COMMUNITY FIRST HEALTH PLANS

TEXAS STAR Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Updated August 2022

STAR MEMBER HANDBOOK

MEMBER SERVICES (210) 227-2347

TOLL FREE 1-877-434-2347

Atascosa • Bandera • Bexar • Comal • Guadalupe • Kendall • Medina • Wilson

Community First Health Plans is a proud member of the University Health family.

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STAR MEMBER HANDBOOK

Community First Health Plans covers Members in
Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson counties.

STAR MEDICAID MEMBER SERVICES
1-800-434-2347

TEXAS Health and Human Services | TEXAS STAR Your Health Plan ★ Your Choice

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INTRODUCTION

Welcome to Community First Health Plans! We are so happy you chose us for your health care needs. Community First Health Plans was created with the health of our local community in mind. We believe that everyone should have access to quality health care and we are honored that you have put your trust in our hands.

As the only local, non-profit health care plan in this area's STAR Medicaid Health Program, we understand the unique health care needs of our community. We are proud to be your neighbor! We are truly invested in our Members' health and we can help you access the health care services you need including doctors, hospitals, and community resources.

Please read this Member Handbook for information about your health plan benefits and what is covered under your plan.

What if I need help understanding or reading the Member Handbook?
If you need help understanding or reading this handbook, our Member Services Representatives can assist you in both English and Spanish. You can also get this handbook in other formats, such as large print, braille, or audio. We will mail you a copy free of charge within five business days of your request and update your personal record with your preferred language or format. In the future, when you contact us, we will verify this information. You may ask us to update it at any time.

If you prefer this handbook in an alternate format or would like a printed copy, please contact Member Services at one of the toll-free numbers listed below.

MEMBER SERVICES

A Member Services Representative can answer your questions about all covered services under your health care plan. Member Services can also help you select or change your primary care provider (PCP), access services that do not require a referral from your (PCP), send you a new Member ID card, and help resolve any problems or complaints.

CALL	1-800-434-2347 Monday through Friday, 8:00 a.m. to 5:00 p.m. (CST) Message service available on weekends and holidays. This call is free. For emergency services, dial 9-1-1 or go to the nearest emergency room. We have free interpreter services for people who do not speak English.
TTY	1-800-390-1175 24 hours a day, 7 days a week. This call is free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

MENTAL HEALTH & SUBSTANCE USE SERVICES

Call toll-free to talk to someone if you need help right away. You do not need a referral for mental health or substance use services. For emergency services, dial 9-1-1 or go to the nearest emergency room.

CALL	1-877-221-2226 24 hours a day, 7 days a week. This call is free. We have free interpreter services for people who do not speak English.
TTY	1-800-390-1175, 24 hours a day, 7 days a week. This call is free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

NURSE ADVICE LINE

Community First has a Nurse Advice Line available 24 hours a day, 7 days a week, 365 days a year to help you get the care you need.

CALL	1-800-434-2347, 24 hours a day, 7 days a week. This call is free. We have free interpreter services for people who do not speak English.
TTY	1-800-390-1175, 24 hours a day, 7 days a week. This call is free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

VISION

Envolve provides routine eye care services to our Members. Call Member Services for help finding a network vision provider near you.

CALL	1-800-434-2347 Monday-Friday, 8:00 a.m. to 5:00 p.m. This call is free.

DENTAL

Call your Medicaid dental plan for information about preventive dental services.

CALL	**DentaQuest** 1-800-516-0165 **MCNA Dental** 1-800-494-6262 **United Healthcare Dental** 1-877-901-7321

PRESCRIPTION DRUG MEDICATIONS

Community First's partner for pharmacy benefits is Navitus. Call the toll-free number listed on your pharmacy benefits Member ID card or call Community First Member Services for information about your prescription drug medication benefits.

CALL	1-800-434-2347 Monday-Friday, 8:00 a.m. to 5:00 p.m. This call is free.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

NEMT services provide transportation to non-emergency health care appointments for Members who have no other transportation options. Call to reserve a ride at least 48 hours before your appointment.

CALL	**NEMT Member Reservation Line:** 1-888-444-0307 Monday-Friday, 8 a.m. to 5 p.m. This call is free. Information available in both English and Spanish. Interpreter services available. **Where's My Ride?:** 1-888-444-0824 Monday-Friday, 8 a.m. to 5 p.m. This call is free. Information available in both English and Spanish. Interpreter services available.
TTY	7-1-1 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

OTHER HELPFUL NUMBERS

Ombudsman Managed Care Assistance Team	1-866-566-8989
STAR Program Help Line	1-800-964-2777
Texas Health Steps Outreach and Information Hotline	1-877-847-8377

For emergency services, dial 9-1-1 or go to the nearest emergency room.

COMMUNITY FIRST HEALTH PLANS WEBSITE

You can access plan information and resources online 24 hours a day, 7 days a week on our website at CommunityFirstHealthPlans.com including:

- Secure Member Portal
- Member Newsletters
- Value-Added Services available to you as a Community First STAR Member
- Community First Health Plans blog with information about different health topics
- Provider/Pharmacy Directory

COMMUNITY FIRST HEALTH PLANS LOCATIONS

Community First Health Plans has two locations to serve you:

Corporate Office
Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

Community Office at Avenida Guadalupe
Community First Health Plans
1410 Guadalupe Street, Suite 222
San Antonio, TX 78207

OFFICE HOURS

8:30 a.m. to 5:00 p.m.
Monday through Friday, except state-approved holidays
Visit our website at CommunityFirstHealthPlans.com

MEMBER IDENTIFICATION (ID) CARDS

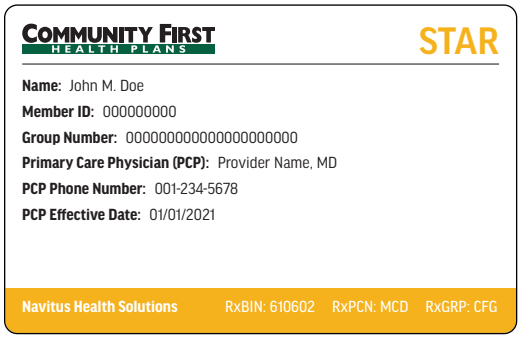
When you sign up to become Community First Health Plans Member, you will receive a Community First Member ID card for each Member. If you do not receive a card, please call Member Services.

YOUR COMMUNITY FIRST MEMBER ID CARD

The following information can be found on your Member ID card:

- Your name
- Member ID number
- Effective date (starting date of coverage under your health care plan)
- Your primary care provider's (PCP) name and phone number
- What to do in the event of an emergency
- How to reach Member Services
- How to get help in Spanish or another language

Community First Health Plans Member ID Cards - STAR



How do I use my Member ID Card?

Carry your Community First Member ID card with you at all times. Show this card to your doctor so they know you are covered by a Medicaid program.

You must show both Your Texas Benefits Medicaid Card and your Community First ID card when you receive health care services.

What if my card is lost or stolen?

If your Community First Member ID Card is lost or stolen, please call Member Services at 1-800-434-2347 and ask for a new one. You can also log in to our secure Member Portal at CommunityFirstHealthPlans.com to print a temporary ID card and/or request a new one.

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 doctor can use the card to find out if you or your child have Medicaid benefits when you go for a visit.

MEMBER IDENTIFICATION (ID) CARDS

You will be issued only one card and you 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 www.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.

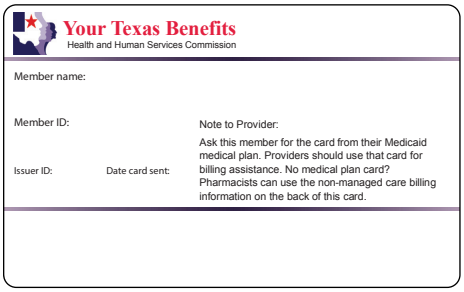
Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your medical and dental information through the secure online network, call toll-free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

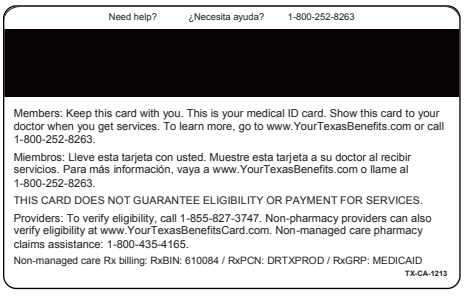
The YTB Medicaid card has these facts printed on the front:

- 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 doctor and drug store if you're in the Medicaid Lock-in program.

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

Your Texas Benefits Medicaid Card





If you forget your card, your doctor, 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 doctors and staff see your available medical and dental information

To access the portal, go to www.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 www.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.

What if my Texas Benefits Medicaid Card is lost or stolen?
If your Texas Benefits Medicaid Card is lost or stolen, you can get a new one by calling toll-free 1-855-827-3748. You will receive a temporary Medicaid ID card called a Form 1027-A in the mail until your new one can be printed. Form 1027A tells Providers about you or your child and the services that you or your child can get during the time period listed.

The back of Form 1027A tells you how and when to use the card. There is also a box that has specific information for Providers. You must take your Form 1027-A and your Community First Member ID card with you when you get any health care services. You will need to show these cards every time you need services. You can use this temporary ID card until you get a new Your Texas Benefits Medicaid Card.

PRIMARY CARE PROVIDER (PCP)

What is a primary care provider (PCP)?
A primary care provider (PCP) is you or your child's own doctor or health care clinic. Your PCP will take care of your medical needs and act as your main health care provider. If a specialist or tests are needed, your PCP will request them for you using a referral and tell you how to make an appointment. If you or your child needs to be admitted to the hospital, your PCP can also arrange your care.

A PCP can be a:

- Pediatrician
- Family or general practitioner
- Internist
- Obstetrician/gynecologist (OB/GYN)
- Nurse Practitioner (NP) or Physician Assistant (PA)

Remember, your PCP is the most important person on you/your child's health care team!

CHOOSING A PRIMARY CARE PROVIDER

How can I/my child get a primary care provider?
You can choose a primary care provider from our STAR Provider Directory at CommunityFirstHealthPlans.com/Find-Provider. You can also call Member Services at 1-800-434-2347 if you need help. If you do not choose a primary care provider, one will be selected for you.

When and why should I/my child see a primary care provider?
Your primary care provider is your best resource for health advice. You should see your primary care provider regularly, even if you have no health concerns. He/she can recommend certain screenings depending on health factors and provide needed preventive care.

Can a clinic (Rural Health Clinic/Federally Qualified Health Center) be my/my child's primary care provider?
Yes. You may pick a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) from our STAR Provider Directory.

Can a specialist ever be considered a primary care provider?
If you have a very serious medical condition, you may ask for a specialist to act as your primary care provider. The specialist must be approved by Community First Health Plans. The specialist must also be willing to be your primary care provider.

What if I choose to go to another doctor who is not my primary care provider?
For routine care, you should always go to your primary care provider. If you go to another doctor who is not your primary care provider, you might be asked to sign a form that says you will pay the bill. You may go to a different doctor for Texas Health Steps checkups or family planning services.

How do I get medical care when my primary care provider's office is closed?
If you have an urgent problem, call your primary care provider first. Your primary care provider, or a doctor on-call is available to you, either in-person or by phone, 24 hours a day, seven days a week.

You can also call our 24/7 Nurse Advice Line at 1-800-434-2347. The nurse might give you at-home medical advice or refer you to an urgent care center/hospital emergency room, if needed.

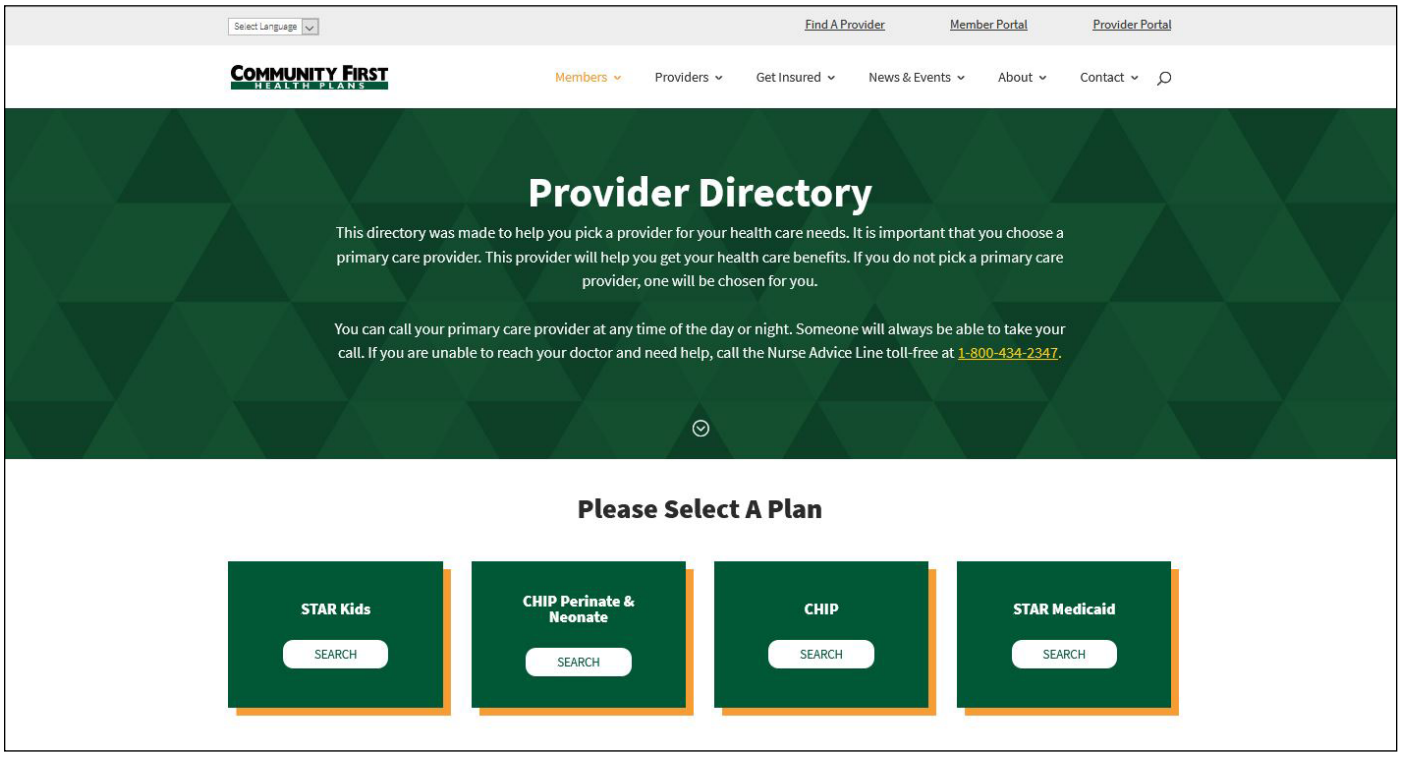
CHANGING YOUR PRIMARY CARE PROVIDER

How can I change my/my child's primary care provider?
A Member Services Representative can help you choose a new primary care provider. Call Member Services toll-free at 1-800-434-2347.

You can also submit a request to change your PCP at CommunityFirstHealthPlans.com through our secure Member Portal or write to us at:

Community First Health Plans
Attention: Member Services
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

For a list of PCPs in the Community First network, visit our STAR Provider Directory at CommunityFirstHealthPlans.com/Find-Provider.



You can also call Member Services if you have questions about your PCP's professional qualifications or for a current list of in-network PCPs and other providers.

PRIMARY CARE PROVIDER (PCP)

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 1-800-434-2347.

You can also submit a request to change your primary care provider at CommunityFirstHealthPlans.com through our secure Member Portal or write to us at:

Community First Health Plans
Attention: Member Services
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

When will my/my child's primary care provider change become effective?
If you change your primary care provider, the change will become effective immediately.

What if my/my child's primary care provider leaves Community First Health Plans' network?
We will send you a letter to inform you that your primary care provider has left our network and that we have chosen a new primary care provider for you or your child. If you prefer to select a different primary care provider, call Member Services and tell us the doctor you want.

If you or your child is receiving medically necessary treatments, you might be able to stay with your current doctor, even if he/she leaves our network, if he/she is willing to continue seeing you or your child. When we find a new doctor in our network who can provide the same type of care, we will change your doctor.

Are there reasons why a request to change my primary care provider may be denied?
Community First might deny your primary care provider change request if:

- The doctor you chose does not take patients with your needs.
- The doctor you chose is not accepting new patients.
- You are in the hospital when you make the request.

Can my primary care provider move me to another primary care provider for non-compliance?
Yes, for the following reasons:

- You miss three appointments in a row during a six-month period and do not contact your doctor before your missed appointment.
- You do not follow your doctor's advice.
- You are rude, abusive, or do not work with your doctor or your doctor's staff.

PHYSICIAN INCENTIVE PLAN INFORMATION

Community First Health Plans cannot make payments under a physician incentive plan if the payments are designed to induce Providers to reduce or limit Medically Necessary covered services to Members. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call 1-800-434-2347 to learn more about this.

MAKING AN APPOINTMENT

How do I make an appointment with my/my child's primary care provider?
Call your primary care provider (PCP) to make an appointment. You can find his/her number on your Community First Member ID card. Tell your PCP's office you are a Community First Health Plans Medicaid Member and have your Community First Member ID card and Your Texas Benefits Medicaid card with you when you call.

What do I need to bring with me to my/my child's doctor appointment?

- Your Community First Member ID card
- Your Texas Benefits Medicaid Card
- Immunization (shot) records
- A list of all medications you/your child are currently taking
- Community First Health Plan's checkup checklist

We care about your health. Preventive care services like regular health checkups with your PCP are essential to helping create better health outcomes and help your doctor get to know you or your child so they can help plan for future health care needs.

COMMUNITY FIRST CHECKUP CHECKLIST

What To Ask At Your Health Checkup

5 questions to ask your Primary Care Provider (PCP)

Here are a few important questions you might want to ask your primary care provider at your next health checkup. Print and take this list with you to your appointment or pull it up on your phone while you are waiting to be seen.

1. **This is how I'm feeling. Do these symptoms seem normal to you?** Tell your primary care provider exactly how you're feeling. Be honest. Ask if what you're feeling is normal.
2. **What screening tests do I need?** Ask your primary care provider if they recommend certain screenings depending on your age, gender, and family history.
3. **Am I at a healthy weight?** If you want to lose weight, ask for help creating a diet and exercise plan.
4. **Are there better treatment options available for my condition?** If you're not happy with your current medication or treatment, ask for other options.
5. **What should I do before my next visit?** Ask when you should be seen next and what you can work on between appointments.

TEXAS HEALTH STEPS

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

TEXAS HEALTH STEPS

What services are offered by Texas Health Steps?
Texas Health Steps gives your child:

- Free regular medical checkups starting at birth.
- Free dental checkups starting at six 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 letter from Texas Health Steps telling you when it's time for a checkup. Call your child's doctor or dentist to set up the checkup.
- Set up the checkup time that works best for your family.

If the doctor 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.
- Other health and dental care.
- Treatment for other medical conditions.

Call Community First Health Plans toll-free at 1-800-434-2347 or Texas Health Steps toll-free at 1-877-847-8377 (1-877-THSTEPS) if you:

- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps.
- Need help finding or 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 doctor, dentist, hospital, or drug store. Contact Community First for more information.

Does my doctor have to be a part of the Community First Health Plans network for a Texas Health Steps checkup?
No. You can use any Texas Health Steps provider in the state.

Do I have to have a referral for a Texas Health Steps checkup?
You do not need a referral from your primary care provider to receive a Texas Health Steps checkup. If you need help finding a doctor, call Member Services at 1-800-434-2347.

What if I need to cancel an appointment?
Please call your doctor or dentist as soon as possible if you cannot make your Texas Health Steps medical or dental visit. They can help you reschedule the appointment.

What if I am out of town and my child is due for a Texas Health Steps checkup?
If you have moved or are out of town when your child's Texas Health Steps exam is due, call Member Services for help.

What if I am a Traveling Farmworker?
You can get your checkup sooner if you are leaving the area.

HAVE QUESTIONS ABOUT TEXAS HEALTH STEPS?

CALL MEMBER SERVICES AT **1-800-434-2347** OR TEXAS HEALTH STEPS AT **1-877-847-8377 (1-877-THSTEPS)** TOLL-FREE IF YOU:

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

TYPES OF MEDICAL CARE

ROUTINE MEDICAL CARE

What is routine medical care?
Routine medical care is the regular care you get from your PCP to help keep you healthy, such as regular checkups. You can call your PCP to make an appointment for routine medical care. Routine medical care includes:

- Regular checkups
- Treatment when you are sick
- Follow-up care when you have medical tests
- Prescriptions

What should I do if my child or I need routine medical care?
Contact your PCP to make an appointment for routine medical care including regular health checkups.

How soon can I expect to be seen?
You can expect to be seen for routine medical care within two weeks.

URGENT MEDICAL CARE

What is urgent medical care?
Another type of medical 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 medical care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Community First Health Plans Medicaid.

For help, call us toll-free at 1-800-434-2347. You also can call our 24-hour Nurse Advice Line at 1-800-434-2347 for help with getting the care you need.

How soon can I expect to be seen?
You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor 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 Community First Health Plans Medicaid.

EMERGENCY MEDICAL CARE

What is 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; or
5. In the case of a pregnant women, 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 an average knowledge of medicine and health:

1. Requires immediate intervention or medical attention without which the Member would present an immediate danger to themselves or others; or
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 that are needed to evaluate or stabilize an Emergency Medical Condition or Emergency Behavioral Health Condition, including post-stabilization care services.

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

What do I do in case of a true emergency?

- Go to the nearest emergency room.
- Call 9-1-1 if you need help getting to the hospital.
- Call your personal doctor as soon as possible after your emergency care.
- Your personal doctor will give you follow-up care.

How soon can I expect to be seen for emergency care?
You will be seen as soon as possible. You might have to wait if your condition is not serious. If you have a life-threatening condition, you will get care right away.

What do I do if my child needs emergency dental care?
During normal business hours, call your child's dentist to find out how to get emergency services. If your child needs emergency dental services after the dentist's office has closed, call us toll-free at 1-800-434-2347 or call 9-1-1.

Are emergency dental services covered by the health plan?
Community First 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.
- Treatment and devices for craniofacial anomalies.
- Hospital, physician, and related medical services such as drugs for any of the above conditions.

What if I or my child gets sick when I or my child are out town or traveling?
If you or your child need medical care when traveling, call us toll-free at 1-800-434-2347 and we will help you find a doctor.

If you or your child need emergency services while traveling, go to a nearby hospital, then call us toll-free at 1-800-434-2347.

What if I or my child are out of the state?
We cover true emergencies anywhere in the United States.

What if I or my child are out of the country?
Medical services performed out of the country are not covered by Medicaid.

SPECIALISTS AND REFERRALS

What if I/my child need to see a special doctor (specialist)?
Your primary care provider will send you to see a specialist if you need more care or different services.

What is a referral?
If your doctor thinks you need to see to a specialist, you may need approval from Community First. Your doctor will take care of the paperwork, called a referral, and can help you make the appointment. If you need additional help, call Member Services.

How soon can I or my child expect to be seen by a specialist?
You should be seen within two weeks. If you have an urgent problem, the specialist should see you within 24 hours. If you cannot get an appointment within these time frames, call Member Services for help.

Can I get a second opinion?
You can always get a second opinion. The second doctor must be in our network. Call Member Services if you need help finding another doctor.

What services do not need a referral?

- Behavioral health services
- Pregnancy and delivery services
- Eye exams for all Members
- Glasses for Members under 21 years of age
- Texas Health Steps checkups from any Medicaid provider
- Family planning services from any Medicaid provider

YOUR PLAN BENEFITS

What are my/my child's health care benefits? How can I get these services?
Your primary care provider will work with you to make sure you get the services you/your child needs. These services must be given by your doctor or referred by your doctor to another Provider. Here is a list of some of the health care benefits you can get as a Community First Member:

BENEFITS CHART

BENEFIT	DESCRIPTION
Ambulance services	Emergency and non-emergency
Audiology services	Includes hearing aids for children and adults

Behavioral Health services	• Inpatient mental health services for children (birth through age 20)
	• Acute inpatient mental health services for adults
	• Outpatient mental health services
	• Psychiatry services
	• Mental Health Rehabilitative (MHR) services
	• Counseling services for adults (21 years of age and over)
	• Outpatient substance use disorder treatment services including:
	  ○ Assessment
	  ○ Detoxification services
	  ○ Counseling treatment
	  ○ Medication assisted therapy
	• Residential substance use disorder treatment services including:
	  ○ Detoxification services
	  ○ Substance use disorder treatment (including room and board)

BENEFIT	DESCRIPTION
Birthing services	Provided by a physician or certified nurse midwife (CNM) in a licensed birthing center
Cancer services	Screening, diagnostic, and treatment
Chiropractic services	
Dialysis	
Durable Medical Equipment (DME) and supplies	
Early Childhood Intervention (ECI) services	
Emergency services	
Family planning services	
Home health care services	
Hospital services	Inpatient and outpatient hospital services including: • Inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting • Substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting • Drugs and biologicals provided in an inpatient setting
Laboratory services	
Mastectomy, breast reconstruction, and related follow-up procedures	Inpatient and outpatient services including: • Services provided at an outpatient hospital and ambulatory health care center as clinically appropriate • 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

BENEFIT	DESCRIPTION

Medical checkups and Comprehensive Care Program (CCP) services	For children (birth through age 20) through the Texas Health Steps Program including:
	• Private duty nursing
	• Prescribed Pediatric Extended Care Center (PPECC) services,
	• Certified respiratory care practitioner services
	• Therapies
	  ○ Speech
	  ○ Occupational
	  ○ Physical

Oral evaluation and fluoride varnish	In conjunction with Texas Health Steps medical checkup for children (ages 6 months through 35 months)
Outpatient drugs and biologicals	Including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
Podiatry	
Prenatal care	Provided in a licensed birthing center by a: • Physician • Certified nurse midwife (CNM) • Nurse practitioner (NP) • Clinical nurse specialist (CNS) • Physician assistant (PA)
Primary care services	
Preventive services	Includes an annual adult well check for patients 21 years of age and over
Radiology, imaging, and X-rays	
Specialty physician services	
Mental Health Targeted Case Management (TCM)	
Mental Health Rehabilitative (MHR) services	
Therapy	Includes 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.
Telemedicine	
Telemonitoring	To the extent covered by Texas Government Code §531.01276
Telehealth	

How can I find out more about these services?
To learn more about your/your child's benefits as a Community First Member, please call Member Services at 1-800-434-2347.

LIMITS TO COVERED SERVICES

Are there any limits to covered services?
There may be limits to some covered services depending on your age. If you have questions about limits on any covered services, ask your doctor or call Member Services.

SERVICES NOT COVERED

What services are not covered?
The following is a list of some of the services **NOT** covered by the STAR Program or Community First Health Plans.

- Out-of-area routine care
- Services outside the United States
- Experimental surgery or procedures
- Eye surgery to correct nearsightedness, farsightedness, or blurred vision
- Abortions not covered by federal and state regulations
- Acupuncture
- Infertility treatments, including artificial insemination and in-vitro fertilization
- Reversal of voluntary sterilization
- Custodial care such as cooking, cleaning, bathing, and feeding, which are not medically necessary
- Personal convenience items such as a television, phone or grooming supplies, which are not medically necessary
- Cosmetic or plastic surgery that is not medically necessary
- Sex-change surgery
- Autopsies

If you have questions about whether or not a service is covered, please call Member Services at 1-800-434-2347.

VALUE-ADDED SERVICES

What extra benefits do I get as a Member of Community First Health Plans?
Community First offers the most Value-Added Services to our Members. We're here to help you and your family every step of the way.

Community First Members in the STAR Program receive the following Value-Added Services at no-cost:

VALUE-ADDED SERVICE	LIMITS & RESTRICTIONS
Baby car seat or safe sleep play yard	Upon completion of Healthy Expectations Maternity Program baby shower and prenatal/ postpartum visits, as required.
Enhanced vision benefits with up to $125 for frames or $75 for contact lenses	Available every year for Members ages 21 and up; every other year for Members 22 and up. Limited to either contact lenses or glasses, not both. Replacement of eyewear due to loss or breakage is available as allowed by benefit program. Otherwise, replacement is available when there is a change in vision.
No-cost sports/school physicals	One physical each year for Members up to age 19.
24-Hour Nurse Advice Line	None
Prenatal services with up to $140 in gift cards	Upon Member's enrollment in Healthy Expectations Maternity Program and agreement to receive Healthy Baby texts ($20); Healthy Expectations baby shower attendance ($10); attendance of first prenatal visit in first trimester or within 42 days of enrolling in the health plan ($20); receipt of the flu shot ($20); attendance of postpartum visit 7-84 days after delivery ($20). Member may be eligible to receive an additional $50 gift card reimbursement upon attendance of a birthing class or towards pregnancy pillow. Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.
Low-cost dental services	For Members ages 21 and up. If Member shows no signs or symptoms of periodontal disease, the dentist may perform basic preventive cleaning at no additional charge.
Healthy Expectations Maternity Program baby shower	Limited to one baby shower pregnancy, one diaper bag, and one gift card per Member. Baby shower must be hosted during Member's pregnancy. Limitation does not include mothers expecting multiples.
Zumba classes with free fitness giveaways	Giveaways upon Member's attendance of three Zumba classes or reaching a weight goal.

VALUE-ADDED SERVICE	LIMITS & RESTRICTIONS
Up to $50 reimbursement for birthing classes	Birthing class must be through the hospital where the Member will deliver their baby.
No-cost stop smoking classes	None
Asthma supply kit and asthma-friendly pillow cover	One asthma-friendly pillow cover per year.
Transportation assistance to medical appointments and health classes when NEMT services are unavailable.	Children under the age of 18 must be accompanied by a parent or guardian. Transportation provided by established San Antonio VIA bus routes.
Healthy lifestyle classes	For Members ages 12 and up (unless otherwise indicated in the program) with a signed release by a medical provider.
$25 gift card for attending follow-up appointment after leaving a behavioral health hospital	Must attend appointment within seven days of discharge. Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.
Online mental health resources	None
Bike safety and repair classes with free giveaway	Upon completion of the bike safety class, Members and their families will receive a free giveaway.
Prescription Savings Card approved for use by uninsured family members	None
Smart phone with up to 500 minutes including unlimited texting and 1 GB of data	Limited to one per household.

How can I get these benefits?
To learn how you can receive these benefits as a Community First Health Plans Member in the STAR Program, please call 210-358-6060.

HEALTH EDUCATION PROGRAMS

What health education classes does Community First Health Plans offer?
In addition to extra benefits, Community First also offers no-cost health education programs to help you stay healthy. Our **Health & Wellness Programs** include:

- **Diabetes in Control: Diabetes Management Program** - Participating Members will receive ongoing information on topics such as controlling your blood sugar, tips for talking to your doctor, routine diabetes screening tests, your role in understanding diabetes and preventing complications, blood sugar testing and supplies, and what to do when you are sick.
- **Asthma Matters: Asthma Management Program** - Participating Members will receive ongoing information to help you understand the causes or triggers of your asthma; how to work toward normal or near-normal lung function; how to safely participate in physical activity without having asthma symptoms; tips to decrease the frequency and severity of flare-ups; how to have more restful sleep; and increase your quality of life.

- **Healthy Expectations: Maternity Program** - Participating Members will receive ongoing information about prenatal health; a baby shower with gifts; home visits for high-risk pregnancies; information about how to care for your baby after he/she is born; access to a lactation consultant; and more.
- **Healthy Living: Healthy Lifestyle Management Program** - Participating Members will receive ongoing, age-appropriate information on stress management; quitting smoking; exercise; a heart-healthy lifestyle; and a list of community resources offering nutrition, smoking cessation, and exercise classes.
- **Healthy Heart: Blood Pressure Management Program** - Participating Members will receive ongoing, age-appropriate education on high blood pressure; appropriate use of medication; exercise; and kidney disease. Members are also provided a list of community resources offering blood pressure, nutrition, and fitness programs.
- **Healthy Mind: Behavioral Health Management Program** - Participating Members will receive guidance to help determine the type of behavioral health assistance needed and information to help you choose a professional counselor or doctor or other mental health services, including outpatient counseling services; individual, family, and group counseling; and alternative treatments.

Your doctor may recommend you/your child participate in one of Community First's Health & Wellness programs. If you are interested in participating or would like to learn more, please visit CommunityFirstHealthPlans.com/Health-and-Wellness-Programs or email healthyhelp@cfhp.com.

Members will also receive health education at all Texas Health Steps checkups.

Community First also offers other tools to help provide personalized preventive health care services including:

- Member health risk assessments
- Flu shot reminders
- Women's health reminders
- Medical checkup reminders

BEHAVIORAL HEALTH & SUBSTANCE ABUSE

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

Medicaid behavioral health benefits cover:

- Care for mental or emotional problems
- Care for substance use disorder or alcohol problems

Call the Community First Behavioral Health Hotline at 1-877-221-2226 if you have an urgent problem. You can call for help 24 hours a day, seven days a week.

Do I need a referral for this?

You do not need a referral for mental health or substance misuse services. If you have a problem because of mental illness, alcohol, or drugs, please call us. You can call 24 hours a day, seven days a week. A Member Services Representative can help you find professionals close to you.

What are mental health rehabilitation services (MHR) and mental health targeted case management (TCM)?
These are services that help Members with severe mental illness, behavioral, or emotional problems.

How do I get these services?
Community First Health Plans can help Members get access to care and community support through MHR and mental health TCM. To get help, please call 1-800-434-2347.

HELP ACCESSING HEALTH CARE

OTHER SERVICES

What other services can Community First Health Plans help me get?
Community First Health Plans can help Members get non-capitated services. Non-capitated services are Texas Medicaid programs and services that are not included in Community First Health Plans covered services. However, Members may be eligible to receive services from Texas Medicaid providers including:

- Personal care services for children under the age of 21
- Audiology services and hearing aids for children under the age of 21
- DSHS mental health rehabilitation

Community First can help if you have questions about these or other non-capitated services. Please call Member Services at 1-800-434-2347 for more information.

INTERPRETERS

Can someone interpret for me when I talk with my doctor?
Yes. Member Services can provide interpretation services.

Who do I call for an interpreter? How far in advance to I need to call?
Call Member Services at least 24 hours before your medical visit at 1-800-434-2347.

Interpreters can be scheduled to help you 24 hours a day, 7 days a week. This includes holidays and weekends.

How can I get a face-to-face interpreter in a Provider's office?
Call Member Services and we schedule an interpreter to help you during your visit.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

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 doctor, dentist, hospital, pharmacy, and other places you get 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.
- 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) 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, per person.
- 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.

How do I get a ride?
Community First Health Plans will provide you with information on how to request NEMT services. You should request NEMT services as early as possible, and at least 48 hours 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 Community First prior to the approved and scheduled trip if your medical appointment is canceled.

To schedule a ride, please call:
NEMT Member Reservation Line: 1-888-444-0307 (TTY 7-1-1)
Monday through Friday, from 8 a.m. to 5 p.m.
Information available in both English and Spanish. Interpreter services available.

When you call, please be ready to provide:

- Medicaid ID number (from Your Texas Benefits Medicaid ID card).
- The name, address, and phone number of the place you are going.
- The medical reason for your visit.

Your driver will call, give you your pickup time, and provide you with his or her direct phone number. Keep this number with you. If you need help after hours or are unable to

contact your driver, please call:

Where's My Ride?: 1-888-444-0824 (TTY 7-1-1)
Monday through Sunday, from 5 a.m. to 7 p.m.
Information available in both English and Spanish. Interpreter services available.

PRESCRIPTION DRUG BENEFITS

HOW TO GET YOUR/YOUR CHILD'S MEDICATIONS

What are my prescription drug benefits?
Medicaid pays for most medicine your doctor says you or your child need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

If you need assistance with finding a pharmacy, please call Member Services at 1-800-434-2347 or visit CommunityFirstHealthPlans.com to use the Pharmacy Locator.

What do I bring with me to the drug store?
You should bring your Community First Health Plans Member ID card and Your Texas Benefits Medicaid Card. Show both cards to the pharmacist.

Who do I call if I have problems getting my/my child's medications?
If you have problems getting your covered medications, please call Member Services at 1-800-434-2347. We can work with you and your pharmacy to make sure you get the medication(s) you need.

What if I can't get the medication my doctor ordered approved?
If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your or your child's medication. Call Community First at 1-800-434-2347 for help with your medications and refills.

What if I lose my/my child's medication(s)?
If you lose your medications, call your doctor for help. If your doctor's office is closed, the pharmacy where you got your medications may be able to help you. You can also call Member Services for help at 1-800-434-2347.

NETWORK DRUG STORES

How do I find a network drug store?
You can call Member Services for help finding a network drug store. You can also find a list of network drug stores at CommunityFirstHealthPlans.com.

What if I go to a drug store not in the network?
If you go to a drug store that is not in the network, your prescription may not be covered. You may be responsible for the charges of the prescription medication. You will need to take your prescription to a pharmacy that accepts Community First Health Plans.

How do I transfer my prescriptions to a different network pharmacy?
If you need to transfer your prescription(s), take the following steps:

1. Call the new network pharmacy you'd like to transfer your prescription(s) to and give

the needed information to the pharmacist; or

2. Bring your prescription container to the new network pharmacy.

How do I get my medicine if I am traveling?
Community First Health Plans has network pharmacies in all 50 states. If you will need a refill while on vacation, call your doctor for a new prescription to take with you.

MEDICATION DELIVERY

What if I need my medications delivered to me?
You may be able to have your medications delivered to you through the mail. Community First's partner for pharmacy benefits is Navitus. Their mail order partner is H-E-B. Please call Member Services at 1-800-434-2347 if you'd like to see if your pharmacy offers medication delivery by mail.

COPAY

Will I have a copay for my/my child's medications?
Medicaid members do not have a copay for prescription drugs.

What if I paid out of pocket for a medicine and want to be reimbursed?
If you had to pay for a medicine, please contact Member Services at 1-800-434-2347 for assistance with reimbursement.

MEDICAID LOCK-IN PROGRAM

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 doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more, call Community First Health Plans at 1-800-434-2347.

DURABLE MEDICAL EQUIPMENT (DME)

What if I need durable medical equipment (DME) or other products normally found in a pharmacy?
Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all Members, Community First Health Plans pays for

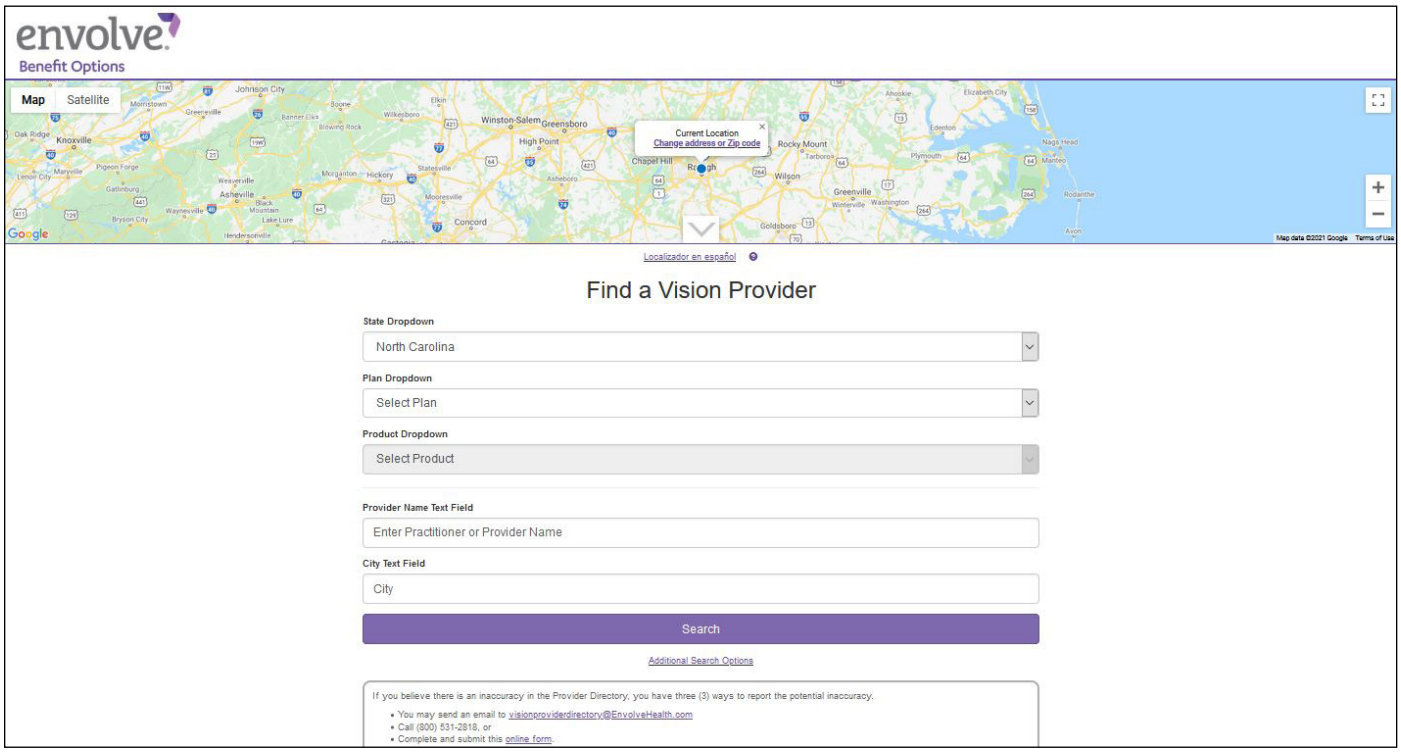
nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), Community First Health Plans also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call Member Services at 1-800-434-2347 for more information about these benefits.

VISION SERVICES

How do I or my child get eye care services?
Community First Health Plans partners with Envolve to provide routine eye care services to our Members. You can call Member Services at 1-800-434-2347 for help finding an Envolve provider near you.

You can also look up Envolve providers on our website at CommunityFirstHealthPlans.com or by visiting VisionBenefits.EnvolveHealth.com.



What are my/my child's vision benefits?
Community First STAR Members ages birth through 20 receive one vision exam yearly. Members 21 and over receive one vision exam every two years.

You must get your eye care services from Community First network eye care providers. If you need help finding a Provider, call Member Services at 1-800-434-2347.

DENTAL SERVICES

How do I/my child get dental services?
Community First 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 of traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.

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

Community First 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.

What do I do if I/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 is closed, call Member Services at 1-800-434-2347 or call 9-1-1.

What do I do if I/my child needs routine dental care?
Routine dental is provided through DentaQuest, MCNA Dental, or United Healthcare Dental. You may pick the Dental Maintenance Organization (DMO) of your choice.

DentaQuest: 1-800-516-0165
MCNA Dental: 1-800-494-6262
United Healthcare Dental: 1-877-901-7321

You can also call Member Services for help making a routine dental appointment or for more information.

FAMILY PLANNING SERVICES

How do I get family planning services? Do I need a referral for this?
For family planning services, you can go to any Provider that accepts Medicaid. You do not need a referral from your primary care provider. You should also talk to your doctor about family planning. He/she can help you pick a family planning provider. You can also call Member Services at 1-800-434-2347.

Where do I find a family planning services provider?
You can find the locations of family planning providers near you online at https://www.dshs.state.tx.us/famplan/, or you can call Community First Health Plans at 1-800-434-2347 for help finding a family planning provider.

EARLY CHILDHOOD INTERVENTION

What is Early Childhood Intervention (ECI)?
ECI is a statewide program for families with children, age birth to three, with disabilities and developmental delays. ECI supports families to help their children reach their potential through developmental services. Services are provided by a variety of local agencies and organizations across Texas.

Do I need a referral for this?
You can ask for a referral from your child's primary care provider for ECI services. However, a referral is not required. You can call ECI directly and request an evaluation without a referral.

Where do I find an ECI provider?
To find an ECI provider, call the DARS Inquiries Line at 1-800-628-5115.

SERVICE MANAGEMENT

What is Service Management?
If you are a Member with special health care needs, Service Management can help ensure you get the health care services you need from your health plan and other services that might not be covered by your health plan like food, housing, personal care services, and special programs like Community First Choice.

Special health care needs that may qualify for Service Management include:

- Serious, ongoing illnesses;
- Chronic or complex conditions;
- Disabilities; and
- Conditions that require therapeutic intervention and evaluation by appropriately trained staff.

How can I get Service Management?

For questions about Service Management and to learn if you're eligible to receive it, please contact Member Services at 1-800-434-2347.

WOMEN'S HEALTH SERVICES

OB/GYN CARE

ATTENTION FEMALE MEMBERS

What if I need OB/GYN care? Do I/my child have the right to choose an OB/GYN?
Community First Health Plans allows you to pick any OB/GYN, whether that doctor is in the same network as your primary care provider or not.

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 doctor within the network.

How do I choose an OB/GYN?
You can find a list of available OB/GYN doctors from the STAR Provider Directory at CommunityFirstHealthPlans.com.

You can also call Member Services at 1-800-434-2347 if you need help choosing an OB/GYN.

If I do not choose an OB/GYN, do I still have direct access or will I need a referral?
You still have direct access to an OB/GYN, even if you do not choose one. You do not need a referral.

Can I stay with my OB/GYN if they are not with Community First Health Plans?

- If your OB/GYN is not in our network and you are **NOT** pregnant, you will have to pick a new OB/GYN from the STAR Provider Directory. You can also call Member Services if you need help choosing an OB/GYN.
- If you **ARE** pregnant and your OB/GYN is not in our network, please call Member Services for assistance.

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

What is Case Management for Children and Pregnant Women?
Case Management for Children and Pregnant Women is a Texas Medicaid benefit for eligible patients who have medical-related needs that might affect their health care. The patients must be eligible for Medicaid and be either:

- A child birth through age 20 with a health condition or health risk, or
- A woman of any age who has a high-risk pregnancy.

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.
- 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?
Contact Community First Health Plans at 1-800-434-2347 for more information or call Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8:00 a.m. to 8:00 p.m.

- Community First Health Plans Case Management: (210) 413-8649 | chelp@cfhp.com
- Community First Health Plans Website: CommunityFirstHealthPlans.com

CARE DURING PREGNANCY

What if I or my child is pregnant? Who do I need to call?
Call Member Services at 1-800-434-2347 and we can help you pick an OB/GYN. It is very important to start your prenatal care right away.

How soon can I be seen after contacting my OB/GYN for an appointment?
You should be seen for prenatal care within two weeks of your request. If you cannot get an appointment within two weeks, call Member Services.

Where can I find a list of birthing centers?
To find a list of participating hospitals to give birth, please use our Provider Directory at CommunityFirstHealthPlans.com. You can also call Member Services if you need help finding a participating hospital.

What other services/education/activities does Community First offer pregnant women?
Community First Health Plans has a special prenatal program for pregnant Members called Healthy Expectations: Maternity Program. Healthy Expectations provides educational material and other resources to help you learn how to keep both you and your newborn healthy before and after delivery.

Learn more about Healthy Expectations by reviewing the Health Education Programs section in this Member Handbook. You can also visit CommunityFirstHealthPlans.com/Health-and-Wellness-Programs, call (210) 358-6055, or email healthyhelp@cfhp.com for more information.

CHOOSING A PRIMARY CARE PROVIDER FOR YOUR BABY

Can I pick a primary care provider for my baby before the baby is born?
As soon as Community First Health Plans knows you are pregnant, we will send you information about your pregnancy and your unborn baby. Community First will ask you to choose a primary care provider (PCP) for your baby, even before the baby's birth. This will ensure that your baby's PCP will check the baby while in the hospital, and then take care of your baby's health care needs after you and the baby are discharged from the hospital.

How and when can I switch my baby's primary care provider (PCP)?
There is no limit on how many times you can change your or your baby's primary care provider. You can change primary care providers by calling Member Services at 1-800-434-2347.

You can also submit a request to change your baby's primary care provider through our secure Member Portal at CommunityFirstHealthPlans.com or write to us at:

Community First Health Plans
Attention: Member Services
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

When will my baby's primary care provider change become effective?
If you change your baby's primary care provider, the change will become effective immediately.

NOTIFYING YOUR HEALTH PLAN AFTER GIVING BIRTH

How do I sign up my newborn baby for health care coverage?
If you are a Community First Member when you have your baby, your baby automatically becomes a Community First Member as well on his/her date of birth. Community First will get information from the hospital to add your baby as a new Member, and the hospital will also notify Medicaid about the baby's birth.

It is still important that you contact the Department of State Health Services (DSHS) office to also report the birth of your baby. This will ensure that your baby can get all the covered health care services he/she needs.

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

After I've given birth, how and when do I tell my health plan?
You should let Community First know as soon as possible about the birth of your baby. We may already have the information about your baby's birth, but call us so we can verify the correct date of birth for your baby and also confirm that the name we have for your baby is correct.

After I've given birth, how and when do I tell my caseworker?
Call your Medicaid caseworker as soon as possible after your baby is born. That way, your baby can get a Medicaid number and start receiving benefits right away.

Who do I call if I or my child has special health care needs and I need someone to help?
Community First offers Service Management for Members with special health care needs. You can read more about Service Management in this handbook. Please call Member Services at 1-800-434-2347 if you need help.

SPECIAL HEALTH PROGRAMS

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 Texas Women's Health Program and the Department of State Health Services (DSHS). These services are for women who apply for 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 Texas Women's Health Program, write, call, or visit the program's website:

Healthy Texas Women Program
P.O. Box 14000
Midland, TX 79711-9902
Phone: 1-800-335-8957
Website: www.HealthyTexasWomen.org
Fax: 1-866-993-9971 (toll-free)

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 level must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a co-payment, but no one is turned down for services because of a lack of money.

Primary Health Care focuses on 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 doctor 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 http://txclinics.com/

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

Website: www.dshs.state.tx.us/phc/
Phone: (512) 776-7796
Email: PPCU@dshs.state.tx.us

DSHS EXPANDED PRIMARY HEALTH CARE PROGRAM

The DSHS Expanded Primary Health Care program provides primary, preventive, and screening services to women age 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: http://txclinics.dshs.texas.gov/chcl/.

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.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx
Phone: (512) 776-7796
Fax: (512) 776-7203
Email: PPCU@dshs.state.tx.us

DSHS FAMILY PLANNING PROGRAM

The DSHS 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 http://txclinics.dshs.texas.gov/chcl/.

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

Website: www.dshs.state.tx.us/famplan/
Phone: (512) 776-7796
Fax: (512) 776-7203
Email: PPCU@dshs.state.tx.us

ADVANCE DIRECTIVES

What if I am too sick to make a decision about my medical care?
You can give instructions about your future medical care before you get sick. These are called "advance directives."

What are advance directives? How do I get an advance directive?
Advance directives are written instructions to your family about what to do if you become very sick. Community First has a booklet with information about advance directives that we can send to you, free-of-charge. Call Member Services at 1-800-434-2347 to request this booklet.

RENEWING YOUR HEALTH CARE COVERAGE

You must renew you/your child's Medicaid coverage every year. In the months before your/your child's coverage is due to end, HHSC will send you a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on your family's income and cost deductions.

Instructions and additional information can also be found at YourTexasBenefits.com. Here you can:

- Sign up for alerts in "'Alert Settings'" to receive an email or text message when it is time to renew your benefits.
- Check your renewal date online.
- Renew your benefits online.
- Check the status of your renewal.

What do I have to do if I need help with completing my renewal application?
Call Community First Health Plans Member Services if you need help completing your renewal application.

What happens if I lose my Medicaid coverage?
If you lose Medicaid coverage but get it back again within six 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.

MEMBER BILLING

What if I get a bill from my doctor?
You should not get a bill from your doctor for any services covered under Medicaid. You might receive a bill if you go to a doctor who is not in the Community First network. You might also get a bill if you receive treatment in an emergency room for a problem that is not an emergency.

Who do I call? What information will they need?
Call Member Services if you receive a medical bill. We can help you figure out what to do. Be sure to have a copy of the bill in front of you when you call.

CHANGE OF ADDRESS

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 Community First Health Plans Member Services Department at 1-800-434-2347. Before you get Medicaid services in your new area, you must call Community First, unless you need emergency services. You will continue to get care through Community First until HHSC changes your address.

MEDICAID AND PRIVATE INSURANCE

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

MEDICALLY NECESSARY

To be covered by our plan, the care you receive must be Medically Necessary. Medically Necessary means:

1. For Members birth through age 20, the following Texas Health Steps services:
   a) screening, vision, and hearing services; and
   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. Janek, 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, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, 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 healthcare practice guidelines and standards that are endorsed by professionally recognized healthcare 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) are not experimental or investigative; and

g) are not primarily for the convenience of the member or Provider; and

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

MEMBER RIGHTS & RESPONSIBILITIES

MEMBER RIGHTS

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a) Be treated fairly and with respect.
   b) 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 primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another Provider in a reasonably easy manner. That includes the right to:
   a) Be told how to choose and change your health plan and your primary care provider.
   b) Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c) Change your primary care provider.
   d) Change your health plan without penalty.
   e) 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:
   a) 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.
   b) Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a) Work as part of a team with your Provider in deciding what health care is best for you.
   b) Say yes or no to the care recommended by your Provider.

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:
   a) Make a complaint to your health plan or to the state Medicaid program about your

health care, your Provider, or your health plan.
b) Get a timely answer to your complaint.
c) Use the plan's appeal process and be told how to use it.
d) Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
e) Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and get 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:
   a) Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b) Get medical care in a timely manner.
   c) 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.
   d) 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.
   e) 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, 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 doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services provided to your child. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

MEMBER RESPONSIBILITIES

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a) Learn and understand your rights under the Medicaid program.
   b) Ask questions if you do not understand your rights.
   c) Learn what choices of health plans are available in your area.
2. You must abide by the health plan's policies and procedures and Medicaid policies and procedures. That includes the responsibility to:
   a) Learn and follow your health plan's rules and Medicaid rules.
   b) Choose your health plan and a primary care provider quickly.
   c) Make any changes in your health plan or primary care provider in the ways established by Medicaid and by the health plan.

d) Keep your scheduled appointments.
e) Cancel appointments in advance when you cannot keep them.
f) Always contact your primary care provider first for your non-emergency medical needs.
g) Be sure you have approval from your primary care provider before going to a specialist.
h) 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:
   a) Tell your primary care provider about your health.
   b) Talk to your Providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c) Help your Providers get your medical records.
4. You must comply with Electronic Visit Verification requirements if you receive services delivered by an attendant or nursing services by allowing the attendant to use your telephone to call a toll-free number when he or she starts and ends work, or allow the attendant to use alternate devices when he or she starts and ends work.
5. 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:
   a) Work as a team with your Provider in deciding what health care is best for you.
   b) Understand how the things you do can affect your health.
   c) Do the best you can to stay healthy.
   d) Treat Providers and staff with respect.
   e) Talk to your Provider about all of your medications.

Additional Member Responsibilities when 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 can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

CHANGING HEALTH PLANS

What if I want to change health plans?
You can change your health plan by calling the Texas STAR, STAR Kids, or STAR+PLUS 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 Community First Health Plans ask that I get dropped from their health plan (for non-compliance, etc.)?
Yes, for the following reasons:

- You move out of our service area
- You enter a hospice or long-term care facility
- You do not follow Community First policies and procedures
- You allow someone else to use your Community First Member ID card
- You are rude, abusive, or do not work with your doctor or your doctor's staff
- You are non-compliant or do not follow your doctor's medical advice

COMPLAINT PROCESS

What should I do if I have a complaint?
We want to help. If you have a complaint, please call us toll-free at 1-800-434-2347 to tell us about your problem. A Community First Health Plans Member Services Representative can help you file a complaint. Just call 1-800-434-2347. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the Community First complaint process, you can file a complaint to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make 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, TX 78711-3247

If you can get on the Internet, you can submit your complaint at hhs.texas.gov/managed-care-help.

What are the requirements and time frames for filing a complaint?
You can file a complaint with Community First at any time.

How long will it take to process my complaint?
We will mail you a letter within five (5) days to tell you we have received your complaint.

Then, we will mail you our decision within 30 days.

APPEAL PROCESS

What can I do if my doctor asks for a service or medicine for me/my child that's covered, but Community First Health Plans denies or limits it?
Community First might deny a health care service or medicine if it is not medically necessary. A medicine can also be denied:

- If the medicine does not work better than other medicines on the Community First Preferred Drug List.
- If there is another medicine that is similar that you must try first that you have not used before.

If you disagree with the denial, you can ask for an appeal.

How will I find out if a service or medicine is denied?
You will receive a letter telling you if a service or medicine has been denied. You will also receive an appeal form.

When do I have the right to ask for an appeal?
You can appeal if you are not satisfied with the decision. You can also ask for an appeal if Community First denied payment of services in whole or in part.

How do I file an appeal?
You may provide appeal information by phone, in writing, or in person.

If you would like someone to file an appeal on your behalf, you may name a representative in writing by sending a letter containing his/her name to Community First. A doctor or other medical provider may be your representative.

For more information, call Member Services at 1-800-434-2347.

Can someone from Community First help me file an appeal?
Yes, a Member Services Representative can help you file an appeal.

What are the time frames for the appeal process?
You must request an appeal within 60 days from the date on your notification of the denial, reduction, or suspension of previously authorized services. You have the right to ask for an extension of up to 14 days if you want to provide more information in your appeal

A letter will be mailed to you within five (5) days to tell you that we have received your appeal. We will then mail you our decision within 30 days.

If Community First needs more information, we might ask for an extension of up to 14 calendar days. If we need an extension, we will call you as soon as possible to explain that there is a need for more information and that the delay is in your (the Member's) interest. We will also send you written notice of the reason for delay.

Community First will resolve your appeal as soon as possible based on your health

condition and no later than the 14 day extension. If you are not happy with the delay, you may file a complaint by calling Member Services at 1-800-434-2347.

Can I still keep getting medical services while Community First is processing my appeal?
You have the right to keep getting any current medical services Community First already approved while we process your appeal, if you file your appeal on or before:

- 10 days from the date you received our decision letter, or
- The date our decision letter says your medical services will be reduced or end.

If the services that are the subject of the appeal are not approved during the appeal, you may be responsible for the cost of the services you received during the appeal.

What if I am not satisfied with the decision? When can I request an External Medical Review and State Fair Hearing?
You can request an External Medical Review and State Fair Hearing no later than 120 days after the date Community First Health Plans mails you the appeal decision notice.

You also have the option to request only a State Fair Hearing Review no later than 120 days after Community First Health Plans mails you the appeal decision notice.

EXPEDITED APPEAL PROCESS

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

How do I ask for an Expedited Appeal and who can help me file one?
A Community First Member Services Representative can help you request an Expedited Appeal. Call Member Services at 1-800-434-2347.

Does my request for an Expedited Appeal have to be in writing?
Your request does **NOT** have to be in writing. You may ask for an Expedited Appeal by phone, in person, or in writing.

You have the right to ask for an extension of up to 14 days if you want to provide more information.

What are the time frames for an Expedited Appeal?
If we have all the information we need, we will have an answer within 1 to 3 days after we receive your Expedited Appeal.

What happens if Community First denies my request for an Expedited Appeal?
We will notify you if we deny your request for an Expedited Appeal. Your request will then be moved to the regular appeal process. We will send you a written notice of this change by mail within two (2) calendar days.

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 either call 1-800-434-2347 or send a letter to the health plan at

Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

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 or calling Community First Health Plans. To qualify for an emergency State Fair Hearing through HHSC, you must first complete Community First Health Plans' internal appeals process.

EXTERNAL MEDICAL REVIEW

Can a Member 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 MCO Internal Appeal Decision letter and mail or fax it to Community First Health Plans by using the address or fax number at the top of the form;
- Call Community First Health Plans at 1-800-434-2347; or
- Email Community First Health Plans at qmappeals@cfhp.com.

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.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting the Member's Community First Health Plans at 1-800-434-2347 or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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 Community First Health Plans. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete Community First Health Plans' internal appeals process.

WASTE, ABUSE, AND FRAUD

Do you want to report Waste, Abuse, or Fraud?
Let us know if you think a doctor, dentist, pharmacist at a 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.

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
  - Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

Member Services: 1-800-434-2347

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

- When reporting about a Provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of Provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the Provider and facility, if you have it
  - Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud

INFORMATION AVAILABLE TO MEMBERS

As a Member of Community First Health Plans, you can ask for and get the following information each year:

- Information about Network Providers – at a minimum primary care doctors, 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, and, when applicable, professional qualifications, specialty, medical school attended, residency completion and board certification status.
- Any limits on your freedom of choice among Network Providers.
- Your rights and responsibilities.
- Information on complaint, appeal, External Medical Review, and State 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.
- 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 of 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 the 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.
- Community First Health Plan's practice guidelines.

MEMBER ADVOCATES

Community First Health Plans provides STAR Members access to Member Advocates physically located within our service area.

Member Advocates must inform Members of the following:

1. Their rights and responsibilities,
2. The complaint process,
3. The appeal process,

4. Covered services available to them, including preventive services, and
5. Non-capitated services available to them.

Member Advocates are trained and knowledgeable about Community First's complaints and conflict resolution process. Member Advocates must assist Members with understanding and using Community First's complaint process, including how to write a written complaint. Member Advocates are also responsible for monitoring complaints they become aware of through Community First's complaint process.

Member Advocates are trained and knowledgeable about Community First's appeals process. Member Advocates must assist Members in writing or filing an appeal and monitoring the appeal through Community First's appeals process until the issue is resolved.

Member Advocates are responsible for making recommendations to Community First's management on any changes needed to improve either the care provided, or the way care is delivered. Member Advocates are also responsible for helping or referring Members to community resources that are available to meet Members' needs if services are not available from Community First as covered services.

CONFIDENTIALITY

We are committed to ensuring that your personal health information is secure and confidential. Our doctors and other providers must do the same. Community First's use of protected health information (PHI) will only be used to administer your health plan and fulfilling state and federal requirements. Your personal health information will not be shared with anyone else without your express written approval. You have the right to access your medical records. You have the right to consent in writing for specific individuals to have access to your PHI. Authorizations that are granted by you will be shared with those individuals specifically noted in your written approval.

Community First has physical, electronic, and procedural safeguards in place to protect your information. Oral, written or electronic information is protected. Community First policies and procedures state all Community First employees must protect the confidentiality of your protected health information (PHI). An employee may only access PHI when they have an appropriate reason to do so. Each employee must sign a statement that he or she understands Community First's privacy policy. On a yearly basis, Community First will send a notice to employees to remind them of this policy. Any employee who does not follow Community First's privacy policies is subject to discipline. This can include up to and including dismissal.

For a copy of our Notice of Privacy Practices, please visit our website at CommunityFirstHealthPlans.com.

GLOSSARY OF TERMS

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

Complaint – A grievance that you communicate to your health insurer or plan.

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

Durable Medical Equipment (DME) – Equipment ordered by a health care provider for everyday or extended use. Coverage for DME may include but is not limited to: oxygen equipment, wheelchairs, crutches, or diabetic supplies.

Emergency Medical Condition – An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.

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

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

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

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

Grievance – A complaint to your health insurer or plan.

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

Health Insurance – A contract that requires your health insurer to pay your covered health care costs in exchange for a premium. Home Health Care - Health care services a person receives in a home.

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

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

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

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

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

Non-participating Provider – A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.

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

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

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

Pre-authorization – A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision or approval, sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.

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

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

Prescription Drugs – Drugs and medications that by law require a prescription.

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

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

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

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

Skilled Nursing Care – Services from licensed nurses in your own home or in a nursing home. Specialist - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

COMMUNITY FIRST HEALTH PLANS

Non – Discrimination Notice

Community First Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Community First Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Community First Health Plans:

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

If you need these services, contact the Community First Health Plans director of Compliance at (210) 510-2482.

If you believe that Community First Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with:

Pamela Mata, Compliance Manager
12238 Silicon Dr., Suite 100,
San Antonio, Texas 78249
Phone: (210) 510-2484 • TTY: 1-800-390-1175
Fax : (210) 358-6014
Email: pmata@cfhp.com

Community First Health Plans provides Members the following:

1. Written and/or oral interpretation to help understand information and materials provided by our plan
2. A toll-free and typewriter/ Telecommunications Device for the Deaf (TTY/TDD) telephone number 1-800-390-1175 available 24 hours a day, 7 days a week to Members who have difficulties hearing or speaking
3. Access to auxiliary aids and services, including materials in alternative formats

For more information or to access these services, please call Community First Member Services at 1-800-434-2347 (1-800-390-1175 TTY).

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pamela Mata, Compliance Manager, is available to help you.

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-434-2347 (TTY: 1-800-390-1175).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-434-2347 (TTY: 1-800-390-1175).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務. 請致電 1-800-434-2347 (TTY:1-800-434-2347)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-434-2347 (TTY: 1-800-390-1175) 번으로 전화해 주십시오.

ر ق م 1-800-434-2347 ق م ب ر ا ت ص ل
باﻟ مجان . ل ك ف ت ت وى ة ا ل غ و
عدة ا ل م اس خدمات ف إن ا ل ل غة،اذكر
ت تحدث ك نت إذا م لحوظة :
1-800-390-1175 :واﻟ ا ل مص هات

ک ا ل ۔ ہ ی ں د س ت ای ب م ی ں م فت
خدمات ک ی مدد ک ی زب ا ن ک و آپ ت و
خ : ر ادر آپ ا گ ر دو ا ر و ب ے ت ل،ی ں ہ
بر 1-800-434-2347 (TTY: 1-800-390-1175).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-434-2347 (TTY: 1-800-390-1175).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-434-2347 (ATS : 1-800-390-1175).

ध्यान द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-434-2347 (TTY: 1-800-390-1175) पर कॉल कर।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید. 1-800-434-2347 (TTY: 1-800-390-1175) فراهم می باشد. با

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-434-2347 (TTY: 1-800-390-1175).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-434-2347 (TTY: 1-800-390-1175) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-434-2347 (телетайп: 1-800-390-1175).

注意事項：日本語を話される場合，無料の言語支援をご利用いただけます. 1-800-434-2347 (TTY:1-800-390-1175)まで、お電話にてご連絡ください.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທ 1-800-434-2347 (TTY: 1-800-390-1175).

STAR MEMBER HANDBOOK

COMMUNITY FIRST
HEALTH PLANS

12238 Silicon Drive, Ste. 100
San Antonio, Texas 78249
CommunityFirstMedicaid.com

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