.
- 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.

HIPAA Notice of Privacy Practices

BCBSTX needs to give you a HIPAA Notice of Privacy Practices as well as a State Notice of Privacy Practices. The HIPAA Notice of Privacy Practices talks about how BCBSTX can use or give out your protected health information and your rights to that information under federal law. The State Notice of Privacy Practices talks about how BCBSTX can use or give out your nonpublic private financial information and your rights to that data under state law. Please take a few minutes and review these notices. You can go to the BAM website at **www.bcbstx.com/medicaid** to sign up to get these notices by email. Our contact information is found at the end of the notices.

YOUR RIGHTS

When it comes to your health information, you have certain rights.

This section talks about your rights and some of the things we can do to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this by using the contact information at the end of this notice.
- We will give you a copy or outline of your health and claims records within 30 days of the request unless we ask for more time. We may charge a small fee.

Ask us to fix health and claims records

- You can ask us to fix your health and claims records if you think they are not right. Ask us how to do this by using the contact information at the end of this notice.
- We may say "no" to your request to fix your records and we will tell you why in writing within 60 days.

Ask for private communications

- You can ask us to reach you in a certain way or to send mail to another address. Ask us how to do this by using the contact information at the end of this notice.
- We will provide a response to all requests. We will say "yes" if you tell us you would be in danger if we do not.

Ask us what not to use or share

- You can ask us not to share or use certain health information. Ask how to do this by using the contact information at the end of this notice.
- We do not have to agree with your request and we may say "no" if it would affect your care.

Get a list of those with whom we have shared data

- You can ask us for a list of when we shared your information, who we shared it with and why during the last six years. Ask us how to do this by using the contact information at the end of this notice.
- We will provide this information to you; however, we will not provide you information about your care payment. We will provide you this information one time a year for free – we may charge a small, cost-based fee if you ask again within 12 months.

Get a copy of this Notice

- You can ask for a paper copy of this notice at anytime, even if you are OK with getting the notice by mail. To get a copy of this notice, use the contact information at the end of this notice and we will send you one.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can also request information and make decisions for you.
- We will make sure that these individuals are allowed to get information about you before we make it available.

File a complaint if you feel your rights are violated

- If you feel we have not done the right thing with your information, you can complain to us. Use the contact information found at the end of the Notice.
- You can also complain to the U.S. Department of Health and Human Services Office for Civil Rights by calling **1-877-696-6775**; or by visiting **www.hhs.gov/ocr/privacy/hipaa/complaints** or by sending a letter to them at: 200 Independence Ave., SW, Washington, D.C. 20201.
- You have a right to complain and if you complain, we will not hold it against you.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you know how you want us to share your information in the times described below, tell us and we will follow your orders. Use the contact information at the end of this notice.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in payment for your care
- Share information in a bad situation and help you fix the problem
- Reach you for fundraising efforts

If there is a reason you cannot tell us who we can share information with, we may share it if we believe it is best for you. We may also share information for health or safety reasons.

We never sell or use your information for promotional purposes unless you give us your written OK.

INFORMATION USE AND SHARING

How do we use or share your health information?

We use or share your health information in the following ways.

Help you with the health care treatment you get

- We can use your health information and share it with doctors or health staff who treat you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange more services.

Run our operations

- We can use and give out your information to support and improve our operations.

Example: We use health information to create better services for you.

We cannot use your genetic information to decide whether we will give you care except for long-term care plans.

Pay for your health services

- We can use and give out your health information to your health plan sponsor for plan administration purposes.

Example: We share information about you with your dental plan to make a payment for your dental work.

Administer your plan

- We may give out your health information to your health plan sponsor for plan administration purposes.

Example: We may provide certain information to your health plan sponsor to explain how we charge for our services.

How else can we use or share your health information?

We also can share your information to help the public good; for example, public health and research. We have to meet many laws before we can share your information for these reasons. For more information go to: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Help with public health and safety issues

- We can share your health data to:
  - Stop diseases
  - Help with product recalls
  - Show bad reactions to a drug
  - Show suspected harm, neglect or home violence
  - Stop or lessen a threat to someone's health or safety

Do research

- We can use or share your information for health research.

Follow the law

- We share information about you when a state or federal law says we have to; for example, we may share information with the Department of Health and Human Services so they can check to see that we follow privacy laws.

Answer organ/tissue donation requests and work with certain experts

- We can share your health information with an organization that helps with organ or tissue donation.
- We can share your information with a medical examiner, coroner or funeral director.

Address workers' compensation, police and other government requests

- We can use or share your health information:
  - For workers' compensation claims
  - For police purposes or with a law enforcement official
  - With health oversight firms for activities approved by law
  - For special government functions such as military, national security and presidential protective services or with prisons regarding inmates.

Answer to lawsuits and legal actions

- We can share your information in response to a court order or in response to a request to show up in court.

Certain health information

- State laws may ask us to be extra careful with information about certain health conditions or diseases. For example, the law may stop us from sharing or using data about HIV/AIDS, mental health, alcohol or drug abuse and genetic data without your OK. In these situations, we follow what state law says.

OUR DUTIES

When it comes to your information, we have certain duties

- We must keep your health information safe and secure.
- We must let you know if your information has been shared or used by someone that could have a bad effect on you.
- We must follow the privacy practices that are described in this notice and make sure that you can get a copy of the notice.
- We will not use or share your information except as described here unless you tell us we can in writing.

You may change your mind at anytime. Let us know in writing if you change your mind.

For more information:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

State Notice of Privacy Practices

BCBSTX collects nonpublic private information about you from your health plan, your health care claims, your payment information and other types of reporting firms. BCBSTX agrees to:

- Not give out your information even if you stop being a customer to any non-affiliated third parties except with your OK or according to the law.
- Limit the workers that can see your information to those who perform jobs needed to run our business and give care to our customers.
- Have security and privacy practices that protect your information from unauthorized use.
- Use your information only to process your claims, to bill you and to provide you with customer service.
- Use your information according to the law.

BCBSTX is able to share your information with certain third parties who either perform jobs or services for us. Here are some examples of third parties that we can share your data with:

- Our affiliates
- Clinical and other business partners that offer services on our behalf
- Insurance brokers or agents, financial services firms, stop-loss carriers
- Regulatory and other governmental groups including the police
- Your group health plan

You have a right to ask us what nonpublic financial information we have about you and ask for a copy of this information.

CHANGES TO THESE NOTICES

We have the right to change the terms of these notices and the changes we make will apply to all the information we have about you. If we make changes, the law requires that we mail you a copy of this notice.

CONTACT INFORMATION

You can get a copy of the Notice at anytime by:

1. Going to the website at **https://www.bcbstx.com/medicaid/pdf/medicaid-hipaa-notice-tx.pdf** or
2. Calling us at the toll-free number found on the back of your ID card.

If you have any questions about your rights or these notices, contact us in one of these ways:

1. Call us at **1-877-361-7594** or
2. Write us at Privacy Office
   Divisional Vice President
   Blue Cross and Blue Shield of Texas
   PO Box 804836
   Chicago, IL 60680-4110

Part 17

Your Health Care Rights and Responsibilities

Member Rights and Responsibilities for CHIP Members and CHIP Perinate Newborn Members

At BCBSTX, we want to make sure you and your child get the health care you need. We also want to make sure your rights as a member are respected.

Member Rights

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
2. Your health plan must tell you if they use a 'limited provider network.' This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. 'Limited provider network' means you cannot see all the doctors who are in your health plan. If your health plan uses 'limited networks,' you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same 'limited network.'
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.

5. You have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
6. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
7. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
8. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
9. Children who are diagnosed with special health care needs or a disability have the right to special care.
10. If your child has special medical problems and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services. Ask your plan about how this works.
11. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
12. Your child has the right to emergency services if you reasonably believe your child's life is in danger or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment depending on your income. Copayments do not apply to CHIP Perinatal Members.
13. You have the right and responsibility to take part in all the choices about your child's health care.
14. You have the right to speak for your child in all treatment choices.
15. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
16. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.
17. You have the right to talk to your child's doctors and other providers in private and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
18. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to file a complaint or appeal and have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
19. You have a right to know that doctors, hospitals and others who care for your child can advise you about your child's health status, medical care and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

20. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals and others cannot require you to pay any other amounts for covered services.
21. You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
22. You have a right to make recommendations about the BCBSTX member rights and responsibilities policy.
23. You have the right to receive information about the organization, it's services, its practitioners and providers and member rights and responsibilities.
24. You have the right to be treated with respect and recognition of your dignity and your right to privacy.
25. You have a right to participate with practitioners in making decisions about your health care.
26. You have a right to voice complaints or appeals about the organization or the care it provides.

Member Responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must supply as much information as possible to BCBSTX, the doctors and providers so they can provide care.
3. Follow the care plans and instructions that you agreed on with your doctor or provider.
4. You must become involved in the doctor's decisions about your child's treatments.
5. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
6. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
7. You must learn about what your health plan does and does not cover. Read your member handbook to understand how the rules work.
8. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
9. If your child has CHIP, you are responsible for paying your doctor and other provider copayments that you owe them. If your child is getting CHIP Perinatal Program services, you will not have any copayments for that child.
10. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members or health plans.
11. You must talk to your provider about your medications that are prescribed.
12. You have the responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

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

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**.

Part 18

Definitions

Here are some of the terms used in this book:

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

Approval by BCBSTX means you got an OK ahead of time from us. You can learn more about this in **Part 3: How to Use Your Health Plan with BCBSTX**.

Benefits are the health care services and drugs covered under this plan.

Complaint is a grievance that you communicate to your health insurer or plan.

Copayment is 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.

Cosmetic surgery is done when medically necessary to change or reshape normal body parts so they look better.

Disenroll means to stop using the health plan because:

- You are not eligible.
- You change your health plan.

Durable Medical Equipment (DME) is equipment ordered by a health care provider for everyday or extended use. Coverage for DME may include but is not limited to: oxygen equipment, wheelchairs, crutches or diabetic supplies.

Emergency medical care means health care services provided in an in-network or out-of-network hospital emergency department, free-standing emergency medical facility or other comparable facility by in-network or out-of-network doctors, providers or staff at that place to assess and stabilize medical conditions. These services also include any medical screening exam or other evaluation as needed by state or federal law that is needed to decide if it is an emergency medical condition or if an emergency behavioral health condition exists.

Emergency medical condition is an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid harm.

Emergency medical transportation is ground or air ambulance services for an emergency medical condition.

Emergency room care is emergency services you get in an emergency room.

Emergency services are evaluations of an emergency medical condition and treatment to keep the condition from getting worse.

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

Grievance is a complaint to your health insurer or plan.

Habilitation services and devices are 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 is a contract that requires your health insurer to pay your covered health care costs in exchange for a premium.

Health plan is a company that offers managed care health insurance plans.

Home health care services are health care services a person receives in a home.

Home health care providers give your child skilled nursing care and other services at home.

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

Hospital is a place where your child gets inpatient and outpatient care from doctors and nurses.

Hospitalization is care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital outpatient care is care in a hospital that usually doesn't require an overnight stay.

Inpatient care is when your child has to stay the night in a hospital or other place for the medical care he or she needs.

Medically necessary services are 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.

1 Health care services that are:
   - Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member or endanger life.

- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions.
- Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies.
- Consistent with the member's diagnoses.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency.
- Not experimental or investigative.
- Not primarily for the convenience of the member or provider.

2 Behavioral Health Services that:

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

Network is made up of the facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-participating provider is 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 when there are no other providers, your health insurer can contract to pay a non-participating provider.

Outpatient care is when your child does not have to stay overnight in a hospital or other place to get the medical care he or she needs.

Participating provider is a provider who has a contract with your health insurer or plan to provide covered services to you.

Physician services are health-care services a licensed medical physician (M.D. -Medical Doctor or D.O. -Doctor of Osteopathic Medicine) provides or coordinates.

Plan is a benefit, like Medicaid, which provides and pays for your health-care services.

Pre-authorization is a decision by your health insurer or plan that a health-care service, treatment plan, prescription drug or Durable Medical Equipment that you or your provider has requested, is medically necessary. This decision or approval (sometimes called prior authorization, prior approval or pre-certification) must be obtained prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.

Premium is the amount that must be paid for your health insurance or plan.

Prescription drug coverage is health insurance or plan that helps pay for prescription drugs and medications.

Prescription drugs are drugs and medications that by law require a prescription.

Primary care physician is a physician (M.D. -Medical Doctor or D.O. -Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Primary care provider (PCP) is the provider you have for most of your child's health care. This person helps get your child the care he or she needs. Your child's PCP must OK most care ahead of time, unless it is an emergency.

Prior authorization (prior OK) means both BCBSTX and your child's health care provider agree ahead of time that the service or care you asked for is covered.

Provider is 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.

Types of health care providers include:

- **Audiologist -** a provider who tests your child's hearing.
- **Certified nurse midwife -** a registered nurse trained to care for you and your child during pregnancy and childbirth.
- **Certified registered nurse anesthesiologist (CRNA) -** a nurse trained to give your child anesthesia.
- **Chiropractor -** a provider who treats your child's spine or other body structures.
- **Dentist -** a doctor who takes care of your child's teeth and mouth.
- **Family practitioner -** a doctor who treats common medical issues for people of all ages.
- **General practitioner -** a doctor who treats general medical conditions.
- **Licensed vocational nurse -** a licensed nurse who works with your child's doctor.
- **Marriage, family and child counselor -** a person who helps with family problems.
- **Nurse practitioner or physician assistant -** a person who works in a clinic or doctor's office and does these things:
  - Finds out what's wrong with your child.
  - Takes care of your child.
  - Treats your child within limits.
- **Obstetrician/gynecologist (OB/GYN) -** a doctor who takes care of OB/GYN related health concerns (this includes pregnancy and childbirth).
- **Occupational therapist -** a provider who helps your child regain daily life skills and activities after an illness or injury.
- **Optometrist -** a provider who takes care of your child's eyes and vision.
- **Orthotist -** a provider who works with a range of splints, braces and special footwear to aid movement, correct deformity and relieve discomfort.
- **Pediatrician -** a doctor who treats children from birth to their teen years.
- **Physical therapist -** a provider who helps your child build his or her body's strength after an illness or injury.
- **Podiatrist or chiropodist -** a doctor who takes care of your child's feet.
- **Psychiatrist -** a doctor who treats mental health issues and prescribes drugs.
- **Registered nurse -** a nurse with more training than a licensed vocational nurse (LVN) and is licensed to do certain complex duties with your child's doctor.
- **Respiratory therapist -** a provider who helps your child with breathing.

- **Speech pathologist -** a provider who helps your child with his or her speech.
- **Surgeon -** a doctor who can operate on your child.

Prudent layperson means an average person who uses good judgment or common sense and has an average knowledge of health and medicine.

Reconstructive surgery is done when there is a problem with a part of your child's body. This problem could be caused by:

- A birth defect
- Disease
- Injury

It is medically necessary to make that part look or work better.

Referral means your PCP sends you to another provider for services. You may get some services without a referral from your PCP. Services you can get without a referral include:

- In-network OB/GYN
- Family planning
- Emergency care
- Outpatient behavioral (mental) health
- Vision

Rehabilitation services and devices are 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 is services from licensed nurses in your own home or in a nursing home.

Skilled nursing facility is a place where your child can get 24-hour-a-day nursing care that only a trained health professional can give.

Specialist is a physician specialist that 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 is 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.

Urgent medical condition is NOT an emergency BUT needs medical care within 24 hours.

Part 19

Details about CHIP Covered Services

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending doctor) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products, and the administration of those products, that are not provided free-of-charge to the patient • X-rays, imaging and other radiological tests (facility technical component) • Laboratory, including biomarker testing, and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor and delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor and delivery until birth and services related to miscarriage or a non-viable pregnancy. Services include: • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component)

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
(Continued) Inpatient General Acute and Inpatient Rehabilitation Hospital Services	• Hospital, physician and related medical services, such as anesthesia, associated with dental care • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: – Dilation and curettage (D&C) procedures – Appropriate provider-administered medications – Ultrasounds • Histological examination of tissue samples • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: – all stages of reconstruction on the affected breast – external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – surgery and reconstruction on the other breast to produce symmetrical appearance – treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit	Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services 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) are a covered benefit. 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 • histological examination of tissue samples
(Continued) Inpatient General Acute and Inpatient Rehabilitation Hospital Services	• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: – cleft lip and/or palate; or – severe traumatic skeletal and/or congenital craniofacial deviations; or – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Skilled Nursing Facilities (Includes rehabilitation hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	Not a covered benefit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging and radiological tests (technical component) • Laboratory, including biomarker testing, and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy	Services include, the following 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

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
(Continued) Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center	• Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products and the administration of those products that are not provided free-of-charge to the patient • 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 – histological examination of tissue samples • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Surgical implants • Other artificial aids including surgical implants • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: – cleft lip and/or palate – severe traumatic skeletal and/or congenital craniofacial deviations	• Outpatient services associated 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 – histological **1.** 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. **2.** Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy. **3.** Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
(Continued) Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center	• Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: – all stages of reconstruction on the affected breast – external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; surgery and reconstruction on the other breast to produce symmetrical appearance – treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under inpatient and outpatient services and do not count toward the DME 12-month period limit	**4.** Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once 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 members 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 gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. **5.** 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	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Physician/ Physician Extender Professional Services	Services include, but are not limited to, the following: • American Academy of Pediatrics recommended Well Child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, inpatient services and outpatient services • Laboratory (including biomarker testing), X-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals and materials administered in a physician's office • Allergy testing, serum and injections • Professional component (in/outpatient) of surgical services, including: – Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care – Administration of anesthesia by physician (other than surgeon) or CRNA – Second surgical opinions – Same-day surgery performed in a hospital without an over-night stay – Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician-performed technical and interpretive components)	Services include, but are not limited to the following: • American Academy of Pediatrics recommended Well Child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, inpatient and outpatient services • Laboratory, X-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals and materials administered in a physician's office • Allergy testing, serum and injections

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
(Continued) Physician/ Physician Extender Professional Services	• Physician and professional services for a mastectomy and breast reconstruction include: – all stages of reconstruction on the affected breast – external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – surgery and reconstruction on the other breast to produce symmetrical appearance – treatment of physical complications from the mastectomy and treatment of lymphedemas • In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician and professional services for a mastectomy and breast reconstruction include: – all stages of reconstruction on the affected breast – external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – surgery and reconstruction on the other breast to produce symmetrical appearance – treatment of physical complications from the mastectomy and treatment of lymphedemas – In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by Cesarean section	• Professional component (in/outpatient) of surgical services, including: – Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care – Administration of anesthesia by physician (other than surgeon) or CRNA – Second surgical opinions – Same-day surgery performed in a hospital without an over-night stay – Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician-performed technical and interpretive components) • 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 confirmation. • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis and FIUT.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
(Continued) Physician/ Physician Extender Professional Services	• Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: – dilation and curettage (D&C) procedures – appropriate provider-administered medications – ultrasounds – histological examination of tissue samples • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: – cleft lip and/or palate – severe traumatic skeletal and/or congenital craniofacial deviations – severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment	• 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 – histological examination of tissue samples

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Covered, unlimited prenatal care and medically necessary care related to diseases, illness or abnormalities related to the reproductive system and limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: **1.** One visit every four weeks for the first 28 weeks or pregnancy **2.** One visit every two to three weeks from 28 to 36 weeks of pregnancy **3.** One visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary. Benefits are limited to: • Limit of 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation 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.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
(Continued) Prenatal Care and Pre-Pregnancy Family Services and Supplies		Visits after the initial visit must include: • interim history (problems, marital status, fetal status) • physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) • 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 members 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)
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Limitation: Applies only to CHIP members.	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	CHIP Members: Covers prenatal services and birthing services rendered in a licensed birthing center. CHIP Perinate Newborn Members: Covers services rendered to a newborn immediately following delivery.	Covers prenatal services and birthing services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: **1.** One visit every four weeks for the first 28 weeks of pregnancy **2.** One visit every two to three weeks from 28 to 36 weeks of pregnancy **3.** One visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary. Benefits are limited to: • Limit of 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation 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 and is subject to retrospective review.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
(Continued) Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center		Visits after the initial visit must include: • interim history (problems, marital status, fetal status) • physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) • 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 members 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

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000, 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury or disability and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements	Not a covered benefit, with the exception of a limited set of disposable medical supplies, published at **www.txvendordrug.com/formulary/** and only when they are obtained from a CHIP-enrolled pharmacy provider.
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies • Services are not intended to replace the child's caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • Does not require PCP referral	Not a covered benefit.
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis. The visits can be furnished in a variety of community-based settings, such as school or home-based or in a state-operated facility. Services including, but not limited to: • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination	Not a covered benefit.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
(Continued) Outpatient Mental Health Services	• A Qualified Mental Health Provider – Community Services (QMHP-CS). Services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education and crisis services. • Does not require PCP referral	Not a covered benefit.
Inpatient Substance Use Treatment Services	Services include, but are not limited to: • Inpatient and residential substance use treatment services including withdrawal management and crisis stabilization and 24-hour residential rehabilitation programs • Does not require PCP referral	Not a covered benefit.
Outpatient Substance Use Treatment Services	Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for substance use disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services and life skills training • Does not require PCP referral	Not a covered benefit.
Rehabilitation Services	Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational and speech therapy • Developmental assessment	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness • Up to a maximum of 120 days with a six-month life expectancy • Patients electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Emergency Services, Including Emergency Hospitals, Physicians and Ambulance Services	MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: • Emergency services based on a prudent layperson's definition of an emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, seven days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts and treatment relating to oral abscess of tooth or gum origin	MCO 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 unborn child until birth. • Emergency services based on a prudent lay person's definition of an 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 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.

Covered Benefit	CHIP Members and CHIP Perinatal Newborn Members	CHIP Perinatal Members (Unborn child)
Transplants	Services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	Not a covered benefit.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month period limit for a plan- approved program. • Health Plan defines plan-approved program. • May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach, informing case management, care coordination and community referral.	Covered benefit.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals • Drugs and biologicals provided in an inpatient setting.	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals • Drugs and biologicals provided in an inpatient setting Services must be medically necessary for the unborn child.

If you have questions, call the Customer Advocate Department toll-free at **1-888-657-6061** (TTY: **711**) from 8 a.m. – 5 p.m. Central time, Monday - Friday or the 24/7 Nurse Advice Line at **1-844-971-8906**.

To get auxiliary aids and services, or to get written or oral interpretation to understand the information given to you, including materials in alternative formats such as large print, braille or other languages, please call the BCBSTX Customer Advocate Department at the number on the back of your member ID card.

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at **1-855-710-6984**.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: **1-855-664-7270** (voicemail)
TTY/TDD: **1-855-661-6965**
Fax: **1-855-661-6960**
Email: civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: **1-800-368-1019**
TTY/TDD: **1-800-537-7697**
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at
https://www.bcbstx.com/medicaid/pdf/medicaid-non-discrimination-tx.pdf

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-855-710-6984** (TTY: **711**) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **1-855-710-6984** (TTY: **711**) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **1-855-710-6984** (TTY: **711**) أو تحدث إلى مقدم الخدمة الخاص بك.

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **1-855-710-6984** (TTY: **711**) 或咨询您的服务提供商。
Français French	ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **1-855-710-6984** (TTY: **711**) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie **1-855-710-6984** (TTY: **711**) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે બીજી ભાષા બોલો છો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક મદદ અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. **1-855-710-6984** (TTY: **711**) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। **1-855-710-6984** (TTY: **711**) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: Se parli italiano, puoi usufruire gratuitamente di servizi di assistenza linguistica. Sono inoltre disponibili, senza costi, strumenti e servizi ausiliari per ricevere informazioni in formati accessibili. Chiama il numero **1-855-710-6984** (TTY: **711**) o rivolgiti a un assistente.
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **1-855-710-6984** (TTY: **711**)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHÓÓ: Diné Bizaad k'ehjí éí dinits'á'go, t'áá nizaad k'ehjí níká a'doo wołgo bohónéedzą. Łahgo bee ata' hodoonigo áádóó éí doodago ałtaa át'éego níka a'doowołgo t'áá jiik'e nábee ahoot'i'. **1-855-710-6984** (TTY: **711**) jį' hodíílni éí doodago nits'íís náyaa áhályánii bich'į' hadíídzi.
فارسي Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و تماس خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با **1-855-710-6984** (TTY: **711**) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **1-855-710-6984** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **1-855-710-6984** (TTY: **711**) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **1-855-710-6984** (TTY: **711**) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاونامداد اور خدمات بھی مفت دستیاب ہیں۔ **1-855-710-6984** (TTY: **711**) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں.
Tiếng Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số **1-855-710-6984** (TTY: **711**) hoặc trao đổi với người cung cấp dịch vụ của bạn.