dell children's Health Plan

SEPTEMBER 2026 - AUGUST 2027

Dell Children's Health Plan

STAR Member Handbook

1-855-921-6284 (TTY 7-1-1) | DellChildrensHealthPlan.com

MS-0526-108

TEXAS STAR
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

Scan the QR code if you need help finding a provider, urgent care or after-hours clinic. You can also go to DellChildrensHealthPlan.com, or call the 24-hour Nurse Advice Line at **1-855-712-6700 (TTY 7-1-1).** If you think you are having a medical emergency call **9-1-1** or go to the nearest emergency room.

1-855-921-6284 (TTY 7-1-1)

Welcome to Dell Children's Health Plan!

Information about your health plan

Welcome! Dell Children's Health Plan is a Health Maintenance Organization (HMO) committed to getting you the right care close to home. Your Dell Children's Health Plan benefits are your STAR benefits, plus the value-added services you get for being our member. To find out about providers and hospitals in your area, visit **DellChildrensHealthPlan.com** and go to the Find a Doctor page. You may also call Member Services at **1-855-921-6284 (TTY 7-1-1).**

Your Dell Children's Health Plan member handbook

This handbook will help you understand your health plan and the STAR benefits you get from us. If you have questions or need help understanding or reading this member handbook, call Member Services. You can get this information for free in other formats such as large print, braille or audio. The other side of this handbook is in Spanish.

If you have questions after you read the handbook, call Member Services at **1-855-921-6284 (TTY 7-1-1).** Member Services Representatives are available from 8 a.m. to 5 p.m. Central time, Monday through Friday. except for state-approved holidays. Calls received from 5 p.m. to 8 a.m. will be directed to voicemail.

Important Phone Numbers

All numbers are toll-free

Member Services If you have any questions about you or your child's Dell Children's Health Plan, call Member Services toll-free at 1-855-921-6284 (TTY 7-1-1). You can call us Monday through Friday from 8 a.m. to 5 p.m. Central time, except for state-approved holidays. Calls received from 5 p.m. to 8 a.m. will be directed to voicemail. If we can't help you right away, we will help you the next business day. Our Member Services representatives speak English and Spanish, and many other languages. Interpreter services are also available.	**Call 1-855-921-6284 (TTY 7-1-1).** Member Services can help you with: • Your child's providers • Provider appointments • Your perinate providers • Transportation • Healthcare benefits • Getting services • What to do in an emergency or crisis • Cost-sharing information • Well care • Healthy living • Special kinds of health care • Rights and responsibilities • Complaints and medical appeals
What to do in an emergency **If you have an emergency, you should call 9-1-1 or go to the nearest hospital emergency room right away.** If you need advice, call your or your child's primary care provider or our 24-hour Nurse Advice Line seven days a week at **1-855-712-6700 (TTY 7-1-1).** For urgent care, you should call your or your child's primary care provider even on nights and weekends. He or she will tell you what to do. If you call the primary care provider's office when it's closed, leave a message with your name and a phone number where you can be reached. Someone should call you back within 30 minutes to tell you what to do.	**Call 9-1-1 in an emergency.**
24-hour Nurse Advice Line The 24-hour Nurse Advice Line is available to all members 24 hours a day, seven days a week. Call if you need advice on: • How soon you or your child needs care • What kind of care is needed for an illness or injury • How you can care for yourself or your child before seeing the provider • How you can get your child care • How and where to get urgent care services • How to treat a cold	**1-855-712-6700 (TTY 7-1-1)**
Service Coordination Disease management and case management	**1-844-964-3015 (TTY 7-1-1)**
Special Delivery pregnancy program	**1-844-964-3015 (TTY 7-1-1)**
Pharmacy	**1-855-921-6284 (TTY 7-1-1)**

1-855-921-6284

Vision			**1-800-879-6901**
Dental plans	DentaQuest: **1-800-516-0165**	MCNA: **1-855-691-6262**	United Healthcare Dental: **1-877-901-7321**
Behavioral health and substance use services The behavioral health and substance use services line is available to members 24 hours a day, seven days a week at **1-800-424-1764 (TTY 7-1-1).** The call is free, and you can talk to someone in English or Spanish. For other languages, interpreter services are available. You can call the behavioral health and substance use services line for help getting services. If you or your child has an emergency, you should call 9-1-1 or go to the nearest hospital emergency room right away.			**24 hours a day, seven days a week at 1-800-424-1764 (TTY 7-1-1).**
Non-emergency medical transportation	Call **1-844-867-2742 (TTY 7-1-1)** 24 hours a day, seven days a week, 365 days a year, except for state-approved holidays. You can talk to someone in English or Spanish. For other languages, interpreter services are available. You can pick the "Where's My Ride?" option to find out the status of your ride between 5 a.m. to 7 p.m. Central time Monday through Saturday when you are waiting for a scheduled ride.		
Members with Special Health Care Needs (MSHCN)			**1-844-964-3015 (TTY 7-1-1)**
Your Texas Benefits			**YourTexasBenefits.com**
Texas Enrollment Broker Helpline			**1-800-964-2777**
Ombudsman Managed Care Assistance Team			**1-866-566-8989**
Medicaid Hotline			**1-800-252-8263**
Texas Early Childhood Intervention Program			**1-800-628-5115**
Texas Health Steps			**1-877-847-8377**
Women, Infants and Children (WIC) Program			**1-800-942-3678**
Information and referral line for State of Texas Residents Find resources for food, health, housing and other services			**2-1-1**
Texas Health and Human Services Commission			**1-866-566-8989**
Texas Department of State Health Services (DSHS) Family and Community Health Services Help and Referral Line			**1-800-422-2956**

1-855-921-6284 (TTY 7-1-1)

Table of Contents

About Your Health Plan

You need to go to your provider now

When is it time for a well-care visit?

All Dell Children's Health Plan members need to have regular Texas Health Steps checkups or adult well-care visits. This way your primary care provider or provider can see if you have a problem before it is a bad problem. When you become a Dell Children's Health Plan member, call your provider and make the first appointments for you and your child within 90 days.

Well care for children: The Texas Health Steps program

Children need more wellness checkups than adults. These medical checkups, for children birth through age 20 who have Medicaid, are called Texas Health Steps. When your child becomes a Dell Children's Health Plan member, we may contact you to remind you to take your child for a checkup.
Your child should get Texas Health Steps checkups at the times listed below:

Texas Health Steps medical checkups schedule for your child	
Birth	9 months old
3-5 days	12 months old
By 1 month old	15 months old
2 months old	18 months old
4 months old	2 years old
6 months old	$2^{1/2}$ years old

After age $2^{1/2}$, your child should visit the provider every year. Dell Children's Health Plan encourages and covers annual checkups for children ages 3 through 20.

Be sure to make these appointments and take your child to his or her provider when scheduled. These checkups help find health problems before they get worse and harder to treat and can prevent health problems that make it hard for your child to learn and grow. If your child's provider or dentist finds a health problem during a checkup, your child can get the care he or she needs such as eye exams and glasses, hearing tests and hearing aid or dental care.

Are you a migrant farm worker?

We will help you find providers and clinics and help you set up appointments for your children. Your child can receive his or her checkup or service sooner if you are leaving the area.

1-855-921-6284 (TTY 7-1-1)

What if I become pregnant?

If you think you are pregnant, call your provider or OB-GYN right away.

If you have any questions or need help making an appointment with your provider or OB-GYN, please call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

Your Dell Children's Health Plan ID card

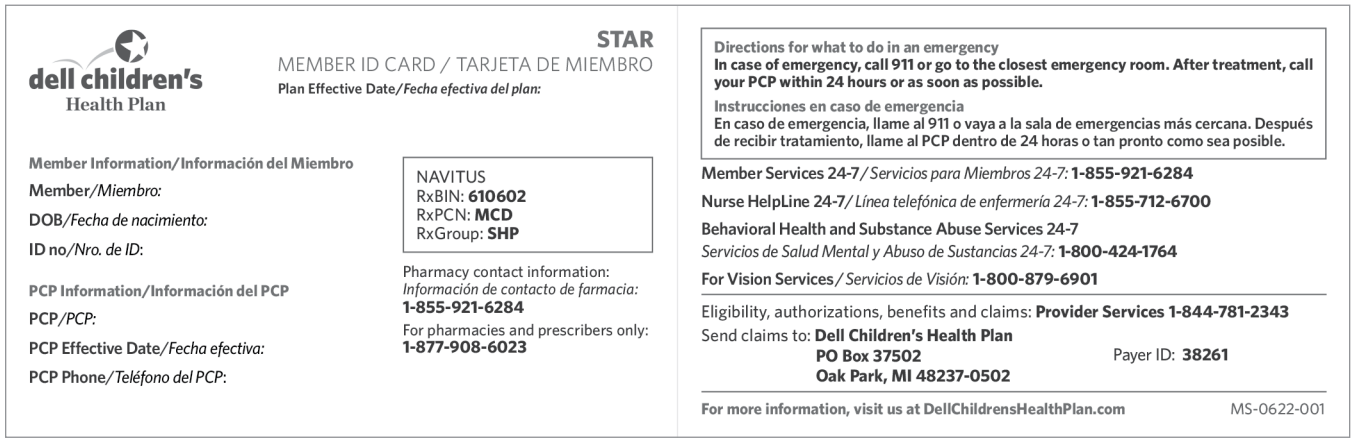
When you sign up to become a member, you will receive an ID card for each member.

What does my Dell Children's Health Plan ID card look like? How do I use it?

If you don't have your Dell Children's Health Plan ID card yet, you'll get it soon. Please carry it with you at all times. Show it to any provider, hospital or drug store you visit. You don't need to show your ID card before you get emergency care. The card tells providers, hospitals and drug stores you're a Dell Children's Health Plan member and who your provider is. It also tells them Dell Children's Health Plan will pay for the medically needed services listed in the "Benefits" section of this handbook.

You may also print your ID card from our member portal at **https://dchp-member.com**. You'll need to register and log in to the member portal on the website to access your ID card information.

STAR ID card


dell children's Health Plan

STAR
MEMBER ID CARD / TARJETA DE MIEMBRO
Plan Effective Date/*Fecha efectiva del plan:*

Member Information/Información del Miembro
Member/*Miembro:*
DOB/*Fecha de nacimiento:*
ID no/*Nro. de ID:*

PCP Information/Información del PCP
PCP/*PCP:*
PCP Effective Date/*Fecha efectiva:*
PCP Phone/*Teléfono del PCP:*

NAVITUS
RxBIN: **610602**
RxPCN: **MCD**
RxGroup: **SHP**

Pharmacy contact information:
Información de contacto de farmacia:
1-855-921-6284
For pharmacies and prescribers only:
1-877-908-6023

Directions for what to do in an emergency
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.
Instrucciones en caso de emergencia
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.

Member Services 24-7/*Servicios para Miembros 24-7:* **1-855-921-6284**
Nurse HelpLine 24-7/*Línea telefónica de enfermería 24-7:* **1-855-712-6700**
Behavioral Health and Substance Abuse Services 24-7
Servicios de Salud Mental y Abuso de Sustancias 24-7: **1-800-424-1764**
For Vision Services/*Servicios de Visión:* **1-800-879-6901**

Eligibility, authorizations, benefits and claims: **Provider Services 1-844-781-2343**
Send claims to: **Dell Children's Health Plan**
PO Box 37502
Oak Park, MI 48237-0502
Payer ID: **38261**

For more information, visit us at DellChildrensHealthPlan.com
MS-0622-001

How do I read my Dell Children's Health Plan ID card?

Your Dell Children's Health Plan ID card has the name and phone number of your provider on it. Your ID card lists many of the important phone numbers you need to know, like our Member Services and our 24-hour Nurse Advice Line. It also lists the numbers for vision care and pharmacy services.

About Your Health Plan

How do I replace my Dell Children's Health Plan ID card if it is lost or stolen?

If your ID card is lost or stolen, call us right away at **1-855-921-6284 (TTY 7-1-1)**. We'll send you a new one. You may also print your ID card from our member portal at **https://dchp-member.com**. You'll need to register and log in to the member portal to access your ID card information.

Your Texas Benefits (YTB) Medicaid card

When you are approved for Medicaid, you will get a YTB Medicaid card. This plastic card will be your everyday Medicaid card. You should carry and protect it just like your driver's license or a credit card. Your provider can use the card to find out if you have Medicaid benefits when you go for a visit.

You will be issued only one card and will receive a new card only if your card is lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free **1-800-252-8263**, or by going online to order or print a temporary card at **YourTexasBenefits.com**.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at **1-800-252-8263.** You can also call 2-1-1. First pick a language and then pick option 2.

Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid providers to help them decide what health care you need. If you don't want your providers to see your medical and dental information through the secure online network, call toll-free at **1-800-252-8263** or opt out of sharing your health information at **YourTexasBenefits.com**.

The YTB Medicaid card has these facts printed on the front:

- Your name and Medicaid ID number
- The date the card was sent to you
- The name of the Medicaid program you're in if you get:
- Medicare (QMB, MQMB)
- Healthy Texas Women Program (HTW)
- Hospice
- STAR Health
- Emergency Medicaid, or
- Presumptive Eligibility for Pregnant Women (PE)
- Facts your drug store will need to bill Medicaid
- The name of your provider and drug store if you're in the Medicaid Lock-in program.

1-855-921-6284 (TTY 7-1-1)

The back of the YTB Medicaid card has a website you can visit **YourTexasBenefits.com** and a phone number you can call toll-free **(1-800-252-8263)** if you have questions about the new card.

If you forget your card, your provider, dentist or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

The YourTexasBenefits.com Medicaid client portal

You can use the Medicaid client portal to do all of the following for yourself or anyone whose medical or dental information you are allowed to access:

- View, print and order a YTB Medicaid card
- See your medical and dental plans
- See your benefit information
- See STAR and STAR Kids Texas Health Steps alerts
- See broadcast alerts
- See diagnoses and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid providers and staff see your available medical and dental information

To access the portal, go to **YourTexasBenefits.com**

- Click Log In
- Enter your user name and password. If you don't have an account, click Create a new account.
- Click Manage
- Go to the "Quick links" section.
- Click Medicaid & CHIP Services
- Click View services and available health information

Note: The **YourTexasBenefits.com** Medicaid Client Portal displays information for active clients only. A Legally Authorized Representative may view the information of anyone who is a part of their case.

About Your Health Plan

What if I need a temporary ID verification form?

If you've lost or do not have access to YTB Medicaid card and need a temporary Medicaid card, you need to fill out a temporary ID verification form (Form 1027-A). You can get this form by calling your local HHSC benefits office. To find your local HHSC benefits office, call 2-1-1, pick a language, and then select option 2. Show this form to your provider the same way you would present a YTB Medicaid card. Your provider will accept this form as proof of Medicaid eligibility. You can also go online at **YourTexasBenefits.com** and print a temporary ID card after logging in to your account.

Primary care providers

What is a primary care provider?

A primary care provider, also called a main provider, is the provider you see for most of your regular health care. When you enrolled in Dell Children's Health Plan, you should have picked a primary care provider in our plan. If you didn't, we assigned you one who should be located close to you. Your primary care provider's name and phone number are printed on your Dell Children's Health Plan ID card.

Your primary care provider will also send you to specialists, other providers or hospitals when you need special care or services he or she can't provide.

Can a specialist ever be considered a primary care provider?

A specialist can serve as a primary care provider if you have a disability, special health care needs, or a chronic, life-threatening illness or condition where:

- You may need to be hospitalized many times for your condition
- You need to get most of your care from a specialist
- Your primary care provider isn't able to arrange the care you need

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

When you go to your provider's appointment, bring:

- Your Dell Children's Health Plan ID card
- Your YTB Medicaid card
- Any medicines you're taking and your vaccination records
- Any questions you want to ask your provider

If the appointment is for your child, bring the same items listed above.

1-855-921-6284 (TTY 7-1-1)

How can I change my primary care provider?

Call Member Services if you need to change your primary care provider. You can go to **DellChildrensHealthPlan.com** to find a new one.

Can a clinic be my primary care provider?

Yes, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) in our plan can serve as your primary care provider.

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

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling Member Services toll-free at **1-855-921-6284 (TTY 7-1-1)** or writing to:

Dell Children's Health Plan
1345 Philomena St., Ste. 305
Austin, TX 78723

When will my primary care provider change become effective?

We can change your provider on the same day you ask for the change. The change will be effective immediately. Call the provider's office if you want to make an appointment.

Are there any reasons why a request to change a primary care provider may be denied?

You won't be able to change your provider if:

- The provider you picked doesn't take new patients
- The new provider isn't in our plan

Can my primary care provider move me to another primary care provider for non-compliance?

Your primary care provider may ask for you to change to another primary care provider if:

- You don't follow his or her medical advice over and over again
- Your provider agrees a change is best for you
- Your provider doesn't have the right experience to treat you
- You were assigned to the provider by mistake (like an adult assigned to a child's provider)

About Your Health Plan

What if I choose to go to another provider who is not my primary care provider?

Talk to your primary care provider first about any care you need from other providers. He or she can refer you to other providers in our plan and help coordinate all the care you need.

How do I get medical care after my primary care provider's office is closed?

If you need to talk to your primary care provider after the office is closed, call his or her phone number on your ID card. Someone should call you back within 30 minutes to tell you what to do. You may also call our 24-hour Nurse Advice Line 24 hours a day, seven days a week for help at **1-855-712-6700 (TTY 7-1-1).**

If you think you need emergency care, see the "What is emergency medical care?" section of this handbook, call 9-1-1 or go to the nearest emergency room right away.

What is the Medicaid Lock-in program?

You may be put in the lock-in program if you do not follow Medicaid rules. It checks how you use Medicaid drug store services. Your Medicaid benefits remain the same. Changing to a different MCO will not change the lock-in status.

To avoid being put in the Medicaid Lock-in program:

- Pick one drug store at one location to use all the time
- Be sure your main provider, main dentist or the specialists they refer you to are the only providers that give you prescriptions
- Do not get the same type of medicine from different providers

To learn more, call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

In some cases, you may be approved to get medication from another pharmacy, such as:

- You move out of the geographical area (more than 15 miles from the lock-in pharmacy)
- The lock-in pharmacy doesn't have the prescribed medication and it won't be available for more than 2-3 days
- The lock-in pharmacy is closed for the day and you need the medication right away

You should call Member Services at **1-855-921-6284 (TTY 7-1-1)** if you need approval to receive a medication at a pharmacy other than the lock-in pharmacy.

1-855-921-6284 (TTY 7-1-1)

Physician incentive plans

Dell Children's Health Plan cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit medically necessary covered services to members. You have the right to know if your primary care provider (main provider) is part of this physician incentive plan. You also have a right to know how the plan works. You can call **1-855-921-6284 (TTY 7-1-1)** to learn more about this.

Changing health plans

What if I want to change health plans?

You can change your health plan by calling the Texas STAR Program Helpline at **1-800-964-2777.** You can change health plans as often as you want.

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 Dell Children's Health Plan ask that I get dropped from their health plan (for noncompliance, etc.)?

There are several reasons you could be dropped from Dell Children's Health Plan, including:

- You're no longer eligible for Medicaid
- You let someone else use your Dell Children's Health Plan ID card
- You try to hurt a provider, a staff person or a Dell Children's Health Plan associate
- You steal or destroy provider or Dell Children's Health Plan property
- You go to the emergency room over and over again when you don't have an emergency
- You go to providers or medical facilities outside Dell Children's Health Plan over and over again
- You miss appointments 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've done something that may lead to being dropped from our plan, we'll contact you. We'll ask you to tell us what happened. If you have any questions about your enrollment, call Member Services at **1-855-921-6284 (TTY 7-1-1)**. The Texas Health and Human Services Commission will decide if we ask that you be moved to another health plan.

Member Benefits

1-855-921-6284 (TTY 7-1-1)

Benefits

What are my health care benefits?

Your primary care provider will give you the care you need or refer you to another provider. Some Dell Children's Health Plan benefits are only for members who are a certain age or have a certain kind of health problem. If you have a question or aren't sure if we offer a certain benefit, call Member Services.

STAR Medicaid covered services include, but are not limited to, medically necessary:

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral health services, including:
    - Inpatient mental health services
    - Outpatient mental health services
    - Psychiatry services
    - Mental health rehabilitative services
    - Counseling services for adults (21 years of age and older)
    - Outpatient substance use disorder treatment services, including:
        - Assessment
        - Detoxification
        - Counseling
        - Medication-assisted therapy
    - Residential substance use disorder treatment (including room and board and detoxification services)
    - Applied Behavior Analysis (ABA) for autism
- Birthing services provided by a provider or certified nurse-midwife in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnosis and treatment
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early childhood intervention
- Emergency services

Member Benefits

- Family planning
- Home health care
- Hospital services, including inpatient and outpatient
- Laboratory services
- Mastectomy, breast reconstruction and related follow-up procedures, including:
    - Inpatient services; outpatient services provided at an outpatient hospital or ambulatory health care center, as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
        - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed
        - Surgery and reconstruction on the other breast to produce symmetrical appearance
        - Treatment of physical complications from the mastectomy and treatment of lymphedemas
        - Prophylactic mastectomy to prevent the development of breast cancer
        - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
- Medical checkups and Comprehensive Care Program services for children (from birth through age 20) through the Texas Health Steps program
- Mental health targeted case management
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Outpatient drugs and biologicals, including those dispensed by a pharmacy or administered by a provider
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Primary care
- Preventive services, including an annual adult well check for patients 21 years of age and older
- Radiology, imaging and X-rays
- Specialty physician services
- Telehealth
- Telemedicine

1-855-921-6284 (TTY 7-1-1)

- Telemonitoring, to the extent covered by Texas Government Code §531.01276
- Therapies—physical, occupational and speech
- Transplantation of organs and tissues
- Vision (includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses)

How do I get these services?

Your primary care provider will help you get these types of services or you can call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

What if Dell Children's Health Plan doesn't have a provider for one of my covered benefits?

If a plan benefit isn't available through a provider in our plan, we'll arrange for you to see one outside of the plan. We'll reimburse him or her according to state rules. You must call Member Services at **1-855-921-6284 (TTY 7-1-1)** to arrange services with a provider outside of our plan except in an emergency.

Are there any limits to any covered services?

There may be some limits to care, such as for chiropractic services, based on Medicaid covered benefits. You can call Member Services at **1-855-921-6284 (TTY 7-1-1)** for a complete list of benefits and limitations.

What is pre-approval?

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

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

Member Benefits

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

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

What services are not covered by Dell Children's Health Plan?

Dell Children's Health Plan doesn't offer the benefits and services below. These services aren't covered by fee-for-service Medicaid either.

- Anything that is not medically necessary
- Anything experimental such as a new treatment being tested or hasn't been shown to work
- Cosmetic surgery that isn't medically necessary
- Sterilization for members under age 21
- Routine foot care except for members with diabetes or poor circulation
- Fertility treatment services
- Treatment for disabilities connected to military service
- Weight loss program services
- Reversal of voluntary sterilization
- Private room and personal comfort items when hospitalized
- Sex reassignment surgery

To learn more about services not covered by Dell Children's Health Plan, please call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

What are my prescription drug benefits?

Medicaid pays for most medicine your provider prescribes. Adults as well as children can get as many prescriptions as are medically necessary. You may fill your prescription at any pharmacy in our plan unless you're in the Medicaid Lock-in program.

1-855-921-6284 (TTY 7-1-1)

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

You don't have to pay for health plan care benefits. You don't pay any premiums, enrollment fees, deductibles, copays or cost sharing.

What extra benefits do I get as a member of Dell Children's Health Plan? How can I get these services?

Dell Children's Health Plan gives you extra health care benefits just for being our STAR member. These extra benefits are called value-added services. We give you these value-added services to help keep you healthy and to thank you for choosing Dell Children's Health Plan as your healthcare plan. Call Member Services to learn more about these value-added services and how to get them, or visit our website at **DellChildrensHealthPlan.com**.

24-Hour Nurse Line

Nurse Advice Line Registered nurses are available 24/7 to answer health questions, provide care guidance, and help members decide where to seek care, including ER visits.	**Members can call Carenet at 1-855-712-6700 (TTY 7-1-1).** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**

Behavioral Health – Online Mental Health Resources

Behavioral health mobile app NeuroFlow is a free 24/7 secure online tool accessible through web or mobile app to help members learn to reduce stress, anxiety, depression, burnout, chronic pain or substance use. For members 18 years old and older.	**Members access NeuroFlow by logging into their account at Member.MagellanHealthcare.com or by downloading the NeuroFlow app on their mobile device.** **1. Click the "What's Your Health Plan? dropdown.** **2. Type Dell and select Dell Children's Health Plan.** **3. Click the Next button.** **4. Once you arrive at the NeuroFlow registration page, enter your information and create a password.**

Extra Vision Services

Expanding vision allowance Get up to $100 every two years for glasses or contacts, in addition to standard vision benefits.	**Members can access services by visiting a participating Superior Vision provider.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**

Member Benefits

Extra help with Getting a Ride (when state services are not available)

Transportation assistance Transportation assistance when not available through NEMT or state programs. Includes WIC, pregnancy classes, applications, health plan events, NICU visits (approval required). Limits may apply.	**Call MTM Health at 1-844-867-2742 (TTY 7-1-1) 24 hours a day, seven days a week, 365 days a year. Members can also use the MTM Link App, available on the App Store or Google Play.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**

Sports and School Physicals

One sports or school physical per year Ages 6 up to 18: One sports or school physical every 12 months with a contracted provider to support school sports participation	**Members can self-refer to a contracted provider for sports or school physicals.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**

Help for Members with Asthma

Allergy-free pillow cover One allergy-free pillow cover every 12 months for members diagnosed with asthma enrolled in the asthma management program.	**Members can request these items by contacting Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance and will be referred to the asthma service coordination program.**
Allergy-free mattress cover One allergy-free mattress cover every 12 months for members with asthma enrolled in the asthma management program. Mattress covers are available in sizes twin through king.	**Members can request these items by contacting Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance and will be referred to the asthma service coordination program**.

Extra Help for Pregnant Women and New Moms

Prenatal visit reward $75 reward (750 points) for completion of a prenatal visit within 42 days of enrollment with the health plan, in any trimester.	**Members can access the value-added service by completing the eligible activity and meeting reward criteria. Rewards are issued through the Finity website: DCHPMemberRewards.com.** **Members may also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**

1-855-921-6284 (TTY 7-1-1)

Postpartum checkup reward $100 reward (1,000 points) for completion of a postpartum checkup 7–84 days after delivery.	**Members can access the value-added service by completing the eligible activity and meeting reward criteria. Rewards are issued through the Finity website: DCHPMemberRewards.com.** **Members may also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**
Pregnancy classes Pregnancy classes covering trimester care, delivery, postpartum and postpartum depression. Available as live or self-paced online (choose one per pregnancy).	**Members can register online at anybabycan.org/programs/parenting-classes.** **For online self-paced, members can contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**
Convertible car seat Complete 6 prenatal visits and receive a voucher for 1 convertible car seat. Limit 1 per pregnancy per child. Use voucher within 3 months.	**Qualifying members can receive a voucher by email or mail to redeem at Simply Safety Centers at Dell Children's Medical Center locations.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**
Postpartum food delivery One-time delivery of fresh produce or prepared meals for postpartum members after delivery. Request within 3 months of delivery.	**Members can request in-home food delivery by calling GA Foods at 1-800-852-2211.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**
Doula support services Home visits during pregnancy and up to 3 months after birth. Includes doula support during labor and up to 2 postpartum visits.	**Members can access services by contacting Giving Austin Labor Support at givingaustinlaborsupport.org or by calling 1-512-934-2171.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**
Baby showers Attend a health plan baby shower and complete a pregnancy notification form to receive a diaper pack; includes education, resources and giveaways.	**Members can view events on Dell Children's Health Plan website, our Facebook page, call 512-324-DCHP (3247) or email DCHPCommunityOutreach@ascension.org.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**

Member Benefits

Healthy Play and Exercise Programs

YMCA gym membership YMCA membership for ages 0 through 14. Must enroll at a contracted location and use at least once every 30 days.	**Members can show proof of coverage at YMCA of Hays locations to enroll. Membership ends if coverage changes and requires use at least every 30 days to remain active.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**
Summer and spring camp experience Ages 9 through 18: Sponsored overnight camp promoting outdoor activity and development. Subject to eligibility and medical clearance.	**Eligible members can register at elranchito.org/register-for-camp and complete required application, screening, and health forms, including medical clearance.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**
Planet Fitness membership Monthly membership to participating Planet Fitness centers, for members ages 15 through 65 to support physical activity and overall wellness.	**Members can enroll by calling Member Services at 1-855-921-6284 (TTY 7-1-1). Once activated, members will receive instructions to complete registration at a selected Planet Fitness location. Members must use the membership monthly to remain eligible.**

Extra Help for Individuals with Intellectual or Developmental Disabilities

Education advocacy support Help with IEP or 504 plans, school accommodations and education rights for members with health or developmental needs.	**Members can request support through Service Coordination and will be referred to LaChance School Health Strategies, who will contact the member directly. A Legally Authorized Representative may submit a request on behalf of a member with intellectual or developmental disabilities.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**
Autism and speech development app Mobile learning app for members ages 2 through 8 with autism or speech delay diagnosis to support development and communication skills.	**Members with a provider diagnosis of autism or speech delay can contact Dell Children's Health Plan or their Service Coordinator for access. Eligible members will receive a secure GoManda link by email at no cost.** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**

1-855-921-6284 (TTY 7-1-1)

Health and Wellness Services

Emergency food assistance Short-term food delivery during a qualifying life event, such as illness, job loss or disaster. Approval required.	**Members can request emergency in-home food delivery by contacting Member Services at 1-855-921-6284 (TTY 7-1-1). Once approved, member information is shared with GA Foods, who will contact the member to coordinate dietary needs, shipping details and delivery timing.**
Spiritual care and wellness support Spiritual care supports coping with illness, loss, grief or pain and promotes emotional well-being. Includes online resources for overall wellness. 	**To speak to a chaplain online:** **1. Scan the QR code or go to bit.ly/3lfuBxi.** **2. Complete the form to speak with a chaplain.** **3. Select "I am an: Insurance Member" and "Health plan: Dell Children's Health Plan".** **4. You'll receive a Zoom link via text and a chaplain will join the meeting within 10 minutes.** **To speak with a chaplain over the phone: Chaplains can be reached via telephone Monday to Friday 8 a.m. to 4 p.m. Central time at 1-833-789-4487 (TTY 7-1-1)** **Members can also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.**

GED Support

GED preparation course Online GED classes and coaching to help you pass the GED test. For members ages 17-65. If not used for 30 days, service must be restarted.	**Members may request GED assistance by calling Member Services at 1-855-921-6284 (TTY 7-1-1).**
GED test cost support Cost of the GED test covered for members ages 17 through 20. One-time benefit.	**Members may request GED assistance by calling Member Services at 1-855-921-6284 (TTY 7-1-1). Voucher details are emailed within two business days after processing.**

Member Benefits

Gift Programs

Members can earn reward points by completing healthy activities. Then, use your points to shop in the online rewards store and choose from hundreds of items!

Behavioral health follow-up reward

$20 reward (200 points) per visit for completing a behavioral health follow-up within 7 days of discharge. Limit 2 rewards per year.

Texas Health Steps checkup reward

(Ages 3–11): $20 reward (200 points) for members ages 3–11 who complete a timely Texas Health Steps checkup. Limit 1 reward per year and 1 reward per visit.

(Ages 12–20): $50 reward (500 points) for members ages 12–20 who complete a Texas Health Steps checkup. If multiple rewards apply, only the highest-value reward is given. One reward per visit.

New member Texas Health Steps reward

$20 reward (200 points) for members ages 3 through 20 for completing a Texas Health Steps checkup within 90 days of enrollment.

Infant Texas Health Steps completion reward

$120 reward (1,200 points) after completing all 6 Texas Health Steps checkups from birth through 15 months on the state-approved schedule. Available after all 6 checkups are completed.

Infant Texas Health Steps reward (18, 24, and 30 months)

$50 reward (500 points) for STAR members for completion of infant Texas Health Steps checkups at 18, 24, and 30 months.

Early childhood vaccines reward

$75 reward (750 points) for completion of 5 Combo 10 vaccines; additional $125 reward (1,250 points) for completion of all 10 vaccines. One-time benefit.

High school educational achievement reward

Earn $25 reward (250 points) per semester for a 3.0+ GPA, 90%+ class attendance or attending an IEP/504 meeting. Submit proof within 90 days.

Members can access the value-added service by completing the eligible activity and meeting reward criteria.

Rewards are issued through the Finity website: DCHPMemberRewards.com.

Members may also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.

ADHD follow-up reward

$20 reward (200 points) for members ages 6 through 12 for a follow-up visit within 30 days of starting an ADHD medication. Limit 1 reward per member.

Adult doctor visit reward

$20 reward (200 points) for completion of one annual ambulatory visit with a contracted provider. Excludes ER and urgent care. Limit 1 reward per year.

Chlamydia screening reward

$25 reward (250 points) for women ages 16 through 24 for completion of a chlamydia screening. Limit 1 reward per year.

Members can access the value-added service by completing the eligible activity and meeting reward criteria.

Rewards are issued through the Finity website: DCHPMemberRewards.com.

Members may also contact Member Services at 1-855-921-6284 (TTY 7-1-1) for assistance.

What health education classes does Dell Children's Health Plan 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:

- Dell Children's Health Plan services and how to get them
- Childbirth
- Infant care
- Parenting
- Pregnancy
- Other classes or events about health topics

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.

Service coordination

What is service coordination?

Service coordination is a covered benefit for all STAR members. It is a program for members who have a long-term health condition like diabetes, asthma, mental health or another condition that needs special care and attention. We help you get the care you (or your child) need, when you need it. You can be referred to service coordination by your healthcare provider, yourself or by meeting certain criteria. You can opt in or opt out of service coordination at any time.

Member Benefits

Service coordination can help members with:

- Complex case management
- Asthma
- Diabetes
- Behavioral health
- High-risk pregnancy
- Other chronic health care conditions

What do service coordinators do?

- Listen to you to understand your specific needs
- Work with community agencies that will help you (or your child) get the extra care that you need
- Help you get important facts to help you better understand your (or your child's) illness or condition
- Make a plan of care with your help and the help of your (or your child's) provider to help you best manage your/your child's condition
- Follow your (or your child's) health condition and help to make sure you are getting the care you need
- Get medical supplies or equipment
- Work on school or education issues
- Work on other problems
- Teach you how to find and get other services
- Offer smoking cessation services

How can I talk with a service coordinator?

You don't need a referral from a provider to talk to a service coordinator. Call Service Coordination at **1-512-324-3015 (TTY 7-1-1)** or **1-844-964-3015 (TTY 7-1-1)** and ask to speak to one. Service coordinators are available Monday through Friday from 8 a.m. to 5 p.m. Central time. If you need to leave a message, they have confidential voicemail available 24 hours a day.

Members with Special Health Care Needs (MSHCN)?

Dell Children's Health Plan has a service coordination program that offers families help with you or your child's special needs. The services range from simple outreach and information to intensive service coordination. They also include coordination with and referral to community resources to help families with transportation and basic living needs. Your information will be given to a service coordinator.

1-855-921-6284 (TTY 7-1-1)

The service coordinator is a licensed nurse or social worker. The service coordinator will call you to assess your needs. The service coordinator will work with you to develop a service plan. You can decline or opt out of service coordination at any time.

We have a system for identifying and contacting members who have special health care needs to offer service management. If you believe you or your child has special health care needs, you may also call us at **1-844-964-3015 (TTY 7-1-1)** or 1-**512-324-3015 (TTY 7-1-1).**

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

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

MSHCN include:

- Early Childhood Intervention (ECI) program participants
- Farm worker's children
- Former foster care children
- Pregnant women identified as high risk, including:
    - Pregnant members age 35 and older or 15 and younger;
    - Pregnant members diagnosed with preeclampsia, high blood pressure or diabetes;
    - Pregnant members with mental health or substance use disorder diagnosis;
    - Pregnant Members with a previous pre-term birth, as identified on the perinatal risk report.
- Members with high-cost catastrophic cases or high service utilization, such as a high volume of ER or hospital visits
- Members who have a mental illness with co-occurring substance use
- Members with a serious ongoing illness or chronic complex condition that is anticipated to last for a significant period such as:
    - Members who have been diagnosed with respiratory illness (chronic asthma, COPD or cystic fibrosis), diabetes, heart disease, kidney disease, HIV or AIDS
    - Child members receiving ongoing therapy services which may include physical therapy, speech therapy or occupational therapy (e.g. for longer than six months);
    - Members receiving private duty nursing or prescribed pediatric extended care center services
- Members with behavioral health issues that affect their physical health and ability to follow treatment plans

Member Benefits

- Adoption Assistance and Permanency Care Assistance (AAPCA) program members

What other services can Dell Children's Health Plan help me get?

We can help you with services covered by fee-for-service Medicaid instead of Dell Children's Health Plan. Listed below are agencies and programs that provide other services. You don't need a referral from your provider to get these services. You can call Member Services at **1-855-921-6284 (TTY 7-1-1)** for help. Fee-for-service Medicaid benefits include:

Texas Health Steps dental (including orthodontia)—Medicaid members age 20 and younger can get dental benefits through a managed care organization	Texas Health Steps dental checkups are recommended every 3-6 months, starting at 6 months of age. The different types of dental health services offered for children and young adults who have Medicaid are: preventative services (including exams and cleaning), treatment services (including fillings and crowns), and emergency dental services. **Call 1-877-847-8377 (1-877-THSteps)**
Texas Health Steps environmental lead investigation (ELI)	Environmental lead investigations (ELIs) are a benefit of Texas Medicaid through the Texas Health Steps program for clients aged 20 and younger and who have an elevated blood lead level. Blood lead screening is mandatory for all children during the Texas Health Steps medical checkups at 12 and 24 months of age, or if there is no evidence of a previous blood lead screen for the client. A blood lead screen is the only definitive method to detect recent or ongoing exposure to lead. **Call 1-877-847-8377 (1-877-THSteps)**
Texas Health Steps Personal Care Services for members birth through age 20	PCS is a Medicaid benefit that assists eligible clients who require assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) because of a physical, cognitive, or behavioral limitation related to their disability, physical, or mental illness or chronic condition. ADL services include assistance with bathing, dressing, eating, personal hygiene, and mobility. IADL services include assistance with grocery shopping, cleaning, laundry, meal preparation, and transportation to medical appointments.

1-855-921-6284 (TTY 7-1-1)

Early Childhood Intervention (ECI) case management/service coordination	Service coordinators help families get the services, resources, and support they need to support their child's development. Support includes helping the child and family transition to special education services as appropriate for children exiting ECI at age 3. ECI programs provide comprehensive case management for all members of the child's family as their needs relate to the child's growth and development.
Early Childhood Intervention (ECI) Specialized Skills Training	ECI provides developmental services by coaching families on infant and toddler development and behavior. This includes assisting families with challenging behaviors such as tantrums, biting, picky eating, and sleep issues. ECI professionals understand how infants and toddlers learn, socialize, and how developmental areas are connected. **Call 877-787-8999, select a language and then select Option 3.**
Case Management for Children and Pregnant Women	Case management services provided to Medicaid-eligible children with a health condition or pregnant women with a high-risk condition during pregnancy. **Call 1-855-921-6284 (TTY 7-1-1)**
Texas School Health and Related Services (SHARS)	Current services include: assessment, audiology, counseling, school health services, medical services, occupational therapy, physical therapy, psychological services, speech therapy, special transportation, and personal care services. **Call 1-512-463-9414**
Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program	A Blind Children's Program Specialist—an expert in providing services to children with visual impairments—works with each child and family to create a Family Service Plan. The plan is tailored to the child's unique needs and circumstances, is flexible and will develop along with the child. **Call 877-787-8999, select a language and then select Option 3.**

Member Benefits

Tuberculosis (TB) services provided by Department of State Health Services (DSHS)-approved providers (directly observed therapy and contact investigation)	Network providers coordinate with the local TB control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy (DOT). **Call 1-888-963-7111**
Community First Choice (CFC) services	CFC is a state plan option that allows states to provide home and community-based attendant services and support to eligible Medicaid enrollees under their state plan.
Other state and local agencies and programs such as food stamps, and the Women, Infants, and Children's (WIC) program	WIC is the special supplemental nutrition program for pregnant women, new mothers, and young children. Participants learn about nutrition and how to stay healthy, and receive benefits to purchase healthy foods. Services are free to those who are enrolled in Medicaid. **Call 1-800-942-3678 or visit www.texaswic.org**

Health care and other services

What does medically necessary mean?

Your provider will help you get the services you need that are medically necessary as defined below.

Medically necessary means:

1. For members from birth through age 20, the following Texas Health Steps services:

a. Screening, vision, and hearing services

b. Other health care services, including behavioral health services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

i) Must comply with the requirements of the Alberto N., et al. v. Traylor, et al. partial settlement agreements, and
ii) May include consideration of other relevant factors, such as the criteria described in parts (2)(b — g) and (3)(b — g) of this definition

2. For members over age 20, non-behavioral health-related health care services that are:

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

b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;

c. Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

d. Consistent with the diagnoses of the conditions;

e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency;

f. Not experimental or investigative; and

g. Not primarily for the convenience of the member or provider; and

3. For members over age 20, behavioral health services that:

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

b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

d. Are the most appropriate level or supply of service that can safely be provided

e. Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;

f. Are not experimental or investigative; and

g. Are not primarily for the convenience of the member or provider.

If you have questions regarding an authorization, a request for services or a utilization management question, you can call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

What is routine medical care?

Routine care includes regular checkups, preventive care and appointments for minor injuries and illnesses. Your primary care provider sees you when you're not feeling well, but that's only part of his or her job. He or she also takes care of you before you get sick. This is called well care. See the "What services are offered by Texas Health Steps?" and "When should adults get checkups?" sections of this handbook to learn more.

How soon can I expect to be seen?

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

Member Benefits

What is urgent medical care?

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

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

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

For urgent care, you should call your provider's office, even on nights and weekends. Your provider will tell you what to do. In some cases, your provider may tell you to go to an urgent care clinic. If your provider tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Dell Children's Health Plan Medicaid. For help, call us toll-free at **1-855-921-6284 (TTY 7-1-1).** You also can call our 24-hour Nurse Advice Line at **1-855-712-6700 (TTY 7-1-1)** for help getting the care you need.

How soon can I expect to be seen?

You should be able to see your provider within 24 hours for an urgent care appointment. If your provider tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Dell Children's Health Plan Medicaid.

What is emergency medical care?

After routine and urgent care, the third type of care is emergency care. If you have an emergency, you should call 9-1-1 or go to the nearest hospital emergency room right away. If you want medical advice, call your primary care provider or our 24-hour Nurse Advice Line seven days a week at **1-855-712-6700 (TTY 7-1-1).** Please get medical care as soon as possible. You should call your primary care provider within 24 hours after you visit the emergency room. If you can't call, have someone else call for you. Your provider will give or arrange any follow-up care you need. These services are covered by Medicaid.

Emergency medical care

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

Emergency medical condition means:

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

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

Emergency behavioral health condition means:

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

1. Requires immediate intervention and/or medical attention without which the member would present an immediate danger to themselves or others
2. Which renders the member incapable of controlling, knowing or understanding the consequences of their actions

Emergency services and emergency care means:

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

How soon can I expect to be seen?

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

What is post-stabilization?

Post-stabilization care services are services covered by Medicaid that keep your condition stable following emergency medical care.

Are emergency dental services covered by the health plan?

Dell Children's Health Plan covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

- Treatment for dislocated jaw
- Treatment for traumatic damage to teeth and supporting structures
- Removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Hospital, provider, and related medical services such as drugs for any of the above conditions

Member Benefits

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

During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call us toll-free at **1-855-712-6700 (TTY 7-1-1)** or call 9-1-1.

How soon can I see my provider?

We know how important it is for you to see your provider. We work with the providers in our plan to make sure you can see them when you need to. Our providers are required to follow the access standards listed below.

Emergency, urgent, routine and after-hours care

Care type	Dell Children's Health Plan
Emergency services	As soon as you arrive at the provider for care
Urgent care	Within 24 hours of request
Routine primary care	Within 15 business days of request
Routine specialty care	Within 3 weeks of request
After-hours care	Primary care providers are available 24/7 directly or through an answering service. Refer to the "How do I get medical care after my child's primary care provider's office is closed?" section of this handbook.

Preventive health

Care type	Dell Children's Health Plan
Children (new member)	New members birth through age 20, as soon as possible and no later than 15 business days after enrollment
Children less than 6 months old	Within 15 business days of request
Members age 6 months through 20 years	Within 15 business days of request

Prenatal care

Care type	Dell Children's Health Plan
Initial visit	Within 15 business days of request

Initial visit for high risk or 3rd trimester	Within 5 business days of request or immediately, if an emergency exists
Follow-up visit	Based on the provider's treatment plan

Behavioral health

Care type	**Dell Children's Health Plan**
Urgent care	Within 24 hours of request
Initial visit for routine care	Within 10 business days
Follow-up visit for routine care	Within 3 weeks of request
Case Management for Children and Pregnant Women (CPW) services	Within 14 days

You should call your primary care provider within 24 hours after you visit the emergency room. If you can't call, have someone else call for you. Your provider will give or arrange any follow-up care you need. These services are covered by Medicaid.

How do I get medical care when my primary care provider's office is closed?

Help from your primary care provider is available 24 hours a day. If you call your primary care provider's office when it's closed, leave a message with your name and a phone number where you can be reached. Someone should call you back within 30 minutes to tell you what to do. You may also call our 24-hour Nurse Advice Line to talk to a nurse anytime.

If you think you need emergency care, call 9-1-1 or go to the nearest emergency room right away. Refer to the "What is emergency medical care?" section of this handbook to help you decide if you need emergency care.

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 **1-855-921-6284 (TTY 7-1-1)** and we will help you find a provider. If you need emergency services while traveling, go to a nearby hospital, and then call us toll-free at **1-855-921-6284 (TTY 7-1-1)**.

What if I am out of the state?

If you are outside of Texas and need medical care, please call us toll-free at **1-855-921-6284 (TTY 7-1-1)**. **If you need emergency care, go to the nearest hospital emergency room or call 9-1-1.**

Member Benefits

What if I am out of the country?

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

What if I need to see a special provider (specialist)?

Your primary care provider (PCP) helps coordinate most of your healthcare needs. Sometimes you may need care from another type of provider. These providers are called specialists because they have training in a specific area of medicine. Examples of specialists are:

- Allergist (allergy providers)
- Dermatologists (skin providers)
- Cardiologists (heart providers)
- Podiatrists (foot providers)

We cover services from many different types of specialists. If you need care from a specialist, your primary care provider can refer you to a specialist in our network.

If you have a disability, special health care needs or a chronic complex condition, you can have a specialist as your primary care provider. Please call Member Services for help arranging this.

What is a referral?

A referral is when your primary care provider recommends that you see another provider or receive a service for your health care needs. Your primary care provider may refer you to a specialist in our network if you need care that they cannot provide.

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

You can expect to see a specialist within 3 weeks after you request an appointment. If you need help finding a specialist or scheduling an appointment, call our Member Services.

What services do not need a referral?

You don't need a referral from your primary care provider in order to get needed care from providers in our plan. It's always best to talk to your primary care provider first about any additional care you need. Your primary care provider can help coordinate your care and connect you with other providers in our network.

How can I ask for a second opinion?

You have the right to ask for a second opinion about the health care services you need. This doesn't cost you anything. You can get a second opinion from a provider in our network. If a network provider is not available for a second opinion, your primary care provider can submit a request to us to approve a visit with an out-of-network provider.

1-855-921-6284 (TTY 7-1-1)

How do I get help if I have behavioral (mental) health, alcohol or drug problems?

Sometimes the stress of life can lead to depression, anxiety, marriage and family problems, or alcohol or drug abuse. If you or your child is having these kinds of problems, we have providers who can help. Call **1-800-424-1764 (TTY 7-1-1)** for help finding a provider who will help you. All services and treatment are strictly confidential.

Do I need a referral for this?

You don't need a referral to get help for behavioral health, alcohol or drug problems.

What should I do in a behavioral health emergency?

Call 9-1-1 if you or your child is having a life-threatening behavioral health emergency. You can also go to a crisis center or the nearest emergency room.

What if I'm already in treatment?

If you or your child is already getting behavioral health care when you enroll in Dell Children's Health Plan, ask your provider if he or she is in our health plan. If the answer is yes, you don't need to do anything. If the answer is no, call Member Services at **1-855-921-6284 (TTY 7-1-1)**. We'll work with your provider to keep caring for you or your child until you can get a provider in our health plan.

What are Mental Health Rehabilitative Services and Mental Health Targeted Case Management?

Mental Health Rehabilitative Services help you stay independent in your home and the community, such as:

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

Mental Health Targeted Case Management helps you access medical, social, educational and other services and supports that can help improve your health and your ability to function.

These services are available if you need them based on an appropriate standardized assessment by a mental health professional.

How do I get these services?

If you or a family member has been diagnosed with or has shown signs of this type of condition, we have providers who can help. Call **1-800-424-1764 (TTY 7-1-1)** to find a provider near you.

Member Benefits

How do I get my medications?

Medicaid pays for most medicine your provider says you need. Your provider will write a prescription so you can take it to the drug store or your provider may be able to send the prescription to the drug store for you.

You or your children can get as many prescriptions as medically necessary. You may go to any drug store in the Dell Children's Health Plan network to have your prescription filled, unless you're in the Medicaid Lock-in program.

You should use the same drug store each time you need medicine. This way, your pharmacist will know all the drugs you're taking. He or she can tell you about drug interactions and side effects. If you use another drug store, you should tell the pharmacist about any other medicines you're taking.

How do I find a network drug store?

To find a drug store in our plan, go to our website at **DellChildrensHealthPlan.com** and go to the Find a Provider page. You can also ask the pharmacist or call Member Services for help.

What if I go to a drug store that is not in the network?

The pharmacist will explain that they don't accept Dell Children's Health Plan. You'll need to take your prescription to a drug store in our plan.

What do I bring with me to the drug store?

When you go to the drug store, you should bring:

- Your prescription(s) or medicine bottle(s)
- Your Dell Children's Health Plan ID card
- Your Texas Benefits Medicaid card

What if I need my medications delivered to me?

Many drug stores provide delivery services. Ask your pharmacist if they can deliver to your home.

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

If you have problems getting your Dell Children's Health Plan-covered medications, please call us at **1-855-921-6284 (TTY 7-1-1)**. We can work with you and your drug store to make sure you get the medicine you need.

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

Some medicines require our pre-approval. If your provider cannot be reached to approve a prescription, you may be able to get a 3-day emergency supply of your medication. Call us at **1-855-921-6284 (TTY 7-1-1)** for help with your medications and refills. Ask your pharmacist to dispense a 3-day supply.

1-855-921-6284 (TTY 7-1-1)

What if I lose my medications?

If your medicine is lost or stolen, have your pharmacist call Member Services at **1-855-921-6284 (TTY 7-1-1).**

How do I find out what drugs are covered?

Dell Children's Health Plan uses the state Vendor Drug Program (VDP) list of drugs your provider can choose from. It includes all medicines covered by Medicaid.

To view this list, go to the Texas Formulary Drug Search at **www.txvendordrug.com/formulary/formulary-search.**

When there is a generic drug available, we'll cover it instead of the brand-name drug if it's on the Vendor Drug Program (VDP) formulary. Generic drugs are equal to brand-name drugs as approved by the Food and Drug Administration (FDA).

How do I transfer my prescriptions to a plan drug store?

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

- Call the nearest network drug store and give the needed information to the pharmacist, or
- Bring your prescription container to the new drug store and they'll handle the rest.

Will I have a copay?

Medicaid members do not have copays.

How do I get my medicine if I am traveling?

If you need a refill while on vacation, call your provider and ask for a new prescription to take with you. If you get medication from a drug store that's not in our health plan, then you'll have to pay for that medication. If you pay for medication, you may submit a request for reimbursement. Call Member Services at **1-855-921-6284 (TTY 7-1-1)** 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. Call Member Services at **1-855-921-6284 (TTY 7-1-1)** to get a reimbursement form and submit a claim.

What if I need durable medical equipment (DME) or other products normally found in a drug store?

Some durable medical equipment (DME) and products normally found in a drug store are covered by Medicaid. For all members, Dell Children's Health Plan pays for nebulizers, ostomy supplies and other

covered supplies and equipment if they are medically necessary. For children (birth through age 20), Dell Children's Health Plan also pays for medically necessary prescribed over-the-counter drugs, diapers, formula and some vitamins and minerals.

Call **1-855-921-6284 (TTY 7-1-1)** for more information about these benefits.

How do I get family planning services?

Dell Children's Health Plan will arrange for counseling and education about planning a pregnancy or preventing pregnancy. You can call your primary care provider for help or go to any Medicaid family planning provider. A provider can't require parental consent for minors to receive family planning services and must keep family planning use confidential.

Your provider will bill Medicaid for family planning services.

Do I need a referral for this?

No. You don't need a referral from your provider.

Where do I find a family planning services provider?

You can find the locations of family planning providers near you online at **www.healthytexaswomen.org/family-planning-program**, or you can call Dell Children's Health Plan at **1-855-921-6284 (TTY 7-1-1)** for help finding a family planning provider.

What is Case Management for Children and Pregnant Women?

Case Management for Children and Pregnant Women

Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- Have health problems or
- Are at a high risk for getting health problems

What do case managers do?

A case manager will visit with you and then:

- Find out what services you need
- Find services near where you live
- Teach you how to find and get other services

1-855-921-6284 (TTY 7-1-1)

- Make sure you are getting the services you need

What kind of help can you get?

Case managers can help you:

- Get medical and dental services
- Get medical supplies or equipment
- Work on school or education issues
- Work on other problems

How can you get a case manager?

Call Dell Children's Health Plan at **1-855-921-6284 (TTY 7-1-1)** and ask to speak to a case manager for children and pregnant women.

What is Early Childhood Intervention (ECI)?

ECI is a statewide program for families with children birth to age 3 with disabilities and developmental delays. ECI helps families support their children through developmental services. ECI evaluates and assesses, at no cost to families, to see if they are eligible and what services they'll need. Families and professionals work together to plan services based on the unique needs of the child and family.

The Department of Assistive and Rehabilitative Services (DARS) is the state agency responsible for ECI. A local ECI program will determine if a child can get ECI services, and it will develop a child's individual service plan. Dell Children's Health Plan is responsible for paying for the services in the plan.

Do I need a referral for this?

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

Where do I find an ECI provider?

To get information about ECI services and other resources, call the DARS Inquiries Line at **1-800-628-5115.** You can also search online for an ECI program near you. Go to **https://citysearch.hhsc.state.tx.us**.

Participation in an ECI program is voluntary. If you choose not to use a local ECI program, Dell Children's Health Plan must provide medically necessary services for your child. Call us at **1-855-921-6284 (TTY 7-1-1)** if you need help getting these services.

What is Head Start?

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

Member Benefits

- Language
- Literacy
- Social and emotional development

To find a Head Start program near you, call toll-free **1-866-763-6481** or go to **https://www.benefits.gov/benefit/1941**.

What is Texas Health Steps?

What services are offered by Texas Health Steps?

Texas Health Steps is the Medicaid health care program for STAR children, teens, and young adults, birth through age 20.

Texas Health Steps gives your child:

- Free regular medical checkups starting at birth
- Free dental checkups starting at 6 months of age
- A case manager who can find out what services your child needs and where to get these services

Texas Health Steps checkups:

- Find health problems before they get worse and are harder to treat
- Prevent health problems that make it hard for children to learn and grow like others their age
- Help your child have a healthy smile

When to set up a checkup:

- You will get a text, email or letter from Texas Health Steps telling you when it's time for a checkup; call your child's provider or dentist to set up the checkup. If you provided HHS with an email or phone number on the application, the notice will arrive by phone or email. If you did not provide an email or phone number, or opted out of notifications, a letter will be sent to the address on the application.
- Set up the checkup at a time that works best for your family

If the provider or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:

- Eye tests and eyeglasses
- Hearing tests and hearing aids
- Dental care
- Other health care

1-855-921-6284 (TTY 7-1-1)

- Treatment for other medical conditions

Call Member Services at 1-855-921-6284 (TTY 7-1-1) or Texas Health Steps at 1-877-847-8377 (1-877-THSTEPS) toll-free if you:

- Need help finding a provider or dentist
- Need help setting up a checkup
- Have questions about checkups or Texas Health Steps
- Need help finding and getting other services

If you can't get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the provider, dentist, hospital or drug store. Call **1-844-867-2742** to schedule non-emergent medical transportation.

How and when do I get Texas Health Steps medical and dental checkups for my child?

The first well-child visit will happen in the hospital right after your baby is born. For the next six visits, you must take your baby to his or her provider's office. Children need these checkups even when they're healthy. Your child needs to have checkups at these ages:

Texas Health Steps medical checkups schedule for your child	
Birth	9 months old
3-5 days	12 months old
By 1 month old	15 months old
2 months old	18 months old
4 months old	2 years old
6 months old	$2^{1/2}$ years old
After age $2^{1/2}$, your child should visit the provider every year. Dell Children's Health Plan encourages and covers annual checkups for children ages 3 through 20.	

Be sure to make these appointments. Take your child to his or her provider when scheduled.

Does my provider have to be part of the Dell Children's Health Plan network?

Your child can see any Texas Health Steps provider for these checkups. The Texas Health Steps provider doesn't have to be in our plan.

Member Benefits

Do I have to have a referral?

No. Your child can get Texas Health Steps care without a referral.

What if I need to cancel an appointment?

If you're unable to keep your appointment, you must call your provider and cancel. You can make a new appointment when you call.

What if I am out of town and my child is due for a Texas Health Steps visit?

If you're out of town and your child is due for a Texas Health Steps visit, call your provider's office or Member Services for help.

What If I have moved and my child is due for a Texas Health Steps checkup?

You can go to any Texas Health Steps provider. It is important that you take your Dell Children's Health Plan ID card with you to your checkup. You need to tell Medicaid that you have moved. You can call 2-1-1 for the local Health and Human Services Commission (HHSC) office.

If you can't get your child to the checkup, Medicaid may be able to help. Kids with Medicaid and their parents can get free rides to and from the provider, dentist, hospital or drug store. Call **1-844-867-2742.**

What if I am a migrant farm worker?

Migrant farm workers move to different places to follow seasonal farm work. They could work on farms; in fields; as a food processor or packer; or with dairy products, poultry or livestock during certain times of the year. Your child can get your checkups sooner if you are leaving the area. If you call us and tell us you're a farmworker, we'll:

- Help you find providers and clinics and help you set up appointments
- Let providers know you need to be seen quickly because you may have to leave the area to go to your next job

When should adults get checkups?

Staying healthy means getting regular checkups. Use the chart below to make sure you're up-to-date with your yearly well-care exams.

Exam type	Who needs it?	How often?
Well-care visit	Age 21 and over	Every year
Pelvic exam	Women age 18 and over	Every year

1-855-921-6284 (TTY 7-1-1)

Exam type	Who needs it?	How often?
Fecal blood occult test	Age 45 and over	Every year
Breast self-exam	Women age 20 and over	Once a month
Pap smear	Women ages 21-29	Pap smear only, every 3 years
	Women ages 30-65	Pap smear only, every 3 years Pap smear/human papillomavirus (HPV) co-testing, every 5 years
Clinical breast exam	Women age 20-39	Every 3 years
	Age 40 and over	Every year
Mammogram (breast X-ray)	Women age 40 and over	Every year
Sigmoidoscopy or colonoscopy	Age 45 and over	Every 5 years for sigmoidoscopy Every 10 years for colonoscopy
DRE/PSA (men only)	Age 45 and over	Every year

If I miss my well-care visits or my child's Texas Health Steps checkup, what do I do?

If you or your child doesn't get a well-care visit on time, make an appointment with your provider as soon as you can. If you need help setting up the appointment, call Member Services. Your child will get a reminder card before they are due for an exam.

Non-emergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provide transportation to non-emergency health care appointments for members who have no other transportation options. These trips include rides to the provider, dentist, hospital, pharmacy and other places you receive Medicaid services. These trips do NOT include ambulance trips.

What services are part of NEMT services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.

Member Benefits

- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services.

If you need an attendant to travel to your appointment with you, NEMT services will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years old must be accompanied by a parent, guardian or other authorized adult or have consent from a parent, guardian, or other authorized adults on file to travel alone. Parental consent is not required if the health care service is confidential in nature.

Who do I call?

Call Member Services at **1-855-921-6284 (TTY 7-1-1**) or MTM Health at **1-844-867-274 (TTY 7-1-1)** 24 hours a day, seven days a week, 365 days a year.

How to get a ride?

Dell Children's Health Plan will provide you with information on how to request NEMT services. You should request NEMT services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances, you may request the NEMT service with less notice.

These circumstances include being picked up after being discharged from a hospital, trips to the pharmacy to pick up medication or approved medical supplies, and trips for urgent conditions.

An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

You must notify Dell Children's Health Plan prior to the approved and scheduled trip if your medical appointment is canceled.

1-855-921-6284 (TTY 7-1-1)

Member responsibilities while using NEMT services:

1. When requesting NEMT services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

How do I get eye care services?

You get eye care benefits. You do not need a referral from your provider for these benefits. Please call Superior Vision of Texas at **1-800-879-6901** for help finding a network eye provider (optometrist) in your area.

Eye care services are different for adults and kids:

- If you're 21 or older, you can get an eye exam and glasses every 2 years. You can't get your glasses replaced if you break or lose them.
- If you are age 20 or under, you can get an eye exam and glasses once a year. You can also get your glasses replaced if you lose or break them.
- Under certain conditions, you may get an exam or new glasses more often. For more information, call Superior Vision of Texas at **1-800-879-6901.**

What dental services does Dell Children's Health Plan cover for children?

Dell Children's Health Plan covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

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

Member Benefits

Dell Children's Health Plan covers hospital, physician, and related medical services for the above conditions. This includes services the provider provides and other services your child might need, like anesthesia or other drugs.

Dell Children's Health Plan is also responsible for paying for treatment and devices for craniofacial anomalies.

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

- DentaQuest: **1-800-516-0165**
- MCNA Dental: **1-800-494-6262**
- UnitedHealthcare Dental: **1-877-901-7321**

Can someone interpret for me when I talk with my provider? Who do I call for an interpreter?

Call Member Services at **1-855-921-6284 (TTY 7-1-1)** to tell us if you need an interpreter at least 24 hours before your appointment. This service is also available for visits with your provider at no cost to you.

How far in advance do I need to call?

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

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 provider at his or her office.

What if I need OB-GYN care?

Female members can see any Dell Children's Health Plan network obstetrician or gynecologist (OB-GYN) for female health care needs.

ATTENTION FEMALE MEMBERS: Dell Children's Health Plan allows you to pick an OB-GYN but this provider must be in the same network as your primary care provider.

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

You have the right to pick an OB-GYN without a referral from your primary care provider. An OB-GYN can give you:

- One well-woman checkup per year

- Care related to pregnancy
- Care for any female medical condition
- Referral to special provider within the network

How do I choose an OB-GYN?

You're not required to pick an OB-GYN. However, if you're pregnant, you should pick one to care for you. You can pick any OB-GYN listed in the Dell Children's Health Plan provider directory. If you need help choosing one, call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

If I do not choose an OB-GYN, do I have direct access?

If you don't want to go to an OB-GYN, your primary care provider may be able to treat you for female health care needs. Ask your primary care provider if he or she can give you OB-GYN care. If not, you need to see an OB-GYN. You will find a list of OB-GYNs in the Dell Children's Health Plan provider directory. You can also search for one on our website at **DellChildrensHealthPlan.com** on the Find a Provider page.

Will I need a referral?

You don't need a referral. You can see only one OB-GYN in a month, but you can visit the same one more than once during that month, if needed.

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

Your OB-GYN should see you within two weeks. We can help you find an OB-GYN in our plan, if needed.

Can I stay with my OB-GYN if he or she is not with Dell Children's Health Plan?

In some cases, you may be able to keep seeing an OB-GYN who isn't in our plan. Please call Member Services to learn more.

What if I am pregnant? Who do I need to call?

If you think you're pregnant, call your primary care provider or OB-GYN right away. You don't need a referral from your primary care provider.

What other services/activities/education does Dell Children's Health Plan offer pregnant women?

We work to help keep you and your baby 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:

Member Benefits

- Dell Children's Health Plan services and how to get them
- Childbirth
- Infant care
- Parenting
- Pregnancy
- Other classes or events about health topics

For help finding a community program, call Member Services or dial 2-1-1. You can also find programs online at **neighborhoodresource.findhelp.com**. Please note: Some community organizations may charge a fee for their programs.

Text4Baby mobile tip program

Text4Baby is a free mobile tip program for all pregnant women. This program gives pregnant women and new moms tips to help them care for their health and give their babies the best start in life that they can. If you sign up for this service, you will get free SMS text messages each week, timed to your due date or your baby's first birthday. You can sign up for the service by just texting **BABY to 511411** (or BEBE for Spanish messages). You can use this service from the time you find out you are pregnant through your baby's first birthday.

Special Delivery pregnancy service coordination program

Our Special Delivery program gives pregnant women health information and rewards for getting prenatal and postpartum care. You get a service coordinator to help you get the prenatal care and services you need during your pregnancy and up to your 6-week postpartum checkup. Your service coordinator may call to check on you during your pregnancy. They can also help you find prenatal resources in your community. To find out more about the Special Delivery program, call **1-512-324-3015 (TTY 7-1-1)** or **1-844-964-3015 (TTY 7-1-1).**

When do I need to see my provider when I'm pregnant?

It is very important to see a provider or OB-GYN as soon as you know you are pregnant for prenatal care. When you're pregnant, you must go to your provider or OB-GYN at least:

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

Your provider or OB-GYN may want you to visit more often based on your health needs. Call Member Services at **1-855-921-6284 (TTY 7-1-1)** for help finding an OB-GYN and making an appointment.

1-855-921-6284 (TTY 7-1-1)

What value-added services* and education materials can I get when I'm pregnant and after I have had my baby?

When you're pregnant, Dell Children's Health Plan will send you pregnancy education materials and other helpful tools during your pregnancy, including:

- Convertible car seat for members who complete six prenatal visits during pregnancy. Limit one per pregnancy per child. Use voucher within three months.
- Pregnancy classes to help members prepare for childbirth and to educate and inform about each trimester, delivery and the postpartum period.
- Home visits when pregnant and after delivery. Doula services available during birth as well.
- Fresh food, fruits, vegetables or prepared meals for pregnant members after delivery. Limit to one shipment. Request within three months of delivery.
- Baby showers for pregnant members with education, resources and giveaway items that may include: diapers, diaper bags and blankets.

* These are some of the value-added services for members. Please refer to page 19 for details. Restrictions and limitations may apply.

Where can I find a list of birthing centers?

Please call us at **1-855-921-6284 (TTY 7-1-1)** to find out which birthing centers are in our health plan.

Can I pick a primary care provider for my baby before the baby is born?

Yes, you can pick a primary care provider for your baby before the baby is born.

When you have a new baby

When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery
- 96 hours after a cesarean section (C-section)

You may stay in the hospital for less time if your provider and the baby's provider see that you and your baby are doing well. If you and your baby leave the hospital early, your provider may ask you to have an office or in-home nurse visit within 48 hours.

How and when can I switch my baby's primary care provider?

To switch your baby's primary care provider, go to the Find a Provider link at **DellChildrensHealthPlan.com**. While there, you can search for a new one in our plan, then change your primary care provider on the member portal. To make the change online, you'll need to register first. Once you register, login and update your primary care provider.

Member Benefits

You can also call Member Services if you need help finding a new one. We can change your child's primary care provider on the same day you ask for the change. The change will be effective immediately. Call the primary care provider's office if you want to make an appointment. If you need help making an appointment, call Member Services.

Can I switch my baby's health plan?

For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the STAR Program Helpline at **1-800-964-2777.**

You cannot change health plans while your baby is in the hospital.

How do I sign up my newborn baby?

The hospital where your baby is born should help you start the Medicaid application process for your baby. Check with the hospital social worker before you go home to make sure the application is complete.
You should also call 2-1-1 to find your local Health and Human Services Commission (HHSC) office to make sure your baby's application has been received. If you're a Dell Children's Health Plan member when you have your baby, your baby will be enrolled with Dell Children's Health Plan on his or her date of birth.

How and when do I tell Dell Children's Health Plan?

Remember to call Dell Children's Health Plan Member Services as soon as you can to let your case manager know you had your baby. We will need to get information about your baby, too. You may have already picked a primary care provider for your baby before he or she was born. If not, we can help you pick a primary care provider for him or her.

How can I receive health care after my baby is born (and I am no longer covered by Medicaid)?

After your baby is born, you may lose Medicaid coverage. You may be able to get some health care services through the Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

Healthy Texas Women Program

The Healthy Texas Women Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.
To learn more about services available through the Healthy Texas Women Program, write, call, or visit the program's website:

1-855-921-6284 (TTY 7-1-1)

- Healthy Texas Women
  P.O. Box 149021
  Austin, TX 78714-9021
- **Phone:** 1-866-993-9972
- **Website: www.healthytexaswomen.org**
- **Fax:** (toll-free) 1-866-993-9971

DSHS Primary Health Care Program

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

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

- Diagnosis and treatment
- Emergency services
- Family planning
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your provider orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at **www.211texas.org.**

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

- **Website: www.hhs.texas.gov/services/health/primary-health-care-program**
- **Phone:** 211
- **Email: PrimaryHealthCare@hhs.texas.gov**

DSHS Expanded Primary Health Care program

The Expanded Primary Health Care program provides primary, preventive, and screening services to

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women aged 18 and above whose income is at or below the program's income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breastfeeding.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at **www.211texas.org**.

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

- **Website: www.hhs.texas.gov/services/health/primary-health-care-program**
- **Phone:** 211
- **Email: PrimaryHealthCare@hhs.texas.gov**

DSHS Family Planning Program

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

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at **www.healthytexaswomen.org/healthcare-programs/family-planning-program**.

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

- **Website: https://www.healthytexaswomen.org/family-planning-program**
- **Phone:** 512-776-7796
- **Email: famplan@hhs.texas.gov**

How and when do I tell my caseworker?

After you have your baby, call your HHSC benefits office to tell them your baby was born. The hospital will also tell Medicaid about the baby's birth. Call your caseworker by calling 2-1-1 after your baby is born. You DO NOT have to wait until you get your baby's Social Security number to get your baby signed up.

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

Members with disabilities, special health care needs or chronic complex conditions have a right to direct access to a specialist. This specialist may serve as your primary care provider. Please call Member Services at **1-855-921-6284 (TTY 7-1-1)** so this can be arranged.

What if I am too sick to make a decision about my medical care?

You can have someone make decisions on your behalf if you're too sick to make decisions for yourself.

1-855-921-6284 (TTY 7-1-1)

Please call Member Services at **1-855-921-6284 (TTY 7-1-1)** if you would like more information about the forms you need.

What are advance directives?

Emancipated minors and members aged 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 provider 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 provider or by calling Member Services. Dell Children's Health Plan 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 provider. Your provider 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 provider 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 provider about these forms.

Recertify your Medicaid benefits on time

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

Don't lose your health care benefits! You could lose your benefits even if you still qualify. Every 12 months you need to renew your benefits. The Health and Human Services Commission (HHSC) will send you a letter telling you it's time to renew your Medicaid benefits. The letter will have instructions to tell you how to renew. If you don't renew by the date in the letter, you'll lose your health care benefits.

You can apply for and renew benefits online at **YourTexasBenefits.com**. Click on Manage Your Account and set up an account to get easy access to the status of your benefits.

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

We want you to keep getting your health care benefits from us if you still qualify. To renew, go to **YourTexasBenefits.com** and click on Manage Your Account. Follow the directions there to renew.

Member Benefits

What happens if I lose my Medicaid coverage?

If you lose Medicaid coverage but get it back again within six (6) months, you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same primary care provider you had before.

If you're no longer eligible for Medicaid based on income, your children may be eligible for the Children's Health Insurance Program (CHIP). To find out more, call 2-1-1, pick a language, and select option 2.

What if I get a bill from my provider? Who do I call? What information will they need?

Always show your Dell Children's Health Plan ID card and YTB Medicaid 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 Dell Children's Health Plan ID card and current YTB Medicaid card to make sure you're not sent a bill for services Dell Children's Health Plan covers. You don't have to show your Dell Children's Health Plan ID card before you get emergency care. If you do get a bill, send the bill with a letter saying you have been sent a bill to:

Dell Children's Health Plan
Attn: Member Advocates
1345 Philomena St., Ste.305
Austin, TX 78723

In the letter, include:

- Your name
- Your telephone number
- Your Dell Children's Health Plan ID number

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

- The name of the provider you got services from
- The date of service
- The provider's phone number
- The amount charged
- The account number, if known

You can call Member Services at **1-855-921-6284 (TTY 7-1-1)** for help.

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and Member Services at **1-855-921-6284 (TTY 7-1-1)**. Before you get Medicaid services in your new area, you must call Dell Children's Health Plan, unless you need emergency services. You will continue to get care through Dell Children's Health Plan until HHSC changes your address.

1-855-921-6284 (TTY 7-1-1)

What if I need to update my address or phone number and I'm in the Adoption Assistance and Permanency Care Assistance Program?

The adoptive parent or permanency care assistance caregiver should contact the Department of Family and Protective Services (DFPS) regional adoption assistance eligibility specialist assigned to his or her case. If the parent or caregiver doesn't know who the assigned eligibility specialist is, they can contact the DFPS hotline, **1-800-233-3405,** to find out. The parent or caregiver should contact the adoption assistance eligibility specialist to assist with the address change.

What if I have other health insurance in addition to Medicaid?

Medicaid and private insurance

You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

- Your private health insurance is canceled
- You get new insurance coverage
- You have general questions about third party insurance

You can call the hotline toll-free at **1-800-846-7307.**

If you have other insurance you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

Rights and Responsibilities

1-855-921-6284 (TTY 7-1-1)

What are my rights and responsibilities?

Member rights

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:

- Be treated fairly and with respect.
- Know that your medical records and discussions with your providers will be kept private and confidential.

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:

- Be told how to choose and change your health plan and your primary care provider.
- Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
- Change your primary care provider.
- Change your health plan without penalty.
- Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:

- Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
- Be told why care or services were denied and not given.
- Be given information about your health, plan, services, and providers.
- Be told about your rights and responsibilities.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

- Work as part of a team with your provider in deciding what health care is best for you.
- Say yes or no to the care recommended by your provider.

Rights and Responsibilities

5. You have the right to use each complaint and appeal process available through the Managed Care Organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:

- Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
- Get a timely answer to your complaint.
- Use the plan's appeal process and be told how to use it.
- Ask for an external medical review and state fair hearing from the state Medicaid program and get information about how that process works.
- Ask for a state fair hearing without an external medical review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

- Have telephone access to a medical professional 24 hours a day, seven days a week to get any emergency or urgent care you need.
- Get medical care in a timely manner.
- Be able to get in and out of a health care provider's office; this includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
- Have interpreters, if needed, during appointments with your providers and when talking to your health plan; interpreters include people who can speak in your native language, help someone with a disability or help you understand the information.
- Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. 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.

8. You have a right to know that providers, hospitals and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Providers, hospitals and others cannot require you to pay copayments or any other amounts for covered services.

10. You have a right to make recommendations to your health plan's member rights and responsibilities.

1-855-921-6284 (TTY 7-1-1)

Member responsibilities

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    - Learn and understand your rights under the Medicaid program.
    - Ask questions if you do not understand your rights.
    - Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    - Learn and follow your health plan's rules and Medicaid rules.
    - Choose your health plan and a primary care provider quickly.
    - Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
    - Keep your scheduled appointments.
    - Cancel appointments in advance when you cannot keep them.
    - Always contact your primary care provider first for your nonemergency medical needs.
    - Be sure you have approval from your primary care provider before going to a specialist.
    - Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    - Tell your primary care provider about your health.
    - Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    - Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices and take action to keep yourself healthy. That includes the responsibility to:
    - Work as a team with your provider in deciding what health care is best for you.
    - Understand how the things you do can affect your health
    - Do the best you can to stay healthy
    - Treat providers and staff with respect
    - Talk to your provider about all of your medications

Rights and Responsibilities

Additional member responsibilities while using NEMT services

1. When requesting NEMT services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

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

You and your providers can get a copy of these rights and responsibilities by mail, fax or email. Call Member Services at **1-855-921-6284 (TTY 7-1-1)**, and ask for a copy. You can also download a copy from our website by going to **DellChildrensHealthPlan.com/for-members/how-your-plan-works** and choosing Member Rights and Responsibilities.

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 **1-855-921-6284 (TTY 7-1-1)** to tell us about your problem. A Dell Children's Health Plan Member Services Representative or a Member Advocate can help you file a complaint. Most of the time, we can help you right away or at the most within a few days. Dell Children's Health Plan cannot take any action against you as a result of your filing a complaint.

Can someone from Dell Children's Health Plan 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 **1-855-921-6284 (TTY 7-1-1).**

1-855-921-6284 (TTY 7-1-1)

How long will it take to process my complaint?

Dell Children's Health Plan will answer your complaint within 30 calendar days from the date we receive it.

What are the requirements and timeframes for filing a complaint?

You can tell us about your complaint by calling us at **1-855-921-6284 (TTY 7-1-1)** or writing us at:

Dell Children's Health Plan
Attn: Complaints Specialist
1345 Philomena St., Ste. 305
Austin, TX 78723.

We will send you a letter within five business days of getting your complaint. This means that we received your complaint and have started to look at it. The letter will contain the description of Dell Children's Health Plan's complaint process and timeframes for processing. We may call you to get more information.

Dell Children's Health Plan will investigate the complaint and will send you a resolution letter within 30 calendar days following the receipt of the complaint. This letter will tell you what we have done to address your complaint. The complaint resolution letter includes the process to appeal the decision when the member or member's representative is not satisfied with Dell Children's Health Plan response.

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.

How do I file a complaint with the Health and Human Services Commission once I have gone through the Dell Children's Health Plan complaint process?

If you are a Medicaid member, once you have gone through the Dell Children's Health Plan complaint process, if you are not satisfied with the answer to your complaint, you can file a complaint with the Health and Human Services Commission (HHSC) by calling toll-free **1-866-566-8989.** If you would like to file your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you can get on the Internet, you can send your complaint in an email to **https://hhs.texas.gov/omcat**.

Do I have the right to a complaint appeal?

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

Rights and Responsibilities

Dell Children's Health Plan
Attn: Complaints Specialist
1345 Philomena St., Ste. 305
Austin, TX 78723

When we get your request, we will send you a letter within 5 business days. This means we have your request and started to work on it. You can also call us at **1-855-921-6284 (TTY 7-1-1)** to ask for a complaint appeal.

We will send you a letter within 30 calendar days of getting your request. The letter will tell you the complaint appeal decision. This letter will also give you the information used to make the decision.

Appeals process

What can I do if my provider asks for a service or medicine for me that is covered but Dell Children's Health Plan denies or limits it?

There may be times when we say we will not pay for all or part of the care that has been recommended. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Dell Children's Health Plan to look again at the care your provider asked for and we said we will not pay for. A designated representative can be a family member, your provider, an attorney, a friend or any person you choose.

If you ask someone (a designated representative) to file an appeal for you, you must also send a letter to Dell Children's Health Plan to let us know you have chosen a person to represent you. Dell Children's Health Plan must have this written letter to be able to consider this person as your representative. We do this for your privacy and security.

You can appeal our decision in 3 ways:

- You can call Member Services at **1-855-921-6284 (TTY 7-1-1)**
- You can fill out the **Appeal Request Form**, included in the denial letter.
- You can send us a letter to:
  Dell Children's Health Plan Appeals
  1345 Philomena St., Ste 305
  Austin, TX 78723.

How will I find out if services are denied?

Dell Children's Health Plan will send you a letter if a requested service is denied or limited. If you disagree with the decision, you may file an appeal for all the services or part of the services denied.

1-855-921-6284 (TTY 7-1-1)

What are the time frames for the appeals process?

If we deny all or part of a service your doctor recommends, you have the right to appeal our decision. You can request an appeal by completing the Member Notice of Adverse Benefit Determination Form included with your denial letter. This form also allows you to name a designated representative to help you with your appeal, so you do not need to send a separate authorization letter if you complete that section.

You must send your appeal within 60 days of the date on your denial letter. After we get your appeal, we will send you a letter within 5 business days to let you know we received it and to tell you if we need anything else. We may also contact your doctor if we need more medical information.

A doctor who has not seen your case before will look at your appeal. He or she will decide how we should handle your appeal. We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal unless we need more information from you or the person you asked to file the appeal for you. If we need more information, we may extend the appeals process for 14 days. If we extend the appeals process, we will let you know the reason for the delay. You may also ask us to extend the process if you know more information that we should consider.

How can I continue receiving services that were already approved?

To continue receiving services that had already been approved by Dell Children's Health Plan but may be part of the reason for your appeal, you must file the appeal on or before the later of:

- 10 business days after we send the notice to you to let you know we will not pay for or cover all or part of the care, or
- The date the notice says the service will end

If the decision on your appeal upholds our first decision, you may be asked to pay for the services you received during the appeals process.

If the decision on your appeal reverses our first decision, Dell Children's Health Plan will pay for the services you received while your appeal was pending.

Can someone from Dell Children's Health Plan help me file an appeal?

Yes, a Member Advocate or Member Services Representative can help you file an appeal with Dell Children's Health Plan or with the appropriate state program. Please call Member Services at **1-855-921-6284 (TTY 7-1-1)**, Monday through Friday, 8 a.m. to 5 p.m. Central time.

Can I request a state fair hearing?

Yes. You can ask for a state fair hearing after the Dell Children's Health Plan internal appeal process is complete. See the next sections, "Expedited appeals" and "State fair hearings", to learn more.

Rights and Responsibilities

Expedited appeals

What is an emergency appeal?

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

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

You or the person you ask to file an appeal for you (a designated representative) can request an expedited appeal. You can request an expedited appeal orally or in writing by either:

- Calling Member Services at **1-855-921-6284 (TTY 7-1-1)**, Monday through Friday, 8 a.m. to 5 p.m. Central time.
- Sending a letter to:
  Dell Children's Health Plan
  Attn: Appeals
  1345 Philomena St., Ste. 305
  Austin, TX 78723

What are the time frames for an emergency appeal?

If you feel your health will be seriously harmed by waiting for a decision on your health plan appeal, you or your provider can ask for an emergency health plan appeal. We'll review your case and determine if you qualify for an emergency health plan appeal. We must decide to approve or deny your appeal within 72 hours of your request. If you do not qualify for an emergency appeal, we will let you know. We will process your appeal according to the standard timeframe. You can file a complaint if you do not agree with our decision to deny your request for an emergency health plan appeal.

After we receive your letter or call and agree your request for an appeal should be expedited, we will send you a letter with the answer to your appeal. We will do this within 72 hours from receipt of your appeal request.

If your appeal is about an ongoing emergency or hospital stay, we will call you with an answer within 1 business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal within 72 hours.

What happens if Dell Children's Health Plan denies the request for an emergency appeal?

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

1-855-921-6284 (TTY 7-1-1)

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 **1-855-921-6284 (TTY 7-1-1)**, Monday through Friday, 8 a.m. to 6 p.m. Central time.

External medical review information

Can I ask for an external medical review?

If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for an external medical review. An external medical review is an optional, extra step the member can take to get the case reviewed before the state fair hearing occurs.
The member may name someone to represent them by contacting the health plan and giving the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the external medical review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the external medical review within 120 days, the member may lose his or her right to an external medical review. To ask for an external medical review, the member or the member's representative may either:

- Fill out the "State Fair Hearing and External Medical Review Request Form" provided as an attachment to the member notice of internal appeal decision letter and mail or fax it to Dell Children's Health Plan by using the address or fax number at the top of the form;
- Call Dell Children's Health Plan at **512-324-3013** or **1-855-962-4453 (TTY 7-1-1)**; or
- Email Dell Children's Health Plan at **dchp-UM@ascension.org**

If the member asks for an external medical review within 10 days from the time the member gets the appeal decision from the health plan, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final state fair hearing decision is made. If the member does not request an external medical review within 10 days from the time the member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The member may withdraw the member's request for an external medical review before it is assigned to an independent review organization or while the independent review organization is reviewing the member's external medical review request. An independent review organization is a third-party organization contracted by HHSC that conducts an external medical review during member appeal processes related to adverse benefit determinations based on functional necessity or medical necessity. An external medical review cannot be withdrawn if an independent review organization has already completed the review and made a decision.

Rights and Responsibilities

Once the external medical review decision is received, the member has the right to withdraw the state fair hearing request. The member may withdraw a state fair hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the member continues with a state fair hearing and the state fair hearing decision is different from the independent review organization decision, it is the state fair hearing decision that is final. The state fair hearing decision can only uphold or increase member benefits from the independent review organization decision.

Can I ask for an emergency external medical review?

If you believe that waiting for a standard external medical review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized representative may ask for an emergency external medical review and emergency state fair hearing by writing or calling Dell Children's Health Plan. To qualify for an emergency external medical review and emergency state fair hearing review through HHSC, you must first complete Dell Children's Health Plan's internal appeals process.

State fair hearing

Can I ask for a state fair hearing?

If you, as a member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a state fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the state fair hearing within 120 days of the date on the health plan's letter with the internal appeal decision. If you do not ask for the state fair hearing within 120 days, you may lose your right to a state fair hearing. To ask for a state fair hearing, you or your representative should contact us by:

- **Writing to:**
  Dell Children's Health Plan
  1345 Philomena St., Ste. 305
  Austin, TX 78723
- **Calling us:** 512-324-3013 or 1-855-962-4453 (TTY 7-1-1), Monday through Friday, 8 a.m. to 6 p.m. Central time
- **Emailing us:** at **dchp-UM@ascension.org**.

You have the right to keep getting any service the health plan denied or reduced based on previously authorized services, at least until the final state fair hearing decision is made if you ask for a state fair

hearing by the later of: (1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or (2) the day the health plan's internal appeal decision letter says your service will be reduced or end. If you do not request a state fair hearing by this date, the service the health plan denied will be stopped. If you ask for a state fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most state fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied. HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Can I ask for an emergency state fair hearing?

If you believe that waiting for a state fair hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency state fair hearing by:

- **Writing to:**
  Dell Children's Health Plan
  1345 Philomena St., Ste. 305
  Austin, TX 78723
- **Calling us:** 512-324-3013 or 1-855-962-4453 (TTY 7-1-1), Monday through Friday, 8 a.m. to 6 p.m. Central time
- **Emailing us:** at **dchp-UM@ascension.org**.

To qualify for an emergency state fair hearing through HHSC, you must first complete Dell Children's Health Plan's internal appeals process.

Fraud, waste and abuse information

Do you want to report waste, abuse or fraud?

Let us know if you think a provider, dentist, pharmacist at a drug store, other health care providers, or a person getting 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 services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid ID
- Using someone else's Medicaid ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

Rights and Responsibilities

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

- Call the OIG Hotline at **1-800-436-6184**
- Visit **https://oig.hhsc.state.tx.us** and click the red "Report Fraud" box to complete the online form
- Report directly to your health plan:
  Dell Children's Health Plan
  Attn: Compliance Officer
  1345 Philomena St., Ste. 305
  Austin, TX 78723
  1-855-921-6284

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

When reporting about a provider (a provider, 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 (provider, 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 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

1-855-921-6284 (TTY 7-1-1)

Quality Management

What does Quality Management do for you?

The Dell Children's Health Plan Quality Management program is here to make sure you are being cared for. We look at services you have received to check if you are getting the best preventive health care. If you have a chronic disease, we check if you're getting help managing your condition.

The Quality Management department develops programs to help you learn more about your health care. We also conduct an annual member satisfaction survey. This helps us learn how we can better serve you and make sure our providers are taking good care of you. If you receive a notice to fill out a satisfaction survey please take the time to fill it out.

We work with our network providers to help them care for you. You may get mailings from us about satisfaction surveys, taking preventive health steps or managing an illness. We want you to help us improve by telling us what we can do better. Please tell us how happy you are with your provider and with us. To learn more about our Quality Management program, please call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

What are clinical practice guidelines?

Dell Children's Health Plan uses national clinical practice guidelines for your care. Clinical practice guidelines are nationally recognized, scientific, proven standards of care. These guidelines are recommendations for physicians and other health care providers to diagnose and manage your specific condition. If you would like a copy of these guidelines, call Member Services at **1-855-921-6284 (TTY 7-1-1)**.

Information that must be available once a year

As a member of Dell Children's Health Plan, you can ask for and get the following information each year.

- Information about network providers—at a minimum, primary care providers, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal, and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits; this is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits, including authorization requirements.

Rights and Responsibilities

- How you get benefits, including family planning services, from out-of-network providers, and/or limits to those benefits.
- How you get after-hours and emergency coverage and/or limits to those kinds of benefits, including:
    - What makes up emergency medical conditions, emergency services, and post-stabilization services.
    - The fact that you do not need prior authorization from your primary care provider for emergency care services.
    - How to get emergency services, including instructions on how to use the 9-1-1 telephone system or its local equivalent.
    - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
    - A statement saying you have a right to use any hospital or other settings for emergency care
    - Post stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your primary care provider.
- The Dell Children's Health Plan practice guidelines.

How is new technology evaluated?

The Dell Children's Health Plan Medical Director and our providers look at advances in medical technology and new ways to use existing medical technology. We look at advances in:

- Medical procedures
- Behavioral health procedures
- Medicines
- Devices

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

1-855-921-6284 (TTY 7-1-1)

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.

Rights and Responsibilities

Term	Definition
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
Hospital outpatient care	Care in a hospital that usually doesn't require an overnight stay.
Medically necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Network	The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.
Non-participating provider	A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.
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.—Provider 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.

1-855-921-6284 (TTY 7-1-1)

Term	Definition
Primary care physician	A provider (M.D. - Medical Doctor or D.O. - Provider of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.
Primary care provider	A provider (M.D.—Medical Doctor or D.O.—Provider 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 provider (M.D.—Medical Doctor or D.O.—Provider of Osteopathic Medicine), health care professional, or health care facility licensed, certified, or accredited as required by state law.
Rehabilitation services and devices	Health care services such as physical or occupational therapy that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.
Skilled nursing care	Services from licensed nurses in your own home or in a nursing home.
Specialist	A provider 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.

HIPAA notice of privacy practices

The original effective date of this notice was April 14, 2003. The most recent revision date is March 2021.

Please read this notice carefully. This tells you:

- Who can see your protected health information (PHI).
- When we have to ask for your OK before we share your PHI.
- When we can share your PHI without your OK.
- What rights you have to see and change your PHI.

Rights and Responsibilities

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you are a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your providers, clinics, labs, and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that is told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
    - Lock our offices and files.
    - Destroy paper with health information so others cannot get it.
- Saved on a computer (called technical), we:
    - Use passwords so only the right people can get in.
    - Use special programs to watch our systems.
- Used or shared by people who work for us, providers, or the state (called administrative), we:
    - Make rules for keeping information safe.
    - Teach people who work for us to follow the rules.

When it is OK for us to use and share your PHI

We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it is OK. Sometimes, we can use and share it without your OK:

- For your medical care
    - To help providers, hospitals and others get you the care you need
- For payment, health care operations and treatment
    - To share information with the providers, clinics and others who bill us for your care
    - When we say we will pay for health care or services before you get them (called prior authorization or pre-approval)
    - To find ways to make our programs better, as well as support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, health care operations and treatment. If you do not want this, please visit **DellChildrensHealthPlan.com** for more information.

1-855-921-6284 (TTY 7-1-1)

- For health care business reasons
    - To help with audits, fraud and abuse prevention programs, planning and everyday work to find ways to make our programs better
- For public health reasons
    - To help public health officials keep people from getting sick or hurt
- With others who help with or pay for your care
    - With your family or a person you choose who helps with or pays for your health care, if you tell us it is OK
    - With someone who helps with or pays for your health care, if you cannot speak for yourself and it is best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research, or other things listed below. We have to get your written OK before we share psychotherapy notes from your provider about you.

You may tell us in writing that you want to take back your written OK. We cannot take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can—or the law says we have to—use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we are asked
- To answer legal documents
- To give information to health oversight agencies for things such as audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to worker's compensation if you get sick or hurt at work

Rights and Responsibilities

Your rights

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We do not have your whole medical record, though. If you want a copy of your whole medical record, ask your provider or health clinic.
- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we do not have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past 6 years we shared your PHI with someone else. This will not list the times we shared it because of health care, payment, everyday health care business, or some other reasons we did not list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for one by email.
- If you pay the whole bill for a service, you can ask your provider not to share the information about that service with us

What we have to do

- The law says we must keep your PHI private except as we said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we will do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, such as if you are in danger.
- We must tell you if we have to share your PHI after you asked us not to.
- If state laws say we have to do more than what we said here, we will follow those laws
- We have to let you know if we think your PHI has been breached.

1-855-921-6284 (TTY 7-1-1)

Contacting you

We, along with our affiliates and vendors, may call or text you using an automatic telephone dialing system or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we will not contact you in this way anymore. Or you may call **1-855-921-6284 (TTY 7-1-1)** toll-free to add your phone number to our Do Not Call list.

What to do if you have questions

If you have questions about our privacy rules or want to use your rights, please call Member Services toll free at **1-855-921-6284 (TTY 7-1-1)** Monday through Friday, 8 a.m. to 6 p.m. Central time.

What to do if you have a complaint

We are here to help. If you feel your PHI has not been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

You may write to or call the Department of Health and Human Services:

- Office for Civil Rights
  U.S. Department of Health and Human Services
  1301 Young St., Ste. 1169
  Dallas, TX 75202
- **Phone:** 800-368-1019
- **TDD:** 800-537-7697
- **Fax:** 214-767-0432

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we will tell you about the changes in a letter. We also will post them on our website, **DellChildrensHealthPlan.com**.

Race, ethnicity and language

We get race, ethnicity and language information about you from state agencies for Medicaid and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need.
- Create programs to improve health outcomes.

Rights and Responsibilities

- Create and send health education information.
- Let providers know about your language needs.
- Provide interpretation and translation services.

We do not use this information to:

- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information

We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It is often taken for insurance reasons.

- We may use your PI to make decisions about your:
    - Health
    - Habits
    - Hobbies
- We may get PI about you from other people or groups such as:
    - Providers
    - Hospitals
    - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We will let you know before we do anything where we have to give you a chance to say no.
- We will tell you how to let us know if you do not want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact Member Services toll free at **1-855-921-6284 (TTY 7-1-1)** Monday through Friday, 8 a.m. to 5 p.m. Central time.

1-855-921-6284 (TTY 7-1-1)

Dell Children's Health Plan follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

Communicating with you is important

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Member Advocate at **1-855-921-6284 (TTY 7-1-1)**.

Your rights

Do you feel you didn't get these services or we discriminated against you for reasons listed above? you can file a complaint. File by mail, email or phone:

- Dell Children's Health Plan
  Attn: Member Advocate
  1345 Philomena St., Ste. 305
  Austin, TX 78723
- **Phone:** 1-855-921-6284 (TTY 7-1-1)
- **Email: DCHPcomplaints@ascension.org**

Rights and Responsibilities

Need help filing?

Call a Member Advocate at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **Office for Civil Rights Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**.
- **By mail:**
  HHSC Civil Rights Office
  701 W. 51st Street
  Mail Code W206
  Austin, Texas 78751
- **By phone:** Toll Free (888) 388-6332 or (512) 438-4313 (TTY: (877) 432-7232
- **By Fax:** (512)-438-5885

1345 Philomena St., Suite 305
Austin, TX 78723

We go above and Beyond
Vamos más allá

dell children's
Health Plan

Follow us on

MS-0526-108