Driscoll Health Plan

CHIP Perinatal Member Handbook

SERVING THE NUECES SERVICE AREA

SEPTEMBER 2021
CHIP PERINATAL-MHB

CHIP | TEXAS Health and Human Services

MEMBER SERTVICES
Toll-free:
1-877-451-5598
TTY: 1-800-735-2989
driscollhealthplan.com

An affiliate of Driscoll Health System

Your CHIP Perinatal benefits include:

- Up to 20 prenatal visits.
- Prescriptions and prenatal vitamins.
- Hospital care for labor and delivery of the baby.
- Two doctor visits for the mother after the baby is born.
- Regular checkups, vaccines and prescriptions for your baby after your baby leaves the hospital.

CHIP Perinatal Value-Added Services*

DENTAL CARE FOR PREGNANT WOMEN 19 YEARS OF AGE OR OLDER

- Up to $500 in dental services. Includes dental exam, x-rays, teeth cleanings, and gum treatment.

GIFTS FOR COMPLETING CHECKUPS

- $25 gift card for Pregnant Members who get a Prenatal Checkup during the first trimester or within 42 days of joining DHP.
- Up to $75 gift card for Members who complete a Triple P, DHP, or Case Management educational program.

EXTRA HELP FOR PREGNANT WOMEN

- $100 gift card for Pregnant Members who attend a Cadena de Madres educational baby shower.
- Members can get help to learn about breastfeeding and nutrition.
- $20 gift card for completing a Pregnancy Health Risk Assessment.
- New moms can attend a Parenting Class.

For a listing of our Baby Showers and Parenting Classes, please visit:

driscollhealthplan.com/get-ready-for-baby

TRANSPORTATION SERVICES

- Help with getting a ride to any health care-related visits.

****This is not an all-inclusive list of extra services. Restrictions and/or limitations apply. These extra services are valid September 1, 2021 – August 31, 2022.***

For more information on these services, please visit our website or call Member Services:
driscollhealthplan.com | 1-877-451-5598 | 1-800-735-2989 TTY

Dear Driscoll Health Plan Member:

Thank you for choosing Driscoll Health Plan (DHP)! We are here to provide quality health care for you and your family.

Driscoll Health Plan covers a wide range of services and benefits. This handbook will help you get to know your coverage. It will help you get the services you need and learn more about Driscoll Health Plan's extra benefits.

We want you to be satisfied with your health care services. If you have any questions or have trouble seeing or reading this handbook, please call Member Services for help. Call toll-free at **1-877-451-5598**.

You can also visit our website to learn more at: driscollhealthplan.com

The Member Handbook is reviewed once per year. If there are any changes to the handbook, we will notify you through newsletters and other mailings.

Preventative care is very important because it helps you stay well. It is important to get your exams on time each year. We urge you to read the sections on ***Things You Can Do to Stay Healthy*** and ***Taking Care of Yourself and Your Family***. These sections tell you what you need to do to stay healthy.

We look forward to serving you.
Welcome to the Driscoll Health Plan Family!

Phone Numbers

Member Services	
Regular business hours 8 a.m. to 5 p.m. CST, Monday-Friday, excluding state approved holidays. You can leave a message after hours, on weekends and holidays. Our staff speaks English and Spanish. Interpreter services are available. For an Emergency, dial 911 or go to your nearest emergency room.	
Nueces Service Area	1-877-451-5598
TTY for the deaf and hard of hearing	1-800-735-2989
Behavioral Health Hotline	
Available 24 hours a day, 7 days a week. For an Emergency, dial 911 or go to your nearest emergency room. Our staff speaks English and Spanish. Interpreter services are available.	
Nueces Service Area	1-877-330-3312
Other Important Phone Numbers	
Chip Program Help Line	1-800-647-6558
Pharmacy Assistance	1-877-451-5598
TTY for the deaf and hard of hearing	1-800-735-2989
Non-Emergency Medical Transportation-SafeRide Health	1-833-694-5881

Website:

driscollhealthplan.com

Address:

Driscoll Health Plan
4525 Ayers Street
Corpus Christi, TX 78415

What do I do if I Need Help Or Need the Member Handbook in a Different Format?

Our staff speaks English or Spanish and can help you with questions. We also have special services for people who have trouble reading, hearing, seeing, or speaking a language other than English or Spanish. You can also ask for this Handbook and any other Member materials in audio, larger print, Braille, and other languages. To get help with language assistance and auxiliary aids services free of charge, call Member Services at **1-877-451-5598** (TTY: 1-800-735-2989).

Table of Contents

Welcome

Welcome to the Driscoll Health Plan (DHP) family! Driscoll Health Plan is a nonprofit community-based health plan. Driscoll Health Plan is part of the Driscoll Health System. Together, we have been taking care of kids and their families for over 60 years. We are committed to ensuring you get the best health care. We offer a large network of providers, specialists, and hospitals. You will have access to quality doctors and our expert staff.

This handbook contains information about how the health plan works. It tells you what to expect and provides answers to many questions. The Member Handbook includes information on:

- Choosing your Provider
- Getting Emergency Care
- Taking Care of Yourself
- Benefits
- Interpreter and Transportation Services
- Prescription Coverage
- And many other topics

Please take the time to read this handbook. Our staff speaks English and Spanish and can help answer your questions. We also have special services for people who have trouble reading, hearing, seeing, or speaking a language other than English or Spanish. Members or their legally authorized representatives can ask for the handbook in audio, larger print, Braille, and other languages. To get help, call Member Services toll-free or the TTY line listed on your Member ID card.

Important Things You Should Know

Things You Can Do To Stay Healthy

Preventive care is an important part of staying healthy. You can stay healthy by getting timely checkups, getting vaccines, and making regular visits to your doctor. Working together, we can keep you and your family healthy and happy.

The following are some things you can do to stay healthy:

- ❖ Establish a good relationship with your doctor. You and your doctor need to work as a team.
- ❖ Your doctor will help take care of all your pregnancy health care needs.
- ❖ Call your Perinatal Provider to schedule appointments. Tell them you are a DHP CHIP Perinatal member.
- ❖ Call your Perinatal Provider whenever you need health care.

Be focused on prevention:

- ❖ Get your checkups on time.
  - ✓ Newborns should be seen by a doctor ***3-5 days after birth.***
  - ✓ Pregnant women should get a prenatal exam within ***42 days of enrollment or in the first trimester.***
  - ✓ New moms should have a post-partum exam within ***21-56 days after delivery***.
- ❖ Be sure to mail in the completed health risk assessment in your welcome packet. This assessment will help our Case Managers know what help you need.

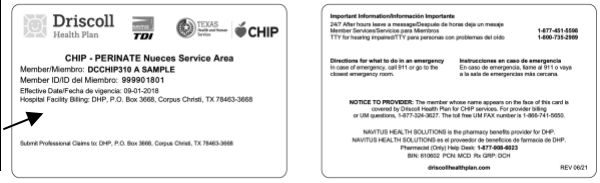
Call your doctor for non-emergency care. He or she can get you the right care that you need. Only visit the emergency room for an emergency.

Member Identification (ID) Card

You will get a CHIP Perinate ID card after joining Driscoll Health Plan. Make sure everything on the card is correct. Call Member Services at **1-877-451-5598** if you have any questions. While you are pregnant, you will receive a DHP CHIP Perinatal ID card for your unborn child. After birth, your newborn child will receive a DHP CHIP Perinatal Newborn ID card for either Medicaid or CHIP. Keep your ID card with you at all times. Take your ID card with you when you go to a doctor's visit and to the pharmacy.

DHP CHIP Perinate ID Card

Facts about you or your child



Reading your DHP CHIP Perinate ID Card

The front of the DHP CHIP Perinatal ID card shows important facts about you. It contains your name, your DHP ID number, and your unborn child's coverage dates. The back of the ID card shows important phone numbers for emergencies and DHP Member Services. An example of your ID card is shown above.

Using your DHP CHIP Perinate ID Card

Carry your DHP CHIP Perinatal ID card with you at all times. That way, you will have it with you if there is an emergency. Also, show your ID card to your Perinatal Provider when you go to their office for a visit so that they will know you are a DHP Member.

If you lose your ID Card or Move

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

CHIP Perinatal Eligibility

CHIP Perinatal Program coverage continues through the delivery of your newborn. During the enrollment process, you will have the chance to pick a CHIP Perinatal Health Plan.

ATTENTION: If you meet the Medicaid income requirements, your baby will be moved to Medicaid and get 12 months of continuous Medicaid coverage from their date of birth.

If you meet the CHIP Perinatal requirements, your baby will continue to receive 12 months of continuous CHIP Perinatal coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

Please contact Texas Health and Human Services Commission (HHSC) to report any changes to your information by calling 2-1-1 or 1-877-541-7905. You can also go to yourtexasbenefits.com to report these changes. A change to your information could affect the eligibility for you or someone living in your household. You may also be subject to penalties under federal law if false or untrue information is provided.

CHIP Perinatal Coverage Renewal

When does CHIP Perinatal Program coverage end?

Coverage for CHIP Perinate Members continues through the delivery of your newborn. New moms can have two post-partum visits within eight weeks of delivery. Coverage for CHIP Perinate Newborn Members ends after 12 months of coverage.

How does renewal work? Will the State send me anything when my CHIP Perinatal Coverage ends?

In the 10th month of your child's coverage, you will receive a CHIP or Medicaid renewal form for your child. You must fill it out and send it to HHSC. HHSC will decide if your child is able to get Medicaid or CHIP after his or her CHIP Perinate Newborn coverage ends. Call DHP Member Services at **1-877-451-5598** to get help with filling out your renewal application.

WAYS TO RENEW AND GET HELP

- **Website:** Go to yourtexasbenefits.com
- **Phone:** "Your Texas Benefits" app is in the IOS App Store for IPhone/Google Play Store for Android Phones
- **Call**: 2-1-1 to request a renewal packet
- **Call**: Member Services for Help toll-free at **1-877-451-5598**

Member Services

How can Member Services Help You?

Our expert Member Services staff is available from 8 a.m. to 5 p.m., Monday-Friday. You can leave a message after hours, on weekends, and holidays. Your call will be returned the next business day.

Our expert staff can help you with:

- Questions about your benefits and coverage.
- Changing your Primary Care Provider.
- Changing your address or phone number.
- Mailing of a lost Member ID card.
- Your complaints, appeals, or concerns.

Member Portal

As a Member of Driscoll Health Plan, you can use our Member Portal by visiting: driscollhealthplan.com

Here you can find important information such as your Case Manager information, Value-Added Services, and how to renew your health benefits. You can also print a copy of your Driscoll Health Plan ID card. Here are some helpful instructions to get you started:

- Click **Member Portal**
- Enter your MyChart Username and Password
- Click **Sign In**
- New User? Click **Sign Up Now**
- Follow the steps to register your account

If you have any questions, please call Member Services toll-free at **1-877-451-5598**.

Download the Driscoll Health System Mobile App

Driscoll Health Plan has a new mobile application linked to MyChart.

How do I get it?

Go to Google Play or Apple App Store and search for Driscoll Health System!

- *New MyChart users*: send an email to MyChart.help@dchstx.org and ask for your activation code or call **1-877-324-7543**
- *Current users*: will be redirected to download the new app

Need help downloading the app?

Call Member Services toll-free at **1-877-324-7543** or email: DHPmemberservices@dchstx.org

What information can I access?

Conveniently view your health care information in a secure and confidential environment.

- View Member ID cards
- Check your list of medications
- Review medical records and lab results
- Manage family appointments

Choosing Your Doctor

What is a CHIP Perinatal Provider?

As a Member of Driscoll Health Plan, you will get to choose a doctor, called a Perinatal Provider. This health care provider will know your medical history. He or she will help you get the care you need so that your newborn can be as healthy as possible. Your Perinatal Provider will provide prenatal care. Also, your Perinatal Provider will arrange for medical tests or special treatments, if needed. Your Perinatal Provider is the first person you should call when you have concerns about your health or your unborn child's health. He or she will provide the care you need or help direct you to someone who can help you.

Except in an emergency, you should always call your Perinatal Provider before getting health care services. Your Perinatal Provider or another doctor can be reached by phone 24 hours a day, 7 days a week. If you go to a doctor who is not your Perinatal Provider, you might have to pay the bill.

How do I choose a CHIP Perinatal Provider?

You may choose a Perinatal Provider from the DHP Provider Directory or you can get help picking a Perinatal Provider by calling Driscoll Health Plan Member Services at **1-877-451-5598**.

If you go to a Provider that is not in DHP's network, you might have to pay the bill.

How can I change my Perinatal Provider?

You can change your Perinatal Provider by calling DHP Member Services at **1-877-451-5598**.

Do I need a referral?

You do not need a referral to go see your CHIP Perinatal Provider.

How soon can I expect to be seen after contacting a Perinatal Provider for an appointment?

You should be able to get an appointment for routine care within two weeks. If you have had problems with previous pregnancies, or if you are more than seven months pregnant, you should be given an appointment within five days of the request.

Can I stay with a Perinatal Provider if they are not with DHP?

If you have 16 weeks or less remaining before the expected delivery date of your baby, you can stay with your current doctor until after your postpartum checkup, even if the doctor is, or becomes, out of network. Otherwise, you will need to pick a Perinatal Provider that is in DHP's network.

Can a Clinic be my CHIP Perinatal Provider?

Your Perinatal Provider can be a doctor, a health clinic, a Federally Qualified Health Center (FQHC), or a Rural Health Clinic (RHC) that is contracted with DHP to provide pregnancy services.

Can I choose my child's Primary Care Provider before he or she is born? What information do they need?

You will need to pick a Primary Care Provider for your newborn baby. The Primary Care Provider is the doctor who takes care of your baby's medical needs. This includes all checkups and vaccines (immunizations). You can pick your child's Primary Care Provider before he or she is born if you would like.

Who do I call?

Just call DHP Member Services at **1-877-451-5598** and give us the name and address of the Primary Care Provider you picked from the DHP Provider Directory. If needed, you can change your baby's Primary Care Provider later. If you do not pick a

Primary Care Provider for your baby, DHP will pick one for you.

Can a clinic be my baby's Primary Care Provider?

You can pick a clinic as the Primary Care Provider for your baby. This can be a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). If you have questions, call DHP Member Services at **1-877-451-5598**.

Can a Specialist be my child's Primary Care Provider?

Driscoll Health Plan might allow a special doctor to be your baby's Primary Care Provider. This is for Members with Special Health Care Needs (MSHCN). You must sign a form called the "Agreement for Specialist to Function as a Primary Care Provider." The Specialist must also sign the form agreeing to be the Primary Care Provider. Our Medical Director will review the Agreement and will make a decision within 30 days of receiving the request. You will receive a letter telling you about our decision. If your request is not approved, you have the right to appeal the decision. The date you can start getting services will be the first day of the month when the request was made. To learn more, call DHP Member Services toll-free, at **1-877-451-5598**.

Physician Incentive Plan

Driscoll Health Plan cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. You have the right to know if your Primary Care Provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call **1-877-451-5598** to learn more about this.

Covered Benefits for Pregnant Members

The CHIP Perinatal Program is designed to provide prenatal services to unborn children of pregnant, low-income women who do not qualify for Medicaid. Unlike with CHIP, there is no 90-day waiting period before coverage can begin. Also, there is no CHIP asset test before joining. Covered services for CHIP Perinate Pregnant Members must meet the CHIP Perinatal definition of "Medically Necessary."

What is Medically Necessary?

Medically Necessary means:

(1) Health Care Services that are:

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

(2) Behavioral Health Services that:

a. are reasonable and necessary for the diagnosis or treatment of a mental health or

chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

b. are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
c. are furnished in the most appropriate and least restrictive setting in which the services can be safely provided;
d. are the most appropriate level of supply of service that can be safely provided;
e. could not be omitted without adversely affecting the Member's mental and/or unborn child's physical health or the quality of care rendered;
f. are not experimental or investigative; and
g. are not primarily for the convenience of the mother, the Member, or provider.

Getting Routine Medical Care

What is routine medical care?

Routine Perinatal Care includes regular checkups and care during your pregnancy by your Perinatal Provider. During a routine visit, your Perinatal Provider can give you medications, if needed.

How soon can I expect to be seen?

You should be able to get an appointment for routine care within two weeks.

It is important to keep your appointment. If you cannot keep an appointment, call to let your Primary Care Provider know.

What do I need to bring to a Perinatal Provider's appointment?

- ✓ Your Driscoll Health Plan Member ID card
- ✓ List of health care concerns
- ✓ Medications you are taking, including any herbal supplements
- ✓ Medical records if you are a new patient

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

Your Primary Care Provider or another doctor is available by phone 24 hours a day, 7 days a week. If you get sick at night or on the weekend, you can call your Primary Care Provider's office number for help. The office will have an answering service or message on how to contact your Primary Care Provider. Your Primary Care Provider should return your call within 30 minutes.

How do I get after-hours care?

You may also visit an in-network after-hours clinic or urgent care center for sudden illness. You should contact the doctor's office if you are unsure about going to an after-hours clinic or urgent care center.

For a list of Driscoll Children's Hospital Clinics and other after-hours clinics/urgent care centers, visit: driscollhealthplan.com/services/after-hours-care

Getting Urgent and Emergency 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:

- A minor to moderate asthma attack
- Earaches, sore throat, muscle sprains/strains
- A minor illness with fever if a child is more than two months old
- A skin rash because of an insect bite

How soon can I expect to be seen?

You or your child should be able to see your doctor within 24 hours for an urgent care appointment.

You should always call your Perinatal Provider before going to the emergency room or to another provider. If your Perinatal Provider feels you should go to an emergency room, he or she will tell you.

What is Emergency Medical Care?

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 the 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.

If there is an emergency, go to the closest Emergency Room right away or call 911.

Examples of when to go to the emergency room are when someone:

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

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

If you go to the Emergency Room, be sure to call your Perinatal Provider within 24 hours or as soon as you are medically stable.

How soon can I expect to be seen?

Emergency Care is there for you 24 hours a day, 7 days a week.

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

If you or your child needs medical care when traveling, call us toll-free at **1-877-451-5598,** and we will help you find a doctor.

If you or your child needs emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-877-451-5598**.

What if I get sick when I am out of state?

If you need medical care when traveling, call us toll-free at **1-877-451-5598** and we will help to find a doctor.

If you need emergency services while traveling, go to a nearby hospital, and then call us toll-free at **1-877-451-5598**.

What if I get sick when I am out of the country?

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

What is a referral?

A referral is a request from your doctor for you to see another doctor.

What services do not need a referral?

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

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

What is post-stabilization?

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

Taking Care of Yourself and Your Family Preventative Health or Self-Management

Health Education

What Health Education classes does Driscoll Health Plan offer?

We want you to stay healthy. Driscoll Health Plan provides information on things such as:

- Vaccines
- Texas Health Steps checkups
- Diabetes
- Asthma
- Pregnancy

You can get this information from the:

- Member Handbook or Welcome Packet
- Member newsletter
- DHP's website
- Case Managers and Social Workers

Health Education Text Messages

DHP will send health education text messages. Members may opt-out at any time. Restrictions and limitations may apply. To learn more, please call Member Services.

What other services and education does Driscoll Health Plan offer to Pregnant Members?

Cadena de Madres–Educational Baby Showers

Driscoll Health Plan wants to help you keep your baby from being born too early. Each month we have baby showers that you can attend. At the baby showers, we teach you about:

- Eating healthy and breastfeeding.
- How smoking, alcohol, and drugs affect you and your baby.
- What to look for if there are problems during your pregnancy.
- Knowing the signs of early labor and when to get help.
- What to expect during labor and delivery.

The Cadena de Madres Program also offers:

- Nutritional Counseling (at no cost)
- Breastfeeding Consultations (at no cost)

For a listing of our Baby Showers and Parenting classes, please visit:

driscollhealthplan.com/get-ready-for-baby

Text4baby Program

Get free text messages on your cell phone each week. The Text4baby messages will give you tips about being pregnant and more. To sign up, text the word BABY to 511411. You can also sign up using the Text4baby app. Download it for free on iTunes or Google Play App Stores. Learn more at: text4baby.org/

Other Preventative Care Programs

DSHS Primary Health Care Services Program

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

Primary Health Care focuses on the prevention of disease, early detection, and early intervention of health problems. The main services provided are:

- Health education
- Emergency services
- Family planning services
- Diagnosis and Treatment
- Diagnostic testing, including X-rays and lab services
- Preventive health services, including vaccines (immunizations)

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

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

Toll-free Number: 1-800-222-3986, Ext. 5922
Email: PrimaryHealthCare@hhs.state.tx.us
Website: hhs.texas.gov/services/health/primary-health-care-services-program

DSHS Family Planning Program

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

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at: txclinics.dshs.texas.gov/chcl/

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

Website: healthytexaswomen.org/healthcare-programs/family-planning-program
Phone Number: 512-776-7796
Fax Number: 512-776-7203
Email: famplan@hhsc.state.tx.us

Where do I find a family planning service provider?

To locate family planning providers near you visit the program's website or call Member Services.
healthytexaswomen.org/find-doctor

Zika Virus

What is the Zika Virus?

The Zika virus is spread mostly through the bite of an infected mosquito. The Zika virus can be spread from a pregnant mother to her child and through sexual contact with an infected male partner.

Where is the Zika Virus?

Zika virus outbreaks are present in many countries. Within the United States, the Zika virus may be present in the counties of South Texas.

Who is at risk?

During pregnancy, the Zika virus can cause birth defects, including a rare brain condition in which a baby's head is smaller than normal.

What are the symptoms?

Symptoms are flu-like. The illness linked with Zika is usually mild with symptoms lasting for a few days to a week. The most common symptoms of Zika are fever, rash, joint pain, and pink eye.

At this time, all pregnant women should have a screening during pregnancy. Those with concerns should see their Primary Care Physician or OB provider.

How can I protect myself from the Zika Virus?

At this time, no vaccine exists to prevent the Zika virus, but there are ways to protect yourself. All pregnant women should apply mosquito spray or lotion while pregnant. Mosquito spray or lotion is safe when applied properly and is safe for the fetus. Always read the instructions on the label before using. Wearing protective clothing can help as well. In addition, because the virus can be sexually transmitted, it is recommended that all pregnant women in these affected areas also have their partners wear condoms.

Breast Pumps

Why you would need a breast pump?

- Your baby is premature and unable to suck.
- Your baby has severe feeding problems.
- You cannot make enough milk supply because of illness.
- You and your baby are separated.
- You had more than one baby.
- For other reasons, as approved by Driscoll Health Plan.

How do I get a breast pump?

No Approval Needed If:

- Your doctor gives you a prescription for a manual or electric single breast pump that costs $300 or less.

Approval Needed If:

- Your doctor gives you a prescription for an electric or hospital-grade breast pump that costs more than $300.
- You had more than one breast pump per pregnancy or within three years, whichever is greater.
- Your doctor will have to get approval from Driscoll Health Plan.

Where can I get a breast pump?

You can get a breast pump through any Driscoll Health Plan Network Pharmacy or Durable Medical Equipment Provider. To find a pharmacy or provider go to driscollhealthplan.com or call Member Services for help at **1-877-451-5598.**

Special Services

Interpreter Services

Can someone interpret for me when I talk with my Perinatal Provider?

Yes. Your doctor's office will arrange for an interpreter to help you during your visit.

Who do I call for an interpreter?

Call your doctor's office for help.

How far in advance do I need to call?

Language interpreter services held over the phone do not require advance notice.

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

The interpreter your doctor's office arranges for you can be someone that comes to the office. Contact

your doctor at least 48 hours in advance to make these arrangements.

Benefits and Service

References to "you," "my," or "I" apply if you are a CHIP Member. References to "my child" apply if your child is a CHIP Member or a CHIP Perinatal Unborn Child Member.

CHIP Perinatal Program coverage starts the first day of the month your unborn child joins the program. Coverage lasts for 12 months if the family's income is above 185% of the federal poverty level but below 200% of the federal poverty level. For example, if your baby joins when you are three months pregnant and the child is born six months later, your baby will have six months of prenatal care, and six months of full CHIP coverage upon delivery. If the family's income is at or below 185% of the federal poverty level, your baby will get 12 months of continuous Medicaid coverage beginning at birth.

Covered services for newborns can be found in either the CHIP Member Handbook or the Medicaid/STAR Member Handbook. This handbook will be mailed to you once your baby is born.

What are the CHIP Perinatal Program benefits?

Benefits and services for Pregnant Members are limited to prenatal and postpartum care, labor, and delivery of the child. Below is a listing of the benefits for Pregnant Members.

How do I get these services?

Call Member Services at **1-877-451-5598**. We will be happy to explain how to use your unborn child's CHIP Perinatal Program benefits.

Are there any limits on any covered services?

For any limits to any services, see the list of covered services in the benefits table that is located on pages 17-22.

What if I have other children in CHIP?

If your other children are in the CHIP Program, they will remain in the CHIP Program, but they will be placed in the same health plan as your CHIP Perinatal Program coverage. Co-payments, cost sharing, and enrollment fees still apply for your children who are in the CHIP Program.

Can my newborn be covered by Medicaid?

An unborn child who is enrolled in the CHIP Perinatal Program will be moved to Medicaid for 12 months of continuous Medicaid coverage, beginning on the date of birth, if your family has an income at or below 185% of the federal poverty level. For a family that has an income of 186% to 200% of the federal poverty level, the child will stay in CHIP after birth for 12 months of continuous CHIP coverage.

Benefits Table

The following table contains information on your benefits, limitations, and co-pays:

Type of Benefit	Description of Benefit	Limitations
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include but are not limited to, the following: • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services 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	For CHIP Perinates in families with incomes 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 with 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 with delivery until birth, and services related to miscarriage or a non-viable pregnancy.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center	Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital- based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications, and biologicals that are medically necessary prescription and injection drugs	• Laboratory and radiological services are limited to services that directly relate to ante partum care and the delivery of the covered CHIP Perinate until birth. • 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,

Type of Benefit	Description of Benefit	Limitations
	• 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. • 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: o Dilation and curettage (D&C) procedures o Appropriate provider-administered medications o Ultrasounds o Histological examination of tissue samples	gestational age confirmation or miscarriage, or non- viable pregnancy. • Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. • Laboratory tests are limited to: non-stress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and Rh antibody screen; repeat antibody screen for RH negative women at 28 weeks followed by Rho immune globulin administration, if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.

Doctor / Doctor Extender Professional Services	Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and the delivery of the covered unborn child until birth • Physician office visits, in-patient, and out-patient services • Laboratory, x-rays, imaging, and pathology services including technical component and/or professional interpretation • Medically necessary medications, biologicals, and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: ○ Surgeons and assistant surgeons for surgical procedures directly related to the labor with deliver of the covered unborn child until birth ○ Administration of anesthesia by Physician (other than surgeon) or CRNA ○ Invasive diagnostic procedures directly related to the labor with delivery of the unborn child ○ Surgical services associated with miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) • Hospital-based Physician services (including Physician performed technical and interpretive components) • 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, Cordocentesis, and FIUT • 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: o Dilation and curettage (D&C) procedures o Appropriate provider-administered medications o Ultrasound o Histological Examination of tissue samples	
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: • One visit every 4 weeks for the first 28 weeks of pregnancy • One visit every 2- 3 weeks from 28- 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary. • Visits after the initial visit must include: o Interim history (problems, marital status, fetal status) o Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) o Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin	• Limit of 20 prenatal visits and 2 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.

	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 related to labor and delivery. • Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid threshold (who will not qualify for Medicaid once born).
Services rendered by a Certified Nurse Midwife or Physician in a licensed birthing center	Covers prenatal and birthing services rendered in a licensed birthing center. More frequent visits are allowed as Medically Necessary. • 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 (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).	Prenatal services are subject to the following limitations. Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: • One visit every 4 weeks for the first 28 weeks of pregnancy; • One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery. Benefits are limited to: Limit of 20 prenatal visits and 2 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.
Emergency Services, including Emergency Hospitals, Doctors,	Driscoll Health Plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

and Ambulance Services	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 prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when 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 (a) miscarriage or (b) a non- viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a 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; and • Drugs and biologicals are provided in an inpatient setting.	Services must be medically necessary for the unborn child.

Extra Benefits

What extra benefits do I get as a Driscoll Health Plan Member?

When you join Driscoll Health Plan, you get Value-Added Services that Medicaid does not offer.

What is a Value-Added Service?

In addition to your regular health benefits, Driscoll Health Plan offers extra services to our Members at no cost. Driscoll Health Plan wants you and your family to stay healthy and enjoy life. Therefore, we offer a Value-Added Service for everyone in the family.

How can I get these benefits for my unborn child?

For questions on how to get these services, contact Member Services at **1-877-451-5598**.

*These extra services are valid from September 1, 2021 through August 31, 2022.

Value-Added Services

Type of Benefit	Description of Benefit	Limitations or Restrictions
Dental Services for Pregnant Women	Up to $500 in dental services. Includes dental exam, x-rays, two teeth cleanings, and gum treatment.	CHIP Perinatal Members 19 years of age and older
Gifts for Completing Checkups	$25 gift card for Pregnant Members who get a Prenatal Checkup.	The Prenatal Checkup must occur within 42 days of joining DHP or in the first trimester
	Up to $75 gift card for Members who complete a Triple P, DHP, or Case Management educational program.	Must complete education program to receive gift card
Extra Help for Pregnant Women For a listing of our Baby Showers and Parenting classes please visit: driscollhealthplan.com/ get-ready-for-baby	$100 gift card for Pregnant Members who attend a Cadena de Madres educational baby shower.	• At certain locations • One per Member per pregnancy
	Breastfeeding and nutrition help.	• For all Pregnant Members • No age restrictions
	Parenting Classes	• Members who had a baby within 90 days • One gift card for one class per Member, per pregnancy
	$20 gift card for completing a Pregnancy Health Risk Assessment.	• New CHIP Perinate Members • Must complete the Pregnancy Health Risk Assessment

Transportation Services	Help with getting a ride to any health care-related visit.	• Health-related visits consisting of doctor appointments, therapy appointments, specialty appointments • Within 25-mile radius, or upon approval • Up to 5 riders including DHP Member and parent or attendant • Visits outside of Driscoll Network or Service area: prior authorization is required by Driscoll Health Plan

Exclusions

What services are not covered by the CHIP Perinatal Program?

The CHIP Perinatal Program has limited covered benefits for Pregnant Members. Some health care services are not covered. DHP or your Perinatal Provider will try to help you get care within your community for services that are not covered by the CHIP Perinatal Program for Pregnant Members. You can call DHP Member Services for help at **1-877-451-5598.**

The benefit exclusions for CHIP Perinate Pregnant Members are:

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth. Inpatient mental health services
- Inpatient mental health services
- Outpatient mental health services
- Durable medical equipment or other medically related remedial devices
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies, when they are obtained from an authorized pharmacy provider
- Home and community-based health care services
- Nursing care services
- Dental services
- Inpatient substance abuse treatment services and residential substance abuse treatment services
- Outpatient substance abuse treatment services

- Physical therapy, occupational therapy, and services for people with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the labor with delivery of the covered unborn child
- Transplant services
- Tobacco cessation programs
- Chiropractic services
- Medical transportation not directly related to labor or threatened labor, miscarriage or non-viable pregnancy, or delivery of the covered unborn child
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, phone, television, newborn infant photographs, meals for guests of Member, and other articles which are not needed for the specific treatment related to labor with delivery or post-partum care
- Experimental or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations needed by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance, or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child and services provided by an FQHC (Federally Qualified Health Center)
- Services, supplies, meal replacements, or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy, and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails)

- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

Costs of Your DHP CHIP Perinate Insurance

What are co-payments?

A co-payment is when you have to pay a part of the bill each time your child needs health care services.

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

CHIP Perinate Members do not have any cost-sharing responsibilities so there are no co-payments or deductibles for you to pay.

What if I need services that are not covered by the CHIP Perinatal Program?

Only those services that are listed in this Member Handbook are paid for by the DHP CHIP Perinatal Program.

Will I have to pay for services that are not covered benefits?

You might have to pay for services that are not covered by the CHIP Perinatal Program

Health Care and Other Services Offered

References to "you," "my," or "I" apply if you are a CHIP Member. References to "my child" apply if your child is a CHIP Member or a CHIP Perinate Newborn Member

Pharmacy and Prescriptions

How do I get my medications?

You can go to any pharmacy that is part of the DHP network. To find the closest pharmacy, call Member Services at **1-877-451-5598**.

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

There are no co-payments for prescriptions for the CHIP Perinatal Program. In most cases, you cannot get more than a 34-day supply. The CHIP Perinatal prescription drug benefit does not cover:

- Over-the-counter medications
- Birth control medications prescribed only for birth control purposes
- Nutritional products
- Medications that must be given in a doctor's office or health care facility

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

Call Member Services at **1-877-451-5598** if you need help finding a pharmacy or need help getting your prescription.

What are my unborn child's prescription drug benefits?

Prescription drugs are covered for pregnant women in the CHIP Perinatal Program.

How do I find a network drug store?

A network pharmacy can be found on the pharmacy network list at driscollhealthplan.com or contact Member Services for help finding a network drug store.

What if I go to a pharmacy not in-network?

The pharmacy can call the Pharmacy Help Line on the back of your ID card. They will help you find a pharmacy in the network.

What do I bring with me to the pharmacy?

You will need to bring your Driscoll Health Plan ID card with you to the pharmacy.

What if I need my medications delivered to me?

Please call Member Services if you need to have your medications delivered to your home. We will give you the number of a pharmacy that will deliver to you.

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

Please contact Member Services with any problems getting your medications.

What if I cannot get the medication my doctor ordered approved?

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

Call Driscoll Health Plan toll-free at **1-877-451-5598** for help with your medications and refills.

What if I lose my medication?

You should keep your medications in a safe place. If you lose your medications, call Member Services. We will work with your doctor and pharmacy to help you get a replacement.

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

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

What if I need more than 34 days of a prescribed medication?

The pharmacy can only give you an amount of medication that you need for the next 34 days. For any other questions, please call Driscoll Health Plan at **1-877-451-5598.**

Changing Health Plans

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, or
- 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 health plan within 15 days of getting the enrollment packet, HHSC will pick a plan for your unborn child and send you the information for 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 at the end of the other children's enrollment period, whichever happens last. At that point, you can pick a different health plan for your children.
- You can ask to change health plans:
  - for any reason within 90 days of enrollment in CHIP Perinatal;
  - if you move into a different service delivery area; and
  - for a cause at any time.

Who do I call?

To learn more, call CHIP toll-free at 1-800-964-2777.

How many times can I change health plans?

You can change health plans:

- for any reason within 90 days of enrollment in CHIP Perinatal; and
- for a cause at any time.

How many times can I change my or my child's Primary Care Provider?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us toll-free at **1-877-451-5598** or writing to:
Driscoll Health Plan
Attn: Eligibility and Enrollment Team
4525 Ayers Street
Corpus Christi, TX 78415

When will my health plan change become effective?

The health plan change will become effective the following month after you have requested the change.

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

Yes. Driscoll Health Plan may ask that you be taken out of our health plan for "good cause."

Good cause could be:

1. Fraud or abuse by a Member
2. Threats of physical acts leading to harming DHP staff or providers
3. Theft
4. Refusal to go by the DHP policies and procedures, like:
   a. Letting someone use your CHIP ID card
   b. Missing appointments to your provider over and over
   c. Being rude or acting out against a provider or a DHP staff member
   d. Using a doctor that is not a DHP provider over and over

Driscoll Health Plan will not ask you to leave the health plan without trying to work with you. If you have questions about this process, call Member Services at **1-877-451-5598**. The Texas Health and

Human Services Commission will decide if a Member can be told to leave the program.

Other Important Information

What do I have to do if I move?

As soon as you have your new address, give it to HHSC by calling 2-1-1, or updating your account on yourtexasbenefits.com and call Driscoll Health Plan Member Services at **1-877-451-5598**. Before you get CHIP services in your new area, you must call Driscoll Health Plan Member Services, unless you need emergency services. You will keep getting care through Driscoll Health Plan until HHSC changes your address.

What if I get a bill from a Provider?

In the CHIP Perinatal Program, there are no co-payments and no deductibles for Members to pay out-of-pocket. All covered services should be paid by DHP directly to your provider.

Who do I call?

If you get a bill from your provider, please call DHP Member Services at **1-877-451-5598.** We will contact the provider's office and help explain your benefits.

What information will they need?

When you call us, please have your child's ID card and the provider's bill ready. DHP Member Services will need these to help you.

Mental Health Parity and Addiction Equity Act

Driscoll Health Plan follows all laws and regulations for the Mental Health Parity and Addiction Equity Act and protects unfair and unequal treatment in regards to benefits provided by our plan.

Complaints

Driscoll Health Plan Member Advocates are here to help you with writing and filing complaints. Member Advocates will help you through the complaint process. If you have a question about the covered services or preventative services of Driscoll Health Plan, call **1-877-451-5598**.

Complaint Process

What should I do if I have a complaint?

We want to help. If you have a complaint, please call us toll-free at **1-877-451-5598** to tell us about your problem. A Driscoll Health Plan Member Advocate can help you file a complaint. Just call **1-877-451-5598**. Most of the time, we can help you right away or at the most within a few days. Driscoll Health Plan cannot take any action against you as a result of filing a complaint.

Driscoll Health Plan Complaint Procedures

You or someone acting on your behalf, and health care providers may file a written or oral complaint. Use the phone number and address referenced below to file your oral or written complaint.

Driscoll Health Plan
Quality Management Department
Attn: Performance Excellence Team
4525 Ayers Street
Corpus Christi, TX 78415
Toll-free Number: 1-877-451-5598
Fax Number: 361-808-2725

Who do I call?

We want to help you. If you have a question about how to file a complaint, please call Member Services toll-free at **1-877-451-5598**.

Can someone from Driscoll Health Plan help me file a complaint?

Yes. Driscoll Health Plan Member Advocates can help you with filing a complaint.

What are the requirements and timeframes for filing a complaint?

You can make your complaint verbally or in writing.

We will mail you a letter to let you know we received the complaint. We will send this letter within five business days of receiving your complaint. We will send you a form with the letter to complete and mail to us. This form will give us more details about your complaint, but is not required. We will review it and notify you in writing within 30 days of the outcome. All complaints are reviewed to make sure that there is a follow-up. They are also reviewed to make sure that timely answers are given.

How long will it take to process my complaint?

We will provide you with an answer within 30 days of receiving your complaint.

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

If you are not satisfied with the answer to your complaint, you can also contact the Texas Department of Insurance. You can call the number below or to make your request in writing send it to:

Texas Department of Insurance
Consumer Protection
P.O Box 149091
Austin, Texas 78714-9091
Toll-free Number: 1-800-252-3439
Fax Number: 512-490-1007

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

Do I have the right to meet with a Complaint Appeal Panel?

You also have the right to appear before a Complaints Appeal Panel. This panel is made up of DHP employees, doctors, and other CHIP Members. The doctors on this panel were not involved with the original complaint response. The doctors will have experience in the care that is being reviewed. You may also submit a written appeal to the Complaints Appeal Panel. DHP will complete the appeals process by the 30th day after the date the written request for appeal was received.

If your appeal is for an ongoing emergency or continued stay in the hospital, we will review this appeal quickly, depending on the immediacy of the case. We will respond no later than one business day after the request for appeal is received. Because of this urgent review, your appeal will be reviewed by a doctor or provider of similar specialty as the condition, procedure, or treatment your child received, and the doctor or provider will not have been involved with your child's care before.

Appeals

What can I do if my doctor asks for a service or medicine for me that is covered, but Driscoll Health Plan denies or limits it?

There might be times when the DHP Medical Director denies these services. When this happens, you can file an appeal for the denial of payment for services in whole or part. For help with how to fill out the appeal form call Member Services toll-free at **1-877-451-5598**.

How will I find out if services are denied?

We will send a letter if the services are denied. The form to appeal the denial will be included. You do not have to return the form for us to process your appeal.

What are the timeframes for the Appeal Process?

- You can file an appeal within 60 days from the day you get the denial letter.
- We will send you a letter within 5 working days after getting your appeal.
- We will complete the review within 30 days.
- You have the right to ask for an independent/external review.

How do I submit an appeal?

- You or your provider may request an appeal orally or in writing.
- If you choose to submit an appeal in writing, you may use the appeal form that was included in the denial letter.
- A request for an oral appeal will be treated in the same manner as a written appeal. The date of the oral request will be treated as the filing date of the request.

Can someone from DHP help me file an Appeal?

Yes. Call us toll-free at **1-877-451-5598** for help with filing an appeal. A Member Advocate will help you.

Specialty Appeals

If you are not pleased with our decision, your provider of record may ask for a specialty appeal. A specialty appeal requests that a specific type of specialty provider review the case. The provider must request this type of appeal in writing within 10 working days from the date the appeal was requested or denied. The request will be reviewed by a health care provider in the same or similar specialty. This provider will have the knowledge of the medical condition, procedure, or treatment that is being reviewed. The specialty appeal will be completed and we will send our written decision within 15 working days of receipt of the request for the specialty appeal.

Expedited MCO Appeal

What is an Expedited Appeal?

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

How do I ask for an Expedited Appeal?

Call Member Services toll-free at **1-877-451-5598** to ask for an expedited appeal.

Who can help me file an Expedited Appeal?

If you need help in filing this appeal, call Member Services and we will arrange for a Member Advocate to help you.

Does my request have to be in writing?

Your request does not have to be in writing. You or your doctor can call us to request this type of appeal orally.

What are the timeframes for an Expedited Appeal?

Your request will be reviewed and a verbal response will be given to you and your doctor within one day of asking for the appeal. We will send you a letter within 72 hours with the response.

What happens if DHP denies the request for an Expedited Appeal?

If DHP denies your request for an expedited appeal, we will refer your appeal to the regular appeal process. We will call you to tell you of the denial right away. We will then follow up with a letter within two calendar days.

Independent/External Review Process

What is an Independent/External Review?

An independent/external review is a review of a health plan's appeal decision to deny services by an outside reviewer. If you or your doctor have completed Driscoll Health Plan's appeal process and are not happy with the response, you (or your doctor) may request an external review. Maximus, an external records reviewer, reviews adverse determinations (denials) of an appeal upheld by DHP.

An adverse determination is a determination (decision) by a utilization review agent (like DHP)

that suggests the health care services provided or recommended are experimental or investigational or are not medically necessary. Utilization review means a review of the medical necessity and appropriateness of health care services. This includes prospective (in the future), concurrent (what is happening right now), or retrospective review (what has happened in the past).

These forms of review are also used by DHP to determine the experimental or investigational nature of health care services. Maximus may review an appeal for experimental and investigational service request that has been denied by DHP.

How do I ask for an Independent/External Review?

If you are not pleased with the Driscoll Health Plan's appeal decision, you may request an external review through Maximus. You must request a review within four months from the date you receive the final adverse determination letter. Your letter will include a Maximus HHS-Administered Federal External Review Request Form.

To request an external review, send the completed form directly to:

MAXIMUS Federal Services
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax: 1-888-866-6190

You may also ask for a review online. To complete a request form online please visit: externalappeal.cms.gov/ferpportal/#/requestReviewOnline

An authorized representative may ask for an external review on your behalf. You and your authorized representative must complete and sign an HHS Federal External Review Process Appointment of Representative (AOR) Form. You may access the form by visiting: externalappeal.cms.gov/ferpportal/#/forms

If you have questions about your external review or would like to request an AOR Form, please call 1-888-866-6205, ext. 3326.

What are the timeframes for this process?

A Maximus reviewer will send a letter about their final review decision as soon as possible, but no later than 45 days after the reviewer receives the request for an external review. DHP will pay for the service if the decision is to offer the requested service.

What if I need an Appeal decision quickly?

If your child is in the hospital or needs an appeal decision quickly because of his or her condition, you do not need to go through the regular process. You may ask for an expedited external review. Maximus will make a decision about your child's care as quickly as medical circumstances require, but no later than within 72 hours of receiving the request. Maximus will give a verbal decision. You will also receive a letter with the Maximus decision within 48 hours of the verbal notice. DHP will follow the final Maximus decision.

Report Waste, Abuse, and Fraud

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

Let us know if you think a doctor, dentist, pharmacist at a pharmacy, other health care providers, or a person getting CHIP benefits are 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 card

- Using someone else's CHIP ID card
- Not telling the truth about the amount of money or resources he or she has to get benefits

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

- Call the OIG Hotline at 1-800-436-6184.
- Visit oig.hhs.texas.gov/report-fraud-waste-or-abuse and select the box labeled **IG's Fraud Reporting Form**; or
- You can report directly to your health plan:
  Driscoll Health Plan
  Attn: Chief Privacy Officer
  4525 Ayers Street
  Corpus Christi, TX 78415

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

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider
- Name and address of 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 the person lives
- Specific details about the waste, abuse, or fraud

Managed Care Terminology

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

Complaint - A grievance that you can talk about to your health insurer or plan.

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

Durable Medical Equipment (DME) - Equipment 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 Condition - An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.

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

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

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

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

Grievance - A complaint to your health insurer or plan.

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

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

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

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

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

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

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

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

Non-participating Provider - A provider who does not 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.

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

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

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

Pre-authorization - 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 before receiving the requested service. Pre-authorization is not a promise your health insurance or plan will cover the cost.

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

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

Prescription Drugs - Drugs and medications that, by law, require a prescription.

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

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

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

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

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

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

Urgent Care - Care for an illness, injury, or condition serious enough that a reasonable person would

seek care right away, but not so severe as to require emergency room care.

Information That is Available to Members Once a Year

As a Member of Driscoll Health Plan, you can ask for and get the following information each year:

- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits.
- How you get benefits including authorization requirements.
- Information about benefits available under the CHIP Perinate Program, including amount, duration, and scope of benefits. This is designed to make sure you know the benefits to which you are entitled.
- Information on a complaint, appeal, and internal/external process.
- Your rights and responsibilities.
- Any limits on your freedom of choice among network providers.
- Information about network providers – at a minimum Primary Care Providers, specialists, and hospitals in our service area. This information will include names, addresses, phone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- How you get after-hours and emergency coverage and limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services, and post-stabilization services?
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - How to get emergency services, including instructions on how to use the **911** phone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by CHIP Perinate.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- Driscoll Health Plan's practice guidelines.
- Provider Directory.
- Results of Member Satisfaction Surveys.

Driscoll Health Plan's Partner's Providing Care/Services

We contract with other companies that help provide services for you. The following is a list of these companies:

Avail Solutions – provides the Behavioral Health 24 hour hotline
Navitus Health Solutions, LLC – provides prescription drugs
Envolve Vision – provides services for the vision benefit
SafeRide Health – provides non-emergency medical transportation services (NEMT)
SPH Analytics – conducts member satisfaction surveys
Pacific Interpreters – provides interpretation services

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 are 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 follow a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you disagree with your health plan, you must first try to fix 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 Member Handbook to know 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 toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at: hhs.gov/ocr/index.html

Discrimination is Against the Law

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

If you believe that Driscoll Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Driscoll Health Plan
Quality Management Department
Attn: Performance Excellence Team
4525 Ayers Street
Corpus Christi, TX 78415
1-877-324-7543, TTY: 800-735-2989
Email: filegrievance@dchstx.org

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Chief Privacy Officer is ready to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at hhs.gov/civil-rights/index.html or by mail or phone at:

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

Complaint forms are available at: hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Driscoll Health Plan:

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

If you need these services, contact Member Services at **1-877-324-7543** (TTY: 1-800-735-2989).

Proficiency of Language Assistance Services

ATTENTION: If you speak Spanish, Vietnamese, Chinese, Korean, Arabic, Urdu, Tagalog, French, Hindi, Persian, German, Gujarati, Russian, Japanese, or Laotian, language assistance services, free of charge, are available to you. Call 1-877-324-7543.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-324-7543.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-324-7543.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-324-7543。

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-324-7543번으로 전화해 주십시오.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-324-7543 (لصم هاتف رقم) والبكم:

Urdu
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-877-324-7543 کریں۔

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-324-7543.

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-324-7543.

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-324-7543 पर कॉल करें।

Persian
کمک که دارید را این حق باشید داشته Persian مورد در سوال ، میکنید کمک او به شما که کسی یا شما، گر
نمایید دریافت رایگان طور به را خود زبان به اطالعات و .1-877-324-7543 نمایید حاصل تماس.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-324-7543.

Gujarati
Driscoll Health Plan લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી 1-877-324-7543.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-324-7543.

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-324-7543まで、お電話にてご連絡ください。

Laotian
ຖ້າທ່ານ, ຫຼື ຄົນ ່ທທ່ ານກ ໍາລັງຊ່ ວຍເຫຼ ືອ, ມ ໍຄາຖາມກ ່ ງວກັບ Laotian, ທ ່ ານມ ີສດ ່ ທຈ ະໄດ ້ ຮັບການຊ ່ ວຍເຫຼ ືອແລະ ໍ ຂ ້ ມ ູ ນຂ ່ າວສານ ່ ທເປ ັ ນພ າສາຂອງທ ່ ານ ໍ ່ ບມ ຄ ່ າໃຊ ້ จ ่ าย. ການໂອ ້ ລ ົ ມກ ັ ບນ ายພ าสา, ใช ้ โทหา 1-877-324-7543.

Summary of DHP Privacy Policies

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

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

This section explains your rights and some of our responsibilities 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. • We will provide a copy of a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we have shared your health information for six years before the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. You may also get an electronic copy of this notice on our website: driscollhealthplan.com
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 exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html • We will not retaliate against you for filing a complaint.

Our Uses and Disclosures

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

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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 disaster relief situation • If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

How do we typically use or share your health information?

We typically use or share our health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services*.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.	***Example:*** *We use health information about you to develop better services for you.*

Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. To learn more visit: hhs.gov/hipaa/index.html

Help with public health and safety issues	• We can share health information about you for certain situations such as: ○ Preventing disease ○ Helping with product recalls ○ Reporting adverse reactions to medications ○ Reporting suspected abuse, neglect, or domestic violence ○ Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when a person dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ○ For workers' compensation claims ○ For law enforcement purposes or with a law enforcement official ○ With oversight agencies for activities authorized by law ○ For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach happens that may have comprised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- To learn more visit: hhs.gov/hipaa/index.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be ready upon request, on our website, and we will mail a copy to you.

Contact Information

If you have any questions about this notice, need more information about your privacy rights, would like additional copies of this notice, or require a translation of this notice in another language, you may contact Driscoll Health Plan at **1-877-451-5598**.

You may also contact our Chief Privacy Officer at **1-877-324-7543**, or by sending a letter to:

Driscoll Health Plan
Attn: Chief Privacy Officer
4525 Ayers Street
Corpus Christi, TX 78415

Sharing of Health Information

We have a health information-sharing program that your doctor can use when treating you. The program collects your up-to-date health information. Your doctor can see things like the medications you are taking, lab test results, and health problems you are having. Your doctor will be able to make sure he or she does not prescribe medications that should not be taken together or that cause allergic reactions. This information helps your doctors give you the best possible care. When your doctors have all of your medical facts they are better able to help you. This will help keep you safe.