Driscoll Health Plan

CHIP | TEXAS Health and Human Services

CHIP MEMBER HANDBOOK

NUECES

SEPTEMBER 2024

AN AFFILIATE OF
DRISCOLL HEALTH SYSTEM

MEMBER SERVICES

Toll-free:
1-877-451-5598
TTY: 1-800-735-2989

driscollhealthplan.com

CHIP-MHB

Driscoll
Health Plan

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 to 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. 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, understanding, 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. You will receive printed materials within five business days. To get help with language assistance and auxiliary aids services at no cost to you, call Member Services at **1-877-451-5598** (TTY: 1-800-735-2989).

To learn more or request member materials visit us at: driscollhealthplan.com

The Member Handbook is reviewed once per year. If there are any health plan changes, we will let you know 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	
Available 24/7, 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 on 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
Nurse Advice 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	1-833-532-0223
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	1-833-532-0218
Vision Services	
Nueces Service Area	1-888-268-2334
Dental Services	
DentaQuest	1-800-508-6775
MCNA Dental	1-855-691-6262
United Healthcare Dental	1-877-901-7321
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-Urgent Transportation-SafeRide Health	1-833-694-5881

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

Our staff speaks English and Spanish and can help you answer your questions. We also have special services for people who have trouble reading, hearing, seeing, understanding, 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 at no cost to you call Member Services at **1-877-451-5598** (TTY: 1-800-735-2989).

Driscoll Health Plan
4525 Ayers St
Corpus Christi, Texas 78415
Visit us at driscollhealthplan.com

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 70 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 Primary Care Provider
- Getting emergency care
- Taking care of yourself
- Case and Disease Management
- Behavioral Health and Substance Use Services
- Benefits
- Interpreter Services
- Prescription coverage
- And many other topics

Please take the time to read this handbook. We want you to be satisfied with your health care services. 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, understanding, or speaking a language other than English or Spanish. You can also ask for this handbook and any other member materials in audio, large print, braille, and other languages. You will receive printed materials within five business days. To get help with language assistance and auxiliary aids services at no cost to you, call Member Services at **1-877-324-7543** (TTY: 1-800-735-2989). Members or their legally authorized representatives can send their request in writing to the address below.

Driscoll Health Plan
4525 Ayers St
Corpus Christi, TX 78415

You can also request member materials by visiting: driscollhealthplan.com

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.

Be focused on prevention:

Get your checkups and vaccines on time.

- ✓ If you are overdue or due for a well-child checkup, you should have your checkup ***within 90 days after joining Driscoll Health Plan***.
- ✓ 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 postpartum exam within ***7-84 days after delivery***.
- ✓ Regular yearly well-child checkups on or soon after your child's birthday.

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. They 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 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. Each family member who joins Driscoll Health Plan should have their own ID card. Always keep your ID card with you. Take your ID card with you when you go to a doctor's visit and the pharmacy. Call Member Services if you lose your card. We can mail you a new ID card right away.

Each of your children will have a different card. You will not get a new DHP CHIP card every month. You will get a new one if you lose your ID card or if you call us to change your Primary Care Provider.

Reading the DHP CHIP ID Card

The front of the DHP CHIP ID card shows important facts about your child, your Primary Care Provider's name, and phone number. It also shows the amounts (co-payments) you might have to pay for your doctor visits, hospital visits, or prescriptions. The back of the card shows important phone numbers for emergencies or other help from DHP Member Services.


Driscoll Health Plan

TDI

TEXAS Health and Human Services

CHIP

CHIP Nueces Service Area

Member/Miembro: **DCCHIP03 A SAMPLE**

Member ID/ID del Miembro: **999901401**

Effective Date/Fecha de vigencia: 09-01-2018

PCP: PRIMARY CARE PHYSICIAN

PCP Phone #/Numero de telefono: (555) 777-1234

Effective Date of PCP/Fecha de vigencia de PCP: 10-01-2018

Co-payment Amounts/Co-pagos:

OV: $25 *ER: $75 IP: $125 RX Brand: $35 RX Generic: $10

No Co-payment for CHIP Perinate Newborn

No hay Co-pago para los recien Nacidos Perinatal

ER co-pays apply only for non-emergent ER visits/ Los copagos por visitas a la sala de emergencias solo se aplican si la visita no es una emergencia.


Important Information/Información Importante

24/7 After hours leave a message/Despues de horas deja un mesaje

Member Services/Servicios para Miembros 1-877-451-5598

TTY for hearing impaired/TTY para personas con problemas del oido 1-800-735-2989

24/7 Behavioral Health Line/Linea de Servicios de Salud Mental 1-833-532-4218

24/7 Nurse Line/Linea de Ayuda de Enfermeras 1-833-532-0223

All Vision Services/Todos los Servicios para la vista 1-888-268-2334

Directions for what to do in an emergency

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

Instrucciones en caso de emergencia

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Despues de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

NOTICE TO PROVIDER: The member whose name appears on the face of this card is covered by Driscoll Health Plan for CHIP services. For provider billing or UM questions, 1-877-324-3627. The toll free UM FAX number is 1-866-741-5650.

Submit Claims to: DHP, P.O. Box 3668, Corpus Christi, Texas 78463-3668

NAVITUS HEALTH SOLUTIONS is the pharmacy benefits provider for DHP.

NAVITUS HEALTH SOLUTIONS es el proveedor de beneficios de farmacia de DHP.

Pharmacist (Only) Help Desk: **1-877-908-6023**

BIN: 610502 PCN: MCD Rx GRP: DCH

driscollhealthplan.com

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Using the DHP CHIP ID Card

Carry your child's DHP CHIP ID Card with you when your child gets any health care services. You must show your CHIP ID card each time for any health service.

If you lose an ID Card or Move

If you lose the DHP CHIP 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 Eligibility

Laws passed by the U.S. Congress and the Texas Legislature started the Children's Health Insurance Program (CHIP) in Texas. CHIP helps children of families with incomes too high to qualify for Medicaid but too low to afford private insurance coverage easily. You may be able to qualify for CHIP benefits based on income limits. To learn more, please visit: yourtexasbenefits.com

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 Coverage Renewal

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

Look for an envelope marked "time-sensitive" 3-4 months before your benefits end. This will be your renewal letter telling you what to do. Renew before the due date so you do not lose your benefits.

WAYS TO RENEW AND GET HELP

- **Website:** Go to yourtexasbenefits.com
- **Phone:** Download "Your Texas Benefits" app in the IOS App Store or Google Play Store
- **Call:** 2-1-1 or 1-877-541-7905 to request a renewal packet
- **Call:** Member Services **1-877-451-5598**

Member Services

How can Member Services Help You?

Our expert Member Services staff is ready to help you 24 hours, 7 days a week. Regular business hours are from 8 a.m. to 5 p.m., Monday-Friday. You can leave a message after hours, on weekends, and holidays. You can also send us an email at: DHPmemberservices@ddchstx.org

A DHP staff member will respond 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, and 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 Service Coordinator 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 MyChart support line at 361-694-5980.

Driscoll Health System Mobile App

Driscoll Health Plan has a mobile application. It is now linked to MyChart.

How do I get it?

Go to your app store and search for Driscoll Health System! Once the app is downloaded you will see the Driscoll Health System logo on your phone. You should review and accept the terms to continue.

- *New MyChart users:* Call 361-694-5980 to ask for your activation code.
- *Current users:* Enter your username and password.

Need help downloading the app?

Call MyChart support line at 361-694-5980.

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 Primary Care Provider "Your Medical Home"

What is a Primary Care Provider?

A Primary Care Provider is a doctor, nurse practitioner, or physician assistant who takes care of your medical needs. Your PCP will make sure you get regular checkups. They will write prescriptions for medicines and supplies and will refer you to see a specialist. It is important you have a good relationship with your Primary Care Provider. Your Primary Care Provider needs to know your medical history to be able to provide you with the best care. You need to take part in decisions about your health care. You and your Primary Care Provider will make the right decisions to keep you healthy.

Can a Specialist ever be a Primary Care Provider?

Members with Special Health Care Needs (MSHCN) can request to have a specialist as their Primary Care

Provider (PCP). DHP may allow a Specialist to be your child's PCP after a review by our Medical Director. Members with Special Health Care Needs (MSHCN) must sign the "Agreement for a Specialist to Function as a Primary Care Provider." The Specialist must also sign the form agreeing to be your Primary Care Provider. Our Medical Director will review the signed "Agreement for a Specialist to Function as a Primary Care Provider" form. We will mail you a letter within 30 days of receiving your request, to let you know our decision. You have the right to appeal the decision if your request is not approved. The start date of this change will be the first of the month following the date the "Agreement for Specialist to Function as a Primary Care Provider" form is signed by the Medical Director. To learn more, call DHP Member Services toll-free at **1-877-451-5598**.

Can a clinic be my/my child's Primary Care Provider (Rural Health Clinic/Federally Qualified Health Center)?

You may choose a clinic as your Primary Care Provider. This can be a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

Selecting your Primary Care Provider

Upon joining Driscoll Health Plan, we will assign you to a Primary Care Provider. You can call Member Services if you would like to choose another Primary Care Provider.

How can I get a copy of the Provider Directory?

Visit driscollhealthplan.com to see the Provider Directory. It is updated every week. You can also call Member Services to get a copy.

How can I change my/my child's Primary Care Provider?

Driscoll Health Plan wants you to be happy with your Primary Care Provider. You can change your Primary Care Provider if:

- You need a different doctor to take care of you.
- You move farther away from your Primary Care Provider.
- Your Primary Care Provider is no longer a part of Driscoll Health Plan's network.
- You do not get along with your Primary Care Provider.

You can change Primary Care Providers by calling Member Services. The Driscoll Health Plan Provider Directory lists all Primary Care Providers.

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

There is no limit on how many times you can change your/your child's Primary Care Provider. You can change Primary Care Providers by calling Member Services toll-free at **1-877-451-5598** or writing to:

Driscoll Health Plan
Member Services Department
Eligibility Team
4525 Ayers Street
Corpus Christi, TX 78415

When will my Primary Care Provider (PCP) change become effective?

You can change your PCP at any time. If you have seen your PCP within the current month, the change will become effective on the first day of the following month. If you have NOT seen your PCP within the current month, the change will become effective on the first day of the month in which the change is made. The PCP change may be expedited if DHP decides it is in the best interest of both the Member and the current PCP.

Are there any reasons why a request to change a Primary Care Provider may not be approved?

Reasons you might not be able to have the Primary Care Provider you have chosen:

- The Primary Care Provider picked is not seeing new patients.
- The Primary Care Provider picked is no longer a part of Driscoll Health Plan.

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

It is important to follow your Primary Care Provider's advice. Your Primary Care Provider might ask us to assign you to another Primary Care Provider if:

- You do not follow his or her advice.
- You and your Primary Care Provider do not get along.
- You miss appointments without calling to cancel.

Your Primary Care Provider must tell us if he or she wants you to change your Primary Care Provider. Driscoll Health Plan will contact you and ask you to pick another Primary Care Provider.

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

If you choose to see another doctor who is not your Primary Care Provider, Driscoll Health Plan must approve the services. For questions, contact Member Services.

You can go to any provider who is part of Driscoll Health Plan if you need:

- 24-hour emergency care from an emergency room.
- Family Planning services and supplies.

You can choose another provider for routine eye exams, mental health or substance use, and OB/GYN care. For all other care, you must only see the Primary Care Provider listed on your Driscoll Health Plan ID card.

What is an Out of Network Provider?

An out of network provider does not have a contract with Driscoll Health Plan. It may be hard to get services approved. In some cases, such as when there are no other providers, Driscoll Health Plan can contract to pay a non-participating provider, but it is not guaranteed.

What if I choose to go to a Provider who is not part of Driscoll Health Plan network?

If you choose to see a doctor who is not part of the Driscoll Health Plan network, DHP must approve the services. This service will require prior authorization or approval from DHP. If the service is not approved, DHP will not cover the service. The out of network provider will bill you for these services and you may have to pay for them out of pocket. For questions, contact Member Services.

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.

Getting Care from a Special Doctor (Specialist)

What is a specialist?

A specialist is a doctor for certain types of health care like cardiology (heart health), orthopedics (bones and joints), or gynecology (women's health).

What if I/my child need to see a special doctor?

The Primary Care Provider can help you decide if you need to see a specialist. In general, you cannot go to another doctor or get a special service unless the Primary Care Provider agrees to make a referral.

What is a referral?

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

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

Call Member Services to speak with a Case Manager. The Case Manager will help you.

How soon can I expect to be seen by a specialist/how soon can I expect my child to be seen by a Specialist?

You should be able to get an appointment within 30 days for non-urgent care or within 24 hours for urgent care.

How can I ask for a second opinion?

Driscoll Health Plan will pay for a second opinion. The Case Management staff will help you to get approval for a second opinion if one is needed. Call Member Services at **1-877-451-5598** to speak to a Case Manager.

What services do not need a referral?

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

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

It is good to let your doctor know when receiving care from other doctors.

Care that Requires a Health Plan Approval (Prior Authorization)

What is a Prior Authorization?

Some services will require your Primary Care Provider or other providers to contact Driscoll Health Plan to get approval before getting the service.

What services need Prior Authorization?

The services that need prior authorization are:

• All admissions to a hospital (except in an emergency situation, where telling Driscoll Health Plan within 24 hours of admission is required)
• Admission to a rehabilitation center
• Outpatient surgery
• Rehabilitation therapy (physical therapy, speech therapy, and occupational therapy)
• Home health services, including home intravenous therapy
• Referral to a Specialist doctor other than an OB/GYN or Mental Health doctor
• Durable Medical Equipment that cost over $300
• Use of ambulance for medical transportation (not emergency transport)
• Asking for services by a provider who does not have a contract with Driscoll Health Plan
• Other forms of medical treatment (such as hypnosis, massage therapy
• Some outpatient diagnostic testing
• Clinician administered drugs

For authorization, you or your doctor may call the Member Services number toll-free at **1-877-451-5598**, Monday-Friday, 8 a.m. to 5 p.m., CST. If there is no authorization for the service, you might have to pay for it.

You have a right to know the cost of any service before you or your child receives that service. If you agree to get services that DHP does not cover or authorize, you might have to pay for them.

Your/your child's hospital stay is reviewed every day. Services might be reviewed after they are delivered or paid.

How long will it take to process a routine authorization?

Routine authorizations will be processed within three business days. It could take up to 14 days if we need more information from your doctor.

How do I know if my services have been approved or denied?

Driscoll Health Plan will mail you a letter letting you know if the request for services has been approved or denied. You will be notified within three business days if all supporting medical information has been provided with the request. If we must request supporting medical information from the ordering provider, you will be notified within 3-14 days. You can call Member Services toll-free at **1-877-451-5598** for more information.

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.

What is Medically Necessary Care?

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

Medically Necessary means:

(1) Health Care Services that are:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life;

(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;

(c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(d) consistent with the Member's diagnosis;

(e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(f) not experimental or investigative; and

(g) not primarily for the convenience of the Member or provider; and

(2) Behavioral Health Services that:

(a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(d) are the most appropriate level of supply of service that can be safely provided;

(e) could not be omitted without adversely affecting both the Member's mental and physical health or the quality of care rendered;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the Member or provider.

Getting Routine Care from a Doctor

What is Routine Care?

Routine care is for things like yearly well-child checkups, school exams, vaccines, and health screenings. Your Primary Care Provider will help with all your health care needs. Be sure to call your Primary Care Provider whenever you have a medical question or concern. Call your Primary Care Provider's office to schedule your routine care.

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

You/your child 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 doctor's appointment?

- ✓ Your Driscoll Health Plan Member ID card
- ✓ Your shot record
- ✓ Medications you are taking

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 Primary Care Provider's office if you are unsure about going to an after-hours clinic or urgent care.

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

Urgent Medical Care

What is Urgent Medical Care?

Another type of care is urgent care. Some injuries and illnesses are probably not emergencies but can become 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

What should I do if my child is in need of urgent medical care?

If your child has an urgent need, call your child's doctor first. Tell them your child's symptoms and ask for an appointment as soon as possible. They will refer you to a hospital if your child needs emergency care. Some examples are minor burns, earaches, sore throat, or muscle sprains/strains. After hours or on the weekends, call your child's doctor first and he or she will tell you what steps to take next. For help, call us toll-free at **1-877-451-5598**.

What should I do if I am in need of urgent medical care?

If you have an urgent medical need, you should call your doctor's office first and your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. You will need to go to a clinic that takes Driscoll Health Plan CHIP. For help, call us toll-free at **1-877-451-5598**.

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

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

Emergency Medical Care

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

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

- placing the Member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant CHIP Member, serious jeopardy to the health of the CHIP Member or her unborn child.

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

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

What is Emergency Services or Emergency Care?

"Emergency services" and "emergency care" mean health care services provided in an in-network or out-of-network hospital emergency department, freestanding emergency medical facility, or other comparable facilities by in-network or out-of-network doctors, providers, or facility staff to evaluate and stabilize emergency medical conditions or emergency behavioral health conditions. Emergency services also include any medical screening examination or other evaluation needed by state or federal law that is necessary to decide whether an emergency medical condition or an emergency behavioral health condition exists.

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

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

What do I do if I need/my child needs Emergency Dental Care?

During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call Member Services toll-free at **1-877-451-5598**.

What is post-stabilization?

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

Out of Area Doctor Appointments

If you need to see a doctor out of area, contact Member Services. All out of area appointments require prior authorization.

What if I or my child get sick when we are out of town or traveling?

If you/your child need medical care when traveling, call Member Services toll-free at **1-877-451-5598** and we will help you find a doctor.

If you/your child need emergency services while traveling, go to a nearby hospital, then call Member Services toll-free at **1-877-451-5598.**

What if I am/my child is out of the state?

If you have an emergency while out of the state, go to the nearest emergency room.

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

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

When Should I Go See My Doctor, Urgent Care or the Emergency Room (See Table)

Health Care Provider	Why would I use this Health Care Provider?	What type of services would they provide?	How long should I expect to wait?
Primary Care Provider (PCP) 	A Primary Care Provider knows your health history. Your primary care doctor sees you for regular checkups, treats you for urgent care matters, prescribes medicine or supplies you may need, and refers you to a specialist when you need one. Call your Primary Care Provider whenever possible and they will refer you to an Urgent Care Center or Hospital, if needed.	• Well-child checkups • Vaccines • Follow-up checkup • Flu shots • Pregnancy tests • Treatment of minor skin conditions	You/your child should be able to be seen for routine care within two weeks. There may be reduced wait times with a scheduled appointment.
Urgent Care Center 	Urgent care centers provide treatment when you have an injury or illness that requires immediate care, but is not serious enough to go to the emergency room. You should also go to an urgent care center if your primary care doctor is not available.	Treatment of: • Earache • Minor/common infections (e.g., strep throat) • Minor cuts • Sprains/Strains • Minor broken bones • Minor burns	You/your child should be seen within 24 hours. Urgent Care Centers are often open after regular doctor's office hours. Walk-ins are welcome, but waiting periods may vary.
Emergency Room (ER) 	Emergency rooms provide immediate treatment of life-threatening conditions. If you have severe symptoms or believe your condition is life-threatening, you should go to the emergency room or call **911**.	Treatment of: • Shortness of breath • Chest or abdominal pain • Large open wounds • Major burns • Severe head injury • Major broken bones • Uncontrolled bleeding • Criminal attack (mugging, rape, stabbing, gunshot) • Poisoning or overdose of medications or alcohol • Danger to self or others • Severe allergic reaction or bitten by an animal	You/your child can be seen 24 hours a day, 7 days a week. However, waiting times may be longer because patients with life-threatening emergencies will be treated first.

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
- Well-Child 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.

Care for Infants and Children

Newborn Care

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

Yes. Call Member Services and pick a Primary Care Provider for the baby.

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

If you do not pick a Primary Care Provider for your baby, Driscoll Health Plan will pick a doctor for your baby. You can call Member Services if you would like to choose another Primary Care Provider.

For CHIP Perinatal Members

How do I get coverage for my newborn baby?

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

Your baby will keep getting 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.

How and when do I tell Driscoll Health Plan and my Caseworker?

It is important to call Member Services as soon as your baby is born. We can help you get health services for your baby. Call your caseworker by calling 2-1-1 or 1-877-541-7905 after your baby is born. They will be able to answer questions about your baby's benefits.

Can I switch my baby's health plan?

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

Well-Child Checkups

What are Well-Child Checkups?

Well-child checkups provide medical and dental preventative care for CHIP children birth through age 18. These checkups are at no cost to you.

Well-child checkups give your child:

- Medical checkups starting at birth, at no cost
- Dental checkups starting at six months of age, at no cost

Why is the Well-Child Checkup important?

This checkup is very important and helps your child stay healthy. You may find health problems before they get worse and harder to treat. It can help prevent health problems that make it hard for your child to learn and grow. It also helps your child have a healthy smile.

Please call your child's doctor as soon as possible to schedule this appointment. If you need help scheduling your appointment, please call Member Services.

If your child's doctor or dentist finds a health problem during a checkup, your child can get the care they need such as:

- Eye exams and glasses
- Hearing tests and hearing aids
- Other health and dental care

When should my child get a Well-Child Checkup?

Schedule for when to get well-child checkups	
Birth to 1 Year	**1 and older**
Babies need checkups at: • 3 to 5 days old • 1 to 2 weeks old • 2 months old • 4 months old • 6 months old • 9 months old Doctors check if babies are healthy and growing normally. Dental checkups start at age 6 months. The dentist will put fluoride on your child's teeth at this time. PCP's can do dental varnish as well.	Young children need checkups at: • 12 months old • 15 months old • 18 months old • 24 months old • 30 months old • 3 and older or shortly after your child's birthday The doctor checks your child's hearing and vision at this time. Your child needs dental checkups every 6 months.
5 to 10 Years	**11 to 19 Years**
Older children need checkups once per year. Schedule the visit on your child's birthday as an easy way to remember. The dentist may coat your child's teeth with sealants to help avoid tooth rot.	Teens and young adults need checkups once per year. Schedule the visit on your child's birthday as an easy way to remember. Your doctor may talk to your child about how to lead a healthy lifestyle.

Immunizations (Vaccines)

Why is it important to get immunizations?

Immunizations are vaccines provided by the Primary Care Provider. Infants are most at risk of getting infectious diseases like mumps and measles. These vaccines help to prevent the spread of disease and protect infants and children against dangerous complications.

Driscoll Health Plan wants to help keep you and your family healthy. We want you to get all your vaccines when you are supposed to.

During the first year, you should take your child to the doctor every few months for their well-child checkups. At that time, they will get their vaccines.

Driscoll Health Plan will pay for you and your child's vaccines. It will not cost you any money.

It is up to you to schedule an appointment for you and your child to get these vaccines. Your provider can help you set up regular visits so that you can stay on track and get all your vaccines.

To review the most current charts, go to the CDC website at: cdc.gov/vaccines

You can also go to the Driscoll Health Plan website at:

driscollhealthplan.com/immunization-schedules

Women's Health

What if I need/my daughter needs OB/GYN Care?

Do I have the right to choose an OB/GYN?

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

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

Driscoll Health Plan allows you or your daughter to pick any OB/GYN, whether that doctor is in the same network as your/your daughter's Primary Care Provider or not.

How do I choose an OB/GYN?

To choose an OB/GYN, call Member Services. You can also have the OB/GYN doctor be your Primary Care Provider. If you want the OB/GYN doctor to be your Primary Care Provider, call Member Services.

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

You have the right to choose an OB/GYN for yourself or your daughter without a referral from your/your daughter's Primary Care Provider.

Will I need a referral?

No, you will not need a referral from your Primary Care Provider to see an OB/GYN doctor.

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

You should be able to get an appointment within two weeks of your request.

Can I/my daughter stay with an OB/GYN who is not with Driscoll Health Plan?

If you are at least six months pregnant, you can stay with the same OB/GYN doctor even if the doctor is not with Driscoll Health Plan. To learn more, call Member Services.

Exams and Screenings

Driscoll Health Plan provides routine exams and screenings for you. CHIP may not provide certain services. The Healthy Texas Women Program can help supplement certain female needs. To learn more, please visit: healthytexaswomen.org

Mammograms

A mammogram is a breast x-ray. It screens you for breast cancer. The exam helps reduce the number of cancer cases and increases the survival rate. A mammogram can find breast cancer before symptoms even happen.

The American Cancer Society recommends yearly mammograms starting at age 40. Women in their 20s and 30s need a clinical breast exam every three years. Some women may need earlier screenings if there is family history or other risk factors.

Care for Pregnant Women

What if I am pregnant/what if my daughter is pregnant?

It is very important that you call Driscoll Health Plan to tell us you are pregnant and what doctor you selected to see.

Who do I need to call?

Call Member Services if you are pregnant. It is very important to start prenatal care immediately.

Care During Pregnancy

There are many things you can do to have a healthy pregnancy and a healthy baby. Some of the things that you can do to stay healthy are:

- Get a prenatal visit within 42 days of joining Driscoll Health Plan or within the first three months of your pregnancy.
- Tell your provider about your pregnancy history.
- Do not smoke, drink, or misuse prescription drugs.
- Take prenatal vitamins.
- Eat healthy.
- Take good care of your teeth and get regular dental checkups.

Case Management for Pregnant Women

Case Management for Pregnant Women provides services to high-risk pregnant women of all ages. Our nurses will help with any medical, social, or educational service that you might need. A nurse case manager will:

- Get in touch with you by phone or mail.
- Help you find an OB/GYN doctor.
- Evaluate your health care needs.
- Provide education on pregnancy.
- Help coordinate special needs visits and transportation.

Call Driscoll Health Plan's Case Management at **1-877-222-2759** if you have questions or need help.

Services and Education for Pregnant Members

Get Ready for Baby - Educational Baby Showers

Driscoll Health Plan wants to help keep your baby from being born too early. Each month we have baby showers. You can sign up for one scheduled class. Classes may be available at select locations, in person, or virtual. At the baby showers, we teach you about:

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

The Get Ready for Baby 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 Google Play or App Store. Learn more at: text4b.com

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 many 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 Provider 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/lotion while pregnant. Mosquito spray/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.

How can I get mosquito spray/lotion?

You can get mosquito spray/lotion at no cost to you. Get a prescription from your doctor. Then, take that prescription to your pharmacy, and they will give you the mosquito repellant. To learn more, visit: txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/p-9-formulary-coverage/mosquito-repellents

Breast Pumps

Why you would need a breast pump?

- Your baby is premature and unable to suck.
- Your baby has severe feeding problems.
- You can't 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.
- You can get a prescription after baby is born for up to 12 months after delivery.

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?

Driscoll Health Plan covers breast pumps with a prescription from your doctor. You can get a breast pump from:

- aeroflowbreastpumps.com
- breastpumpdepot.com
- Driscoll Health Plan Network Pharmacy
- Durable Medical Equipment Provider

To find a participating pharmacy or provider go to driscollhealthplan.com or call Member Services for help.

Help After Pregnancy

Postpartum Medicaid Coverage Extension

Texas Health and Human Services Commission (HHSC) will provide 12 months of postpartum CHIP (Children's Health Insurance Program) coverage. The 12 months of postpartum coverage begins the month after a pregnancy has ended.

Who is eligible for the extended postpartum coverage?

- CHIP members who are pregnant or become pregnant and a woman who enrolls because they become pregnant.
- CHIP members who were enrolled while pregnant or are no longer pregnant but are still within their 12-month postpartum period.
- Women who transitioned from CHIP to Healthy Texas Women (HTW) after their pregnancy ended and who are within their 12-month postpartum period will be reinstated to full coverage with CHIP.

CHIP Perinatal (CHIP-P) recipients are not eligible for 12 months of postpartum coverage. They will continue to receive CHIP-P coverage through the end of the month when their pregnancy ends, plus two postpartum visits.

Do I need to reapply to get the extended postpartum coverage?

If you are a CHIP member, you do not need to apply to extend your coverage. You will get a notice by mail or through Your Texas Benefits account.

Your coverage will be reinstated for the remainder of the 12-month postpartum period if you are not a current CHIP member. You must have also been enrolled in CHIP while pregnant, be within your 12-month postpartum period, and still be a resident of Texas.

What other CHIP-covered services can I get during the extended postpartum period?

These include but are not limited to:

- Regular medical checkups.
- Prescription drugs and vaccines.
- Hospital care and services.
- X-rays and lab tests.
- Vision and hearing care.
- Access to medical specialists and mental health care.
- Treatment of special health needs and preexisting conditions.

Is there a reason I may not be covered during the extended postpartum period?

You may not be covered if you:

- voluntarily withdraw
- move out of Texas
- become ineligible because of fraud, abuse, or perjury
- die

To learn more about the postpartum extended coverage, visit hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/medicaid-pregnant-women-chip-perinatal or call 2-1-1 and choose Option 2.

Postpartum Visit

It is important for you to take care of yourself even after your baby is born. Call your doctor to schedule your postpartum checkup as soon as possible. Your checkup should be completed within 7-84 days of having your baby.

During your postpartum visit, you could talk to your doctor about:

- Your feelings
- Breast health
- Weight loss
- Exercise
- Maternal warning signs you may have during the postpartum period

Some women may experience pregnancy-related complications for up to a year after pregnancy. These complications may become life-threatening if not identified and treated timely.

The Hear Her Campaign provides information about common conditions that may increase maternal health risks. To learn more, visit cdc.gov/hearher/index.html

Postpartum Education

After delivery, we offer new moms a home visit and a parenting class. During this visit and class, you will learn about things such as:

- Importance of a postpartum checkup
- Newborn checkups
- Basic newborn care
- Getting vaccines
- Safety tips

Healthy Texas Women

Healthy Texas Women (HTW) offers services from annual exams and family planning to disease screenings and treatments.

- HTW provides health and family planning services to women 18-44 at no cost.
- HTW also provides services to women between the ages of 15 to 17 years old and have a parent or legal guardian who apply, renew, and report changes to your case on your behalf.
- The Family Planning Program provides family planning and reproductive healthcare to eligible women and men ages 64 and younger at low or no cost.
- Breast and Cervical Cancer Services may also be available to help women get cancer screenings and health services.

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

Healthy Texas Women
P.O. Box 149021
Austin, TX 78714-9021
Toll-free Number: 1-866-993-9972
Fax Number: 1-866-993-9971
Website: healthytexaswomen.org

Case and Disease Management

What is Case Management?

Case Management helps you manage your health care needs. Driscoll Health Plan offers you one-on-one nurse coaching and helps with obtaining other resources.

What is Disease Management?

Disease Management helps you manage your health. Our Case Managers will help you if you have asthma, diabetes, mental, and other types of illness.

We will work with you and your doctor to keep you on track. We will remind you about the preventative care you need to stay healthy.

What is Early Childhood Intervention (ECI)?

ECI is a program for children, birth to three, who have disabilities, developmental delays, suspected delays, or are at risk for having delays. ECI also works with babies that may have failed their hearing screening or vision screenings to ensure that they prevent delays in the child's development. ECI provides evaluations at no cost. ECI will help children get needed services such as physical therapy, occupational therapy, speech therapy, and behavior intervention. ECI services end on your child's 3rd birthday, but some children leave before they turn 3 years old. ECI also offers transition services when the child turns 3 years of age.

Driscoll Health Plan's Case Management will coordinate with local ECI Programs in creating a plan for your child.

Do I need a referral?

You can self-refer and do not need a referral from a Primary Care Provider.

Where do I find an ECI Provider?

You can call Case Management to learn more at **1-877-222-2759** for assistance in locating an ECI Provider.

Members with Special Healthcare Needs (MSHCN)

Driscoll Health Plan identifies Members with Special Health Care Needs (MSHCN). This includes Members with disabilities, chronic medical, and behavioral health conditions.

Members are offered case management services. Case Managers will work with families and health care providers to create a care plan. This care plan will include preventive care, primary care, and other health care services a member may need.

Behavioral Health Case Management

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

You will receive the following mental health services as part of the managed care benefit package:

- Targeted case management
- Mental health rehabilitative services

Services included in mental health rehabilitation:

- Crisis intervention services
- Medication training and support services
- Psychosocial rehabilitative services
- Skills training and development services
- Day programs for acute needs

For help to get this service call Case Management toll-free at **1-877-222-2759**.

Behavioral Health

How do I get help if I have a behavioral (mental) health disorder?

You can get help with mental health and substance use disorder. If you need help, call the Behavioral Health Hotline at 1-833-532-0218. You can call 24 hours a day, 7 days a week. You must pick a provider within our Behavioral Health Network.

These services are private, so you don't need a Primary Care Provider to agree to these services.

If you have an emergency related to mental health problems or substance misuse, go to the nearest hospital emergency room, or call **911** for an ambulance.

Mental Health Services

How do I/my child get mental health rehabilitation services and mental health-targeted case management?

Call Member Services for help.

Substance Misuse Services

If you need substance misuse services, you should call the Behavioral Health Hotline at 1-833-532-0218. You can call Member Services for help, as well.

Do I need a referral for this?

You can go to a Driscoll Health Plan provider without a referral from your Primary Care Provider.

Mental Health Parity and Addiction Equity Act

Driscoll Health Plan follows all laws and regulations of the Mental Health Parity and Addiction Equity Act. It protects against unfair and unequal treatment regarding benefits provided by our plan.

Special Services

Interpreter Services

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

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's office at least 48 hours in advance to make these arrangements.

Benefits and Services

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.

What are my/my child's CHIP benefits?

For a full list of benefits please see the Benefits Table that follows.

How do I/my child get these services/how do I get these services for my child?

Call Member Services at **1-877-451-5598**. We will be happy to explain how you or your child can get these 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 28-42.

What are the CHIP Perinate Newborn benefits?

For the CHIP Perinatal Newborn, the benefits are the same as for CHIP Members. For the mother of the CHIP Perinatal Newborn, see the CHIP Perinate Program Member Handbook.

How do I get these services for my child?

The CHIP Perinatal Newborn will begin CHIP services at birth.

What benefits does my baby receive at birth?

The benefits for your newborn baby, which qualifies as a CHIP Member, will be the same benefits as CHIP Members.

What services are not covered?

A list of services not covered by CHIP is on pages 47-48 of this handbook.

Members may ask for a review of services that are not covered. Members may also ask for a review of services when their benefit limit has been reached. DHP may review the request for services on a case-by-case basis. Approvals are based on medical necessity, cost, and whether it will benefit the member's health. DHP will require you to provide clinical documentation to support the medical necessity of the services.

Concurrent Enrollment of a Family Member in CHIP and CHIP Perinatal

If you have other children enrolled in the CHIP Program, they will be moved to Driscoll Health Plan. Copayments, cost-sharing, and enrollment fees still apply to children enrolled in the CHIP Program. An unborn child who is enrolled in CHIP Perinatal will be moved to Medicaid for 12 months of continuous Medicaid coverage, beginning on the date of birth, if the child lives in a family with an income at or below the Medicaid eligibility threshold. An unborn child will keep getting coverage through CHIP after birth as a “CHIP Perinate Newborn” if the child is in a family with an income above the Medicaid eligibility threshold.

Benefits Table

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

Type of Benefit	Description of Benefit	Limitations	Co-Pay
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: • Hospital-provided doctor or provider services • Semi-private room and board (or private if medically necessary as approved by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Member meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications, and biologicals • Blood or blood products not provided free-of-charge to the Member and their administration • X-rays, imaging, and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section	• Requires prior authorization for non-emergency care and following stabilization of an emergency condition • Requires authorization for in-network or out-of-network facility and doctors services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section	Applicable level of inpatient co-pay applies

Type of Benefit	Description of Benefit	Limitations	Co-Pay

	• Hospital, doctor, and related medical services, such as anesthesia, associated with dental care
	• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
	  ○ dilation and curettage (D&C) procedures;
	  ○ appropriate provider administered medications;
	  ○ ultrasounds; and
	  ○ histological examination of tissue samples.
	• Surgical implants
	• Other artificial aids including surgical implants
	• Inpatient services for mastectomy and breast reconstruction include:
	  ○ all stages of reconstruction on the affected breast;
	  ○ external breast prosthesis for the breast (s) on which medically necessary mastectomy procedure (s) have been performed;
	  ○ surgery and reconstruction on the other breast to produce a symmetrical appearance; and
	  ○ treatment of physical complications from the mastectomy and treatment of lymphedemas.
	• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit
	• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and		

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	delivered as part of a proposed and clearly outlined treatment plan to treat: o both cleft lip and palate; or o both severe traumatic skeletal and congenital craniofacial deviations; or o severe facial asymmetry secondary to skeletal defects, and both congenital syndromal conditions and tumor growth or its treatment		
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	• Requires authorization and doctor prescription • 60 days per 12-month period limit	Co-pays do not apply
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products not offered free-of-charge to the Member and the administration of these products • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in	May require prior authorization and doctor prescription	• Applicable level of co-pay applies to prescription drug services • Co-pays do not apply to preventive services

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	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; and o histological examination of tissue samples. • Facility and related medical services, such as anesthesia, associated with dental care, when offered in a licensed ambulatory surgical facility • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: o all stages of reconstruction on the affected breast; o external breast prosthesis for breast(s) on which medically necessary mastectomy procedure(s) have been performed; o surgery and reconstruction on the other breast to produce a symmetrical appearance; and o treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and		

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	delivered as part of a proposed and clearly outlined treatment plan to treat: o both cleft lip and palate; or o both severe traumatic skeletal and congenital craniofacial deviations; or o severe facial asymmetry secondary to skeletal defects, and both congenital syndrome conditions and tumor growth or its treatment		
Doctor / Doctor Extender Professional Services	Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include, but are not limited to the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Doctor office visits, inpatient and outpatient services • Laboratory, x-rays, imaging, and pathology services, including both technical component and professional interpretation • Medications, biologicals, and materials administered in the doctor's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: o Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care o Administration of anesthesia by a doctor (other than a surgeon) or CRNA o Second surgical opinions o Same-day surgery performed in a hospital without an overnight stay o Invasive diagnostic procedures such as endoscopic examination • Hospital-based doctor services (including doctor-performed technical and interpretative components)	May require authorization for specialty services	• Applicable level of co-pay applies to office visits • Co-pays do not apply to preventive visits or to prenatal visits after the first visit

Type of Benefit	Description of Benefit	Limitations	Co-Pay

	• Doctor and professional services for a mastectomy and breast reconstruction include:
	  o all stages of reconstruction on the affected breast;
	  o external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
	  o surgery and reconstruction on the other breast to produce a symmetrical appearance; and
	  o treatment of physical complications from the mastectomy and treatment of lymphedemas.
	• In-network and out-of-network doctor services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
	• Doctor services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Doctor 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; and
	  o histological examination of tissue samples
	• Doctor services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation
	• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies		

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: o both cleft lip and palate; o both severe traumatic skeletal and congenital craniofacial deviations; or o severe facial asymmetry secondary to skeletal defects, and both congenital syndrome conditions and tumor growth or its treatment		
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Covered, unlimited prenatal and medically necessary care related to disease, illness, or abnormalities related to the reproductive system and limitations and exclusions to these services are described under inpatient, outpatient, and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.		
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	Covered services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to help in the treatment of a medical condition, including, but not limited to: • Orthotic braces and Orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids	• Requires prior authorization and doctor prescription • $20,000 per 12-month period limit for DME, prosthetics, devices, and disposable medical supplies (diabetic supplies and equipment are not counted against this cap)	Co-pays do not apply

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	• Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements		
Birthing Center Services	Covers birthing services provided by a licensed birthing center.	Limited to facility services (e.g. labor and delivery)	Co-pays do not apply
Services rendered by a Certified Nurse Midwife or Doctor in a licensed birthing center	Covers prenatal services and birthing services rendered in a licensed birthing center.	Limited to a licensed birthing center	Co-pays do not apply
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies	• Requires prior authorization and doctor prescription • Services are not intended to replace the child's caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on the intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Co-pays do not apply
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state-operated facilities, including but not limited to: • Neuropsychological and psychological testing	• Requires prior authorization for non-emergency services • Does not require a Primary Care Provider referral • When inpatient psychiatric services,	Applicable level of inpatient co-pay applies

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, about court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination	
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including but not limited to: • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development)	• Requires prior authorization • Does not require Primary Care Provider referral • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, about court-ordered commitments to psychiatric facilities, the court order serves as binding determination of	Applicable level of co-pay applies to office visits.

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • A Qualified Mental Health Professional – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or doctor and provides services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such	

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		as day treatment and in-home services), Member and family education, and crisis services	
Inpatient and Residential Substance Abuse Treatment Services	Inpatient substance abuse treatment services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. • When inpatient and residential substance use disorder treatment services are required as: 1) a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or 2) as a condition of probation. • The court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1 15.2.	• Requires prior authorization for non-emergency services • Does not require a Primary Care Provider referral.	Applicable level of inpatient co-pay applies
Outpatient Substance Abuse Treatment Services	Outpatient substance abuse treatment services include, but are not limited to: • Prevention and intervention services that are offered by doctor and non-doctor providers, such as screening, assessment, and referral for chemical dependency disorders • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at	• Requires prior authorization • Does not require Primary Care Provider referral • Outpatient treatment services up to a maximum of: • Intensive outpatient program (up to 12 weeks per 12-month period)	Applicable level of co-pay applies to office visits

Type of Benefit	Description of Benefit	Limitations	Co-Pay
	least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training • When outpatient and residential substance use disorder treatment services are required as: 1) a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or 2) as a condition of probation, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1 15.2.	• Outpatient services (up to 6 months per 12-month period)	
Rehabilitation Services	Services include, but are not limited to the following: • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to, the following: • Physical, occupational and speech therapy • Developmental assessment	Requires prior authorization and doctor prescription	Co-pays do not apply
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have 6 months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness	• Requires authorization and doctor prescription • Services apply to the hospice diagnosis • Up to a maximum of 120 days with a 6-	Co-pays do not apply

Type of Benefit	Description of Benefit	Limitations	Co-Pay
		month life expectancy • Members electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis	
Emergency Services, including Emergency Hospitals, Doctors, and Ambulance Services	Driscoll Health Plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include but are not limited to, the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and doctor services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, or water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin	May require authorization for post-stabilization services	Applicable co-pays apply to non-emergency room visits.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination, and community referral.		

Type of Benefit	Description of Benefit	Limitations	Co-Pay
Transplants	Covered services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow, and peripheral stem cell transplants, including donor medical expenses	Requires authorization	Co-pays do not apply
Vision Benefit	Covered services include: • One (1) examination of the eyes to find the need for and a prescription for corrective lenses per 12-month period, without authorization • One (1) pair of non-prosthetic eyewear per 12-month period	• The health plan may reasonably limit the cost of the frames/lenses. • Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	Applicable level of co-pay applies to office visits billed for the refractive exam
Chiropractic Services	Covered services do not require doctor prescription and are limited to spinal subluxation	• Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modalities offered in one visit) • Requires authorization for additional visits	Applicable level of co-pay applies to chiropractic office visits
Tobacco Cessation Programs	Covered up to $100 for a 12-month period limit for a plan-approved program • Health Plan defines a plan-approved program • May be subject to formulary requirements	Requires authorization	Co-pays do not apply

Type of Benefit	Description of Benefit	Limitations	Co-Pay
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 provided in an inpatient setting.	Some drug benefits require prior authorization.	Applicable level of copay applies to pharmacy dispensed drug benefits.

Extra Benefits

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

When you join Driscoll Health Plan, you get Value-Added Services that CHIP 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?

To learn more about our Value-Added Services please review the Value-Added Services table below. If you have any questions, please contact Member Services at **1-877-451-5598**.

For more information about vision services, contact your vision provider.

For more information about dental services, contact your dental provider.

For questions on how to get any of the Value-Added Services, contact Member Services at **1-877-451-5598**.

*These extra services are valid from September 1, 2024 through August 31, 2025

Value-Added Services		
Type of Benefit	**Description of Benefit**	**Restrictions and/or limitations**
Asthma	$20 gift card after five months of continuous asthma controller medication refills.	• Must meet medical criteria • Refills must be continuous
	A set of hypoallergenic pillow and bed covers.	• Must meet medical criteria • One set per member, per year
	One-time sponsorship to Camp Easy Breathers.	• Ages 7 to 14 • Offered on a first-come, first-served basis • Must meet medical criteria • One sponsorship per member, per lifetime
Healthy Play and Exercise Program	Boys & Girls Club membership	• Ages 6 to 18

Value-Added Services		
Type of Benefit	**Description of Benefit**	**Restrictions and/or limitations**
		• Membership offered on a first-come, first-served basis • Locations include: Alice, Beeville, Corpus Christi, Kingsville, Robstown, and Victoria
Vision	$150 allowance towards frames, lenses, or contact lenses every 2 years.	• Ages 2 to 18 • Limited to members who need glasses
Sports or School Physicals	One sports or school physical.	• Ages 4 to 18 • One physical per member, per year
Transportation	Rides to any local health-related visit or appointment. Includes: • Doctor appointments • Therapy appointments • Specialty appointments • Social Security Administration office • DHP sponsored events	• Must be within the Nueces service area • Must be within a 25-mile radius, or upon approval • Request for a ride must be made two days prior to the visit • Up to 5 riders including DHP member and parent or attendant • Visits outside of Driscoll network or service area requires prior authorization by DHP
Health and Wellness	$50 gift card for joining a health and wellness program. Includes: • Sports program • Gym membership • 5k race • Dance class • Art class • Yoga class • Music lessons	• One gift card per member, per year • Must submit the receipt as proof of participation
	One first aid kit per family.	• Ages 2 to 5 • Must be a new member
	One activity tracker for weight management.	• Ages 10 to 18 • Must meet medical criteria • Must complete the physical fitness modules
	Lice removal treatment	• Up to three visits per year • PCP referral is required • Participating clinics only • May treat family members if DHP member qualifies for treatment

Value-Added Services		
Type of Benefit	**Description of Benefit**	**Restrictions and/or limitations**
Nurse Advice Line	Nurse Advice Line available 24 hours, 7 days a week.	
Help for members with Diabetes	Resistance bands	• Ages 7 and older • Must meet medical criteria • Must be enrolled in case management • One set per member, per year
Behavioral Health	Up to $60 in gift cards for completing a Triple P session.	• One $20 gift card per class, up to three gift cards per family • Must be enrolled in Triple P session • Must complete each Triple P class • Must complete one age group per level • Limited to two different levels
	$25 gift card for completing a mental health follow-up.	• Ages 6 years and older • Follow-up must be with a mental health practitioner • Must be within 7 days of the discharge from in-patient mental health hospital
Gift Programs	Up to $75 in gift cards for completing a DHP or Case Management educational program.	*Classes may be available in person or virtual* • Must be registered for classes • Must not be related to any other VAS
	$25 gift card when you get a COVID-19 vaccine.	• Up to two gift cards per year • Must submit a copy of the vaccination card
	$20 gift card for completing a Kids in Safety Seats class.	• Must complete a Kids in Safety Seats class • One gift card per family
	$20 gift card for completing four on-time newborn Well-Child checkups.	Must have four of the following Well-Child checkups: • 3 to 5 days • 2 weeks • 4 months • 6 months • 9 months
	$20 gift card for completing a 12 and 15 month Well-Child checkup.	Must have the following Well-Child checkups: • 12 months • 15 months

Value-Added Services		
Type of Benefit	**Description of Benefit**	**Restrictions and/or limitations**
	$20 gift card for completing a yearly Well-Child checkup.	Ages 2 to 19
	Menstrual cycle kit	• Up to three kits per year • Member must request kit
	Educational braille learning kit	• Ages 0 to 5 • Must meet medical criteria • One per member, per year
Extra help for pregnant members For a listing of our baby showers and parenting classes, visit: driscollhealthplan.com/get-ready-for-baby *Classes may be available at select locations, in person, or virtual.*	$100 gift card for completing a DHP Get Ready for Baby educational baby shower.	One gift card per member, per pregnancy
	$50 gift card for completing a postpartum checkup.	• Must be within 7-84 days of delivery • One gift card per member, per pregnancy
	$25 gift card for completing a prenatal checkup.	• Must be within the first trimester or within 42 days of joining DHP • One gift card per member, per pregnancy
	$20 gift card for completing a parenting class.	• Must attend within 120 days of delivery • One gift card per member, per pregnancy
	$20 gift card for completing a home visit.	• Moms must call to schedule a home visit • Visit must be within 60 days of delivery • Moms will complete a postnatal screening upon completion of class
	$20 gift card for completing a Pregnancy Health Risk Assessment (HRA).	• Must be a new pregnant member • Must complete the Pregnancy HRA
	One year membership of SHIPT grocery delivery service for high-risk pregnant members.	Must be identified as having a high-risk pregnancy
	Nutritional counseling with a nutritionist.	• Must not qualify for other nutritional counseling programs • Must be a pregnant member
	Lactation consultation	• Must complete within 60 days of delivery • Up to 2 sessions per pregnancy
Over-the-Counter Benefits	$50 gift card for over-the-counter items.	**Ages 6 to 15 months** • Must have 6 months of continuous eligibility

Value-Added Services		
Type of Benefit	**Description of Benefit**	**Restrictions and/or limitations**
		• Must have completed two Well-Child checkups within 6 months • Must download and register in the DHP Mobile App **Ages 13 to 18 years** • Must have 6 months of continuous eligibility • Must have completed one Well-Child checkup within 12 months • Must download and register in the DHP Mobile App
	$50 reimbursement for over-the-counter products to stop smoking and vaping.	• Ages 13 to 18 • One lifetime reimbursement • Only for products not covered by the Pharmacy Benefits Manager • Must submit proof of purchase
	Up to 20% discount on over-the-counter items at the Driscoll Children's Hospital Pharmacy.	• Must show your DHP member ID card • CHIP covered benefits are not included

Exclusions

What services are not covered by Driscoll Health Plan?

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (e.g., cannot be prescribed for family planning)
- Personal comfort items including, but not limited to, personal care kits provided on inpatient admission, phone, television, newborn infant photographs, meals for guests of the patient, and another article that are not needed for the specific treatment of sickness or injury
- Experimental and investigational medical, surgical, or other health care procedures or services that 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 other than a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters Band C, 574, Subchapter D or 462, Subchapter D, and Texas Family Code Chapter 55, Subchapter D.
- Dental devices solely for cosmetic purposes
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices including, but not limited to, artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes unless otherwise pre-authorized by Driscoll Health Plan
- 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 and doctor services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section, and services provided by an FQHC, as provided for in Section 8.1.22 of the Contract
- Services, supplies, meal replacements, or supplements offered for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- 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)

- Replacement or repair of prosthetic devices and durable medical equipment because of misuse, abuse, or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that helps a child with the activities of daily living, such as help in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or given by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires to be given in a public facility or care given while in the custody of legal authorities
- Services or supplies received from a nurse, that do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Doctor/Primary Care Provider
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, And American Samoa)

DME/Supplies			
SUPPLIES	**COVERED**	**EXCLUDED**	**COMMENTS/MEMBER CONTRACT PROVISIONS**
Ace Bandages		X	Exception: If given by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered unless RX given at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – first	X		For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary because of normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet devices, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Able to get coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Able to get coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Able to get coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption because of disease.
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Able to get coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption because of disease (expected to last longer than 60 days when prescribed by the doctor and authorized by the plan.) Doctor documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For Members who could be sustained on an age-appropriate diet • Traditionally used for infant feeding • In pudding form (except for people with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than 12 months of age unless medical necessity is documented and other criteria, listed above, are met

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care given by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan.
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir, and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Able to get coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Able to get coverage for a person with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes, and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Able to get coverage for a person with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies.
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Able to get coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal.
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include belt, pouch, bags, wafer, faceplate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; and c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during an office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits the use of an indwelling catheter ordered by the Primary Care Provider and approved by the plan.
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set, and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catheterization.
Urine Test Kit	X		When decided to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

Costs of Your DHP CHIP Insurance

What are co-payments? How much are they and when do I have to pay them?

Co-payments are part of the doctor's bill or prescription costs that you will have to pay. The following table lists the CHIP co-payment schedule according to the family income. Co-payments for medical services or prescription drugs are paid to the doctor's office or pharmacy at the time of service. You do not need to pay a co-payment for preventive care such as well-child or well-baby visits or immunizations. You do not need to pay a co-payment for pregnancy-related help.

Your child's health plan ID card lists the co-payments that apply to your family. Present your ID card when you receive office visits or emergency room services or have a prescription filled.

If you/your child's health plan card shows a co-pay requirement and you/your child is Native American or Alaskan Native, the Member should call Member Services to have card corrected.

Co-pay Facts:

You do not have to pay an enrollment fee or co-pay if you are:

- Native American
- Alaskan Native
- CHIP Perinate Member
- Have a CHIP Perinate Newborn

You do not have to pay a co-pay for:

- Well-baby checkups
- Well-child checkups
- Preventative checkups, including immunizations
- Pregnancy-related services
- Mental Health and Substance Use Disorder office visits
- Mental Health and Substance Use Disorder residential treatment services

CHIP COST-SHARING TABLE	
	EFFECTIVE July 1, 2022
Enrollment fees (for 12-month enrollment period):	
	Charge
At or below 151% of FPL* or otherwise exempt from cost-sharing	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% FPL	**Charge**
Office Visit (non-preventative) *No Co-Pay is applied for MH/SUD Office Visits.*	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission) **No Co-Pay is applied for MH/SUD residential treatment services.**	$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	**Charge**
Office Visit (non-preventative) *No Co-Pay is applied for MH/SUD Office Visits.*	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) *No Co-Pay is applied for MH/SUD residential treatment services.*	$75
Cost-sharing Cap	5% (of family's income)**
Above 186% up to and including 201% FPL	**Charge**
Office Visit (non-preventative) *No Co-Pay is applied for MH/SUD Office Visits.*	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) *No Co-Pay is applied for MH/SUD residential treatment services.*	$125
Cost-sharing Cap	5% (of family's income)**

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

**Per 12-month term of coverage.

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

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

Dental Services

How do I get dental services for my child?

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

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

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

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

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

Vision Services

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

Eye care services include one examination by an eye doctor per year. You or your child may get one pair of eyeglasses every two years. To learn more about eye exams or glasses, call our eye care vendor at 1-888-268-2334.

Pharmacy and Prescriptions

What are my prescription benefits?

Driscoll Health Plan covers most prescriptions or doctor orders. To learn more call Member Services.

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

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

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

You may have to pay a co-payment for each prescription filled depending on your income. There are no co-payments needed for CHIP Perinate Newborn Members.

How do I find a network pharmacy?

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

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.

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

Please call Member Services if you need to have your prescriptions delivered to your home. We will give you the number of a pharmacy that will deliver to you. There is no charge for this home delivery.

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

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

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

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

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

Please contact Member Services with any problems getting medication.

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

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

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

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

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.

How can I get a list of the prescriptions that are covered by my benefits?

A current list of covered drugs can be found at:

txvendordrug.com/formulary/formulary-search

You can also call Member Services if you need assistance.

Changing Health Plans

What if I want to change health plans?

You are allowed to make health plan changes:

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

Who do I call?

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

How many times can I change health plans?

A CHIP Member may change health plans at any time for these reasons:

- for any reason within 90 days of enrollment in CHIP;
- for any cause at any time; and
- during the yearly CHIP re-enrollment period.

When will my health plan change become effective?

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

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

DHP may request that you be taken out of the health plan for "good cause." Good cause could be:

1. Fraud or abuse by a Member
2. Threats or physical acts leading to harming DHP staff or providers
3. Theft
4. Refusal to go by 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. Keep using a doctor that is not a DHP provider

DHP 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 1-877-541-7905. You can also update 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 my doctor?

You may be responsible for co-pays or deductibles depending on your income. If you do get a bill, call Member Services and we can help you. Have your Member ID card and the bill ready when you call.

Who do I call if I get a bill from my/my child's doctor?

If you get a bill from your Primary Care Provider or other doctor, call Member Services at **1-877-451-5598** and someone will call the doctor's office. We will help to explain your benefits and co-payments.

What information do they need?

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

What do I do if I have other Insurance in addition to CHIP? (Coordination of Benefits)

You need to tell Member Services staff about any other health insurance you have. You should call the Member Services number at **1-877-451-5598** to let us know.

Third-Party Insurance

Children cannot be covered by CHIP and other health insurance at the same time. Families that otherwise qualify for CHIP but have private insurance that costs greater than five percent of the family's gross income must be able to drop the insurance before CHIP coverage can begin. Families with private health insurance that costs less than five percent of the family's gross income are not able to get CHIP.

Injury Caused by Others

In an accident, your accident insurance must pay your bill. Call Member Services to let us know that you were in an accident so we can make sure your health care is paid for.

Member Satisfaction

Member Satisfaction Surveys

Each year we ask a few of our Members to participate in a Satisfaction Survey. The survey asks questions to see how happy you are with your care from Driscoll Health Plan and your provider. Your answers help us improve the care you get. To learn more about the results, call Member Services**.**

Member Advisory Group

Every three months we have Member Advisory Group meetings. This group meets to talk about things you would like us to do differently. You can also tell us what we can do better. Call Member Services if you want to be a member of this group.

Complaints and Appeals

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

Complaints

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. 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 on this page to file your oral or written complaint.

Driscoll Health Plan
Quality Management Department
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. This letter will be sent within five days of receiving your complaint. We will send you a form with this 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 of the outcome within 30 days.

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 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 12030
Austin, Texas 78711-2030
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/get-help-with-an-insurance-complaint.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 the 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

Appeal Process

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

There may be times when DHP's Medical Director denies or limits certain services. When this happens, you can file an appeal to review medical necessity for denial of services. For help with how to fill out the Member appeal form, call Member Services toll-free at **1-877-451-5598** (TTY: 1-800-783-2989).

How will I find out if services are denied?

We will send you a letter if 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 five 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 Appeal

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 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. This letter will approve or deny the request for an Expedited Appeal.

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 not medically necessary, experimental, or investigational. 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 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
3750 Monroe Avenue Suite 705
Pittsford, NY 14534
Fax number: 1-888-866-6190

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

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 decide on 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.

Advance Directives

What if I am too sick to make a decision about my Medical Care?

You might be too sick to make decisions about your health care. If this happens, how will a doctor know what you want? You can make an Advance Directive.

What are Advanced Directives?

An Advance Directive is a living will that lets people know what you want to happen if you get very sick. Another kind of living will is called a Durable Power of Attorney, which lets a friend or family member make decisions about your health care.

How do I get an Advance Directive?

If you want to learn more about Advance Directives, call Member Services toll-free at **1-877-451-5598.**

Report Waste, Abuse, or 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 is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law.

For example, tell us if you think someone is:

- Getting paid for CHIP services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use a CHIP ID card
- Using someone else's CHIP ID card

- Not telling the truth about the amount of money or resources you have 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
  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 the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting about someone who gets benefits, include:

- The person's name
- The person's date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

Medical 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 does not 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 as 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:

- Information about network providers – at a minimum Primary Care Provider, 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, and, when applicable, professional qualifications, specialty, medical school attended, residency completion and board certification status.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on a complaint, appeal, and internal/external process.
- Information about benefits available under the CHIP program, including amount, duration, and scope of benefits. This is designed to make sure you know the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits.
- 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.
  - 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 transportation services
SPH Analytics – conducts member satisfaction surveys
Pacific Interpreters – provides interpretation services
Carenet – provides the 24-hour Nurse Advice Line

Member Rights

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's Primary Care Provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others are paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decides those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's Primary Care Provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to keep going to that doctor for three months and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her Primary Care Provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without being treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment depending on your income. Copayments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals, and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member Responsibilities

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

1. You must try to follow healthy habits. Urge your child to stay away from tobacco and follow a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you disagree with your health plan, you must first try to fix it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to know how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other provider's copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. You must talk to your provider about your medications that are prescribed.

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

Discrimination is Against the Law

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

If you believe that DHP 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
DHP Compliance Officer
4525 Ayers Street
Corpus Christi, TX 78415
1-877-324-7543, TTY: 1-800-735-2989
Email: filegrievance@dchstx.org

You may file a grievance in person, by mail, or email. If you need help filing a grievance, a Member Advocate is available to help you.

You may 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, 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 (TDD)

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 are available to you at no cost. 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 اللغة، اذكر تتوافر اللغوية المساعدة خدمات فإن .بالمجان لك اتصل برقم 1-877-324-7543 (والبكم الصم هاتف رقم):

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

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 داشتهPersian مورد در سوال ، میکنید کمک او به شما که کسی یا شما، گر
.نمایید حاصل تماس1-877-324-7543 .نمایید دریافت رایگان طور به را خود زبان به اطالعات و

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 ່ ຽວກັບ Laotian, ທ ່ ານມ ີສດ ່ ທຈະໄດ ້ຮັບການຊ ່ ວຍເຫຼ ືອແລະ ໍ ຂ ້ ມ ູ ນຂ ່ າວສານ ່ ທເປ ັ ນພາສາຂອງທ ່ ານ ່ ບມ ຄ ່ າໃຊ ້ จ ่ าย. การโอ ้ ว ิ มกับบายพาสา, ใช ้ โทหา 1-877-324-7543.

NOTICE OF PRIVACY PRACTICES

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.
For help translating or understanding this notice, you may contact **1-877-324-7543**.

Purpose: Driscoll Health Plan (DHP) is required by law to maintain the privacy of Protected Health Information (PHI). We are required to provide this notice of our legal duties and privacy practices regarding uses and disclosures of PHI as well as inform you regarding your individual rights. This notice explains the purposes for which we are permitted to use and disclose your PHI.

How We May Use and Disclose Information About You

The following categories describe different ways that we may use and disclose your PHI. Not every potential use and disclosure in a category will be listed.

For Treatment. We are permitted to use and disclose your PHI to a physician or health care provider who is involved in your care or provides you with medical treatment or services. This may include, but is not limited to, the use and disclosure of your PHI to assist with prior authorization decisions related to your benefits.

For Payment. We are permitted to use and disclose your PHI to obtain payment for your health care treatment or services. This may include, but is not limited to, certain activities such as processing claims, determining eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations. We are permitted to use and disclose your PHI for our business operations. This may include, but is not limited to, quality assessment activities, investigating complaints and appeals, and providing case management and care coordination.

To Business Associates for Treatment, Payment, and Healthcare Operations. We are permitted to disclose your PHI to our business associates to carry out treatment, payment, or healthcare operations. Business associates are also required to protect your PHI.

Individuals Involved in Your Care or Payment for Your Care. We may release your PHI to a family member, other relative, close personal friend or designated personal representative who is involved in your medical care if the PHI released is directly relevant to the person's involvement with your care. We may also release information to someone who helps pay for your care.

Appointment Reminders, Treatment Alternatives and Health Related Services. We may use and disclose your PHI to contact you to remind you of an appointment or to provide you with information about treatment options or alternatives, and health care-related benefits or services that may be of interest to you.

Marketing Activities. We may use certain information, such as name, address, or telephone number to contact you in the future to request permission to share your story with the community in official marketing for DHP. You have the right to opt-out if you do not want to be contacted. To do so, please notify us in writing specifying your preferences with regards to being contacted for marketing activities.

SPECIAL SITUATIONS

As Required by Law. We will disclose your PHI when required to do so by federal, state, or local law.

Public Health Activities. We may disclose your PHI for public health activities. This may include, but is not limited to, (1) preventing or controlling disease, injury, or disability; (2) reporting child abuse or neglect; or (3) notifying the appropriate government authority if we believe a member has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws. This may include, but is not limited to, audits and investigations necessary for oversight of government benefit programs.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness or missing person—but only if limited information is disclosed; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct we believe occurred on DHP's premises; and (6) in emergency circumstances to report a crime or to determine the location of the crime, its victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI about you to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also release PHI to funeral directors as necessary to help them carry out their duties.

Organ and Tissue Donation. We may release PHI to organizations that handle organ procurement; or organ, eye, or tissue transplantation; or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Research. Under certain circumstances, we may use and disclose your PHI for research purposes. Before we use or disclose PHI for research, the research project will have been approved through an Institutional Review Board. Pre-approval may not be required when researchers are preparing a research project and need to look at information about members with specific medical needs, so long as the PHI does not leave DHP.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. This may include, but is not limited to, disclosure to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.

To Authorized Governmental Authorities and Military Officials. We may disclose PHI regarding members of the armed forces or to authorized federal authorities for official investigations, intelligence, counterintelligence, or other national security activities.

To Authorized Governmental Programs Providing Public Benefits. We may disclose PHI regarding your eligibility for or enrollment in DHP to another agency administering a government program providing public benefits as authorized or required by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official under specific circumstances.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs.

Disclosures Requiring an Authorization. Other uses and disclosures will be made only with a valid authorization. Except in certain circumstances, we must obtain an authorization for any use or disclosure of PHI for marketing, psychotherapy notes or sale of PHI.

YOUR RIGHTS

You have the following rights regarding the PHI we maintain about you. For questions regarding how to exercise your rights, please utilize the contact information at the end of this notice.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or healthcare operations. We are not required to agree to or abide by your request. If we do agree, we will comply with your request unless the information is required to provide you with emergency treatment, or the agreement has been terminated in accordance with HIPAA guidelines. Requests must be received in writing.

Right to Restrict Disclosures to Health Plans. We will agree to your request to restrict the use or disclosure of PHI for payment or health care operations to a health plan for a service or item for which you, or someone other than the health plan, has paid the health care provider in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your PHI in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. Your request must specify how, where or when you wish to be contacted. This right only applies if you clearly state that the disclosure of all or part of your PHI could endanger you if not communicated by the alternative means or location requested.

Right to Inspect and Receive a Copy. You have the right to request access to inspect, receive a physical or electronic copy, or be provided a summary of your PHI contained in a designated record set. We may deny your request in certain limited circumstances. For example, psychotherapy notes are prohibited from being inspected or copied. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We are required to notify you in advance regarding these charges. If your request is denied we will notify you, and you may request that the denial be reviewed. Another licensed healthcare professional, chosen by DHP, will perform a secondary review. The review will not be conducted by any healthcare professional involved in the denial of your original request. We will comply with the outcome of the review to the extent allowable by law.

Right to Amend. If you believe that information we have about you is incorrect or incomplete, you may request an amendment. You have the right to request an amendment for as long as the information is kept by or for DHP. You must include a reason that supports your request. All requests for amendment should be made in writing. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the PHI kept by or for DHP; (3) is not part of the information that you would be permitted to inspect and copy; or (4) is accurate and complete. DHP will notify you if we deny the request and will include instructions as to how you may appeal the request or file a complaint.

Right to be Notified. You have a right to be notified regarding an unlawful breach of unsecured PHI.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures related to certain disclosures regarding your PHI. We may charge you a reasonable fee if you request a disclosure more than once each year.

Information Maintained in Paper Records. You may request a record of disclosures that have been made to persons or entities other than for treatment, payment or healthcare operations that have taken place in the past six (6) years.

Information Maintained Electronically. Subject to a schedule established by federal law, if we maintain your PHI electronically, you have the right to ask for an accounting of all disclosures. Under federal law, you may request an accounting for a period of three (3) years prior to the date the accounting is requested.

Right to a Copy of This Notice. You have the right to a paper copy of this notice at any time. You may also obtain an electronic copy of this notice by clicking on Notice of Privacy Practices (NOPP) located on DHP's website at driscollhealthplan.com.

Right to Revoke Authorization. You have a right to revoke a previous authorization you have made for uses and disclosures at any time, provided that the revocation is submitted in writing. The revocation will be in effect upon receipt and validation with the exception and to the extent that the entity has previously used or disclosed PHI in reliance on a previous authorization.

Changes to This Notice

We reserve the right to change or revise this notice at any time. The new notice will contain the effective date. DHP reserves the right to apply the amended notice to all previously acquired PHI about you. As part of your annual mailing, you will receive a copy of the current notice in effect.

Complaints: If you believe your privacy rights have been violated, you may file a complaint utilizing the contact information at the end of this notice, or by contacting the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, Phone: 1-800-368-1019, or Email: OCRComplaint@hhs.gov. You will not be penalized for filing a complaint.

Any official requests related to these rights should be directed to:

Driscoll Health System, Chief Privacy Officer
4525 Ayers Street
Corpus Christi, Texas 78415
Office Phone: 1-877-324-7543

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 compromised 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
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.