Amerigroup

CHIP Member Handbook

Amerigroup Texas, Inc.

Bexar, Dallas, Harris, Jefferson, and Tarrant Service Areas

July 2023

800-600-4441 (TTY 711)

myamerigroup.com/TX

CHIP | TEXAS Health and Human Services

1016800TXMENAGP 04/23

Amerigroup

CHIP Member Handbook

Amerigroup Texas, Inc.
Bexar, Dallas, Harris, Jefferson, and Tarrant Service Areas

800-600-4441 (TTY 711)

myamerigroup.com/TX

July 2023

1016800TXMENAGP 04/23

Important Plan Information

Amerigroup

Member Handbook Update

Please read this with care and keep it with your member handbook.

A change to your child's extra benefits starts September 1, 2023.

Below is an update to the chart in the **What extra benefits does my child get as a member of Amerigroup? How can I get these benefits for my child?** section of the handbook:

Value-added benefit	How to get it
This is Quitting*: An interactive, text-based program to help teens ages 13–17 quit vaping or using e-cigarettes. The program focuses on web counseling for up to 12 weeks.	Text the keyword VAPEOUTTX to **88709** to enroll.

*Program name change only.

Do you have questions?
Call Member Services toll-free at **800-600-4441 (TTY 711)**, Monday through Friday from 7 a.m. to 6 p.m. Central time.

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

Welcome to Amerigroup! We're glad you're our member!

Here are some things you should do to get started:

Look for your Amerigroup ID card in the mail. Keep the card with you. You'll use it to get all your services, like doctor visits, prescriptions, and more. If you have private insurance, you'll also have another health plan card to show when you visit a provider.

If you don't receive your member ID card by your first day as a new member, call us at **800-600-4441 (TTY 711)** Monday through Friday from 7 a.m. to 6 p.m.

Stay connected with your health. Download the free Sydney Health mobile app today to access your ID card, search for a doctor, and more.

Register for our secure website. Visit **myamerigroup.com/TX** and register for secure access. When you create an account, you'll get helpful tools at your fingertips:

- Choose or change your primary care provider
- Update your address or phone number
- Send us a secure message
- Request a call-back
- And more!

Want to change your primary care provider? Choose from a large group of doctors who work with our plan. To change your primary care provider online:

- Go to **myamerigroup.com/TX**.
- Use our **Find a Doctor** tool to search for plan providers who are close to home, speak your language, and can meet your needs.
- Log in to your account.
- Select **Your Account**.
- Select **Change Your Primary Care Provider**.

You can also find doctors in our plan using the CHIP provider directory for your location on the **Find a Doctor** page at **myamerigroup.com/TX**. To get a no-cost paper copy of the provider directory or for help changing your primary care provider, call Member Services at **800-600-4441 (TTY 711)**.

We're here for you when you need us. If you have questions about your benefits or health care, you can call Member Services at **800-600-4441 (TTY 711)** Monday through Friday from 7 a.m. to 6 p.m. Central time. You can call the same number for our 24-hour Nurse HelpLine to talk to a nurse anytime, day or night.

Ameritips: Health Tips That Make Health Happen

Your child needs to go to the doctor now!

When is it time for a well-child checkup?
Your child needs to have regular checkups. This way, your child's primary care provider can see if there is a problem before it becomes a bad problem. When your child becomes an Amerigroup member, call his or her primary care provider and make the first appointment before the end of 90 days.

Well-child Checkups for Children
Children need more well-care checkups than adults. Your child should get checkups at the times listed below.

Well-child Checkup Schedule	
Birth	9 months old
3–5 days	12 months old
By 1 month old	15 months old
2 months old	18 months old
4 months old	24 months old
6 months old	30 months old
After age 2 1/2, your child should visit the doctor every year. Amerigroup encourages and covers annual checkups for members ages 3–18.	

Be sure to make these appointments and take your child to his or her doctor when scheduled. Find health problems before they get worse and harder to treat. Prevent health problems that make it hard for your child to learn and grow.

If your child's doctor finds a health problem during a checkup, your child can get the care he or she needs such as eye exams and glasses, hearing tests and hearing aids, or dental care.

What If My Daughter Becomes Pregnant?
If you think your daughter is pregnant, call her doctor or OB/GYN right away. This can help her have a healthy baby.

You don't need a referral to see an OB/GYN. Your child can see only one OB/GYN in a month, but your child can visit the same OB/GYN more than once during that month, if needed.

If you have any questions or need help making an appointment with your child's doctor or OB/GYN, please call Amerigroup Member Services at **800-600-4441 (TTY 711)**.

ALERT! DO NOT LOSE YOUR CHILD'S HEALTH CARE BENEFITS – RENEW ELIGIBILITY FOR CHIP BENEFITS ON TIME!

Amerigroup Member Handbook
For CHIP and CHIP Perinate Newborn Members

2505 N. Highway 360
Suite 300
Grand Prairie, TX 77050

800-600-4441
myamerigroup.com/TX

CONTENTS

INFORMATION ABOUT YOUR CHILD'S HEALTH PLAN 1
Your Amerigroup member handbook 1

IMPORTANT PHONE NUMBERS 1
Amerigroup toll-free Member Services line 1
Amerigroup 24-hour Nurse HelpLine 2
Behavioral Health and Substance Use Disorder Services line 2
Other important phone numbers 2

YOUR AMERIGROUP ID CARD 3
What does my child's Amerigroup ID card look like? 3
How do I read and use my child's Amerigroup ID card? 3

PRIMARY CARE PROVIDERS FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS 3
What is a primary care provider? 3
What do I need to bring to my child's doctor appointment? 4
Can a clinic be my child's primary care provider? 4
How can I change my child's primary care provider? 4
How many times can I change my child's primary care provider? 4
When will my child's primary care provider change become effective? 4
Are there any reasons my request to change my child's primary care provider may be denied? 4
Can a primary care provider move my child to another primary care provider for noncompliance? 4
What if I choose to go to a doctor who is not my child's primary care provider? 5
How do I get medical care after my child's primary care provider's office is closed? How do I get after-hours care? 5
What if Amerigroup doesn't have a provider for one of my covered benefits? 5

PHYSICIAN INCENTIVE PLANS 5

CHANGING HEALTH PLANS 5
What if I want to change health plans? 5
Who do I call? 6

How many times can I change health plans? 6
When will my health plan change become effective? 6
Can Amerigroup ask that my child be dropped from the health plan for noncompliance? 6

COVERAGE FOR NEWBORNS 6

BENEFITS FOR CHIP AND CHIP PERINATE NEWBORN MEMBERS 7

What are my child's CHIP or CHIP Perinate Newborn program benefits? 7
- How do I get these services for my child? 7
- Are there any limits to covered services? 7
- What is preapproval? 7
- What are the CHIP Perinate Newborn benefits? What benefits does my baby receive at birth? 8
- What services are not covered? 8
- What are my child's prescription drug benefits? 8

What are copays? 8
- How much are they and when do I have to pay them? 9

What are CHIP cost-sharing caps? 9
When will I get an explanation of benefits? 10
What extra benefits does my child get as a member of Amerigroup? How can I get these benefits for my child? 10
What health education classes does Amerigroup offer? 14
What is Disease Management? 14
- Disease Management 14
- How it works 15
- How to join 15
- Useful phone numbers 15
- Disease Management rights and responsibilities 16

What is a Member with Special Health Care Needs (MSHCN)? 17
- What is service coordination for Members with Special Health Care Needs? How can I get service coordination for my child? 17
- What will a service coordinator do for my child? 17
- How can I talk with a service coordinator? 18

What is Case Management? 18
HEALTH CARE AND OTHER SERVICES FOR CHIP AND CHIP PERINATE NEWBORN MEMBERS 18
What does medically necessary mean? 18
How is new technology evaluated? 19
What is routine medical care? 19
- How soon can I expect my child to be seen? 19

What is urgent medical care? 19
- What should I do if my child needs urgent medical care? 20
- How soon can I expect my child to be seen? 20

What is emergency medical care? 20
- What is an emergency, an emergency medical condition, or an emergency behavioral health condition? 20
- What is emergency services or emergency care? 21
- How soon can I expect my child to be seen? 21

What do I do if my child needs emergency dental care? 21
What is post-stabilization? 21
How soon can my child see a doctor? 21
How does my child get medical care after hours? 22
What if my child gets sick when he or she is out of town or traveling? 22
What if my child is out of the state? 22
What if my child is out of the country? 23
What if my child needs to see a special doctor (specialist)? 23
What is a referral? 23
What services don't need a referral? 23
How soon can I expect my child to be seen by a specialist? 23
How can I ask for a second opinion? 23
How do I get help if my child has mental health, alcohol, or drug problems? 23
Do I need a referral for this? 24
How do I get my child's medications? 24
How do I find a network drugstore? 24
What if I go to a drugstore not in the network? 24
What do I bring with me to the drugstore? 24
What if I need my child's medications delivered to me? 24
Who do I call if I have problems getting my child's medications? 24
What if I can't get the medication my child's doctor ordered approved? 25
What if my child's medication is lost? 25
What if my child needs an over-the-counter medication? 25
How do I find out what drugs are covered? 25
How do I transfer my child's prescriptions to a network pharmacy? 25
How do I get my child's medicine if I am traveling? 25
What if I paid out-of-pocket for a medicine and want to be reimbursed? 26
What if my child needs birth control pills? 26
How do I get eye care services for my child? 26
How do I get dental services for my child? 26
What is Early Childhood Intervention? 26
Does my child need a referral for this? 27
Where do I find an ECI provider? 27
What is Head Start? 27
What if my child can't use standard transportation to get to health care appointments? 27
Can someone interpret for me when I talk with my child's doctor? 27
Who do I call for an interpreter? 27
How far in advance do I need to call? 27
How can I get a face-to-face interpreter in the provider's office? 28
What if my daughter needs OB/GYN care? Does she have the right to choose an OB/GYN? 28
ATTENTION FEMALE MEMBERS: 28
How do I choose an OB/GYN? 28
If I don't choose an OB/GYN, do I have direct access? 28
Will I need a referral? 28
How soon can my daughter be seen after contacting an OB/GYN for an appointment? 28
Can my daughter stay with an OB/GYN who is not with Amerigroup? 28

What if my daughter is pregnant? 29
Who do I need to call? 29
What other services/activities/education does Amerigroup offer pregnant women? 29
My Advocate™ 29
Helping your child and her baby stay healthy 30
NICU Programs 30
How and when do I tell Amerigroup? 30
Who do I call if my child has special health care needs and I need someone to assist me? 30
What if I get a bill from my child's doctor? Who do I call? 31
What information do they need? 31
What do I have to do if my child moves? 31
Recertify your child's CHIP benefits on time 31
What are my rights and responsibilities? 32
Member rights 32
Member responsibilities 33
What are advance directives? 34
How do I get an advance directive? 34

QUALITY MANAGEMENT 34
What does quality management do for you? 34
What are clinical practice guidelines? 34

HOW WE MAKE DECISIONS ABOUT YOUR CARE 35

COMPLAINT PROCESS 35
What should I do if I have a complaint? Who do I call? 35
Can someone from Amerigroup help me file a complaint? 35
How long will it take to process my complaint? 35
What are the requirements and time frames for filing a complaint? 35
If I am not satisfied with the outcome, who else can I contact? 36
Do I have the right to meet with a complaint appeal panel? 36

PROCESS TO APPEAL A CHIP ADVERSE DETERMINATION (DENIAL) 36
What can I do if my child's doctor asks for a service or medicine for my child that's covered but Amerigroup denies or limits it? 36
How will I find out if services are denied? 37
What are the time frames for the appeal process? 37
What is a specialty review? 37
When do I have the right to ask for an appeal? 37
Does my request have to be in writing? 38
Can someone from Amerigroup help me file an appeal? 38

EXPEDITED APPEALS 38
What is an expedited appeal? 38
How do I ask for an expedited appeal? Does my request have to be in writing? 38
What are the time frames for an expedited appeal? 38
What happens if Amerigroup denies the request for an expedited appeal? 38
Who can help me file an expedited appeal? 39

INDEPENDENT REVIEW ORGANIZATION PROCESS 39
What is an independent review organization? 39
Can I ask for an external review by an IRO before I exhaust the Amerigroup internal appeal process? 39
How do I ask for a review by an independent review organization? 39
What are the timeframes for this process? 40
FRAUD AND ABUSE INFORMATION 41
Do you want to report CHIP waste, abuse, or fraud? 41
Member Guide to Managed Care Terms 42
ATTACHMENT A - EVIDENCE OF COVERAGE AND SCHEDULE OF BENEFITS AND EXCLUSIONS 44

WELCOME TO AMERIGROUP

INFORMATION ABOUT YOUR CHILD'S HEALTH PLAN

Welcome! Amerigroup is committed to getting your child the right care close to home. As a Children's Health Insurance Program (CHIP) or CHIP Perinate Newborn member, your child's primary care provider will work together with you to help keep your child healthy. To find out about doctors and hospitals in your area, visit **myamerigroup.com/TX** and go to the **Find a Doctor** page. You may also call Member Services at **800-600-4441 (TTY 711)**.

Your Amerigroup member handbook

This handbook will help you understand your Amerigroup health plan. If you have questions or need help understanding or reading your member handbook, call Member Services. You can request this handbook in large print, audio, braille, or another language.

This member handbook is for CHIP members and CHIP Perinate Newborn members. When there are differences in the plan benefits between CHIP and CHIP Perinate Newborn members (like in the section on copays), we will explain those differences. This handbook will help you understand your child's Amerigroup health plan and the CHIP benefits your child gets from us. Your Amerigroup benefits are your CHIP benefits plus the extra value-added benefits your child gets for being our member. 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.

IMPORTANT PHONE NUMBERS

Amerigroup toll-free Member Services line

If you have any questions about your child's Amerigroup health plan, call Member Services toll free at **800-600-4441 (TTY 711)**. You can call us Monday through Friday from 7 a.m. to 6 p.m. Central time, except for state-approved holidays. If you call after 6 p.m. or on a weekend or holiday, leave a voice mail message. A Member Services representative will call you back the next business day.

These are some of the things Member Services can help you with:

- This member handbook
- Member ID cards
- Your child's doctors
- Doctor appointments including three-way calls with you and your doctor's office
- Transportation
- Health care benefits
- Getting services
- What to do in an emergency or crisis
- Cost-sharing information
- Well care
- Special kinds of health care
- Healthy living
- Complaints and medical appeals
- Rights and responsibilities

For members who don't speak English, we can help you in many different languages and dialects, including Spanish. You may also get an interpreter for visits with your child's doctor at no cost to you. Please let us know if you need an interpreter at least 24 hours before your appointment. Call Member Services to learn more.

For members who are deaf or hard of hearing, call 711. Amerigroup will set up and pay for a person who knows sign language to help you during your doctor visits. Please let us know if you need an interpreter at least 24 hours before your appointment.

If you ask for an interpreter less than 24 hours before your appointment, we will still do our best to have an interpreter available for you.

If your child has an emergency, you should call 911 or go to the nearest hospital emergency room right away. If you need advice, call your child's primary care provider or our 24-hour Nurse HelpLine 7 days a week at **800-600-4441 (TTY 711)**.

For urgent care (see the **What is urgent medical care?** section of this handbook), you should call your child's primary care provider even on nights and weekends. If you call the primary care provider's office when it's closed, leave a message with your name and a phone number where you can be reached. Someone should call you back within 30 minutes to tell you what to do. You can also call us to find an urgent care clinic near you, or our 24-hour Nurse HelpLine 7 days a week at **800-600-4441 (TTY 711)** for advice any time, day or night.

Amerigroup 24-hour Nurse HelpLine

The 24-hour Nurse HelpLine is available to all members 24 hours a day, 7 days a week. Call toll-free at **800-600-4441 (TTY 711)** if you need advice on:

- How soon your child needs care.
- What kind of care your child needs.
- How you can care for your child before seeing the doctor.
- How you can get your child care.

Behavioral Health and Substance Use Disorder Services line

The Behavioral Health and Substance Use Disorder Services line is available to members 24 hours a day, 7 days a week at **800-600-4441 (TTY 711)**. The call is free, and you can talk to someone in English or Spanish. For other languages, interpreter services are available. You can call the Behavioral Health and Substance Use Disorder Services line for help getting services.

If your child has an emergency, you should call 911 or go to the nearest hospital emergency room right away.

Other important phone numbers

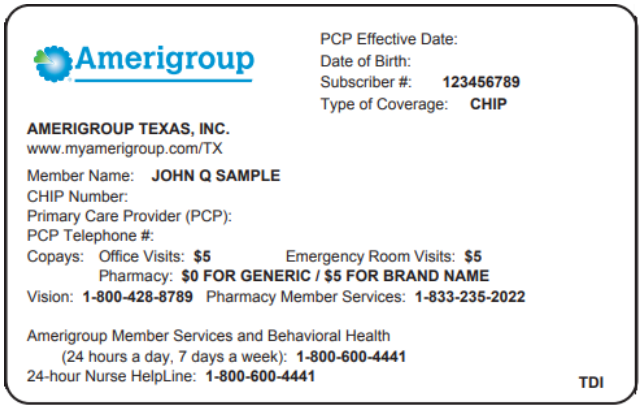
- If you have questions regarding eligibility, call CHIP at **800-964-2777**.
- If you need to contact CHIP about other questions, dial **2-1-1**, pick a language, and then press 2.
- If you have problems getting prescriptions filled, call Pharmacy Member Services at **833-235-2022 (TTY 711)**.
- If you need help with vision care, call Superior Vision of Texas at **800-428-8789**.
- If you have dental questions, call your child's CHIP dental plan:
    - DentaQuest at **800-508-6775**
    - MCNA Dental at **800-494-6262**
    - UnitedHealthcare Dental at **877-901-7321**

- If you have questions about your child's development, call the HHS Office of the Ombudsman at **877-787-8999**.

YOUR AMERIGROUP ID CARD

What does my child's Amerigroup ID card look like?

If you don't have your child's Amerigroup ID card yet, you'll get it soon. Please carry it with you at all times. Show it to any doctor or hospital you visit. **You don't need to show your child's ID card before getting emergency care**. Here is what your child's Amerigroup ID card looks like:



How do I read and use my child's Amerigroup ID card?

The card tells providers and hospitals your child is an Amerigroup member. It also says that Amerigroup will pay for the medically needed benefits listed in the **Benefits for CHIP and CHIP Perinate Newborn Members** section of this handbook.

Your child's Amerigroup ID card lists your copay amounts and important phone numbers you need to know.

How do I replace my child's Amerigroup ID card if it is lost or stolen?

If your child's ID card is lost or stolen, call Amerigroup right away. We'll send you a new one. You may also print a new ID card from our website at **myamerigroup.com/TX**. You'll need to register and log in to the website to access your child's ID card information.

PRIMARY CARE PROVIDERS FOR CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

What is a primary care provider?

A primary care provider is the main doctor who provides most of your child's regular health care. Your child's primary care provider must be in the Amerigroup health plan. The primary care provider will provide a medical home. A medical home means your child's doctor will get to know your child, understand his or her health history, and help him or her get the best possible care. The primary

care provider will also send you to other doctors, specialists, or hospitals when special care or services are needed.

When you enrolled in Amerigroup, you should have picked a primary care provider for your child. If you did not, we assigned one for you. We picked one who should be located close to you. The primary care provider's name and phone number are listed on the ID card.

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

- Your child's Amerigroup ID card.
- Any medicines your child is taking.
- Your child's shot records.
- Any questions you want to ask the doctor.

Can a clinic be my child's primary care provider?

Yes, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) in our plan can be primary care providers.

How can I change my child's primary care provider?

You can change your child's primary care provider by:

- Calling Member Services.
- Looking for the **Tools & Resources** section at the bottom of the home page on our website at **myamerigroup.com/TX** and selecting **Change primary care provider.**

How many times can I change my child's primary care provider?

There is no limit on how many times you can change your child's primary care provider. You can change primary care providers by calling us toll free at **800-600-4441 (TTY 711)** or writing to us at the address in the front of this book.

When will my child's primary care provider change become effective?
We can change your child's primary care provider the same day you ask for the change. The change will start right away. Call the doctor's office if you want to make an appointment. If you need help making an appointment, call Member Services. We'll set up a three-way call with you and your doctor. Call Member Services at **800-600-4441 (TTY 711)**. You can also log in to the secure website at **myamerigroup.com/TX** to send us an email and we'll do the rest.

Are there any reasons my request to change my child's primary care provider may be denied?
You'll not be able to change your child's doctor if:

- The doctor you choose cannot take new patients.
- The new doctor isn't in our plan.

Can a primary care provider move my child to another primary care provider for noncompliance?

Your primary care provider may ask that your child be changed to another primary care provider if:

- You don't follow the provider's medical advice over and over again.
- Your doctor agrees a change is best for your child.

- Your doctor doesn't have the right experience to treat your child.
- You were assigned to the doctor by mistake (like a child assigned to a doctor who only treats adults).

What if I choose to go to a doctor who is not my child's primary care provider?
Talk to your child's primary care provider first about care needed from other doctors. He or she can tell you about other doctors in our plan and help coordinate all the care your child needs.

How do I get medical care after my child's primary care provider's office is closed? How do I get after-hours care?
If your child needs urgent care after your child's primary care provider's office is closed, call the primary care provider phone number on your ID card, even on nights and weekends. If you call the primary care provider's office when it's closed, leave a message with your name and a phone number where you can be reached. Someone should call you back within 30 minutes to tell you what to do.

You may also call our 24-hour Nurse HelpLine, 24 hours a day, 7 days a week, for advice or help finding an urgent care clinic near you. Go to the **What is urgent medical care?** section of this handbook to learn more about urgent care.

If your child has an emergency, call 911 or go to the nearest emergency room right away. If you aren't sure it's an emergency, read the section on **What is emergency medical care?** or call the 24-hour Nurse HelpLine.

What if Amerigroup doesn't have a provider for one of my covered benefits?
If your child can't get a covered benefit from a provider in our health plan, we'll arrange for your child to get the service from a doctor who's not in our plan. We'll pay the provider according to state rules. Call Member Services at **800-600-4441 (TTY 711)** to arrange this service.

You don't need to call us to get emergency care from a doctor who's not in our plan.

PHYSICIAN INCENTIVE PLANS

Amerigroup 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 child's 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 **800-600-4441 (TTY 711)** to learn more about this.

CHANGING HEALTH PLANS

What if I want to change health plans?

You are allowed to make health plan changes:

- For any reason within 90 days of enrollment in CHIP.
- For cause at any time.
- If you move to a different service delivery area.
- During your annual CHIP reenrollment period.

Who do I call?
For more information, call CHIP toll-free at **800-964-2777**.

How many times can I change health plans?
You can change health plans for any reason within 90 days of enrollment in CHIP and for cause at any time. You can also change health plans if you move to a different service delivery area, and during your annual CHIP reenrollment period.

When will my health plan change become effective?
If you call to change your child's health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

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

Can Amerigroup ask that my child be dropped from the health plan for noncompliance?
There are several reasons your child could be disenrolled or dropped from Amerigroup. These reasons are listed below. If you or your child did something that may lead to disenrollment, we'll contact you. We'll ask you to tell us what happened.

Your child could be disenrolled from Amerigroup if:

- Your child is no longer eligible for CHIP.
- You let someone else use your child's Amerigroup ID card.
- You or your child tries to hurt a provider, a staff person, or an Amerigroup associate.
- You or your child steals or destroys provider or Amerigroup property.
- You go to the emergency room over and over again when your child doesn't have an emergency.
- You go to doctors or medical facilities outside the Amerigroup plan over and over again.
- You or your child tries to hurt other patients or makes it hard for other patients to get the care they need.

If you have any questions about your child's enrollment, call Member Services at **800-600-4441 (TTY 711)**.

COVERAGE FOR NEWBORNS
If your baby is born to a family with an income above the Medicaid eligibility threshold, he or she will get the same coverage as a CHIP member beginning at birth. Your baby will get 12 months of continuous coverage through his or her health plan, beginning with the month of enrollment in the CHIP Perinatal program as an unborn child. For example, if an unborn baby is enrolled when the mother is 3 months pregnant, the baby will have 6 months of prenatal care and 6 months of full CHIP benefits as a CHIP Perinate Newborn member after birth.

Enrollment fees and copays don't apply to CHIP Perinate Newborn members but will still apply for

any siblings enrolled in the CHIP program. The family will receive a CHIP renewal form in the 10th month of the child's CHIP Perinate Newborn coverage. The renewal form must be completed and submitted to continue benefits.

BENEFITS FOR CHIP AND CHIP PERINATE NEWBORN MEMBERS

What are my child's CHIP or CHIP Perinate Newborn program benefits?

The following list shows some of your child's health care benefits:

- Regular checkups and office visits
- Prescription drugs and vaccines
- Access to medical specialists and mental health care
- Hospital care and services
- Medical supplies, X-rays, and lab tests
- Treatment for special health needs
- Treatment for pre-existing conditions

Coverage for CHIP and CHIP Perinate Newborn members is the same except for copayments.

For a complete list of benefits, please see the **Evidence of Coverage and Schedule of Benefits and Exclusions** in **Attachment A** at the back of this handbook.

How do I get these services for my child?

Your child's primary care provider will provide most routine care. For specialty care or other care the primary care provider can't provide, he or she will refer you to a specialist or other provider in our plan. If you have a question or are not sure whether we offer a certain benefit, call Member Services for help**.**

Are there any limits to covered services?

Yes. Covered services must be medically necessary and in some cases must be preapproved.

What is preapproval?

Some treatment, care, or services may need our approval before your child's doctor can provide them. This is called preapproval. Your child's doctor will work directly with us to get the approval. The following require preapproval:

- Most surgeries, including some outpatient surgeries
- All elective and nonurgent inpatient services and admissions
- Chiropractic services
- Most behavioral health and substance use disorder services (except routine outpatient and emergency services)
- Certain prescriptions
- Certain durable medical equipment, including prosthetics and orthotics
- Certain gastroenterology procedures
- Digital hearing aids
- Home health services
- Hospice services

- Rehabilitation therapy (physical, occupational, respiratory, and speech therapies)
- Sleep studies
- Out-of-area or out-of-network care except in an emergency
- Advanced imaging (things like MRAs, MRIs, CT scans, and CTA scans)
- Certain pain management testing and procedures

This list is subject to change without notice and isn't a complete list of covered plan benefits. Please call Member Services with questions about specific services.

What are the CHIP Perinate Newborn benefits? What benefits does my baby receive at birth?
If your baby is eligible as a CHIP Perinate Newborn, he or she will get the same coverage as a CHIP member beginning at birth. Your baby will get 12 months of continuous coverage through his or her health plan, beginning with the month of enrollment in the CHIP Perinatal program as an unborn child. For example, if an unborn baby is enrolled when the mother is three months pregnant, the baby will have six months of prenatal care and six months of full CHIP benefits as a CHIP Perinate Newborn member after birth.

What services are not covered?
For a complete listing of services that aren't covered, please see the **Evidence of Coverage and Schedule of Benefits and Exclusions** in **Attachment A** at the back of this handbook. For questions about services not covered by Amerigroup, please call Member Services.

What are my child's prescription drug benefits?
Your child can get as many prescriptions as are medically necessary. We use the Vendor Drug Program (VDP) list of drugs for your doctor to choose from. Some prescriptions might have a copay. Read more about copays in the **What are copays?** section of this handbook. Some prescriptions will need preapproval.

You can go to any pharmacy in our plan to have your prescriptions filled. To find out more, call Member Services at **800-600-4441 (TTY 711)**.

What are copays?

Copays are the amounts that a member has to pay for certain CHIP covered services. This is also known as cost sharing — the member shares the cost of some services. The amounts are based on family income and type of service.

These services don't have copays:
- Well-child or well-baby visits and immunizations (shots)
- Preventive care
- Pregnancy-related services
- Mental health or substance use disorder office visit
- Mental health or substance use disorder residential treatment service

Your child's Amerigroup ID card lists the copay amounts for your child. Show your child's member ID card when you visit a doctor or have a prescription filled. You don't have to show your child's member ID card to get emergency care. If the cost of a covered service is less than the copay

amount, you won't pay any more than the cost of the covered service.

How much are they and when do I have to pay them?
The following table shows the CHIP copay, or cost sharing, schedule according to family income and type of service. You must pay the copay amount at the time of service.

Please note: Enrollment fees and copays don't apply for CHIP Perinate Newborn members and CHIP members who are Native Americans or Alaskan Natives. If your child is a Native American or an Alaskan Native and the ID card shows copay requirements, call Member Services to get a new member ID card with the correct information.

Copay Amounts						
Federal Poverty Level	**Office visits (non-preventive)**	**Non-emergency ER visits**	**Facility stay, inpatient (per admission)**	**Prescription generic drugs**	**Prescription brand drugs**	**Annual cost-sharing/copay caps**
At or below 151%	$5*	$5	$35*	$0	$5	5% cap of family annual gross income
Above 151%, up to and including 186%	$20*	$75	$75*	$10	$25 for insulin, $35 for all other drugs**	5% cap of family annual gross income
Above 186%, up to and including 201%	$25*	$75	$125*	$10	$25 for insulin, $35 for all other drugs**	5% cap of family annual gross income

*** There is no copay amount due for a mental health or substance use disorder office visit or residential treatment service.**
**** Copays for insulin cannot exceed $25 per prescription for a 30-day supply.**

What are CHIP cost-sharing caps?

The member guide you received from CHIP when you enrolled includes a form that you should use to track your CHIP expenses. To make sure you don't exceed your cost-sharing limit, please keep track of your CHIP-related expenses on this form. The enrollment packet welcome letter tells you

exactly how much you must spend before you're eligible to mail the form back to CHIP. If you have misplaced your welcome letter, please call CHIP at **800-964-2777**, and they will tell you what your annual cost-sharing limit is.

When you reach your annual cap, send the form to CHIP and they will notify Amerigroup. We will send you a new member ID card. This new card will show that no copays are due when your child gets services for the rest of the year.

When will I get an explanation of benefits?

There may be times when you'll need to pay a provider for all or part of the cost for a service your child gets. You may also have to pay part of the cost for a prescription. This will happen if you owe a copay. You must also pay a provider for services your child gets that are not benefits included under CHIP.

We'll send you an Explanation of Benefits (EOB) only if the service isn't a CHIP benefit. The EOB will tell you how much you owe the provider. It will explain why you owe the provider a payment. We'll also let the provider know how much you owe. You'll need to make a payment directly to the provider.

You won't get an EOB if you only have to pay a copay. This is because a copay should be paid at the time that you see the provider or get the prescription.

What extra benefits does my child get as a member of Amerigroup? How can I get these benefits for my child?

Amerigroup gives your child extra benefits just for being our member. These extra benefits are designed to make a difference in your child's life. We give your child these benefits to help keep him or her healthy and to thank you for choosing Amerigroup as your child's health care plan. The chart below explains how you can get these extra benefits. Call Member Services to learn more about these extra benefits or visit our website at **myamerigroup.com/TX**.

Value-added benefit	How to get it
Healthy Rewards gift card for completing these healthy activities: • $120 for completing 6 well-child checkups per the American Academy of Pediatrics recommended schedule, for children ages 0–15 months (refer to the **Well-child Checkups for Children** section of this handbook) • $20 per visit for well-child checkups at ages 18, 24, or 30 months • $20 each year for completing well-child checkups, for ages 3–18 years	To receive a reward: • Join the Healthy Rewards program within 30 days after you complete an eligible healthy activity while you are an Amerigroup member. • Your provider will report most healthy activities by submitting a claim within 95 days of your visit. • If you have not received a reward, you must request it within 6 months after the date of your activity.

Value-added benefit	How to get it
• $20 for getting a full series of the rotavirus vaccinations (shots or other type of vaccine) (2–3 visits on different days depending on type of vaccine), for children ages 42 days through 24 months • $25 for a member who has a prenatal checkup in the first trimester of pregnancy or within 42 days of joining the health plan • $50 for a member who has a postpartum checkup within 7 to 84 days after giving birth • $20 for members newly diagnosed with attention deficit hyperactivity disorder (ADHD) who have a follow-up visit with their prescribing provider within 30 days after starting their medication treatment, for members ages 6 to 12 • $20 for having a follow-up outpatient visit with a behavioral health provider within 7 days of discharge from the hospital for a behavioral health stay, up to 4 times per year • $20 for getting a full series of the HPV (Human papillomavirus) vaccination (2 vaccines at least 146 days apart or 3 vaccines on different days), for members from their 9th through 13th birthday	To join the Healthy Rewards program or find information about the program and rewards: • Log in to your account at **myamerigroup.com/TX** to access the Benefit Reward Hub from the Benefits page or • Call the Healthy Rewards Customer Service Line at **888-990-8681 (TTY 711)** Monday through Friday from 8 a.m. to 7 p.m. Central time
Healthy Rewards gift card allowance for over-the-counter products for completing these healthy activities: • $20 for getting a full series of flu (influenza) vaccinations (2 vaccinations on different days), for children ages 6 months through 24 months • $20 each year for getting a flu vaccination, for members age 3 or older Excludes any products covered by CHIP benefits	To receive a reward: • Join the Healthy Rewards program within 30 days after you complete an eligible healthy activity while you are an Amerigroup member. • Your provider will report healthy activities by submitting a claim within 95 days of your visit. • If you have not received a reward, you must request it within 6 months after the date of your activity. To join the Healthy Rewards program or find information about the program and

Value-added benefit	How to get it
	rewards: • Log in to your account at **myamerigroup.com/TX** to access the Benefit Reward Hub from the Benefits page or • Call the Healthy Rewards Customer Service Line at **888-990-8681 (TTY 711)** Monday through Friday from 8 a.m. to 7 p.m. Central time
Online emotional health — secure web and mobile tools you can use 24/7 to help improve your emotional health	Access the Learn to Live Emotional Well-being Resources by visiting **learntolive.com/welcome/TXAmerigroup**. Type TXAmerigroup into the code field and hit "submit." Then, enter your member ID. For members ages 13 and older.
24-hour Nurse HelpLine — nurses are available 24 hours a day, 7 days a week for your health care questions	Call **800-600-4441 (TTY 711)**.
Help getting rides to: • Doctor visits for members with chronic illnesses • Pregnancy, birthing, or newborn classes for pregnant members • Women, Infants, and Children (WIC) offices • Member Advisory Group meetings	Call **800-600-4441 (TTY 711)**. For rides to WIC offices and Member Advisory Group meetings, every member can get one ride per month, with up to 12 rides each year.
Up to $100 for a Boys & Girls Club basic membership for members ages 6 to 18 where available ($50 per semester)	Go to your local Boys & Girls Club.
One sports or school physical every year for members ages 4 to 18	See your primary care provider. A nurse practitioner or physician assistant who is a primary care provider can give your child the sports or school physical.
First-aid kit and a personal disaster plan (1 kit per member per lifetime)	Log in to your account at **myamerigroup.com/TX** to access the

Value-added benefit	How to get it
	Benefit Reward Hub from the Benefits page or call **800-600-4441 (TTY 711)**.
Taking Care of Baby and Me® program — helps our pregnant members, new moms, and their babies get and stay healthy Pregnant members will get pregnancy, postpartum, and newborn educational materials to help them learn about pregnancy and postpartum care. This includes the importance of prenatal and ongoing doctor visits.	Log in to your account at **myamerigroup.com/TX** to access the Benefit Reward Hub from the Benefits page or call **800-600-4441 (TTY 711)**.
Free cellphone/smartphone through the Lifeline program with monthly minutes, data, and texts. If you qualify, you also get: • Unlimited calls to Member Services and member advocates for calls placed through Member Services. • 200 bonus minutes when you join. • 100 bonus minutes for your birthday.	Call **800-600-4441 (TTY 711)** or go to **myamerigroup.com/TX** for more information. Birthday bonus minutes start the month after you join. To see if you qualify for the federal Lifeline Assistance program, go to safelinkwireless.com and fill out the application.
Allergy-free pillow cover (1 per year) for members who have been diagnosed with asthma and participate in a disease or case management program	Log in to your account at **myamerigroup.com/TX** to access the Benefit Reward Hub from the Benefits page or call **800-600-4441 (TTY 711)**.
Help with weight management through a program with 24/7 online access to resources, tools, and activities on healthy snacking, portion management, weight goals, extra calories, and exercise tips	Access the CommonGround Library platform by logging into your secure account at **myamerigroup.com/TX**. For members ages 13 and older.
Pregnancy and early parenting program online 24/7 through web or mobile app to support expecting and new parents	Access the CommonGround Library platform by logging into your secure account at **myamerigroup.com/TX**. For members ages 13 and older.
Kick the Habit for Teens: An interactive, text-based	Text the keyword VAPEOUTTX to **88709** to

Value-added benefit	How to get it
program to help teens ages 13–17 quit vaping or using e-cigarettes. The program focuses on web counseling for up to 12 weeks.	enroll.
Social services resource directory online to help locate community supports such as food and nutrition, housing, education, and employment services	To find services near you, visit **myamerigroup.com/TX** and select **Community Support** under *Get Help*.

What health education classes does Amerigroup offer?

We work to help keep you healthy by holding educational events in your area and by helping you find community health education programs close to you. These events and community programs may include:

- Amerigroup services and how to get them.
- Childbirth.
- Infant care.
- Parenting.
- Pregnancy.
- Quitting cigarette smoking.
- Protecting yourself from violence.
- Other classes or events about health topic.

For events in your area, check the **Community Support** page at **myamerigroup.com/TX** under the *Get Help* tab. For help finding a community program, call Member Services or dial **2-1-1**. Please note: some community organizations may charge a fee for their programs.

What is Disease Management?

Disease Management

A Disease Management (DM) program can help you get more out of life. As part of your Amerigroup benefits, we're here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called DM case managers. They'll help you learn how to better manage your condition, or health issue. You can choose to join a DM program at no cost to you.

What programs do we offer?

You can join a Disease Management program to get health care and support services if you have one of these conditions:

- Asthma
- Bipolar Disorder
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major Depressive Disorder – Adult
- Major Depressive Disorder – Child and Adolescent
- Schizophrenia
- Substance Use Disorder

How it works
When you join one of our DM programs, a DM case manager will:

- Help you create health goals and make a plan to reach them.
- Coach you and support you through one-on-one phone calls.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition and/or treatment plan (ways to help health issues).
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your health care providers, like helping you with:
  - Making appointments.
  - Getting to health care provider visits.
  - Referring you to specialists in our health plan, if needed.
  - Getting any medical equipment you may need.
- Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco like quitting smoking).

Our DM team and your primary care provider are here to help you with your health care needs.

How to join
We'll send your child a letter welcoming them to a DM program, if your child qualifies. Or, call us toll-free at **888-830-4300 (TTY 711)** Monday through Friday from 8:30 a.m. to 5:30 p.m. local time.

When you call, we'll:

- Set your child up with a DM case manager to get started.
- Ask you some questions about your child's health.
- Start working together to create your child's plan.

You can also email us at dmself-referral@amerigroup.com.

Please be aware that emails sent over the internet are usually safe, but there is some risk third parties may access (or get) these emails without you knowing. By sending your information in an email, you acknowledge (or know, understand) third parties may access these emails without you knowing.

You can choose to opt out (we'll take your child out of the program) at any time. Please call us toll-free at **888-830-4300 (TTY 711)** from 8:30 a.m. to 5:30 p.m. local time Monday through Friday to opt out. You may also call this number to leave a private message for your DM case manager 24 hours a day.

Useful phone numbers
In an emergency, call **911**.

Disease Management
Toll-free: **888-830-4300 (TTY 711)**

Monday through Friday
8:30 a.m. to 5:30 p.m. local time
Leave a private message for your case manager 24 hours a day.

After-hours:
Call the 24-hour Nurse HelpLine
24 hours a day, 7 days a week
800-600-4441 (TTY 711)

Disease Management rights and responsibilities
When you join a Disease Management program, you have certain rights and responsibilities. You have the right to:

- Get details about us, such as:
  - Programs and services we offer.
  - Our staff and their qualifications (skills or education).
  - Any contractual relationships (deals we have with other companies).
- Opt out of DM services.
- Know which DM case manager is handling your DM services and how to ask for a change.
- Get support from us to make health care choices with your health care providers.
- Ask about all DM-related treatment options (choices of ways to get better) mentioned in clinical guidelines (even if a treatment is not part of your health plan benefits), and talk about options with treating health care providers.
- Have personal data and medical information kept private.
- Know who has access to your information and how we make sure your information stays secure, private, and confidential.
- Receive polite, respectful treatment from our staff.
- Get information that is clear and easy to understand.
- File complaints to Amerigroup by calling **888-830-4300 (TTY 711)** toll-free, from 8:30 a.m. to 5:30 p.m. local time Monday through Friday and:
  - Get help on how to use the complaint process.
  - Know how much time Amerigroup has to respond to and resolve issues of quality and complaints.
  - Give us feedback about the Disease Management program.

You also have a responsibility to:

- Follow the care plan that you and your DM case manager agree on.
- Give us information needed to carry out our services.
- Tell us and your health care providers if you choose to opt out (leave the program).

Disease Management does not market products or services from outside companies to our members. DM does not own or profit from outside companies on the goods and services we offer.

What is a Member with Special Health Care Needs (MSHCN)?

A Member with Special Health Care Needs (MSHCN) is someone who both:

- Has a serious ongoing illness, a chronic or complex condition, or a disability that will likely last for a long period of time.
- Requires regular, ongoing treatment and evaluation for the condition by appropriate health care personnel.

Examples are:

- Members diagnosed with respiratory illness (such as chronic obstructive pulmonary disease (COPD), chronic asthma, or cystic fibrosis), diabetes, heart disease, kidney disease, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS).
- Child members receiving ongoing therapy services which may include physical therapy, speech therapy, or occupational therapy (such as for longer than six months).
- Members receiving Personal Care Services, Private Duty Nursing, or Prescribed Pediatric Extended Care Center services.

MSHCN also include the following:

- Early Childhood Intervention (ECI) program participants.
- Pregnant women who have a high-risk pregnancy including:
    - Ages 35 and older, or 15 and younger
    - Diagnosed with preeclampsia, high blood pressure, or diabetes
    - Diagnosed with mental health or substance use disorders
    - With a previous preterm birth, as identified on the perinatal risk report
- People who have a mental Illness with substance use disorder.
- People with behavioral health issues, including substance use disorders or serious emotional disturbance (SED) or serious and persistent mental illness (SPMI), that affect their physical health and ability to follow treatment plans.
- Members with high-cost catastrophic cases or high service utilization such as high volume of emergency room or hospital visits.

We have a system for identifying and contacting MSHCN. You may also request an assessment to find out if your child meets the criteria for MSHCN.

What is service coordination for Members with Special Health Care Needs? How can I get service coordination for my child?

Service coordination for MSHCN is when you work with a service coordinator to help you get covered care and services to treat a health condition. A qualified service coordinator will work with you to develop a service plan and make sure all your child's care and services work together. Your service coordinator will work with you and your child's doctors to make sure you get the care and services your child needs. You may also have a specialist serve as your child's primary care provider.

What will a service coordinator do for my child?

They will help you get the services your child needs by:

- Identifying your child's health care needs through an assessment.

- Creating a service plan to meet those needs.
- Discussing the service plan with you, your family, and your representative (if needed) to make sure you understand and agree with it.
- Helping you get needed services.
- Working as a team with you and your child's doctors.
- Making sure all health care and other services you can get outside of Amerigroup are coordinated.

How can I talk with a service coordinator?

You don't need a referral from a doctor to talk to a service coordinator. Call Member Services at **800-600-4441 (TTY 711)** and ask to speak to one. Service coordinators are available Monday through Friday from 8 a.m. to 5 p.m. local time. If one isn't available, you can leave a confidential voice mail.

What is Case Management?

If your child doesn't qualify for MSHCN service coordination, we also have a case management program.

Through this program, we have case managers who can help you manage critical events and health issues that may last for a while. A case manager will help you manage your child's health care needs. To contact a case manager, call Member Services at **800-600-4441 (TTY 711)** and ask to speak to one. They're available Monday through Friday from 8 a.m. to 5 p.m. local time. If you need to leave a message, they have confidential voicemail available 24 hours a day. You can opt out (leave) the program at any time.

HEALTH CARE AND OTHER SERVICES FOR CHIP AND CHIP PERINATE NEWBORN MEMBERS

What does medically necessary mean?

Covered services for CHIP members and CHIP Perinate Newborn members must meet the CHIP definition of medically necessary. **Medically necessary** means:

Nonbehavioral health care services that are:

- 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.
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions.
- Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies.
- Consistent with the member's diagnoses.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

- Not experimental or investigative.
- Not primarily for the convenience of the member or provider.

Behavioral health care services that:

- 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.
- Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
- Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- Are the most appropriate level or supply of service that can safely be provided.
- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
- Are not experimental or investigative.
- Are not primarily for the convenience of the member or provider.

If you have questions regarding an authorization, a request for services, or a denial of services, you can call Member Services at **800-600-4441 (TTY 711)**.

How is new technology evaluated?

The Amerigroup Medical Director and our providers look at advances in medical technology and new ways to use existing medical technology. We look at advances in:

- Medical procedures.
- Behavioral health procedures.
- Medicines.
- Devices.

We review scientific information and government approvals to find out if the treatment works and is safe. We'll consider covering new technology only if the technology provides equal or better outcomes than the existing covered treatment or therapy.

What is routine medical care?

Routine care includes regular checkups, preventive care and treatment for minor injuries and illnesses. Your child sees a primary care provider when he or she is not feeling well, but that's only part of the primary care provider's job. The primary care provider takes care of your child before he or she gets sick. This is called well care.

How soon can I expect my child to be seen?

Your child should be able to be seen by his or her primary care provider within two weeks for routine care.

What is urgent medical care?

Another type of care is **urgent care**. There are some injuries and illnesses that are probably not

emergencies, but can turn into emergencies if they aren't treated within 24 hours. Some examples are:

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

What should I do if my child needs urgent medical care?

For urgent care, you should call the office of your child's primary care provider — even on nights and weekends. The primary care provider will tell you what to do. In some cases, you may be told to go to an urgent care clinic. If the primary care provider tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Amerigroup CHIP. For help, call us toll-free at **800-600-4441 (TTY 711)**. You also can call our 24-hour Nurse HelpLine at the same number for help with getting the care you need.

How soon can I expect my child to be seen?

Your child should be able to see his or her primary care provider within 24 hours for an urgent care appointment. If your child's primary care provider tells you to go to an urgent care clinic, you don't need to call the clinic before going. You must use an urgent care clinic that accepts Amerigroup CHIP.

What is emergency medical care?

After routine and urgent care, the third type of care is **emergency care**. If you need help deciding whether to go to the emergency room, call our 24-hour Nurse HelpLine. The most important thing is to get medical care as soon as possible.

What is an emergency, an emergency medical condition, or an emergency behavioral health condition?

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

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

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

- Requires immediate intervention or medical attention without which the member would present an immediate danger to himself/herself or others, or
- Renders the member incapable of controlling, knowing, or understanding the

consequences of his/her actions.

What is emergency services or emergency care?

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

You should call your child's primary care provider within 24 hours after an emergency room visit. If you can't call, have someone else call for you. Your child's primary care provider will give or arrange any needed follow-up care.

How soon can I expect my child to be seen?

Your child should be able to see a doctor immediately for emergency care.

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

During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call us toll-free at **800-600-4441 (TTY 711)**.

What is post-stabilization?

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

How soon can my child see a doctor?

We know how important it is for your child to see a doctor. We work with the providers in our plan to make sure our members are seen when needed. Our providers are required to follow the access standards listed below.

Care type	Amerigroup
Emergency services	As soon as you arrive at the provider for care
Urgent care	Within 24 hours of request
Routine primary care	Within 14 days of request
Routine specialty care	Within 3 weeks of request
Primary care follow-up visit after emergency room visit or hospital discharge	Within 14 days of visit or discharge
After-hours care	Primary care providers are available 24/7 directly or through an answering service. Refer to the **How does my child get medical care after hours?** section of this handbook.

Preventive Health	
Checkups for children age 6 months and older	Within 60 days of request
Checkups for children less than 6 months old	Within 14 days of request
Prenatal Care	
Initial visit	Within 14 days of request
Initial visit for high risk or 3rd trimester	Within 5 days of request or immediately, if an emergency exists
After initial visit	Based on the provider's treatment plan
Behavioral Health	
Non-life-threatening emergency	Within 6 hours of request
Urgent care	Within 24 hours of request
Initial visit for routine care	The earlier of 10 business days or 14 calendar days from request
Follow-up visit for routine care	Within 3 weeks of request
Follow-up visit after hospital stay	Within 7 days of discharge

You should call your child's primary care provider within 24 hours after you visit the emergency room. Your child's primary care provider will give or arrange any needed follow-up care.

How does my child get medical care after hours?

Except in the case of an emergency (see previous sections), you should always call your child's primary care provider first, before your child gets medical care. Help from your child's primary care provider is available 24 hours a day. If you call the primary care provider's office when it's closed, leave a message with your name and a phone number where you can be reached. Someone should call you back within 30 minutes to tell you what to do. You may also call our 24-hour Nurse HelpLine to talk to a nurse anytime.

If you think your child needs emergency care, call 911 or go to the nearest emergency room right away. Check the **What is emergency medical care?** section of this handbook to help you decide if your child needs emergency care.

What if my child gets sick when he or she is out of town or traveling?

If your child needs medical care when traveling, call us toll-free at **800-600-4441 (TTY 711)** and we'll help you find a doctor.

If your child needs emergency services while traveling, go to a nearby hospital. Then, call us toll-free at **800-600-4441 (TTY 711)**.

What if my child is out of the state?

If your child is outside of Texas and needs medical care, please call us toll-free at **800-600-4441 (TTY 711)**. If your child needs emergency care, go to the nearest hospital emergency room or call **911**.

What if my child is out of the country?

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

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

Your child's primary care provider can take care of most of his or her health care needs, but your child may sometimes need care from other kinds of doctors. These doctors are called specialists because they have training in a special area of medicine. Examples of specialists are:

- Allergists (allergy doctors)
- Dermatologists (skin doctors)
- Cardiologists (heart doctors)
- Podiatrists (foot doctors)
- Oncologists (cancer doctors)

We cover services from many different kinds of doctors that provide specialist care. If your child's primary care provider cannot give needed care, he or she can tell you about specialists in our plan.

What is a referral?

A referral is when your child's primary care provider sends him or her to another doctor or service for care. The primary care provider may refer your child to a specialist in our plan if he or she can't give your child needed care.

What services don't need a referral?

You don't need a referral from your child's primary care provider in order to get needed care from providers in our plan. It's always best to talk to your primary care provider first about any additional care your child needs. Your primary care provider can give you information about other doctors in our plan and help coordinate all the care your child receives.

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

Your child will be able to see a specialist within three weeks from when you call the specialist's office.

How can I ask for a second opinion?

You have the right to ask for a second opinion about the health care services your child needs. This does not cost you anything. You can get a second opinion from a provider in our plan. If a provider in our plan isn't available for a second opinion, your child's primary care provider can submit a request to us to authorize a visit to a provider who is not in our plan.

How do I get help if my child has mental health, alcohol, or drug problems?

Sometimes, the stress of life can lead to depression, anxiety, family problems, or alcohol and drug abuse. If your child is having these kinds of problems, we have doctors who can help. Call Member Services at **800-600-4441 (TTY 711)** for help finding a doctor who will help your child. All services and treatment are strictly confidential.

Do I need a referral for this?

You don't need a referral from your child's primary care provider to get help for mental health, alcohol, or drug problems.

How do I get my child's medications?

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

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

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

How do I find a network drugstore?

To find a drugstore or a pharmacy that takes our health plan:

- Go to our website at **myamerigroup.com/TX** and use our **Find a Doctor** search tool.
- Ask the pharmacist for help.
- Call Member Services.

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

The pharmacist will explain that they don't accept Amerigroup. You'll need to take the prescription to a pharmacy in our plan.

Call Member Services at **800-600-4441 (TTY 711)** for help finding a pharmacy in our plan or if you have an emergency. If you have to pay for your medication for any reason, you can send us a request for reimbursement. Learn more about how to send a request for reimbursement by reading, **What if I paid out-of-pocket for a medicine and want to be reimbursed?**

What do I bring with me to the drugstore?

When you go to the drugstore you should bring:

- Your child's written prescription(s) or medicine bottle(s).
- Your child's Amerigroup ID card.

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

Many pharmacies provide delivery services. Call and ask your pharmacist if they can deliver to your home. If you need help finding a pharmacy that will deliver your medications, call Member Services at **800-600-4441 (TTY 711)**.

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

If you have problems getting your Amerigroup-covered medications, please call us at **833-235-2022 (TTY 711)**. We can work with you and the pharmacy to make sure you get the medicine your child needs.

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

Some medicines require preapproval from Amerigroup. If your child's doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your child's medication.

Call Amerigroup at **833-235-2022 (TTY 711)** for help with your child's medications and refills. Ask the pharmacist to give you a three-day supply.

What if my child's medication is lost?

If your child's medicine is lost or stolen, have your pharmacist call Provider Services at **800-454-3730**.

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

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

How do I find out what drugs are covered?

Your doctor can choose drugs from the Vendor Drug Program (VDP) list of drugs. It includes all medicines covered by CHIP.

To view the list, go to the Texas Formulary Drug Search at txvendordrug.com/formulary.

Your child's medication may be available as a generic drug. A generic drug has the same Food and Drug Administration (FDA) indication as the corresponding brand-name drug and is approved by the FDA. This means both drugs are approved for treatment of the same conditions. Your pharmacy will usually give you the generic drug if it's on the Vendor Drug Program (VDP) formulary. If the prescription says your child needs the brand-name drug, we will cover the brand-name drug instead of giving you a generic.

How do I transfer my child's prescriptions to a network pharmacy?

If you need to transfer your child's prescriptions, all you need to do is:

- Call the nearest pharmacy in our plan and give the needed information to the pharmacist, or
- Bring your prescription bottle to the new pharmacy, and they will handle the rest.

How do I get my child's medicine if I am traveling?

If your child needs a refill while on vacation, call his or her doctor for a new prescription to take with you. If you get medication from a pharmacy that's not in the Amerigroup plan, then you'll have to pay for that medication. If you pay for medication, you may submit a request for reimbursement, if the medicine is covered by CHIP. Please read **How do I find out what drugs are covered?** to find out what drugs are covered by CHIP.

Read the next section to get information on how to get a reimbursement form and submit a claim.

What if I paid out-of-pocket for a medicine and want to be reimbursed?

If you had to pay for a medicine, you may submit a request for reimbursement, if the medicine is covered by CHIP. Please read **How do I find out what drugs are covered?** to find out what drugs are covered by CHIP.

Call us at **833-235-2022 (TTY 711)** to get information on how to get a reimbursement form and submit a claim. The reimbursement form is also available online at **myamerigroup.com/TX** — choose **Pharmacy** under the *Benefits* tab.

What if my child needs birth control pills?

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

How do I get eye care services for my child?

Your child gets vision benefits. You don't need a doctor's referral for these. Please call Superior Vision of Texas at **800-428-8789** for help finding an eye doctor (optometrist) in your area.

How do I get dental services for my child?

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

- Treatment of a dislocated jaw
- Treatment for 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

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

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

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

What is Early Childhood Intervention?

Early Childhood Intervention (ECI) is a statewide program for families with children, from birth to age three, with disabilities and developmental delays. ECI helps families support their children through developmental services. ECI evaluates and assesses, at no cost to families, to see if they are eligible and what services they'll need. Families and professionals work together to plan services based on the unique needs of the child and family.

The Health and Human Services Commission (HHSC) is the state agency responsible for ECI. A local ECI program will determine if a child can get ECI services, and it will develop a child's individual service plan. Amerigroup is responsible for paying for the services in the plan.

Does my child need a referral for this?

You don't need a referral from your child's primary care provider to get these services.

Where do I find an ECI provider?

To get information about ECI services and other resources, call the HHS Office of the Ombudsman at **877-787-8999**. You can also search online for an ECI program near you. Go to the ECI Program Search page at citysearch.hhsc.state.tx.us.

Participation in an ECI program is voluntary. If you choose not to use a local ECI program, Amerigroup must provide medically necessary services for your child. Call us at **800-600-4441 (TTY 711)** if you need help getting these services.

What is Head Start?

Head Start is a program to help your child, age 5 or younger, get ready for school. This program can help with:

- Language.
- Literacy.
- Social and emotional development.

To find a Head Start program near you, call toll-free at **866-763-6481** or go to benefits.gov/benefit/616.

What if my child can't use standard transportation to get to health care appointments?

Trouble getting to the doctor should never stand between your child and his or her health. If your child has a medical condition that causes you to need an ambulance to get to health care appointments, your doctor can send Amerigroup a request. Call Member Services at **800-600-4441 (TTY 711)** to learn more about how your doctor can send a request.

If you need an ambulance for an emergency, your doctor doesn't need to send a request.

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

Interpreter services are available for visits with your child's doctor at no cost to you.

Who do I call for an interpreter?

Call Member Services at **800-600-4441 (TTY 711)** and we'll arrange one for you.

How far in advance do I need to call?

Please let us know at least 24 hours before the appointment if you need an interpreter. If you ask

for an interpreter less than 24 hours before your appointment, we will still do our best to have an interpreter available for you.

How can I get a face-to-face interpreter in the provider's office?
Call Member Services if you need an interpreter when you talk to your child's provider in the office.

What if my daughter needs OB/GYN care? Does she have the right to choose an OB/GYN?

ATTENTION FEMALE MEMBERS:
You have the right to pick an OB/GYN for your daughter without a referral from your daughter's primary care provider. An OB/GYN can give you:

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

Amerigroup allows your daughter to pick any Amerigroup OB/GYN, whether that doctor is in the same network as your daughter's primary care provider or not.

How do I choose an OB/GYN?
You aren't required to pick an OB/GYN. However, if your child is pregnant, she should have an OB/GYN take care of her pregnancy and prenatal needs. You can pick any OB/GYN listed in the Amerigroup provider directory or by using the **Find a Doctor** tool on our website. If you need help choosing one, call Member Services at **800-600-4441 (TTY 711)**.

If I don't choose an OB/GYN, do I have direct access?
If you don't want your child to go to an OB/GYN, your child's primary care provider may be able to treat her for female health-related needs. Ask the primary care provider if he or she can give OB/GYN care. If not, your child will need to see an OB/GYN. You can search for one on our website at **myamerigroup.com/TX** on the **Find a Doctor** page or look at the CHIP Provider Directory for your service area on that same page.

Will I need a referral?
You don't need a referral to see an OB/GYN. Your child can see only one OB/GYN in a month, but your child can visit the same OB/GYN more than once during that month, if needed.

While your child is pregnant, her OB/GYN can be her primary care provider. The nurses on our 24-hour Nurse HelpLine can help you decide if she should see a primary care provider or an OB/GYN.

How soon can my daughter be seen after contacting an OB/GYN for an appointment?
An OB/GYN should see your child within two weeks of the request.

Can my daughter stay with an OB/GYN who is not with Amerigroup?
Your daughter may have been seeing a doctor who is not in our health plan for OB/GYN care. In some cases, she may be able to keep seeing this OB/GYN. Please call Member Services to learn more.

What if my daughter is pregnant?

If you think your daughter is pregnant, call her primary care provider or OB/GYN right away. You don't need a referral to see an OB/GYN in our plan.

Who do I need to call?

Call us at **800-600-4441 (TTY 711)** as soon as you know your daughter is pregnant. She needs to apply right away for Medicaid services. If she joins Medicaid while she is pregnant, the baby can have Medicaid for one year after birth. If your daughter does not join Medicaid while she is pregnant, she will have to apply for coverage for her newborn after the baby is born. This could cause a gap in coverage for her baby. If your daughter is a CHIP member when her baby is born, the baby will have CHIP benefits.

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

It's very important to see a doctor or OB/GYN for care during pregnancy. This kind of care is called prenatal care. It can help your child have a healthy baby.

Our Taking Care of Baby and Me® program gives pregnant women health information and rewards for getting prenatal and postpartum care. Your child gets a care manager to help her get the care and services she needs during pregnancy and through the postpartum checkup. The care manager may call to check on your child and answer questions. He or she can also help you find prenatal resources in your community. To find out more about the Taking Care of Baby and Me program, call Member Services.

Our program also helps pregnant members with complicated health care needs. Nurse care managers work closely with these members to provide:

- Education.
- Emotional support.
- Help in following their doctor's care plan.
- Information on services and resources in the community, such as transportation, Women, Infants, and Children (WIC) program, breastfeeding, and counseling.

Our nurses work with doctors to help keep mothers healthy and deliver healthy babies.

My Advocate™

As part of Taking Care of Baby and Me, your child is also part of My Advocate™ which delivers prenatal, postpartum, and well-child health education by phone, web, and smartphone app that is both helpful and fun. Your child will get to know Mary Beth, the My Advocate™ automated personality. Mary Beth will respond to your child's changing needs as her baby grows and develops. Your child can count on:

- Education they can use.
- Communication with your child's case manager based on My Advocate™ messaging should questions or issues arise.
- An easy communication schedule.
- No cost to your child.

With My Advocate™, your child's information is kept secure and private. Each time Mary Beth calls,

she'll ask you for your child's year of birth. Please don't hesitate to tell her. She needs the information to be sure she's talking to the right person.

Helping your child and her baby stay healthy
My Advocate gives you answers to your questions, plus medical support if your child needs it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn, and answer a question or two over the phone. If you tell Mary Beth you have a problem, you'll get a call back from a care manager. My Advocate topics include:

- Pregnancy and postpartum care.
- Well-child care.
- Postpartum depression.
- Immunizations.
- Healthy living tips.

To learn more about My Advocate, visit myadvocatehelps.com.

While your child is pregnant, it's especially important to take care of her health. She may be able to get healthy food from the Women, Infants, and Children (WIC) program. Member Services can give you the phone number for the WIC program close to you. Just call us.

When your child is pregnant, she must go to her doctor or OB/GYN at least:

- Every 4 weeks for the first 6 months.
- Every 2 weeks for the 7th and 8th months.
- Every week during the last month.

The doctor or OB/GYN may want her to visit more often based on health needs.

NICU Programs
For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program and a NICU Post Traumatic Stress Disorder (NICU PTSD) program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are given an educational resource outlining successful strategies they can use to work with the care team. The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and helping make referral to treatment for PTSD in parents. This program supports mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

How and when do I tell Amerigroup?
Remember to call Amerigroup Member Services as soon as you can to let your case manager know about the baby's birth. We'll need to get information about the baby. You may have already picked a primary care provider for the baby before birth. If not, we can help you pick one.

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

Members with disabilities, special health care needs, or chronic complex conditions have a right to direct access to a specialist. This specialist may serve as your child's primary care provider. Please

call Member Services at **800-600-4441 (TTY 711)** to arrange.

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

Always show your child's Amerigroup ID card when he or she sees a doctor, goes to the hospital, or has tests. Even if the doctor told you to go, you must show the Amerigroup ID card to make sure you don't get a bill for services covered by Amerigroup. **You don't have to show an Amerigroup ID card before your child gets emergency care.** If you do get a bill, send the bill to the Amerigroup location in the front of this book. Include a letter with your bill. Read the next section **What information do they need?** to find out what to include in the letter. You can also call us at **800-600-4441 (TTY 711)** for help.

What information do they need?

In the letter, tell us:

- Your child's name.
- Your telephone number.
- Your child's Amerigroup ID number.

If you can't send the bill, be sure to include in the letter:

- The name of the provider.
- The date of service.
- The provider's phone number.
- The amount charged.
- The account number, if known.

You can also call us at **800-600-4441 (TTY 711)** for help.

What do I have to do if my child moves?

As soon as you have your new address, give it to HHSC by calling **2-1-1** or updating your account on YourTexasBenefits.com and call Amerigroup Member Services at **800-600-4441 (TTY 711)**. Before you get CHIP services in your new area, you must call Amerigroup, unless you need emergency services. You will continue to get care through Amerigroup until HHSC changes your address.

Recertify your child's CHIP benefits on time

Don't lose your child's health care benefits! Every 12 months, you'll need to renew your child's benefits. If not, your child could lose those benefits even if he or she still qualifies. The Health and Human Services Commission (HHSC) will send you a packet about 60 days before your renewal date telling you it's time to renew your child's CHIP benefits. The packet will have instructions on how to renew. If you don't renew by the due date, you'll lose your child's health care benefits.

You can apply for and renew benefits online at YourTexasBenefits.com. Select **Manage your account or applications** and set up an account to get easy access to the status of your child's benefits.

If you have any questions, you can call **2-1-1**, pick a language and then select option 2, or visit the HHSC benefits office near you. To find the office nearest your home, call **2-1-1**, pick a language and then select option 2, or you can go to YourTexasBenefits.com and select **Find an Office** at the bottom of the page.

We want your child to keep getting health care benefits from us if he or she still qualifies. To renew, go to YourTexasBenefits.com and select **Manage your account or applications**. Follow the directions there to renew.

What are my rights and responsibilities?

Member rights

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a limited provider network. This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. Limited provider network means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same limited network.
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to 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 continue seeing 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 getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment depending on your income. Copayments do not apply to CHIP Perinatal members.
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 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.
20. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do, or is to punish you.

Member responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must 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 have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your member handbook to understand 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 providers 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 (HHS) toll-free at **800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at hhs.gov/ocr.

What are advance directives?

Emancipated minors and members ages 18 and over have rights under advance directive laws. An advance directive talks about making a living will. A living will says you may not want medical care if you have a serious illness or injury and may not get better. To make sure you get the kind of care you want if you're too sick to decide for yourself, you can sign a living will. This is a type of advance directive. It's a paper telling your doctor and your family what kinds of care you don't want if you're seriously ill or injured.

How do I get an advance directive?

You can get an advance directive form from your doctor or by calling Member Services. Amerigroup associates can't offer legal advice or serve as a witness. According to Texas law, you must either have two witnesses or have your form notarized. After you fill out the form, take it or mail it to your doctor. Your doctor will then know what kind of care you want to get.

You can change your mind any time after you've signed an advance directive. Call your doctor to remove the advance directive from your medical record. You can also make changes in the advance directive by filling out and signing a new one.

You can sign a paper called a durable power of attorney, too. This paper will let you name a person to make decisions for you when you can't make them yourself. Ask your doctor about these forms.

QUALITY MANAGEMENT

What does quality management do for you?

The Amerigroup Quality Management program is here to make sure your child is being cared for. We look at services your child has received to see if he or she is getting the best preventive health care. If your child has a chronic disease, we check that he or she is getting help to manage the condition.

The Quality Management department develops programs to help you learn more about your child's health care. We have member outreach teams to help you schedule appointments for the care your child needs and arrange transportation if you need it. These services are free because we want to help your child get and stay healthy.

We work with our plan providers to teach them and help them care for your child. You may get mailings from us about taking preventive health steps or managing an illness. We want you to help us improve by telling us what we can do better. To learn more about our Quality Management program, please call Member Services at **800-600-4441 (TTY 711)**.

What are clinical practice guidelines?

Amerigroup uses national clinical practice guidelines for your child's care. Clinical practice guidelines are nationally recognized, scientific, proven standards of care. These guidelines are recommendations for physicians and other health care providers to diagnose and manage your child's specific condition. If you would like a copy of these guidelines, contact Member Services at **800-600-4441 (TTY 711)**.

HOW WE MAKE DECISIONS ABOUT YOUR CARE

Sometimes, we need to make decisions about how we cover care and services. This is called Utilization Management (UM). All UM decisions are based on your child's medical needs and current benefits.

We don't encourage doctors to underuse services. And we don't create barriers to getting health care. Providers and others involved in UM decisions don't get rewarded for limiting or denying care. When we hire, promote, or fire providers or staff, it isn't based on their likelihood to deny benefits. Doctors in our plan use clinical practice guidelines, medical policies, and the benefits of your child's plan to determine necessary treatments and services.

When you or your child's doctor asks for certain care that needs a preapproval, our utilization review team decides if the service is medically necessary and one of your child's benefits. If you disagree with our decision, you or the doctor can ask for an appeal.

To speak with someone on our UM team, call Member Services at **800-600-4441 (TTY 711)** Monday through Friday from 7 a.m. to 6 p.m. Central time.

COMPLAINT PROCESS

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

We want to help. If you have a complaint, please call us toll-free at **800-600-4441 (TTY 711)** to tell us about your problem. An Amerigroup Member Services representative or a member advocate can help you file a complaint. Just call **800-600-4441 (TTY 711)**. Most of the time, we can help you right away or at the most within a few days. Amerigroup cannot take any action against you as a result of your filing a complaint.

Can someone from Amerigroup help me file a complaint?

Yes. A member advocate can help you file a complaint with us or the appropriate state program. Please call Member Services at **800-600-4441 (TTY 711)**.

How long will it take to process my complaint?

Amerigroup will answer your complaint within 30 days from the date we get it. If your complaint is about an ongoing emergency or hospital stay, we'll resolve your complaint as soon as we can based on the urgency of your case and no later than one business day from when we got your complaint.

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

You can tell us about your complaint by calling us or writing us. We'll send you a letter within five business days of getting your complaint to tell you we have your complaint and have started to look at it. If your complaint was made by phone, we'll include a complaint form with our letter. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

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

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

Consumer Protection, MC: CO-CP
Texas Department of Insurance
PO Box 12030
Austin, TX 78711-2030

If you can get on the Internet, you can submit your complaint at www.tdi.texas.gov.

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

Yes. If you're not happy with the answer to your complaint, you can ask us to look at it again. You must ask for a complaint appeal panel in writing. Write to us at:

Member Advocates
Amerigroup
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

When we get your request, we'll send you a letter within five business days. This means that we have your request and started to work on it. You can also call us at **800-600-4441 (TTY 711)** to ask for a complaint appeal panel request form. You must complete the form and return it to us.

We'll have a meeting with Amerigroup staff, providers in the health plan, and other Amerigroup members to look at your complaint. We'll try to find a day and time for the meeting so you can be there. You can bring someone to the meeting if you want to. You don't have to come to the meeting. We'll send you a letter at least five business days before the complaint appeal panel meeting. The letter will have the date, time, and place of the meeting. We'll send you all of the information the panel will look at during the meeting.

We'll send you a letter within 30 days of getting your written request. The letter will tell you the complaint appeal panel's final decision. This letter will also give you the information the panel used to make its decision.

PROCESS TO APPEAL A CHIP ADVERSE DETERMINATION (DENIAL)

What can I do if my child's doctor asks for a service or medicine for my child that's covered but Amerigroup denies or limits it?

There may be times when Amerigroup says we won't pay for all or part of the care your doctor recommends. You have the right to ask for an appeal. An appeal is when you or a person acting on your behalf asks us to look again at the care your child's doctor requested and we denied. You must file an appeal within 60 days from the date on our first denial letter (letter stating we won't pay for a service).

You can appeal our decision two ways:

- Call Member Services at **800-600-4441 (TTY 711)**
- Send us a letter and any information you want us to look at to:

  Amerigroup Appeals
  PO Box 62429
  Virginia Beach, VA 23466-2429

You can have someone else help you with the appeal process. This person can be a family member, friend, your doctor, attorney, or any other person you choose.

How will I find out if services are denied?

If we deny services, we'll send you a letter at the time the denial is made.

What are the time frames for the appeal process?

You, or a person acting on your behalf, must file an appeal within 60 days of the date on the first letter from Amerigroup saying we won't pay for all or part of the recommended care.

When we get your letter or call asking for an appeal, we'll send you a letter within five business days. This letter will let you know we got your appeal. We'll also let you know if we need anything else to process your appeal. Amerigroup will contact your child's doctor if we need medical information about the service.

A licensed physician who has not seen your case before will look at your appeal and make a decision. We'll send you a letter with the appeal decision within 30 calendar days of receiving your appeal request.

What is a specialty review?

A specialty review is a review where a provider who specializes in the type of care your child's provider asked for will look at your child's case. Your child's provider can ask for this either:

- As part of your appeal after our first letter saying we won't pay for all or part of the requested care. Your child's provider must ask for this within 10 business days from the date we receive your appeal request.
- If your appeal is denied and a specialty review was not requested with the appeal. Your child's provider can ask for a specialty review within 10 business days of the date of the appeal denial letter.

When we get the specialty review request, we'll send you a letter within five business days. This letter will let you know we got the specialty review request. We'll send you a decision letter within 15 business days of when we got the request. This letter is our final decision. If you don't agree with our decision, you may ask for an independent external review.

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

You must request an appeal within 60 days from the date on our first letter saying we won't pay for all or part of the service. If you, the person acting on your behalf, or the provider are not happy with the answer to your appeal, the provider can send us a letter to ask for a specialty review if it was not requested as part of your appeal. This letter must be sent within 10 business days from the date on

our letter with the answer to your appeal.

If you file an appeal, Amerigroup will not hold it against you. We'll still be here to help you get quality health care.

Does my request have to be in writing?

No. You can request an appeal by calling Member Services at **800-600-4441 (TTY 711)**.

Can someone from Amerigroup help me file an appeal?

Yes. Call Member Services at **800-600-4441 (TTY 711)** if you need help filing an appeal.

EXPEDITED APPEALS

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 child's health, and taking the time for a standard appeal could jeopardize your child's life or health.

You can request an expedited appeal if you or your child's doctor thinks your child needs the services for an emergency, life-threatening illness, prevention of serious harm to your child, or your child is in the hospital.

How do I ask for an expedited appeal? Does my request have to be in writing?

You can request an expedited appeal orally or in writing:

- You can call Member Services at **800-600-4441 (TTY 711)**
- You can send us a letter at:
  Amerigroup Appeals
  PO Box 62429
  Virginia Beach, VA 23466-2429

You can have someone else help you with the appeal process. This person can be a family member, friend, your doctor, an attorney, or any other person you choose.

What are the time frames for an expedited appeal?

After we get your letter or call and agree your appeal request should be expedited, we'll tell you our decision by the shorter of one business day from when we get all information needed to make a decision or within 72 hours from our receipt of the appeal request. We'll let you know by phone or electronically and written notice will also be sent within 72 hours from our receipt of the appeal request.

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

If we don't agree that your request for an appeal should be expedited, we'll call you right away. We'll send you a letter within two calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

Who can help me file an expedited appeal?
A member advocate or Member Services representative can help you file an expedited appeal. Please call Member Services at **800-600-4441 (TTY 711)**.

INDEPENDENT REVIEW ORGANIZATION PROCESS

What is an independent review organization?
An Independent Review Organization (IRO) is an organization separate from Amerigroup who can look at your appeal. If we deny requested care after an appeal or a specialty review and the decision involved medical judgment, you, the person helping you, or your child's provider can ask for an external review by an IRO.

Can I ask for an external review by an IRO before I exhaust the Amerigroup internal appeal process?

You can ask for an expedited external review:

- If you ask for an expedited appeal after our initial denial and waiting up to 72 hours would seriously jeopardize your child's life, health, or ability to regain maximum function, you can request an expedited external review at the same time.
- When waiting up to 45 calendar days for a standard external review would seriously jeopardize your child's life, health, or ability to regain maximum function.
- If the appeal decision is about an admission, availability of care, continued stay, or health care service for which emergency services were received but the member has not been discharged from the facility.

How do I ask for a review by an independent review organization?
You, a person acting on your behalf, an attorney, or your provider can ask for an external review within four months of getting the appeal decision. There is no cost to you for an external review. MAXIMUS Federal Services, Inc. is the independent review organization that will conduct the external review. You can use forms from MAXIMUS to ask for an external review or send a written request, including any additional information for review.

You can get the MAXIMUS forms by doing one of the following:

- Call Member Services at **800-600-4441 (TTY 711)**.
- Call MAXIMUS at **888-866-6205**.
- Visit externalappeal.cms.gov.

Fill out one or both of the MAXIMUS forms based on who will ask for an external review. Complete:

- The HHS-Administered Federal External Review Request Form to request an external review yourself.
- Both the HHS-Administered Federal External Review Request Form and the Appointment of Representative Form if you want your child's provider or another person to ask for the external review for you.

- Both you and your authorized representative need to complete this form.
- If you are asking for an expedited review, the provider can make the request without this form.

Or, send a written request with:

- Name
- Address
- Phone
- Email address
- Whether the request is urgent
- Signature of member, parent or legal guardian, or authorized representative
- A short description of the reason you disagree with our decision

Send your forms or written request to us at:

Amerigroup Appeals
PO Box 62429
Virginia Beach, VA 23466-2429

You can also send your request directly to MAXIMUS by one of the ways below:

Online:
Externalappeal.cms.gov under the "Request a Review Online" heading

Mail:
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534

Fax: 888-866-6190

If you send additional information to MAXIMUS for the review, it will be shared with Amerigroup so we can reconsider the denial. If you have questions during the external review process, contact MAXIMUS at **888-866-6205** or go to externalappeal.cms.gov.

How to request an expedited external review

- Online: You can select "expedited" when submitting the review request
- Email: FERP@maximus.com
- Call: Federal External Review Process at **888-866-6205**

What are the timeframes for this process?

MAXIMUS will send you a letter with its decision within 45 days after their examiner received your request. For an expedited external review, a decision will be made as quickly as necessary for your child's medical condition, but no longer than 72 hours after the examiner received the request for expedited review. Notice of the decision for an expedited review can be given to you verbally, but

will be followed by a written notice within 48 hours.

FRAUD AND ABUSE INFORMATION

Do you want to report CHIP waste, abuse, or fraud?

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

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

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

- Call the OIG Hotline at **800-436-6184**
- Visit oig.hhs.texas.gov and click the red "Report Fraud" box to complete the online form
- You can report directly to your health plan:
  Compliance Officer
  Amerigroup
  2505 N. Highway 360, Suite 300
  Grand Prairie, TX 75050
  800-839-6275

Other reporting options include:

- Special Investigations Fraud Hotline: **866-847-8247** (reporting can be anonymous)
- Amerigroup Member Services: **800-600-4441**

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 receives 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

MEMBER GUIDE TO MANAGED CARE TERMS

Term	Definition
Appeal	A request for your managed care organization to review a denial or a grievance again.
Complaint	A grievance that you communicate to your health insurer or plan.
Copayment	A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Durable Medical Equipment (DME)	Equipment 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 persons in the last stages of a terminal illness and their families.
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
Hospital Outpatient Care	Care in a hospital that usually doesn't require an overnight stay.
Medically Necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.
Network	The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.
Non-participating Provider	A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.

Term	Definition
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 prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.
Premium	The amount that must be paid for your health insurance or plan.
Prescription Drug Coverage	Health insurance or plan that helps pay for prescription drugs and medications.
Prescription Drugs	Drugs and medications that by law require a prescription.
Primary Care Physician	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.
Primary Care Provider	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.
Provider	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional, or health care facility licensed, certified, or accredited as required by state law.
Rehabilitation Services and Devices	Health care services such as physical or occupational therapy that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.
Skilled Nursing Care	Services from licensed nurses in your own home or in a nursing home.
Specialist	A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
Urgent Care	Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

ATTACHMENT A - EVIDENCE OF COVERAGE AND SCHEDULE OF BENEFITS AND EXCLUSIONS

CHILDREN'S HEALTH INSURANCE PROGRAM HEALTH BENEFIT PLAN
EVIDENCE OF COVERAGE
HEALTH MAINTENANCE ORGANIZATION
NON-FEDERALLY QUALIFIED PLAN

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHOSE CHILD HAS ENROLLED IN **AMERIGROUP** HEALTH BENEFIT PLAN THROUGH THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP). YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM, PAYING THE APPLICABLE PREMIUM AND ACCEPTING THIS EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR CHILD RECEIVING COVERED HEALTH SERVICES AND BENEFITS FROM **AMERIGROUP** THROUGH THE CHIP PROGRAM.

Issued by

Amerigroup Texas, Inc.
800-600-4441

In association with:

Children's Health Insurance Program
P.O. Box 149276
Austin, TX 78714-9983
800-647-6558

HAVE A COMPLAINT OR NEED HELP?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Amerigroup Texas, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Member Services at **800-600-4441 (TTY 711)**
Toll-free: **800-600-4441 (TTY 711)**
Online: **myamerigroup.com/TX**
Email: dl-txmemberadvocates@anthem.com
Mail: Member Advocates
Amerigroup
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: **800-252-3439**
File a complaint: **www.tdi.texas.gov**
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP
Texas Department of Insurance
PO Box 12030
Austin, TX 78711-2030

¿TIENE UNA QUEJA O NECESITA AYUDA?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Amerigroup Texas, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Servicios para Miembros al **800-600-4441 (TTY 711)**
Teléfono gratuito: **800-600-4441 (TTY 711)**
En línea: **myamerigroup.com/TX**
Correo electrónico: dl-txmemberadvocates@anthem.com
Dirección postal: Member Advocates
Amerigroup
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: **800-252-3439**
Presente una queja en: **www.tdi.texas.gov**
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP
Texas Department of Insurance
PO Box 12030
Austin, TX 78711-2030

TABLE OF CONTENTS

I. INTRODUCTION

A. YOUR CHILD'S Coverage under Amerigroup
B. YOUR Contract with CHIP

II. DEFINITIONS

III. **WHEN DOES AN ENROLLED CHILD BECOME COVERED?**

IV. PAYING FOR YOUR CHILD'S COVERAGE

V. TERMINATION OF CHILD'S COVERAGE

A. Disenrollment due to loss of CHIP eligibility
B. Disenrollment by Amerigroup

VI. **PREGNANT MEMBERS AND INFANTS**

VII. YOUR CHILD'S HEALTH COVERAGE

A. Selecting YOUR CHILD'S Primary Care Physician or Primary Care Provider
B. Changing YOUR CHILD'S Primary Care Physician or Primary Care Provider
C. Children with Chronic, Disabling, or Life-Threatening Conditions
D. Emergency Services
E. Out-of-Network Services
F. Continuity of Treatment
G. Notice of Claims
H. Coordination of Benefits
I. Subrogation

VIII. **HOW DO I MAKE A COMPLAINT?**

A. Complaint Process
B. Appeals to Amerigroup
C. Internal Appeal of Adverse Determination
D. External Review by Independent Review Organization
E. Filing Complaints with the Texas Department of Insurance (TDI)
F. Retaliation Prohibited

IX. **GENERAL PROVISIONS**

A. Entire Agreement, Amendments
B. Release and Confidentiality of Medical Records
C. Clerical Error
D. Notice
E. Validity
F. Conformity with State Law

X. **ENROLLMENT PERIOD COPAYMENT MAXIMUM**

XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES

I. INTRODUCTION

A. YOUR CHILD'S Coverage under Amerigroup

Amerigroup provides benefits to YOUR CHILD for Covered Health Services under CHIP and determines whether particular health services are Covered Health Services, as described in **Section XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES** below. If properly enrolled, YOUR CHILD is eligible for the benefits described in **Section XI**. All services must be provided by participating physicians and providers except for emergency services and for out-of-network services that are authorized by Amerigroup. YOU have a Contract with Amerigroup regarding matters stated in this Section I.A, as more fully described in this Contract.

B. YOUR Contract with CHIP

CHIP has determined that YOUR CHILD is eligible to receive coverage and under what circumstances the coverage will end. CHIP also has determined YOUR CHILD'S eligibility for other benefits under the CHIP program.

II. DEFINITIONS

Administrator: The contractor with the state that administers enrollment functions for CHIP Amerigroup members.

Adverse Determination: A decision that is made by US or OUR Utilization Review Agent that the health-care services furnished or proposed to be furnished to a CHILD are not medically necessary or not appropriate.

CHILD: Any child who CHIP has determined to be eligible for coverage and who is enrolled under this plan.

CHIP: The Children's Health Insurance Program which provides coverage to each CHILD in accordance with an agreement between Amerigroup and the Health and Human Services Commission of the state of Texas.

Copayment: The amount that you are required to pay when your CHILD uses certain covered health services within the health benefit plan. Once the copayment is made, you are not required to make further payment for these covered health services.

Covered Health Services or Covered Services or Coverage: Those medically necessary services that are listed in Section XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES, of this health benefit plan. Covered Services also include any additional services offered by Amerigroup as Value-Added Services (VAS) in Section XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES, of this health benefit plan.

Disability: A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Emergency Behavioral Health Condition: Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

1. Requires immediate intervention and/or medical attention without which a CHILD would present an immediate danger to himself, herself, or others
2. That renders a CHILD incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Condition: Means an emergency medical condition or an emergency behavioral health condition.

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

1. Placing the patient's health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or body part
4. Serious disfigurement
5. In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child

Emergency Services and **Emergency Care:** Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition, including post stabilization care services.

Experimental and/or Investigational: A service or supply is experimental and/or investigational if WE determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to Phase I. II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. WE will determine if this item 2 is true based on:
    a. Published reports in authoritative medical literature and
    b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA

3. In the case of a drug, a device or other supply that is subject to FDA approval:
   a. It does not have FDA approval or
   b. It has FDA approval only under its Treatment Investigational New Drug Regulation or a similar regulation
   c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered experimental or investigational if they are determined to be:
      i) Included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Information, and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services or
      ii) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer- reviewed medical publications
4. The physician or provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.
5. Research protocols indicate that the service or supply is experimental or investigational. This item 5 applies for protocols used by the CHILD'S physician or provider, as well as for protocols used by other physicians or providers studying substantially the same service or supply.

Health Benefit Plan or Plan: The coverage provided to CHILD issued by Amerigroup providing covered health services.

Amerigroup: Amerigroup otherwise referred to as US, WE, or OUR.

Home Health Services: Health services provided at a CHILD'S home by health-care personnel, as prescribed by the responsible physician or other authority designated by Amerigroup.

Hospital: A licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

Illness: A physical or mental sickness or disease.

Independent Review Organization: An entity that is certified by the Commissioner of Insurance under Chapter 4202 to conduct independent review of adverse determinations.

Injury or Accidental Injury: Accidental trauma or damage sustained by CHILD to a body part or system that is not the result of a disease, bodily infirmity, or any other cause.

Life-threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medically Necessary Services: Health services that are:

Physical:

- Reasonable and necessary to prevent Illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a disability, cause Illness or infirmity of a CHILD, or endanger life
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of CHILD'S medical conditions
- Consistent with health-care practice guidelines and standards that are issued by professionally recognized health-care organizations or governmental agencies
- Consistent with diagnoses of the conditions
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Are not experimental or investigative
- Are not primarily for the convenience of the CHILD or health-care provider

Behavioral:

- Reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder to improve, maintain, or prevent deterioration of function resulting from the disorder
- Provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
- Are not experimental or investigative and
- Are not primarily for the convenience of the CHILD or health-care provider

Medically necessary services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided, must be provided at the most appropriate level or supply of service which can safely be provided, and which could not be omitted without adversely affecting the CHILD'S physical and/or mental health or the quality of care provided.

Member: Any covered CHILD, up to age 19, who is eligible for benefits under Title XXI of the Social Security Act and who is enrolled in the Texas CHIP program.

Out-of-Area: Any location outside the Amerigroup CHIP Service Area.

Pediatrician: A physician who is board-eligible/board-certified in pediatrics by the American Board of Pediatrics.

Physician: Anyone licensed to practice medicine in the state of Texas.

Primary Care Physician or Primary Care Provider: A physician or provider who has agreed with Amerigroup to provide a medical home to a CHILD and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care and initiating referral for care.

Provider: Any institution, organization, or person other than a physician that is licensed to or otherwise authorized to provide a health-care service in this state. The term includes but is not limited to a hospital, doctor of chiropractic, pharmacist, registered nurse, optometrist, registered optician, pharmacy, skilled nursing facility, or home health agency.

Serious Mental Illness: The following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. Schizophrenia
2. Paranoia and other psychotic disorders
3. Bipolar disorders (hypomanic, manic, depressive, and mixed)
4. Major depressive disorders (single episode or recurrent)
5. Schizoaffective disorders (bipolar or depressive)
6. Pervasive developmental disorders
7. Obsessive-compulsive disorders
8. Depression in childhood and adolescence

Service Area: CHIP provider service area as defined by the Texas Health and Human Services Commission.

Specialist Physician: A participating physician, other than a primary care physician, under contract with Amerigroup to provide covered health services upon referral by the primary care physician or primary care provider.

Urgent Behavioral Health Care: A behavioral health condition that requires attention and assessment within 24 hours but that does not place the CHILD in immediate danger to himself or herself or others, and the CHILD is able to cooperate with treatment.

Urgent Care: A health condition including an urgent behavioral health care that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the CHILD's primary care provider or primary care provider designee to prevent serious deterioration of the CHILD's condition or health.

Usual and Customary Charge: The usual charge made by a group, entity, or person who renders or furnishes covered services, treatments, or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments, or supplies.

Utilization Review: The system for retrospective, concurrent, or prospective review of the

medical necessity and appropriateness of covered health services provided, being provided, or proposed to be provided to a CHILD. The term does not include elective requests for clarification of coverage.

Utilization Review Agent: An entity that is certified by the Commissioner of Insurance to conduct utilization review.

YOU and YOUR: The family or guardian of the CHILD.

III. WHEN DOES AN ENROLLED CHILD BECOME COVERED?

Children enrolling in CHIP for the first time or returning to CHIP after disenrollment will be enrolled the first day of the next month following completion of the enrollment process. Children covered by private insurance within 90 days of application may be subject to a waiting period which extends for a period of 90 days after the last date on which the applicant was covered under a health benefits plan.

IV. PAYING FOR YOUR CHILD'S COVERAGE

If you are required to pay an enrollment fee for your CHILD'S CHIP coverage, the fee is due with YOUR enrollment form.

V. TERMINATION OF CHILD'S COVERAGE

A. Disenrollment due to loss of CHIP eligibility

Disenrollment may occur if YOUR CHILD loses CHIP eligibility. YOUR CHILD may lose CHIP eligibility for the following reasons:

1. "Aging-out" when CHILD turns nineteen
2. Failure to re-enroll by the end of the 12-month coverage period
3. Change in health insurance status (e.g., a CHILD enrolls in an employer-sponsored health plan
4. Death of a CHILD
5. CHILD permanently moves out of the state
6. CHILD is enrolled in Medicaid or Medicare
7. Failure to drop current insurance if CHILD was determined to be CHIP-eligible because health insurance cost under the current Amerigroup totaled 10 percent or more of the family's net income
8. CHILD'S parent or authorized representative requests (in writing) the voluntary disenrollment of a CHILD.
9. Failure to respond to a request of income verification during month six of the enrollment period (only required for certain families) or if the income information provided indicates that the family's income exceeds CHIP income limits

B. Disenrollment by Amerigroup

YOUR CHILD may be disenrolled by US, subject to approval by the Health and Human Services Commission, for the following reasons:

1. Fraud or intentional material misrepresentation made by YOU after 15 days written notice
2. Fraud in the use of services or facilities after 15 days written notice
3. Misconduct that is detrimental to safe plan operations and the delivery of services
4. CHILD no longer lives or resides in the service area
5. CHILD is disruptive, unruly, threatening, or uncooperative to the extent that CHILD's membership seriously impairs Amerigroup or the provider's ability to provide services to the CHILD or to obtain new members, and the CHILD's behavior is not caused by a physical or behavioral health condition
6. CHILD steadfastly refuses to comply with Amerigroup restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Amerigroup to treat the underlying medical condition)

We will not disenroll a CHILD based on a change in the CHILD'S health status, diminished mental capacity, or because of the amount of medically necessary services that are used to treat the CHILD'S condition. WE will also not disenroll a CHILD because of uncooperative or disruptive behavior resulting from his or her special needs, unless this behavior seriously impairs OUR ability to furnish services to the CHILD or other enrollees.

VI. PREGNANT MEMBERS AND INFANTS

When WE receive notice from YOU, YOUR CHILD or YOUR CHILD'S physician or provider that a pregnancy has been diagnosed, WE will notify the HHSC Administrative Service Organization.

Depending on YOUR income and family size, the HHSC Administrative Service Organization may notify YOU and YOUR CHILD about her potential eligibility for Medicaid and of her ability to apply for Medicaid. In that situation, the Administrator will also provide appropriate resource information. A member who is potentially eligible for Medicaid must apply for Medicaid. A member who is determined to be Medicaid-eligible will no longer be eligible for CHIP.

If YOUR CHILD is not eligible for Medicaid, the Administrator will extend YOUR CHILD'S eligibility period, if her eligibility would otherwise expire, to ensure that she continues coverage during her pregnancy and through the end of the second full month following the month of the baby's birth.

Newborns born to CHIP members are automatically enrolled in the mother's CHIP plan. Infants that are Medicaid-eligible are not eligible for CHIP.

VII. YOUR CHILD'S HEALTH COVERAGE

A. Selecting YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU shall, at time of enrollment in Amerigroup, select YOUR CHILD'S primary care physician or primary care provider. A female member may select an Obstetrician/Gynecologist (OB/GYN) to provide covered health services within the scope of the professional specialty practice of the OB/GYN. The selection shall be made from those physicians and providers listed in the Amerigroup-published list of physicians and providers. YOU have the option to choose as a primary care provider a family practice physician with experience in treating children, a pediatrician, or other age-appropriate and qualified health-care provider.

YOU shall look to the selected primary care provider to direct and coordinate CHILD'S care and recommend procedures and/or treatment.

B. Changing YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU may request a change in YOUR CHILD'S primary care physician or primary care provider and a change in YOUR CHILD'S OB/GYN. YOUR request must be made to Amerigroup at least thirty (30) days prior to the requested effective date of the change.

C. Children with Chronic, Disabling or Life-threatening Illnesses

A CHILD who has a chronic, disabling or life-threatening Illness may be eligible to receive services above and beyond those normally provided. If YOUR CHILD is identified as having special health-care needs, YOUR CHILD will be eligible for case management services for Children with Special Health Care Needs (CSHCN) through the Texas Department of State Health Services.

A CHILD who has a chronic, disabling, or life-threatening Illness may apply to the Amerigroup medical director to use a nonprimary specialist physician as a primary care physician. The specialist physician must agree to the arrangement and agree to coordinate all of the CHILD'S health-care needs.

D. Emergency Services

When YOUR CHILD is taken to a hospital emergency department, free-standing emergency medical facility, or comparable emergency facility, the treating physician/provider will perform a medical screening examination to determine whether a medical emergency exists and will provide the treatment and stabilization of an emergency condition.

If additional care is required after the patient is stabilized, the treating physician/provider must contact Amerigroup. Amerigroup must respond within 1 hour of receiving the call to approve or deny coverage of the additional care requested by the treating physician/provider.

If Amerigroup agrees to the care as proposed by the treating physician/provider or if Amerigroup fails to approve or deny the proposed care within 1 hour of receiving the call, the treating physician/provider may proceed with the proposed care.

YOU should notify Amerigroup within 24 hours of any out-of-network emergency services or as soon as reasonably possible.

E. Out-of-Network Services

If covered health services are not available to YOUR CHILD through network physicians or providers, Amerigroup, upon the request of a network physician or provider, shall allow referral to an out-of-network physician or provider and shall fully reimburse the out-of-network physician or provider at the usual and customary charge or at an agreed upon rate. Amerigroup further must provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before Amerigroup may deny a referral.

F. Continuity of Treatment

The contract between Amerigroup and a physician or provider must provide that reasonable advance notice be given to YOU of the impending termination from the plan of a physician or provider who is currently treating YOUR CHILD. The contract must also provide that the termination of the physician or provider contract, except for reasons of medical competence or professional behavior, does not release Amerigroup from its obligation to reimburse the physician or provider who is treating YOUR CHILD of special circumstance, such as a CHILD who has a disability, acute condition, life-threatening Illness, or is past the 24th week of pregnancy, for YOUR CHILD'S care in exchange for continuity of ongoing treatment for YOUR CHILD then receiving medically necessary treatment in accordance with the dictates of medical prudence. Special circumstance means a condition such that the treating physician or provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to YOUR CHILD. Special circumstance shall be identified by the treating physician or provider who must request that YOUR CHILD be permitted to continue treatment under the physician or provider's care and agree not to seek payment from YOU for any amount for which YOU would not be responsible if the physician or provider were still on the Amerigroup network. Amerigroup shall reimburse the terminated physician or provider for YOUR CHILD'S ongoing treatment for 90 days from the effective date of the termination, or for 9 months if YOUR CHILD has been diagnosed with a terminal Illness. For a CHILD who at the time of termination is past the 24th week of pregnancy, Amerigroup shall reimburse the terminated physician or provider for treatment extending through delivery, immediate postpartum care, and follow-up checkup within six weeks of delivery.

G. Notice of Claims

YOU should not have to pay any amount for covered health services except for copayments or

deductibles. If YOU receive a bill from a physician or provider that is more than your authorized copayment or deductible amounts, contact Amerigroup.

H. Coordination of Benefits

Your CHILD'S coverage under CHIP is secondary when coordinating benefits with any other insurance coverage. This means that the coverage provided under CHIP will pay benefits for covered services that remain unpaid after any other insurance coverage has paid.

I. Subrogation

Amerigroup receives all rights of recovery acquired by YOU or YOUR CHILD against any person or organization for negligence or any willful act resulting in illness or injury covered by Amerigroup, but only to the extent of such benefits. Upon receiving such benefits from Amerigroup, YOU and YOUR CHILD are considered to have assigned such rights of recovery to Amerigroup, and YOU agree to give Amerigroup any reasonable help required to secure the recovery.

VIII. HOW DO I MAKE A COMPLAINT?

A. Complaint Process

Complaint means any dissatisfaction expressed by YOU orally or in writing to US with any aspect of OUR operation, including but not limited to, dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions.

If YOU notify US orally or in writing of a complaint, WE will, not later than the 5th business day after the date of the receipt of the complaint, send to YOU a letter acknowledging the date WE received YOUR complaint. If the complaint was received orally, WE will enclose a one-page complaint form clearly stating that the complaint form must be returned to US for prompt resolution.

After receipt of the written complaint or one-page complaint form from YOU, WE will investigate and send YOU a letter with OUR resolution. The total time for acknowledging, investigating, and resolving your complaint will not exceed 30 calendar days after the date WE receive YOUR complaint.

YOUR complaint concerning an emergency or denial of continued stay for hospitalization will be resolved in 1 business day of receipt of YOUR complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

YOU may use the appeals process to resolve a dispute regarding the resolution of YOUR

Complaint.

B. Appeals to Amerigroup

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

2. WE shall send an acknowledgment letter to YOU not later the 5th day after the date of receipt of the request of the appeal.

3. WE shall appoint members to the complaint appeal panel, which shall advise US on the resolution of the dispute. The complaint appeal panel shall be composed of an equal number of OUR staff, physicians or other providers, and enrollees. A member of the appeal panel may not have been previously involved in the disputed decision.

4. Not later than the 5th business day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:
   a. Any documentation to be presented to the panel by OUR staff
   b. The specialization of any physicians or providers consulted during the investigation
   c. The name and affiliation of each of OUR representatives on the panel

5. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:
   a. Appear in person before the complaint appeal panel
   b. Present alternative expert testimony
   c. Request the presence of and question any person responsible for making the prior determination that resulted in the appeal

6. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed 1 business day after YOUR request for appeal.

   Due to the ongoing emergency or continued hospital stay, and at YOUR request, WE shall provide, in lieu of a complaint appeal panel, a review by a physician or provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

7. Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

C. Internal Appeal of Adverse Determination

An adverse determination is a decision that is made by US or OUR utilization review agent that the health-care services furnished or proposed to be furnished to a CHILD are not medically necessary or appropriate.

If YOU, YOUR designated representative, or YOUR CHILD'S physician or provider of record disagree with the adverse determination, YOU, YOUR designated representative, or YOUR CHILD'S physician or provider may appeal the adverse determination orally or in writing.

Within 5 business days after receiving a written appeal of the adverse determination, WE or OUR utilization review agent will send YOU, YOUR designated representative, or YOUR CHILD'S physician or provider a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that YOU, YOUR designated representative, or YOUR CHILD'S physician or provider should send to US or to OUR utilization review agent for the appeal.

If YOU, YOUR designated representative or YOUR CHILD'S physician or provider orally appeal the adverse determination, WE or OUR utilization review agent will send YOU, YOUR designated representative, or YOUR CHILD'S physician or provider a one-page appeal form. YOU are not required to return the completed form, but WE encourage YOU to because it will help US resolve YOUR appeal.

Appeals of adverse determinations involving ongoing emergencies or denials of continued stays in a hospital will be resolved no later than 1 business day from the date all information necessary to complete the appeal is received. All other appeals will be resolved no later than 30 calendar days after the date WE or OUR utilization review agent receives the appeal.

D. External Review by Independent Review Organization

If the appeal of the adverse determination is denied, YOU, YOUR designated representative, or YOUR CHILD'S physician or provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When WE or OUR utilization review agent deny the appeal, YOU, YOUR designated representative, or YOUR CHILD'S physician or provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a life-threatening condition, YOUR CHILD is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of adverse determinations. In life-threatening situations, YOU, YOUR designated representative, or YOUR CHILD'S physician or provider of record may contact US or OUR utilization review agent by

telephone to request the review by the IRO, and WE or OUR utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, WE will abide by the IRO's decision. WE will pay for the IRO review.

The appeal procedures described above do not prohibit YOU from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if YOU believe that the requirement of completing the appeal and review process places YOUR CHILD'S health in serious jeopardy.

E. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through OUR complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030. Complaints to the Texas Department of Insurance may also be filed electronically at www.tdi.texas.gov.

The Commissioner of Insurance shall investigate a complaint against US to determine compliance within 60 days after the Texas Department of Insurance's receipt of the complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1. Additional information is needed
2. An onsite review is necessary
3. WE, the physician or provider, or YOU do not provide all documentation necessary to complete the investigation or
4. Other circumstances beyond the control of the Department occur

F. Retaliation Prohibited

1. WE will not take any retaliatory action, including refusal to renew coverage, against a CHILD because the CHILD or person acting on behalf of the CHILD has filed a complaint against US or appealed a decision made by US.
2. WE shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a physician or provider, because the physician or provider has, on behalf of a CHILD, reasonably filed a complaint against US or has appealed a decision made by US.

IX. GENERAL PROVISIONS

A. Entire Agreement, Amendment

This Contract and any attachments or amendments are the entire agreement between YOU and Amerigroup. To be valid, any changes to this Contract must be approved by an officer of Amerigroup and attached to this Contract.

B. Release and Confidentiality of Medical Records

Amerigroup agrees to maintain and preserve the confidentiality of any and all medical records of YOUR CHILD or YOUR family. However, by enrolling in Amerigroup, YOU authorize the release of information, as permitted by law, and access to any and all medical records of YOUR CHILD for purposes reasonably related to the provision of services under this Contract, to Amerigroup, its agents and employees, YOUR CHILD'S primary care physician or primary care provider, participating providers, outside providers of Utilization Review Committee, CHIP, and appropriate governmental agencies. The Amerigroup privacy protections are described in more detail in its Notice of Privacy Practices. The Notice of Privacy Practices is available at **myamerigroup.com/TX**, or you may request a copy by calling **800-600-4441**.

C. Clerical Error

Clerical error or delays in keeping records for YOUR and YOUR CHILD'S Contract with CHIP:

1. Will not deny coverage that otherwise would have been granted and

2. Will not continue coverage that otherwise would have terminated

If any important facts given to CHIP about YOUR CHILD are not accurate and they affect coverage:

1. The true facts will be used by CHIP to decide whether coverage is in force and

2. Any necessary adjustments and/or recoupments will be made

D. Notice

Benefits under Workers' Compensation are not affected.

E. Validity

The unenforceability or invalidity of any provision of this Evidence of Coverage shall not affect the enforceability or validity of the rest of this Contract.

F. Conformity with State Law

Any provision of this Contract that is not in conformity with the Texas HMO Act, state or federal

laws or regulations governing CHIP, or other applicable laws or regulations shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas HMO Act, state and federal laws or regulations governing CHIP, and other applicable laws or regulations.

X. ENROLLMENT PERIOD FAMILY COPAYMENT MAXIMUM

Under this plan, there is a limit per family on the copayments that YOU must pay for covered health services each enrollment period. It is YOUR responsibility to keep up with how much YOU have paid for covered health services and to provide proof to CHIP. CHIP will notify YOU of the amount of YOUR copayment maximum and will provide YOU with a simplified form that YOU can use to keep up with the amount of copayments that YOU have paid.

YOU must notify CHIP when the maximum copayment under the plan has been paid. When YOU notify CHIP about reaching the copayment maximum, CHIP will issue a new member ID card for each CHILD in YOUR family. The new member ID card will notify participating physicians and providers to waive copayments for the remainder of the enrollment period for the CHILD.

XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES

These health services, when medically necessary, must be furnished in the most appropriate and least restrictive setting in which services can be safely provided, and must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the member's physical health or quality of life.

Emergency care is a covered CHIP service and must be provided in accordance with **Section VII. D. Emergency Services**. Please refer to **Section II, Definitions**, for the definition of "Emergency and Emergency Condition" and the definition of "Emergency Services and Emergency Care" to determine if an emergency condition exists.

There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Copayments apply until a family reaches its specific enrollment period copayment maximum. Copayments do not apply to preventive services or pregnancy-related assistance.

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: • Hospital-provided physician or	• Requires authorization for non- emergency care and care following stabilization of an emergency condition • May require authorization for in- network or out-of-network	Inpatient copayment applies per admission.

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient 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	facility and physician 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 Caesarean section	

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
delivery and 96 hours following an uncomplicated delivery by Caesarean section • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Inpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero); inpatient services associated with miscarriage or nonviable pregnancy include, but are not limited to: – Dilation and curettage (D&C) procedures – Appropriate provider-administered medications – Ultrasound – Histological examination of tissue samples • Presurgical or postsurgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: – Cleft lip and/or palate – Severe traumatic, skeletal, and/or congenital craniofacial deviations – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions		

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
and/or tumor growth or its treatment • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: – All stages of reconstruction on the affected breast – External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – Surgery and reconstruction on the other breast to produce symmetrical appearance – Treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit		
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 physician prescription • 60 days per 12-month period limit	None

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
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 that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia associated with dental care, when provided in a licensed ambulatory surgical facility • Outpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or	• May require prior authorization and physician prescription	None for preventive services

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
a fetus that expired in utero). Outpatient services associated with miscarriage or nonviable pregnancy include, but are not limited to: – Dilation and curettage (D&C) procedures – Appropriate provider-administered medications – Ultrasounds – Histological examination of tissue samples • Presurgical or postsurgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: – Cleft lip and/or palate – Severe traumatic, skeletal, and/or congenital craniofacial deviations or – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment • 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: – All stages of reconstruction		

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
on the affected breast – External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – Surgery and reconstruction on the other breast to produce symmetrical appearance – Treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit		
Birthing center services provided by a licensed birthing center	– Limited to facility services (e.g., labor and delivery – Does not apply to CHIP Perinate Newborn members	
Services rendered by a certified nurse midwife or physician in a licensed birthing center – CHIP members: Coverage includes prenatal services and birthing services rendered in a licensed birthing center. – CHIP Perinate Newborn members: Coverage includes services rendered to a newborn immediately following delivery.		
Physician/Physician Extender Professional Services Services include, but are not limited	May require authorization for specialty services	Copayment applies for office visit.

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
to, the following: • American Academy of Pediatrics- recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, inpatient and outpatient services • Laboratory, X-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biological, and materials administered in physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: – Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care – Administration of anesthesia by physician (other than surgeon) or CRNA – Second surgical opinions – Same-day surgery performed in a hospital without an overnight stay • Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician-performed technical and interpretive		Copays do not apply to preventive visits or to prenatal visits after the first visit.

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
components) • Physician and professional services for a mastectomy and breast reconstruction include: – All stages of reconstruction on the affected breast – External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed – Surgery and reconstruction on the other breast to produce symmetrical appearance – Treatment of physical complications from the mastectomy and treatment of lymphedemas In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by Caesarean section. Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. Physician services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or nonviable pregnancy include, but		

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
are not limited to: • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications • Ultrasounds • Histological examination of tissue samples Presurgical or postsurgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: • Cleft lip and/or palate or • Severe traumatic, skeletal, and/or congenital craniofacial deviations • Severe facial asymmetry secondary to skeletal defects, congenital syndrome conditions, and/or tumor growth or its treatment		
Prenatal Care and Pre-pregnancy Family Services and Supplies Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system; and limitations and exclusions to these services are described under inpatient, outpatient, and physician services. Primary and preventive health benefits do not include pre-pregnancy family		

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
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 that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including 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 • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit	• May require prior authorization and physician prescription • $20,000 per 12-month period limit for DME, prosthetics, devices, and disposable medical supplies (implantable devices, diabetic supplies, and equipment are not counted against this cap)	None

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
• Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.		
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 (RN, L.V.N.) • Skilled nursing visits as defined for home health purposes (may include RN 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 physician prescription Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	None

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a freestanding 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 nonemergency services. Does not require primary care provider referral. When inpatient psychiatric services are ordered by a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, Chapter 574, Subchapters A through G, Texas Family Code Chapter 55, Subchapter D, or as a condition of probation, 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. These requirements are not applicable when the member is considered incarcerated.	Inpatient copayment applies No copayment for residential treatment services
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	May require prior authorization. Does not require primary care provider referral. When outpatient psychiatric services are ordered by a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapter 573, Subchapters B and C, Chapter 574, Subchapters A through G, Texas Family Code Chapter 55, Subchapter D, or as a condition of probation, the court order serves as binding determination of medical	None

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
• Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development)	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. A Qualified Mental Health Provider – 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 physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	
Inpatient 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	Requires prior authorization for nonemergency services Does not require primary care provider referral. When inpatient and residential substance use disorder treatment services are required by a court order consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code, or as a condition of probation, the court order serves as	Inpatient copayment applies No copayment for residential treatment services

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
	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.	
Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment services include, but are not limited to: • Prevention and intervention services that are provided by physician and non- physician providers, such as screening, assessment and referral for chemical dependency disorders • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized nonresidential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training	Requires prior authorization. Does not require primary care provider referral. When outpatient substance use disorder treatment services are required by a court order consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code, or 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.	None
Rehabilitation Services Services include, but are not limited to: • Habilitation (the process of	• May require prior authorization and physician prescription	None

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
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		
Hospice Care Services Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services	Requires authorization and physician prescription Services apply to the hospice diagnosis. Up to a maximum of 120 days with a 6-month life expectancy. • Patients electing hospice services may cancel this election at anytime	None
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services 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	Requires authorization for poststabilization services	Copayment applies for nonemergency ER

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
room and ancillary services and physician 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 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin		
Transplants Covered services include: • 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	None
Vision Benefit Covered services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period without authorization • One pair of nonprosthetic eyewear per 12-month period	• The health plan may reasonably limit the cost of the frames/lenses May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	Copayment applies for office visit

Covered Benefits for CHIP Members and CHIP Perinate Newborn Members	Limitations	Copayments* (see Copayment schedule)
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation.	May require authorization for 12 visits per 12-month period limit (regardless of number of services or modalities provided in one visit) • Requires authorization for additional visits	Copayment applies for office visit
Tobacco Cessation Program Covered up to $100 for a 12-month period limit for a plan-approved program	Requires authorization Health Plan defines plan-approved program. • May be subject to formulary requirements	None
Case management services and Care Coordination These covered services include outreach informing, case management, care coordination, and community referral.		None
Drug Benefits Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biological • Drugs and biologicals provided in an inpatient setting	May require authorization	Copayment applies for generic drugs Copayment applies for brand drugs
Value-added Services	See **Extra Benefits**	None

* Copayments do not apply to preventive services or pregnancy-related assistance.

EXCLUSIONS

- 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 (i.e. cannot be prescribed for family planning)
- Personal comfort items, including, but not limited to, personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical, or other health-care procedures or services that are not generally employed or recognized within the medical community; this exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization")
- Treatment or evaluations required 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 Chapter 573, Subchapters B and C, Chapter 574, Subchapter D, or Chapter 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, an artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise preauthorized by the 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 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 Caesarean section
- Services, supplies, meal replacements, or supplements provided 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
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care (routine foot care does not include treatment of injury or complications of diabetes)
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to 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 assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a 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 be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered, except when ordered by a physician/primary care provider
- Donor nonmedical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)

DME/SUPPLIES

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided 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 provided 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 physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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 device, and glucose strips.
Diapers/ Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide 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, and tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/ Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/ Peripheral IV Therapy	X		Eligible for 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		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral	X		Necessary supplies (e.g., bags, tubing, connectors,

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Nutrition Supplies			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 due to disease.
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a nonfunction or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan). Physician 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 clients 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 twelve months of age unless medical necessity is documented and other criteria, listed above, are met. 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 provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide 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		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual 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		Eligible for individuals 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		Eligible for 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, face plate, 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.
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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			treatments b) As part of covered home care for wound care 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 office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the primary care provider and approved by the plan.
Urinary, Indwelling Catheter, and 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 catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy Supplies			See Ostomy Supplies.