Amerigroup

CHIP Member Handbook
For CHIP Perinate Members

Amerigroup Texas, Inc.

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

May 2023

800-600-4441 (TTY 711)
myamerigroup.com/TX

CHIP | TEXAS Health and Human Services

1016795TXMENAGP 01/23

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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. Central time.

Stay connected with your health. Download the free Sydney Health 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 perinatal provider
- Update your address or phone number
- Send us a secure message
- Request a call-back
- And more

Want to change your perinatal provider? Choose from a large group of providers who work with our plan. To change your 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 Perinate 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 care provider, call Member Services at **800-600-4441 (TTY 711)**.

AMERIGROUP MEMBER HANDBOOK
For CHIP Perinate Unborn Members
2505 N. Highway 360
Suite 300
Grand Prairie, TX 77050
800-600-4441 (TTY 711)
myamerigroup.com/TX

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WELCOME TO AMERIGROUP

Information about your new health plan

Welcome to Amerigroup Texas, Inc. We're committed to getting you the right care close to home. You'll get your prenatal, delivery, and postpartum care through Amerigroup. As a Children's Health Insurance Program (CHIP) Perinatal member, you and your perinatal providers will work together to help you have a healthy baby. To find out about doctors and hospitals in your area, visit **myamerigroup.com/TX** or contact 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 get this information for free in other formats, such as large print, braille, or audio.

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 perinatal 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.

IMPORTANT PHONE NUMBERS

Amerigroup toll-free Member Services line

If you have any questions about your Amerigroup health plan, you can 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 perinatal doctors
- Doctor appointments
- Health care benefits
- Getting services
- What to do in an emergency and/or crisis
- Healthy living
- Complaints and medical appeals
- Rights and responsibilities

Amerigroup 24-hour Nurse HelpLine

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 you need care for an illness
- What kind of health care you need
- What to do to take care of yourself before you see your provider
- How you can get the care that is needed

Other important phone numbers

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

- If you have questions about 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).**

YOUR AMERIGROUP MEMBER ID CARD

What does my Amerigroup ID card look like?

If you don't have your 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 do not need to show your ID card before you get emergency care**. Here's what your Amerigroup ID card looks like:

How do I read and use my Amerigroup ID card?

The card tells providers and hospitals you're an Amerigroup member. It also says that Amerigroup will pay for the medically needed benefits listed in the **Benefits for CHIP Perinate Unborn Members** section of this handbook. **You do not need to show your ID card before you get emergency care**. Your Amerigroup ID card lists important phone numbers you need to know.

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

If your ID card is lost or stolen, call Amerigroup right away. We will 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 ID card information.

PROVIDERS FOR CHIP PERINATE MEMBERS

What is a perinatal provider?

A perinatal provider is the main doctor who provides most of your health care while you're pregnant. Your perinatal provider must be in the Amerigroup health plan. The perinatal provider will also send you to other doctors, specialists, or hospitals when special care or services are needed for the health of your unborn child.

When you enrolled in Amerigroup, you should have picked a perinatal provider. If you didn't, we assigned one for you. We picked one who should be located close to you.

What do I need to bring to a perinatal provider appointment?

You should bring:

- Your Amerigroup ID card
- Any medicines you're taking
- Your health care records
- Any questions you want to ask the doctor

Can a clinic be a perinatal provider?

Yes, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) listed in the Amerigroup CHIP Perinate provider directory can be perinatal providers.

How can I change my perinatal provider?

Call Member Services if you need to change your perinatal provider. You can go to **myamerigroup.com/TX** to find a new one.

How many times can I change my perinatal provider?

There is no limit to the number of times you can change your perinatal provider. You can change perinatal 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.

How do I get medical care after my perinatal provider's office is closed? How do I get after-hours care?

If you need urgent care after your perinatal provider's office is closed, call your perinatal provider, even on nights and weekends. If you call the perinatal 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 24-hour Nurse HelpLine 24 hours a day, 7 days a week for advice.

If you have 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 24-hour Nurse HelpLine.

CHANGING HEALTH PLANS

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

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

What if I want to change health plans?

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

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 ask to change health plans:

- For any reason within 90 days of enrollment in CHIP Perinatal
- If you move to a different service delivery area
- For cause at any time

Who do I call about changing health plans?

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

When will my health plan change become effective?

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

- If you call on or before April 15, your 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 I get dropped from their health plan for noncompliance?

There are several reasons you could be disenrolled or dropped from Amerigroup. These reasons are listed below. If you did something that may lead to disenrollment, we'll contact you. We'll ask you to tell us what happened.

You could be disenrolled from Amerigroup if:

- You're no longer eligible for CHIP
- You let someone else use your Amerigroup ID card
- You try to hurt a provider, a staff person, or Amerigroup associate
- You steal or destroy property of a provider or Amerigroup
- You go to the emergency room over and over again when you do not have an emergency
- You go to doctors or medical facilities outside the Amerigroup plan over and over again
- You try to hurt other patients or make it hard for other patients to get the care they need

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

MEDICAID COVERAGE FOR NEWBORNS

The benefits a newborn will get depend on the family's income.

If the child lives in a family with an income at or below the Medicaid eligibility threshold, an unborn child who is enrolled in the CHIP Perinatal program will be moved to Medicaid and get 12 months of Medicaid benefits, starting on the date of birth.

If the CHIP Perinate member (unborn child) is in a family with an income above the Medicaid eligibility threshold, then he or she will continue to get health care benefits through the CHIP Perinatal program after birth. If your baby is eligible as a CHIP Perinate Newborn, he or she will get the same coverage as a CHIP member starting the day of birth except that copays will not apply until the newborn coverage period expires. Other children covered by CHIP in the same family will still have copays.

BENEFITS FOR CHIP PERINATE UNBORN MEMBERS

What are my unborn child's CHIP Perinatal benefits?

CHIP Perinatal benefits include:

- A perinatal provider you choose in your own community
- Doctors and hospitals nearby in our plan
- Access to perinatal specialists when referred by your perinatal provider
- Up to 20 prenatal visits
- Prescriptions and prenatal vitamins
- Labor and delivery
- Two postpartum visits for the mother after the baby is born
- Regular checkups, immunizations, and prescriptions for the baby after the baby is born

Labor and delivery includes hospital and other costs related to the delivery of the baby. Costs from labor that does not result in a birth and false labor are not covered.

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?

Your perinatal provider will help you get your health care benefits.

What benefits does my baby receive at birth?

It depends on your income.

If your income is at or below the Medicaid eligibility threshold, then your baby will get 12 months of Medicaid health care benefits starting on the day of birth.

If your income is above the Medicaid eligibility threshold, your baby is eligible as a CHIP Perinate Newborn for the same benefits as a CHIP member from the date of birth. Your baby will get a total of 12 months of health care benefits, beginning with the month of enrollment as an unborn child. For example, if your baby is enrolled when you are three months pregnant, your baby will have six months of prenatal care and six months of full CHIP benefits after birth.

What services are not covered?

Some of the services not covered include:

- A mother's hospital visit for services not related to labor with delivery, such as a broken arm or false labor (you can apply for Emergency Medicaid to cover your hospital visit, but you must meet the income limits)
- Specialty treatment for the mother, such as care for asthma, heart conditions, mental health, or substance use disorder

For a complete listing of benefits that are not covered, please see the **Evidence of Coverage and Schedule of Benefits and Exclusions** in **Attachment A** at the back of this handbook.

What are my unborn child's prescription drug benefits?

Under CHIP, Amerigroup pays for most medicine your doctor says you need for your unborn child. We use the Vendor Drug Program (VDP) list of drugs for your doctor to choose from. Your prenatal vitamins are also included. Medication for behavioral health is not included. 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)** or visit our website at **myamerigroup.com/TX.**

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

There is no cost to those who can get CHIP Perinatal benefits from Amerigroup. You don't have to pay any enrollment fees, copays, or cost sharing.

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

Yes. Amerigroup only pays for benefits in your health care plan. If you get services that are not covered, you'll be responsible for payment.

For a complete listing of benefits that are not covered, please see the **Evidence of Coverage and Schedule of Benefits and Exclusions** in **Attachment A** at the back of this handbook.

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

Amerigroup gives you extra health care benefits just for being our CHIP Perinate member. These extra benefits are also called value-added benefits. We give you these benefits to help keep you healthy and to thank you for choosing Amerigroup as your health care plan. 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
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)**
Free cellphone/smartphone through the Lifeline program with monthly minutes, data, and texts. If you qualify, you also receive: • 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.
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 topics

For events in your area, check the Community Resources page at **myamerigroup.com/TX**. 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.

Pregnancy education, including a *Pregnancy and Beyond Resource Guide*, is available on the member website at **myamerigroup.com/TX** under *Get Help***,** and then select **Pregnancy Health**. We are committed to keeping both mom and baby healthy. Materials on this webpage provide a wide range of information such as:

- Prenatal, postpartum, and well-baby care
- Individual case management
- Emotional well-being
- Family planning
- Community resources for food, housing, and other needs
- Health care benefits after pregnancy
- Helpful online tools and apps

Service coordination for Members with Special Health Care Needs

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

A Member with Special Health Care Needs (MSHCN) is a member who has a high-risk pregnancy.

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

What is service coordination for Members with Special Health Care Needs? What will a service coordinator do for me?

Service coordination for MSHCN is when you work with a service coordinator to help you get covered care and services to manage your high-risk pregnancy. A qualified service coordinator will:

- Work with you to create a service plan to ensure you're getting needed care and services
- Make sure you, your family, and your representative (if you have one) understand and agree with your service plan
- Arrange and coordinate needed care and services with your doctors and other providers, even those outside our plan

How can I talk with a service coordinator?

Call Member Services at **800-600-4441 (TTY 711)** and ask to speak to a service coordinator. They're available Monday through Friday from 8 a.m. to 5 p.m. Central time. If you need to leave a message with a service coordinator, they have confidential voice mail available 24 hours a day.

HEALTH CARE AND OTHER SERVICES FOR CHIP PERINATE UNBORN MEMBERS

What does medically necessary mean?

Covered services for CHIP Perinate members must meet the CHIP definition of medically necessary. A CHIP Perinate member is an unborn child.

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 will 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 prenatal checkups and prenatal care. These visits will cover most minor illnesses and injuries that directly relate to your pregnancy. This type of care is known as **routine care**.

How soon can I expect to be seen?

You should be able to see your perinatal provider within two weeks for routine care.

What is urgent medical care?

The second type of care is **urgent care**. There are some injuries and illnesses related to your pregnancy that are not emergencies but can turn into an emergency if they are not treated within 24 hours. Some examples are:

- Throwing up
- Headaches
- Fever over 101 degrees

What should I do if I need urgent medical care?

For urgent care, you should call your perinatal provider — even on nights and weekends. Your doctor will tell you what to do. He or she may tell you to go to his or her office right away, or you may be told to go to some other office to get immediate care. You should follow your perinatal provider's instructions. In some cases, he or she may tell you to go to the emergency room at a hospital for care. See the next question about emergency care to learn more. You also can call 24-hour Nurse HelpLine for help with getting the care you need.

How soon can I expect to be seen?

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

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 24-hour Nurse HelpLine. The most important thing is to get medical care as soon as possible.

What is an emergency and an emergency medical condition?

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

- Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child;
- Stabilization services related to the labor with delivery of the covered unborn child;
- Emergency ground, air and water transportation for labor and threatened labor is a covered benefit;

- Emergency ground, air, and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.

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

What is emergency services or emergency care?

Emergency services or emergency care are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an emergency medical condition, including post-stabilization care services related to labor and delivery of the unborn child.

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

How soon can I expect to be seen?

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

How soon can I see my doctor?

Amerigroup is always finding ways to get you the care you need. Our ability to provide quality access depends on your ability to see plan providers. 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.

Standard Name	Amerigroup
Emergency Services	As soon as you arrive at the provider for care
Urgent Care	Within 24 hours of request
Routine Specialty Care	Within 3 weeks of request
After-Hours Care	Perinatal providers are available 24/7 directly or through an answering service. Refer to the **How do I get medical care after my perinatal provider's office is closed? How do I get after-hours care?** section of this handbook.
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
Follow-up visit	Based on the provider's treatment plan

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

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

If you need emergency care while traveling, go to a nearby hospital, then call us toll-free at **800-600-4441 (TTY 711)**.

What if I am out of the state?

If you're outside Texas and need medical care, please call us toll-free at **800-600-4441 (TTY 711)**. If you need emergency care, go to the nearest hospital emergency room or call **911**.

What if I am out of the country?

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

What is a referral?

A referral is when your perinatal provider sends you to another doctor or service for care for your unborn child that he or she cannot provide. This may be to a specialist or other provider in the Amerigroup plan.

What services don't need a referral?

The following services do not require a referral:

- Emergency care
- Obstetrical/Gynecological care

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

You'll have to pay for any service you get that is not covered by Amerigroup or CHIP Perinatal.

You can apply for emergency Medicaid to cover a hospital visit not related to your pregnancy, but you must meet the income limits.

What is preapproval?

Some treatment, care, or services may need our approval before your doctor can provide them. This is called preapproval. Your 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
- Certain prescriptions
- Out-of-area or out-of-network care except in an emergency
- Advanced imaging (things like MRAs, MRIs, CT scans, and CTA scans)

Preapproval is not needed for emergency services directly related to the delivery of the unborn child (CHIP Perinate member) until birth.

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

How do I get my medications?

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

There are no copayments required for CHIP Perinate 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 do not accept Amerigroup. You will need to take your prescription to a pharmacy that accepts Amerigroup.

Call Member Services at **800-600-4441 (TTY 711)** for help finding a pharmacy that accepts Amerigroup 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 prescription(s) or medicine bottle(s)
- Your Amerigroup ID card

What if I need my 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 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 you need.

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

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

Call Amerigroup at **833-235-2022 (TTY 711)** for help with your medications and refills.

What if I lose my medications?

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

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

The pharmacy cannot give you an over-the-counter medication as part of your CHIP benefit. If you need 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 this list, go to the Texas Vendor Drug Formulary page at **txvendordrug.com/formulary.**

Your 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 your prescription says you need the brand-name drug, we will cover the brand name drug instead of giving you a generic.

How do I transfer my prescriptions to a network pharmacy?

If you need to transfer your 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 medicine if I am traveling?

If you need a refill while on vacation, call your 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. Call us at **833-235-2022 (TTY 711)** 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.

Can someone interpret for me when I talk with my perinatal provider?

Yes. You can get an interpreter for visits with your perinatal provider at no cost to you.

Who do I call for an interpreter?

Call Member Services at **800-600-4441 (TTY 711)** for more information.

How far in advance do I need to call?

Please call Member Services at least 24 hours before your 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 doctor in the office.

How do I choose a perinatal provider and make an appointment?

You can choose a perinatal provider by:

- Calling Member Services for help including three-ways calls with you and the provider's office to make an appointment
- Visiting the *Find a Doctor* page on our website at **myamerigroup.com/TX**

It's easy to make an appointment with your perinatal provider. Call the provider's office during regular business hours. When you call, let the person you talk to know what you need (for example, a checkup or a follow-up visit). Also, tell the provider's office if you are not feeling well. This will let the provider's office know how soon you need to be seen. It may also shorten the wait before you see the provider.

If you need help making an appointment or choosing a perinatal provider, call Member Services.

Will I need a referral?

You don't need a referral to see a perinatal provider that's in our plan.

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

You will be able to see the provider for an initial visit within two weeks after you talk to the perinatal provider's office and set up an appointment. If your pregnancy is high-risk or your initial visit is in your third trimester, you will be able to see the provider within five days of your request or immediately if an emergency exists.

Can I stay with a perinatal provider if the provider is not with Amerigroup?

In some cases, yes, you may be able to keep seeing this doctor for care while you pick a new perinatal provider in the Amerigroup health plan. This could happen if you were getting care from a perinatal provider who is not in our health plan when you joined Amerigroup.

Please call us to find out more about this. Amerigroup will make a plan with you and your provider so we all know when you need to start seeing your new Amerigroup perinatal provider.

What if I get a bill from a perinatal provider? Who do I call?

Always show your Amerigroup ID card when you see a provider, go to the hospital, or go for tests. Even if your provider told you to go, you must show your Amerigroup ID card to make sure you don't get a bill for services covered by Amerigroup. **You do not have to show your Amerigroup ID card before you get emergency care.**

If you do get a bill, send the bill to the member advocate team at the address 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 name
- Your telephone number
- Your 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 I move?

As soon as you have your new address, give it to HHSC by calling **2-1-1** or updating your account on **YourTexasBenefits.com** and call 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.

What are my rights and responsibilities?

Member rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your perinatal provider in private, and to have your medical

records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.

11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
13. 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 having your baby born healthy. You can help by assuming these responsibilities.

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

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at **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.

When does CHIP Perinatal coverage end?

Coverage for your unborn child ends on the last day of the month your baby is born. You should still go to your two perinatal provider visits after you have your baby. Your child can keep getting his or her health care benefits from us through Medicaid or CHIP.

If your income is at or below the Medicaid eligibility threshold, then your baby is eligible for 12 months of Medicaid health care benefits starting on the date of birth.

If your income is above the Medicaid eligibility threshold, your baby can get CHIP benefits through the CHIP program for as long as he or she qualifies.

Will the state send me anything when my CHIP Perinatal benefits end?

Yes. HHSC will send you information telling you what programs your child may be eligible for before CHIP Perinatal benefits end. Please be sure to complete and mail back any forms you receive in the mail.

How does renewal work?

There is no renewal process for CHIP Perinatal. Your child can keep getting health care benefits from us if he or she still qualifies for CHIP or Medicaid.

Can I choose my baby's primary care provider before the baby is born?

Yes.

Who do I call?

Call Member Services at **800-600-4441 (TTY 711)** for help choosing a primary care provider for your baby.

What information do they need?

Have your Amerigroup ID card ready when you call Member Services.

QUALITY MANAGEMENT

What does quality management do for you?

The Amerigroup Quality Management program is here to make sure you're being cared for. We look at services you've gotten to see if you've received the best preventive health care. If you have a chronic

disease, we check that you're getting help to manage the condition.

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

We work with our network providers to help them care for you. 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 care. Clinical practice guidelines are nationally recognized, scientifically proven standards of care. These guidelines are recommendations for physicians and other health care providers to diagnose and manage your specific condition. If you would like a copy of these guidelines, contact Member Services at **800-600-4441 (TTY 711)**.

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 perinatal 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.

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 medical needs and current benefits.

We don't encourage doctors to underuse services. And we don't create barriers to getting health care. Providers don't get rewarded for limiting or denying care. Doctors in our plan use clinical practice guidelines to determine necessary treatments and services.

When you or your doctor asks for certain care that needs a pre-approval, our Utilization Review team decides if the service is medically necessary and one of your benefits. If you disagree with our decision, you or your doctor can request 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 if you file a complaint.

Can someone from Amerigroup help me file a complaint?

Yes. A member advocate or a Member Services representative 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, it will be resolved as quickly as needed for the urgency of your case and no later than one business day from when we receive 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 a 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 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 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 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 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 provider asked for will look at your case. Your 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 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 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 health, and taking the time for a standard appeal could jeopardize your life or health.

You can request an expedited appeal if you or your doctor thinks you need the services for an emergency, life-threatening illness, prevention of serious harm to you, or you're 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 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, 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 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 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:
Appeals Team
Amerigroup
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:
  HHS Federal External Review Request
  MAXIMUS Federal Services
  3750 Monroe Ave., Ste. 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 do I 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 time frames 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 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)
- Mail information to:
  Special Investigations Unit
  740 W Peachtree St NW
  Atlanta, GA 30308

- Amerigroup Member Services: **800-600-4441 (TTY 711)**
- Visit our www.fighthealthcarefraud.com education site
    - At the top of the page, select **Report it** and complete the *Report Waste, Fraud and Abuse* form.

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.

Term	Definition
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.
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.

Term	Definition
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 PERINATAL HEALTH BENEFIT PLAN FOR UNBORN CHILDREN
EVIDENCE OF COVERAGE
HEALTH MAINTENANCE ORGANIZATION
NON-FEDERALLY QUALIFIED PLAN

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

Issued by:

Amerigroup Texas, Inc.
800-600-4441

In association with:

Children's Health Insurance Program Perinatal
PO 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

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I. Introduction

A. Your Unborn Child's Coverage under Amerigroup

Amerigroup provides benefits to your unborn child for covered health services under CHIP Perinatal and determines whether particular health services are covered health services, as described in **Section VIII. Schedule of Benefits, Excluded Services, and Covered Health Services** below. If properly enrolled, your unborn child is eligible for the benefits described in **Section VIII**. 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 Perinatal

CHIP Perinatal has determined that your unborn child is eligible to receive coverage and under what circumstances the coverage will end. CHIP Perinatal also has determined your unborn child's eligibility for other benefits under CHIP Perinatal.

II. DEFINITIONS

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

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 your unborn child are not medically necessary or not appropriate.

Amerigroup: Amerigroup, otherwise referred to as us, we, or our.

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

Covered Health Services or Covered Services or Coverage: Those medically necessary services that are listed in **Section VIII. 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 VIII. 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 the mother of the unborn child would present an immediate danger to unborn child or others

2. That renders the mother of the unborn 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 unborn child's health in serious jeopardy
2. Serious impairment to bodily functions to the unborn child
3. Serious dysfunction of any bodily organ or part that would affect the unborn child
4. Serious disfigurement to the unborn child, or
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 who 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 related to labor and delivery of the unborn child.

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
   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.
   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
      (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

d. 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.
e. Research protocols indicate that the service or supply is experimental or investigational. This item 3 applies for protocols used by the unborn 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 the unborn child issued by Amerigroup providing covered health services.

Home health services: Health services provided at a member'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.

Initial admission: Hospitalization from birth including ICU, transfers from another hospital to a hospital with an NICU, and any readmission that is less than 24 hours post discharge from the initial admission.

Injury or accidental injury: Accidental trauma or damage sustained by the unborn child or the mother of the unborn child to a body part or system that is not the result of a disease, bodily infirmity, or any other cause and could cause harm to the unborn child.

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 an unborn child, or endanger life of the unborn child
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of an unborn 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
- Not experimental or investigative
- Not primarily for the convenience of the mother of the unborn 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
- Not experimental or investigative
- Not primarily for the convenience of the mother of the unborn 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 and 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 unborn child's physical health and/or the quality of care provided.

Member: Any covered unborn child who is eligible for benefits and who is enrolled in the Texas CHIP Perinatal.

Out-of-area: Any location outside the Amerigroup CHIP Perinatal 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.

Perinatal provider: A physician, physician assistant, advanced practice nurse, or other qualified health-care provider who is contracted with Amerigroup to provide covered health services to an unborn child and who is responsible for providing initial and primary care, maintaining the continuity of care, and initiating referrals 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, clinic, skilled nursing facility, or home health agency.

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

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

Unborn child (CHIP Perinate): Any child from conception to birth whom CHIP Perinatal has determined to be eligible for coverage and who is enrolled under this plan.

Urgent behavioral health care: A behavioral health condition that requires attention and assessment within 24 hours, but does not place the mother of the unborn child in immediate danger to the unborn child or others and the mother of the unborn child is able to cooperate with treatment.

Urgent care: A health condition, including 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 her condition as it relates to the unborn child requires medical treatment evaluation or treatment within 24 hours by the perinatal provider or the perinatal provider's designee to prevent serious deterioration of the unborn 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 an unborn 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: Mother of the unborn child.

III. When Does an Enrolled Unborn Child Become Covered?

Coverage of the unborn child begins on the first day of the month in which the unborn child is determined eligible for CHIP Perinatal.

IV. Termination of an Unborn Child's Coverage

A. Disenrollment Due to Loss of CHIP Perinatal Eligibility

Disenrollment may occur if your unborn child loses CHIP Perinatal eligibility. Your unborn child may lose CHIP Perinatal eligibility for the following reasons:

1. Change in health insurance status, e.g., a parent of an unborn child enrolls in an employer-sponsored Amerigroup plan
2. Death of an unborn child
3. Mother of unborn child permanently moves out of the state
4. Unborn child's parent or authorized representative requests (in writing) the voluntary disenrollment of an unborn child
5. Mother of unborn child is enrolled in Medicaid or Medicare

B. Disenrollment by Amerigroup

Your unborn 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. Mother of the unborn child no longer lives or resides in the service area

5. Mother of unborn child is disruptive, unruly, threatening, or uncooperative to the extent that unborn child's membership seriously impairs the ability of Amerigroup or the provider to provide services to the unborn child or to obtain a new member, and the mother of the unborn child's behavior is not caused by a physical or behavioral health condition
6. Mother of the unborn 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 an unborn child based on a change in the unborn child's health status, diminished mental capacity of the mother of the unborn child, or because of the amount of medically necessary services that are used to treat the unborn child's condition. We will also not disenroll an unborn child because of uncooperative or disruptive behavior resulting from the mother of the unborn child's special needs, unless this behavior seriously impairs our ability to furnish services to the unborn child or other enrollees.

V. Your Unborn Child's Health Coverage

A. Selecting Your Unborn Child's Perinatal Provider

You shall, at the time of enrollment in the Amerigroup plan, select your unborn child's perinatal provider. You 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 a family practice physician with experience in prenatal care or other qualified health-care providers as a perinatal provider.

You shall look to the selected perinatal provider to direct and coordinate your unborn child's care and recommend procedures and/or treatment.

B. Changing Your Unborn Child's Perinatal Provider

You may request a change in your unborn child's perinatal provider. Your request must be made to Amerigroup at least 30 days prior to the requested effective date of the change.

C. Emergency Services

When you are taken to a hospital emergency department, freestanding emergency medical facility, or to a comparable emergency facility for care directly related to the labor or delivery of your covered unborn child, the treating physician/provider will perform a medical screening examination to determine whether a medical emergency directly related to the labor with delivery of the covered unborn child exists and will provide the treatment and stabilization of an emergency condition.

If additional care directly related to the labor and delivery of the covered unborn child is required after the unborn child 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 one hour of receiving the call, the treating physician/provider may proceed with the proposed care. Postdelivery services or complications resulting in the need for emergency services for the mother of CHIP Perinatal newborn are not a covered benefit.

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

D. Out-of-Network Services

If covered health services are not available to your unborn 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.

E. 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 unborn 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 unborn child of special circumstance, such as an unborn child who has a disability, an acute condition, or a life-threatening illness, or is past the 24th week of gestation, for your unborn child's care in exchange for continuity of ongoing treatment for your unborn 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 unborn child. Special circumstance shall be identified by the treating physician or provider who must request that your unborn 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 unborn child's ongoing treatment. For an unborn child who at the time of termination is past the 24th week of gestation, Amerigroup shall reimburse the terminated physician or provider for treatment extending through delivery, immediate postpartum care, and follow-up checkups within 60 days of delivery.

F. Notice of Claims

You should not have to pay any amount for covered health services. If you receive a bill from a physician or provider, contact Amerigroup.

G. Coordination of Benefits

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

H. Subrogation

Amerigroup receives all rights of recovery acquired by you or your unborn 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 unborn 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.

VI. 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, no 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 1-page complaint form clearly stating that the complaint form must be returned to us for prompt resolution.

After receipt of the written complaint or 1-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 no 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 no later than the 5th day after the date of receipt of the request of the appeal.
3. We shall appoint members to the complaint appeal panel, who 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. No 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 your

unborn child are not medically necessary or appropriate.

If you, your designated representative, or your unborn child's physician or perinatal provider of record disagrees with the adverse determination, you, your designated representative, or your unborn child's physician or perinatal 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 unborn child's physician or perinatal 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 unborn child's physician or prenatal care provider should send to us or to our Utilization Review agent for the appeal.

If you, your designated representative, or your unborn child's physician or perinatal provider orally appeal the adverse determination, we or our Utilization Review agent will send you, your designated representative or your unborn child's physician or perinatal provider a 1-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 unborn child's physician or perinatal 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 you unborn child's physician or perinatal 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, you are 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 unborn child's physician or Perinatal 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, your designated

representative, or your unborn child's perinatal provider 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 unborn 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:

Texas Department of Insurance
PO Box 12030
Austin, TX 78711-2030

Complaints to the Texas Department of Insurance may also be filed electronically at **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
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 an unborn child because the unborn child or person acting on behalf of the unborn 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 perinatal provider, because the physician or perinatal provider has, on behalf of an unborn child, reasonably filed a complaint against us or has appealed a decision made by us.

VII. 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 your medical records. However, by enrolling in Amerigroup, you authorize the release of information, as permitted by law, and access to any and all of your medical records for purposes reasonably related to the provision of services under this contract, to Amerigroup, its agents and employees, your unborn child's perinatal provider, participating providers, outside providers of Utilization Review Committee, CHIP Perinatal, 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 your records for you and your unborn child's Evidence of Coverage with CHIP Perinatal:

1. Will not deny coverage that otherwise would have been granted
2. Will not continue coverage that otherwise would have terminated

If any important facts given to CHIP Perinatal about you or your unborn child are not accurate and they affect coverage:

1. The true facts will be used by CHIP Perinatal to decide whether coverage is in force
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, and 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, and state or federal laws or regulations governing CHIP, and other applicable laws or regulations.

VIII. 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 can safely be

provided and that could not be omitted without adversely affecting the member's physical health or the quality of life.

Emergency care is a covered CHIP Perinatal service limited to those emergency services that directly relate to the delivery of the covered unborn child until birth and must be provided in accordance with **Section V.C. 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.

Covered benefit	Limitations	Copayments
Inpatient general acute Services include: Covered medically necessary hospital-provided services: • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Inpatient services associated with: — Miscarriage, or — 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 procedures — Appropriate provider-administered medication — Ultrasound — Histological examination of tissue samples	For CHIP Perinates in families with incomes at or below 185 percent of the Federal Poverty Level (FPL), the facility charges are not a covered benefit; however, professional service charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes above 185 percent, up to and including 200 percent of the FPL, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth. Surgical services are limited to services that directly relate to the delivery of the unborn child. Hospital-provided services are limited to labor with delivery until birth.	None

Covered benefit	Limitations	Copayments
Comprehensive outpatient hospital, clinic (including Health Center), and ambulatory health-care center Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health-care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component)	May require prior authorization and physician prescription. Laboratory and radiological services are limited to services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinate until birth. Ultrasound of the pregnant uterus is a covered benefit of CHIP Perinatal when medically indicated.	None

Covered benefit	Limitations	Copayments
• Machine diagnostic tests • Drugs, medications, and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with: — Miscarriage, or — A nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Outpatient services associated with miscarriage or nonviable pregnancy include, but are not limited to: — Dilation and curettage procedures — Appropriate provider-administered medication — Ultrasound • Histological examination of tissue samples	Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or nonviable pregnancy. Amniocentesis, cordocentesis, Fetal Intrauterine Transfusion (FIUT), and ultrasonic guidance for cordocentesis, FIUT are covered benefits of CHIP Perinatal with an appropriate diagnosis. Laboratory tests for CHIP Perinatal are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated 1 per trimester and at 32 to 36 weeks of pregnancy; or complete blood count, urinalysis for protein and glucose every visit, blood type and Rh antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24 to 28 weeks of pregnancy; and other lab tests as indicated by medical condition of client. Surgical services associated with: • Miscarriage or • A nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit	

Covered benefit	Limitations	Copayments
Physician/physician extender professional services Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth • Physician office visits, inpatient and outpatient services • Laboratory, X-rays, imaging and pathology services, including technical component and/or professional interpretation • Medically necessary medications, biologicals, and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: – Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth – Administration of anesthesia by Physician (other than surgeon) or CRNA – Invasive diagnostic procedures directly related to the labor with delivery of the unborn child – Surgical services associated with miscarriage or a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Hospital-based physician services (including physician-performed technical and interpretive components)	Does not require authorization for specialty services for use of contracted providers. Requires authorization for use of out-of-network providers. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of amniocentesis, cordocentesis, Fetal Intrauterine. Transfusion (FIUT); and ultrasonic guidance for amniocentesis, cordocentesis, and FIUT.	None

Covered benefit	Limitations	Copayments
• Professional component associated with: − Miscarriage or − A nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Professional services associated with miscarriage or nonviable pregnancy include, but are not limited to: — Dilation and curettage procedures — Appropriate provider-administered medications — Ultrasounds — Histological examination of tissue samples		
Prenatal care and prepregnancy family services and supplies Covered services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: • 1 visit every 4 weeks for the first 28 weeks of pregnancy; 1 visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy; and 1 visit per week from 36 weeks to delivery; more frequent visits are allowed as medically necessary	Does not require authorization for specialty services for use of contracted providers. Requires authorization for use of out-of-network providers. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of amniocentesis, cordocentesis, Fetal Intrauterine Transfusion (FIUT); and ultrasonic guidance for amniocentesis, cordocentesis, and FIUT.	None
Emergency services, including emergency hospitals, physicians, and ambulance services Health plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery.	Postdelivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.	None

Covered benefit	Limitations	Copayments
Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. • Emergency services based on prudent lay person definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child • Stabilization services related to the labor and delivery of the covered unborn child • Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit • Emergency services associated with: — Miscarriage or — A nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero)		
Case management services Case management services are a covered benefit for the unborn child.	These covered services include outreach informing, case management, care coordination, and community referral.	None
Care coordination services Care coordination services are a covered benefit for the unborn child.		None
Value-added services	See **Extra Benefits**	None

CHIP Perinatal Exclusions from Covered Services for CHIP Perinates

- For CHIP Perinates in families with incomes at or below 185 percent of the federal poverty level, inpatient facility charges are not a covered benefit if associated with the initial perinatal newborn admission; "initial perinatal newborn admission" means the hospitalization associated with the birth
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth; services related to preterm, false, or other labor not resulting in delivery are excluded services
- Inpatient mental health services
- Outpatient mental health services
- Durable medical equipment or other medically related remedial devices
- Disposable medical supplies
- Home and community-based health-care services
- Nursing care services
- Dental services
- Inpatient substance abuse treatment services and residential substance abuse treatment services
- Outpatient substance abuse treatment services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the delivery of the covered unborn child
- Transplant services
- Tobacco cessation programs
- Chiropractic services
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child
- Personal comfort items, including, but not limited to, personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or postpartum care
- Experimental and/or investigational medical, surgical, or other health-care procedures or services that are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties, including but not limited to those for schools, employment, flight clearance, camps, insurance, or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices, including but not limited to an artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss

- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the health plan except for emergency care related to the labor and delivery of the covered unborn child
- Services, supplies, meal replacements, or supplements provided for weight control or the treatment of obesity
- Acupuncture services, naturopathy, and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care (routine foot care does not include treatment 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)
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver; this care does not require the continuing attention of trained medical or paramedical personnel)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services
- Donor nonmedical expenses
- Charges incurred as a donor of an organ
- Coverage while traveling outside of the United States and U.S. territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)