COMMUNITY FIRST HEALTH PLANS

September 1, 2024

TEXAS STAR+PLUS Your Health Plan ★ Your Choice

TEXAS Health and Human Services

STAR+PLUS MEMBER HANDBOOK

MEMBER SERVICES 210-358-6105

TOLL-FREE 1-844-382-2347

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

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

STAR+PLUS MEMBER HANDBOOK

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

STAR+PLUS MEMBER SERVICES
1-844-382-2347

TEXAS Health and Human Services | TEXAS STAR+PLUS 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, Inc. (Community First) 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.

Community First is a Managed Care Organization (MCO) that offers health care for Texans enrolled in the STAR+PLUS program. Community First works with Texas Health and Human Services Commission (HHSC) and with many doctors, clinics, hospitals, and community resources to give you the care you need.

As the only local, non-profit health care plan offering the STAR+PLUS program in our service delivery area, we understand the unique health care needs of our community. We are proud to be your neighbor! We are truly invested in your health.

You are receiving this Member Handbook because you were approved for Medicaid under the STAR+PLUS program. You either chose Community First as your MCO or you were assigned to Community First. 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 another format or would like a printed copy, please contact Member Services at the toll-free number listed below.

Stay Connected With Community First's Member Portal

Community First's Member Portal is a convenient and secure tool to help you manage your health care. By creating a free account, you can:

- View your health history
- Print a temporary Member ID card
- Review your health benefits
- View recommended health actions and rewards you can get for completing them

Visit CommunityFirstMedicaid.com and click on "Member Portal" to register.

NUMBERS TO REMEMBER

If you have any questions, call Community First Member Services toll-free at 1-844-382-2347. Our team is available from 8 a.m. to 5 p.m., Monday through Friday, except for state-approved holidays. Members have the option to speak with a registered nurse and/or leave a message on weekends and holidays. Messages are returned in one business day. Our staff is bilingual in English and Spanish. If you speak another language, call Member Services and we can arrange an interpreter for you.

Community First Member Services 1-844-382-2347
Community First Service Coordination 210-358-6105
Community First Behavioral Health Services 1-844-382-2347
24-Hour Nurse Advice Line 1-844-382-2347
24-Hour Behavioral Health Crisis Line 1-877-221-2226
TTY (Deaf/Hard of Hearing) 711
Ombudsman Managed Care Assistance Team 1-866-566-8989
Member Advocate 1-844-382-2347
Texas STAR+PLUS Program Helpline ..... 1-800-964-2777 or 211
Non-Emergency Medical Transportation 1-888-444-0307
Pharmacy Benefits/Prescription Drugs (Navitus) 1-844-268-9789
Vision Services (Envolve) 1-888-756-8768
Dental Care
- DentaQuest 1-800-516-0165
- MCNA Dental 1-855-691-6262
- United Healthcare Dental 1-877-901-7321

Emergency (life-threatening emergencies) 911
National Suicide & Crisis Lifeline 988

MEMBER SERVICES

If you have questions, call Community First Member Services at 1-844-382-2347. Our Member Services Representatives speak English and Spanish and can:

- Send you a new Member ID card.
- Help you understand your benefits.
- Select or change your primary care provider (PCP).
- Help resolve any health care problems or complaints.
- Help you access services that do not require a referral from your PCP.
- Answer questions about all covered services under your health care plan.

Member Services Representatives are available Monday through Friday, 8 a.m. to 5 p.m. except on state-approved holidays. This call is free. If you need help in a language other than English or Spanish, we have free interpreter services.

Members can also speak to a registered nurse by calling Member Services, 24 hours a day, 7 days a week for medical advice. Or you can leave a message for our Member Services team after hours, on weekends, and on holidays. A Member Services Representative will return your message in one business day.

EMERGENCY SERVICES

Dial **911** or go to the nearest emergency room when someone:

- Is having a severe allergic reaction.
- Is bleeding heavily or has a serious injury.
- Has severe chest pain, is unconscious, or is not breathing.
- Is showing signs of a stroke (face drooping, arm weakness or tingling, speech difficulty).

MENTAL HEALTH, SUBSTANCE USE, AND CRISIS SERVICES

You can get behavioral health and/or substance use disorder help by calling 1-844-382-2347. We will help you find the best provider for your needs. You don't need a referral to get these services.

If you're experiencing a mental health or substance use crisis, call the Community First Behavioral Health Crisis Line toll-free at 1-877-221-2226 24 hours a day, 7 days a week, to talk to a trained professional who can help in English or Spanish. We have free interpreter services for people who speak another language. You can also call 988 toll-free to reach the National Suicide & Crisis Lifeline or go to the nearest emergency room.

The Suicide & Crisis Lifeline 988 can help when someone has:

- Suicidal thoughts or behaviors
- Substance use or mental health crisis
- Paranoia or is feeling out of touch with reality
- Violent or abusive behavior toward oneself or others

SERVICE COORDINATION

STAR+PLUS Members will receive additional support from a Community First Service Coordinator at 210-358-6105. A Service Coordinator can help you:

- Access a provider.
- Identify your needs.
- Understand service delivery options.
- Understand your benefits and services.

Learn more about Service Coordination on page 34.

TTY

If you are deaf or hard of hearing, call 711, 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

Members can call the 24-hour Community First Nurse Advice Line at 1-844-382-2347 at any time for help getting care. Registered nurses who speak both English and Spanish are available to help. This call is free. We have free interpreter services for people who speak a different language. If you're deaf or hard of hearing, call 711.

The 24-hour Nurse Advice Line can help you:

- Learn about covered services.
- Answer questions about medications.
- Get a referral to social service resources.
- Get advice on treating minor injuries or illnesses at home.
- Get advice on whether you should go to an emergency room or urgent care.

VISION CARE

Envolve provides routine eye care services to Community First Members. You can call Envolve Customer Relations at 1-800-334-3937 or Community First Member Services at 1-844-382-2347 for help finding an Envolve provider near you. You can also look up Envolve providers by visiting VisionBenefits.EnvolveHealth.com.

DENTAL CARE

Call your Medicaid dental plan for information about preventive dental services. Community First works with DentaQuest, MCNA Dental, and United Healthcare Dental to provide routine dental services and care.

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

You can also call Community First Member Services at 1-844-382-2347 if you need help finding a dental provider.

PRESCRIPTION DRUG MEDICATIONS

Community First's partner for pharmacy benefits is Navitus. Call Navitus Customer Care at 1-844-268-9789 or Community First Member Services at 1-844-382-2347 for information about your prescription drug medication benefits.

NON-EMERGENCY MEDICAL TRANSPORTATION

Non-emergency medical transportation (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. Community First's partner for NEMT services is MTM.

To schedule a ride, please call 1-888-444-0307, Monday through Friday, from 8 a.m. to 5 p.m. If you need help after hours or are unable to contact your driver, please call 1-888-444-0824, 24 hours a day, 7 days a week. Information is available in both English and Spanish. Interpreter services are available if you speak another language. If you are deaf or heard of hearing, call 711. For more information about NEMT services, please turn to page 26.

COMMUNITY FIRST HEALTH PLANS LOCATIONS

Community First has three locations to serve you:

Corporate Office
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

Avenida Guadalupe Community Office
1410 Guadalupe Street, Suite 222
San Antonio, TX 78207

The Multi-Assistance Center at Morgan's Wonderland™ (MAC)
5210 Thousand Oaks Dr.
San Antonio, TX 78233
(By appointment only)

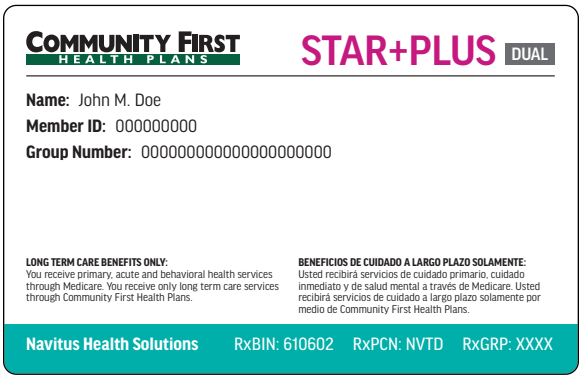
Our Avenida Guadalupe Community Office provides in-person assistance for questions about your health care coverage, renewing your plan, local community resources, and more. Walk-ins are welcome. We also can also help you in-person at our location at the MAC by appointment only.

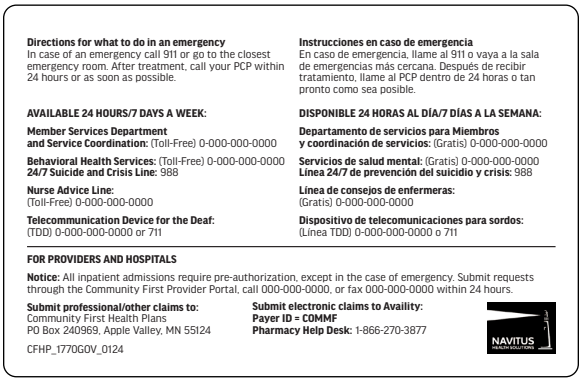
To make an appointment at either location, please go to CommunityFirstMedicaid.com and click on Community Office under the Contact dropdown menu or call 210-358-6105.

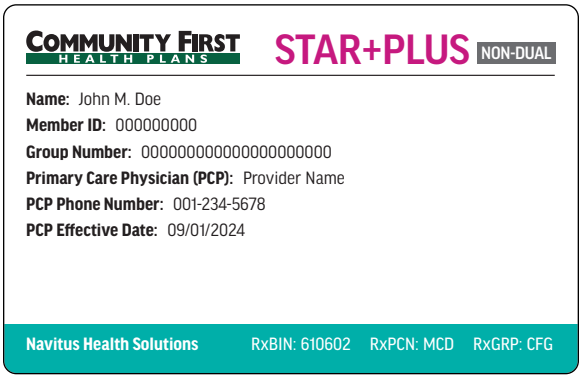
COMMUNITY FIRST MEMBER IDENTIFICATION (ID) CARD

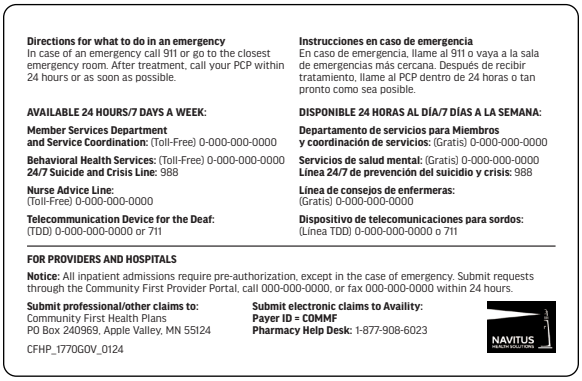
When you sign up to become a Community First Health Plans Member, you will receive a Community First Member ID card. If you do not receive a card, please call Member Services. Here's what the front and back of your Community First Member ID card will look like.

Examples of Community First Health Plans STAR+PLUS Member ID Cards


COMMUNITY FIRST HEALTH PLANS
STAR+PLUS DUAL
Name: John M. Doe
Member ID: 000000000
Group Number: 00000000000000000000
LONG TERM CARE BENEFITS ONLY: You receive primary, acute and behavioral health services through Medicare. You receive only long term care services through Community First Health Plans.
BENEFICIOS DE CUIDADO A LARGO PLAZO SOLAMENTE: Usted recibirá servicios de cuidado primario, cuidado inmediato y de salud mental a través de Medicare. Usted recibirá servicios de cuidado a largo plazo solamente por medio de Community First Health Plans.
Navitus Health Solutions RxBIN: 610602 RxPCN: NVTD RxGRP: XXXX


Directions for what to do in an emergency
In case of an emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.
Instrucciones en caso de emergencia
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.
AVAILABLE 24 HOURS/7 DAYS A WEEK:
Member Services Department and Service Coordination: (Toll-Free) 0-000-000-0000
Behavioral Health Services: (Toll-Free) 0-000-000-0000 **24/7 Suicide and Crisis Line:** 988
Nurse Advice Line: (Toll-Free) 0-000-000-0000
Telecommunication Device for the Deaf: (TDD) 0-000-000-0000 or 711
DISPONIBLE 24 HORAS AL DÍA/7 DÍAS A LA SEMANA:
Departamento de servicios para Miembros y coordinación de servicios: (Gratis) 0-000-000-0000
Servicios de salud mental: (Gratis) 0-000-000-0000 **Línea 24/7 de prevención del suicidio y crisis:** 988
Línea de consejos de enfermeras: (Gratis) 0-000-000-0000
Dispositivo de telecomunicaciones para sordos: (Línea TDD) 0-000-000-0000 o 711
FOR PROVIDERS AND HOSPITALS
Notice: All inpatient admissions require pre-authorization, except in the case of emergency. Submit requests through the Community First Provider Portal, call 000-000-0000, or fax 000-000-0000 within 24 hours.
Submit professional/other claims to: Community First Health Plans PO Box 240969, Apple Valley, MN 55124
Submit electronic claims to Availity: **Payer ID = COMMF** **Pharmacy Help Desk:** 1-866-270-3877
CFHP_1770GOV_0124


COMMUNITY FIRST HEALTH PLANS
STAR+PLUS NON-DUAL
Name: John M. Doe
Member ID: 000000000
Group Number: 00000000000000000000
Primary Care Physician (PCP): Provider Name
PCP Phone Number: 001-234-5678
PCP Effective Date: 09/01/2024
Navitus Health Solutions RxBIN: 610602 RxPCN: MCD RxGRP: CFG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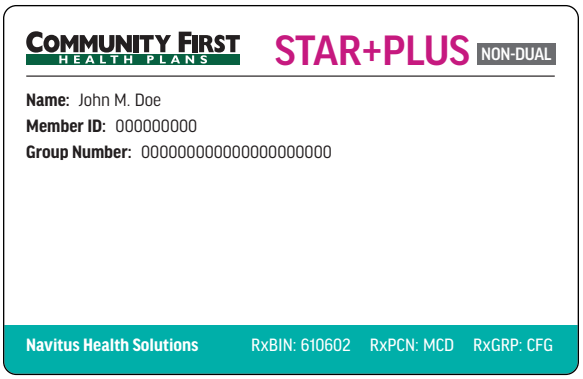
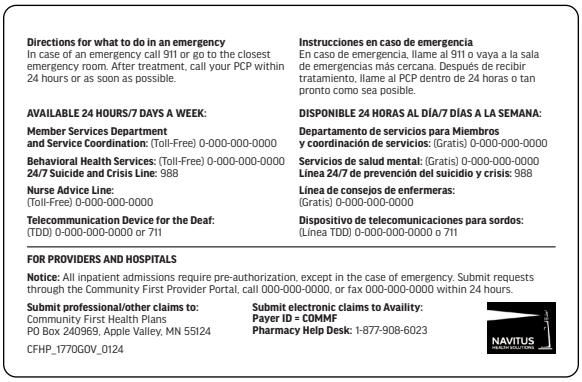
Servicios de salud mental: (Gratis) 0-000-000-0000 **Línea 24/7 de prevención del suicidio y crisis:** 988
Línea de consejos de enfermeras: (Gratis) 0-000-000-0000
Dispositivo de telecomunicaciones para sordos: (Línea TDD) 0-000-000-0000 o 711
FOR PROVIDERS AND HOSPITALS
Notice: All inpatient admissions require pre-authorization, except in the case of emergency. Submit requests through the Community First Provider Portal, call 000-000-0000, or fax 000-000-0000 within 24 hours.
Submit professional/other claims to: Community First Health Plans PO Box 240969, Apple Valley, MN 55124
Submit electronic claims to Availity: **Payer ID = COMMF** **Pharmacy Help Desk:** 1-877-908-6023
CFHP_1770GOV_0124


COMMUNITY FIRST HEALTH PLANS
STAR+PLUS NON-DUAL
Name: John M. Doe
Member ID: 000000000
Group Number: 00000000000000000000
Navitus Health Solutions RxBIN: 610602 RxPCN: MCD RxGRP: CFG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FOR PROVIDERS AND HOSPITALS
Notice: All inpatient admissions require pre-authorization, except in the case of emergency. Submit requests through the Community First Provider Portal, call 000-000-0000, or fax 000-000-0000 within 24 hours.
Submit professional/other claims to: Community First Health Plans PO Box 240969, Apple Valley, MN 55124
Submit electronic claims to Availity: **Payer ID = COMMF** **Pharmacy Help Desk:** 1-877-908-6023
CFHP_1770GOV_0124

How do I use my Member ID Card?

Always carry your Community First Member ID card with you and show it to the doctor, clinic, or hospital to get the care you need. They will need the facts on the card to know that you are a Community First Member. Do not let anyone else use your Community First Member ID card.

Your Community First Member ID card is in English and Spanish, and has:

- Your name
- Member ID number
- Your primary care provider's name and phone number
- 24-hour toll-free number for Community First Member Services
- 24-hour toll-free number for Behavioral Health Services
- Directions on what to do in an emergency

If you are a Community First STAR+PLUS Dual Eligible Member (you get both Medicaid and Medicare) or have other private insurance in addition to Medicaid, your Community First Member ID card will not show your primary care provider's name and phone number. This is because you receive your primary care through your Medicare doctor or if you have other private insurance, a doctor in network with that insurance plan.

What if my Community First Member ID Card is lost or stolen?
If your Member ID Card is lost or stolen, please call Member Services at 1-844-382-2347 and ask for a new one. You can also log in to our secure Member Portal at CommunityFirstMedicaid.com to print a temporary ID card and request a new one.

MEDICAID

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 have Medicaid benefits when you go for a visit.

You will be issued only one card and will receive a new card only if your card is lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free 1-800-252-8263, or by going online to order or print a temporary card at YourTexasBenefits.com. They will provide you with a Temporary Verification Form called Form 1027-A. You can use this form until you receive another card.

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 211. 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 YourTexasBenefits.com.

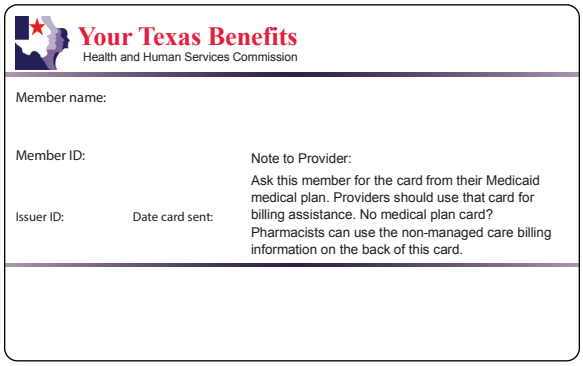
The YTB Medicaid card has these facts printed on the front:

- 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 (YourTexasBenefits.com) and a phone number you can call toll-free (1-800-252-8263) if you have questions about the new card.

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

Your Texas Benefits Medicaid Card


Your Texas Benefits
Health and Human Services Commission

Member name:

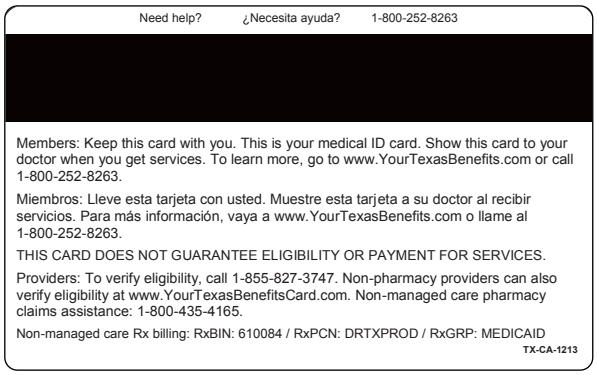
Member ID:

Issuer ID:

Date card sent:

Note to Provider:

Ask this member for the card from their Medicaid medical plan. Providers should use that card for billing assistance. No medical plan card? Pharmacists can use the non-managed care billing information on the back of this card.


Need help? ¿Necesita ayuda? 1-800-252-8263

Members: Keep this card with you. This is your medical ID card. Show this card to your doctor when you get services. To learn more, go to www.YourTexasBenefits.com or call 1-800-252-8263.

Miembros: Lleve esta tarjeta con usted. Muestre esta tarjeta a su doctor al recibir servicios. Para más información, vaya a www.YourTexasBenefits.com o llame al 1-800-252-8263.

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES.

Providers: To verify eligibility, call 1-855-827-3747. Non-pharmacy providers can also verify eligibility at www.YourTexasBenefitsCard.com. Non-managed care pharmacy claims assistance: 1-800-435-4165.

Non-managed care Rx billing: RxBIN: 610084 / RxPCN: DRTXPROD / RxGRP: MEDICAID

TX-CA-1213

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 YourTexasBenefits.com.

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

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

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.

RENEWING YOUR MEDICAID COVERAGE

You must renew your Medicaid coverage every year. Three to four months before your coverage is due to end, Texas Health and Human Services (HHSC) will send you an envelope in the mail marked "Time Sensitive." The envelope will include a renewal form. You may also be asked to provide more information, like an update on your family's income and cost deductions. The easiest way to renew your coverage is to go to YourTexasBenefits.com or download the YourTexasBenefits mobile app. 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 if I need help with completing my renewal application?
Call Community First Health Plans Member Services if you need help completing your renewal application. We also have resources online, including step-by-step instructions on how to renew your coverage, and we can help you over the phone or in-person. Go to CommunityFirstMedicaid.com and click on "How to Renew" under the "Get Insured" drop down menu to learn more or make an appointment to get help.

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. If you have questions about your Medicaid coverage, go to YourTexasBenefits.com or call the STAR+PLUS Program Helpline at 1-800-964-2777.

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 1-844-382-2347. 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.

PRIMARY CARE PROVIDER (PCP)

What is a primary care provider?
When you signed up with Community First, you chose a doctor from our list of providers to be your primary care provider (PCP). A primary care provider (PCP) is your own doctor or health care clinic. This person or clinic will:

- Take care of your medical needs and act as your main health care provider.
- Give you regular checkups.
- Write prescriptions for medicine or supplies when you are sick.
- Tell you if you need to see a specialist.

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. They can recommend certain screenings depending on health factors and provide necessary preventive care.

Can a specialist be my primary care provider?
If you have special health care needs, you may ask for a specialist to act as your primary care provider. The specialist must be approved by Community First Health Plans before they can be your PCP. The specialist must also be willing to be your primary care provider.

You may also pick an obstetrician (OB) or gynecologist (GYN) as your PCP. Call Community First Member Services to find an OB/GYN provider that is also a PCP.

A PCP can be a:

- Medical Doctor (MD)
- Doctor of Osteopathic Medicine (DO)
- Family or general practitioner
- Internist
- Obstetrician/Gynecologist (OB/GYN)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Federally Qualified Health Centers/Rural Health Clinics

Can a clinic (Rural Health Clinic/Federally Qualified Health Center) be my primary care provider?
Yes. You may pick a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) from our STAR+PLUS Provider Directory to be your primary care provider. An FQHC is a nonprofit clinic that provides care to people that live where there aren't many providers available. An RHC provides care to people that live in less populated areas where there aren't many providers available. If you have questions or need help, call Community First Member Services.

What if I choose to go to another doctor who is not my primary care provider?
If you go to a doctor that is not a PCP in the Community First network, Community First will not pay that doctor and you will get billed for the services. Your PCP is your own personal doctor in charge of your health. They keep your medical records, coordinate with any specialists that are involved in your care, know what medications you are taking and

are the best people to make sure you are getting the care you need. **This is why it is very important that you stay with the same doctor.**

If you are a Community First STAR+PLUS Dual Eligible Member, Medicare pays your doctor. That means you do not need to choose a PCP in STAR+PLUS. You can keep seeing the Medicare doctor you have been seeing for your health care.

Remember, your PCP is the most important person on your health care team!

Note: For STAR+PLUS Members who are covered by Medicare, no primary care provider will be assigned.

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 so they can help you plan for future health care needs.

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, 7 days a week.

You can also call our 24/7 Nurse Advice Line at 1-844-382-2347. The nurse might give you at-home medical advice or refer you to an urgent care center/hospital emergency room, if needed.

What if I get sick when I'm out of town or traveling?
If you need medical care when traveling, call us toll-free at 1-844-382-2347, and we will help you find a doctor. If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at 1-844-382-2347.

What if I am out of the state?
If you have an emergency out of state, go to the nearest emergency room for care. If you get sick and need medical care while you are out of state, call your Community First PCP or clinic. Your doctor can tell you what you need to do if you are not feeling well. If you visit a doctor or clinic out of state, they must be enrolled in Medicaid to get paid. Please show your Texas Medicaid ID card and Community First Member ID card before you are seen. Ask the doctor to call Community First for an authorization number. The phone number to call is on the back of your Community First Member ID card.

What if I am out of the country?
If you are outside of the United States and need medical care, any health care services you receive will not be covered by Community First. Medical services performed out of the country are not covered by Medicaid.

CHANGING YOUR PRIMARY CARE PROVIDER

How can I change my primary care provider?
If you are unhappy with your primary care provider, talk to them and let them know your thoughts and concerns. If you're still not happy after speaking with them, a Community First Member Services Representative can help you change your primary care provider. Call Member Services toll-free at 1-844-382-2347.

You can also submit a request to change your PCP through our secure Member Portal. You can access the Member Portal and create an account at CommunityFirstMedicaid.com. You can also 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+PLUS Provider Directory at CommunityFirstMedicaid.com**.**

If you have questions about your PCP's professional qualifications or if you'd like a current list of in-network PCPs and other providers, call Member Services.

How many times can I change my primary care provider?
There is no limit on how many times you can change your primary care provider. You can change your primary care provider by calling Member Services toll-free at 1-844-382-2347.

You can also submit a request to change your primary care provider 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 primary care provider change become effective?
If you change your primary care provider, the change will become effective immediately. After you have changed your primary care provider, you will get a new Community First Member ID card with your new PCP's name and phone number.

What if my 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. If you prefer to select a different primary care provider yourself, call Member Services and tell us which doctor you choose.

If you are receiving medically necessary treatments, you might be able to stay with your current doctor, even if they leave our network, if they are willing to continue seeing you. 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 does not accept Texas Medicaid.
- The doctor you chose is not accepting new patients.
- You are in the hospital when you make the request.
- The doctor you chose does not take patients with your needs.

PRIMARY CARE PROVIDER (PCP)

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

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

Where can I find a list of Community First providers?
The Community First STAR+PLUS Provider Directory is a list of PCPs, physicians, hospitals, and other health care providers that are available to you. You can find this list at CommunityFirstMedicaid.com. Just click on "Find a Provider." If you need help, call Community First Member Services.

MAKING AN APPOINTMENT

How do I make an appointment with my primary care provider?
Call your primary care provider (PCP) to make an appointment. If you need help making an appointment or if you need help with transportation, an interpreter, or other services, call Community First Member Services at 1-844-382-2347.

What do I need to bring with me to my appointment?

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

PHYSICIAN INCENTIVE PLAN INFORMATION

Community First Health Plans rewards doctors for treatments that are cost-effective for people covered by Medicaid. Community First 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 1-844-382-2347 to learn more about this.

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.

SPECIALISTS

What if I need to see a special doctor (specialist)?
Your doctor might want you to see a special doctor (specialist) for certain health care needs. A specialist has received training and has more experience taking care of certain health conditions, illnesses, and injuries. Community First has many specialists who will work with you and your primary care provider to care for your needs.

If you are a Community First STAR+PLUS Dual Eligible Member, you can continue to see the Medicare specialist(s) of your choice.

What is a referral?
Your doctor will talk to you about your health care needs and make plans for you to see a specialist if needed. This is called a referral. Your PCP is the only one who can give you a referral to see a specialist. If you see a specialist or receive services from a specialist without your doctor's referral, or if the specialist is not a Community First provider, you might be responsible for the bill. In some cases, an OB/GYN can also give you a referral for related services. If you need help, call Member Services.

What services do not need a referral?
You do not need a referral from your primary care provider for:

- Emergency services
- Behavioral health services
- OB/GYN care
- Routine vision services
- Routine dental services (for children)
- Family planning services

How soon can I expect to be seen by a specialist?
You should be seen within three 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.

What is prior authorization?
Some medical services require approval from Community First Health Plans. This is called prior authorization. You can learn more about what services require prior authorization by visiting CommunityFirstMedicaid.com. Click on "Prior Authorization" under the "Members" drop down menu. You can also call Member Services at 1-844-382-2347.

How can I ask for a second opinion?
You have the right to a second opinion if you are not satisfied with the plan of care offered by a specialist. Your primary care provider should be able to give you a referral for a second opinion visit for a specialist in our network. Call Member Services if you need help finding another doctor.

What if I need to be admitted to a hospital?
If you need to be admitted to a hospital for inpatient hospital care, your doctor must call Community First to let us know about the admission. If you are a Community First STAR+PLUS Dual Eligible Member, you must follow your Medicare plan rules for hospital admissions.

What if I go to the emergency room?
If you need urgent or emergency attention, you should get medical care right away and then you or the doctor should call Community First as soon as possible. If you are unsure if you need to go to the emergency room, you can call Community First's 24-hour Nurse Advice Line at 1-844-382-2347.

WOMEN'S HEALTH SERVICES

OB/GYN CARE

ATTENTION FEMALE MEMBERS

What if I need OB/GYN care?
Community First Health Plans allows you to pick an OB/GYN, but this doctor must be in the same network as your primary care provider.

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 a specialist within the network.

Do I have the right to choose an OB/GYN as my primary care provider?
Community First has some OB/GYN providers that can be your primary care provider. If you need help picking an OB/GYN, call Community First at 1-844-382-2347.

If I don't choose an OB/GYN as my primary care provider, do I have direct access? Will I need a referral?
Yes, you still have direct access to an OB/GYN, even if you don't choose one as your PCP. You don't need a referral or approval from Community First. Family planning services, OB care, and routine GYN services and procedures can be accessed directly through the Community First OB/GYN you choose.

How do I choose an OB/GYN?
You can find a list of available OB/GYN doctors from the STAR+PLUS Provider Directory at CommunityFirstMedicaid.com. You can also call Member Services at 1-844-382-2347 if you need help choosing an OB/GYN. Once you choose an OB/GYN, you should go to the same OB/GYN for each visit so they can get to know your health care needs.

How soon can I be seen after contacting my OB/GYN for an appointment?
Your OB/GYN should see you within two weeks if you are pregnant. If you are not pregnant, your OB/GYN should see you within three weeks.

Can I stay with my OB/GYN if they are not with Community First Health Plans?
If your OB/GYN is not with Community First, please call Member Services. We will work with your doctor so they can keep seeing you, or we can help you pick a new doctor within the plan.

PREGNANT WOMEN AND NEW MOTHERS

CARE DURING PREGNANCY

What if I am pregnant? Who do I need to call?
If you think or know you are pregnant, make an appointment to see your doctor or an OB/GYN. They will be able to confirm if you are pregnant or not and discuss the care you and your baby will need. It is very important to start your prenatal care right away. When you know that you are pregnant, call Community First Member Services at 1-844-382-2347.

How soon after contacting my OB/GYN can they see me for an appointment?
Your OB/GYN Should see you 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 birthing center close to you, please use our Provider Directory. Go to CommunityFirstMedicaid.com and click "Find a Provider." You can also call Member Services if you need help.

EXTRA BENEFITS FOR PREGNANT WOMEN

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.

PREGNANT WOMEN AND NEW MOTHERS

STAR+PLUS Members who participate in Healthy Expectations may also be eligible to receive up to $90 in gift cards, upon completion of the following:

- Taking online health assessment.
- Receiving a flu shot during pregnancy.
- Attending a Mommy & Me Baby Shower.
- Signing up for health education text messages.
- Attending all required pre- and post-natal checkups.

Mommy & Me Baby Showers are held in-person and virtually. Eligible STAR+PLUS Members who attend a Mommy & Me Baby Shower can receive a diaper bag filled with baby items, a baby car seat or pack and play, and gifts for dads who attend the baby shower with the expecting mom.

Pregnant STAR+PLUS Members are also welcome to join our Maternal Community Health Club that offers:

- Pregnancy, birthing, postpartum, and baby education.
- A community of other pregnant women to answer questions, discuss pregnancy questions or concerns, and provide support.
- A Health Educator assigned to you to help find health services, community resources, and guide you through pregnancy and beyond.
- Baby car seat or pack and play, whichever you did not receive at your Mommy & Me Baby Shower.

You can learn more about Healthy Expectations and the Maternal Community Health Club by reviewing the Health & Wellness Programs and Value-Added Services sections in this Member Handbook. You can also visit CommunityFirstMedicaid.com, call 1-844-382-2347, or email healthyhelp@cfhp.com for more information.

**Limitations or restrictions may apply. Please call 210-358-6105 or email healthyhelp@cfhp.com to see if you qualify for specific maternity health program benefits.*

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

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

What is Case Management for Children and Pregnant Women (CPW)?
Case Management for Children and Pregnant Women (CPW) is a case management program that provides health related case management services to 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.

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 your home.
- 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 I get a CPW case manager?
You can get a case manager by calling Community First Member Services at 1-844-382-2347 or by contacting our Case Management Department at 210-413-8649 or chelp@cfhp.com You can also call Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8:00 a.m. to 8:00 p.m.

YOUR BABY'S HEALTH CARE COVERAGE

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 on their date of birth. Community First will receive information from the hospital to add your baby as a new Member. The hospital will also notify Medicaid about the baby's birth.

It is important to also contact the Department of State Health Services (DSHS) to report the birth of your baby. This will ensure that your baby can get all the covered health care services they need.

After I've given birth, how and when do I tell my health plan? How and when do I tell my caseworker?
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 to verify the correct date of birth for your baby and also confirm your baby's name. Call your Medicaid caseworker as soon as possible after your baby is born. You do not need to wait until you get your baby's Social Security number to get your baby signed up.

Can I choose a primary care provider for my baby before the baby is born?
You can choose your baby's doctor even before they are born. If you need help selecting a doctor for your baby, call Member Services at 1-844-382-2347. Please note: This does not apply to STAR+PLUS Members who are dual-eligible.

How and when can I change my baby's primary care provider?
A Member Services Representative can help you choose a new doctor for your baby. Call Member Services toll-free at 1-844-382-2347. You can also submit a request to change your child's PCP through our secure Member Portal. For a list of primary care

providers in the Community First network, use our STAR+PLUS Provider Directory at CommunityFirstMedicaid.com.

Please note: This does not apply to Community First STAR+PLUS Dual Eligible Members.

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 Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

HEALTHY TEXAS WOMEN PROGRAM

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

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

Healthy Texas Women
P.O. Box 149021
Austin, TX 78714-9021

Phone: 1-800-335-8957
Website: HealthyTexasWomen.org
Phone: 1-877-541-7905 (toll-free)
Fax: 1-866-993-9971

PRIMARY HEALTH CARE PROGRAM (PHC)

The Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200% of the federal poverty level). A person approved for services may have to pay a copayment, 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:

- Emergency services
- Family planning services
- Health education and counseling
- Diagnostic testing, such as X-rays and lab services
- Preventive health services, including immunizations
- Diagnosis and treatment of common health problems

You can apply for PHC services at certain clinics in your area. To find a clinic where you can apply, go to 211Texas.org or call 211 and ask for the nearest provider. To learn more about services you can get through this program, email, call, or visit the program's website:

Website: www.hhs.texas.gov/services/health/primary-health-care-program
Phone: 512-776-5922 or 1-800-222-3986 (toll-free)
Email: PrimaryHealthCare@hhs.texas.gov

FAMILY PLANNING PROGRAM (FPP)

The Family Planning Program has clinic sites across the state that provide high-quality, comprehensive, low-cost, and accessible family planning and reproductive health care services to Texans.

FPP is available to anyone who:

- Is a Texas resident;
- Has an income level at or below 250% of the federal poverty level; and
- Is not eligible for other programs or benefits that provide the same services.

Individuals should contact a clinic that provides FPP services by using the clinic locator at www.healthytexaswomen.org/family-planning-program. Clinic staff will assist with the program application and determine eligibility. To learn more about these services, visit the program's website, call, or email:

Website: www.healthytexaswomen.org/family-planning-program
Phone: 1-800-335-8957
Email: famplan@hhs.texas.gov

BREAST AND CERVICAL CANCER SERVICES

The Breast and Cervical Cancer Services Program provides primary, preventive, and screening services to women age 18 to 64 years whose income is at or below the program's income limits (200% of the federal poverty level). Community health workers will help make sure women get the preventive and screening services they need, such as clinical breast examinations, mammograms, pelvic examinations, and pap tests.

Individuals should contact a clinic that provides Breast and Cervical Cancer services by using the clinic locator at www.healthytexaswomen.org/healthcare-programs/breast-cervical-cancer-services. Clinic staff will assist with the program application and determine eligibility.

To learn more about services you can get through the Breast and Cervical Cancer Services Program, visit the program's website, call, or email:

Website: www.healthytexaswomen.org/healthcare-programs/breast-cervical-cancer-services
Phone: 1-512-776-7796
Fax: 1-512-776-7203
Email: BCCSProgram@hhs.texas.gov

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. They can help you pick a family planning provider. You can also call Member Services at 1-844-382-2347.

Where do I find a family planning services provider?
You can find the locations of family planning providers near you online at HealthyTexasWomen.org or you can call Community First Health Plans Member Services at 1-844-382-2347 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, birth to age 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 ECI?
You can ask for a referral from your 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 can I find an ECI provider?
You can search for an ECI provider in your area by using the ECI Program Search Tool at citysearch.hhsc.state.tx.us. You can also call the Office of the Ombudsman at 1-877-787-8999, select a language, and then select Option 3.

TRAVELING FARMWORKERS

What if I'm a traveling farmworker?
A traveling farmworker is someone who moves to another area or establishes a temporary home in order to work in agriculture/farming.

If you're a traveling farmworker, we can help:

- Get your checkup sooner if you are leaving the area.
- Find mental health services.
- Find a doctor where you are traveling to.
- Get medicine and medical supplies quickly.
- Get vaccines or refill prescriptions before moving.
- Let doctors know you need to be seen quickly before you leave the area.
- Schedule your checkup, vision screening, or dental appointment before you leave.

If you are a traveling farmworker and have questions or need help with your STAR+PLUS benefits, please call Member Services at 1-844-382-2347.

CARE DEFINED

ROUTINE MEDICAL CARE

What is routine medical care?

Routine medical care is the regular care you get from your primary care provider (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:

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

What should I do if I need routine medical care?

Contact your PCP to make an appointment for routine medical care, including regular health checkups. You can always call Community First Member Services if you need help making an appointment.

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 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:

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

What should I do if 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 do need to go to a clinic that takes Community First Health Plans Medicaid. For help finding an urgent care provider, call Community First Member Services toll-free at 1-844-382-2347. You also can call our 24-hour Nurse Advice Line at 1-844-382-2347 for help with getting the care you need.

Community First Members can also get in-home urgent medical care through DispatchHealth. Most appointments can be made the same day. Request an appointment by calling 210-245-7120 or visit Request.DispatchHealth.com.

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. You must go to an urgent care clinic that takes Community First Health Plans Medicaid.

EMERGENCY CARE

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

How soon can I expect to be seen?
Emergency wait times will be based on your medical needs and determined by the emergency facility that is treating you.

What is an emergency medical condition?
An emergency medical condition is a medical condition with 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. Serious disfigurement;
2. Serious impairment to bodily functions;
3. Placing the patient's health in serious jeopardy;
4. Serious dysfunction of any bodily organ or part; or
5. In the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

What is an emergency behavioral health condition?
An 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.

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

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

MEDICALLY NECESSARY

What does medically necessary mean?
To be covered by our plan, the care you receive must be medically necessary. This means it must be reasonable and necessary to prevent or treat illnesses or health conditions or disabilities.

1. For Members birth through age 20, the following Texas Health Steps services are

considered medically necessary:
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:
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.

HELP ACCESSING HEALTH CARE

Community First is committed to removing barriers to care. Everyone deserves access to the health care services they need and to understand the care or treatment they are receiving.

INTERPRETERS

Can someone interpret for me when I talk with my doctor? Can I get a face-to-face interpreter in a Provider's office?
Community First Member Services Representatives speak English and Spanish. If you

speak another language or are deaf or hard of hearing and need help, please call Member Services at 1-844-382-2347 (TTY 711). Community First can arrange for an interpreter to go with you to your doctor's appointment.

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

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. **Transportation services for Community First Members are provided by MTM.**

What services are part of NEMT services?

There are many types of NEMT transportation services, including:

- 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 for the member and $25 per day for an approved attendant. I
- 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 adult on file to travel alone. Parental consent is not necessary if the health care service is confidential in nature.

How do I get a ride?
You can request Community First NEMT services through MTM. If you need a ride, call MTM. MTM has staff that speak English and Spanish and can also provide interpreter

services if you speak another language.

You should request NEMT services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances, you may request the NEMT service with less notice. These circumstances include:

- Being picked up after being discharged from a hospital;
- Trips to the pharmacy to pick up medication or approved medical supplies; and
- Trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

MTM
Member Reservation Line: 1-888-444-0307 (TTY 711)
Monday through Friday, from 8 a.m. to 5 p.m.

Where's My Ride?: 1-888-444-0824 (TTY 711)
24 hours a day, 7 days a week

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.

How do I find out where my ride is?
You can call 1-888-444-0824 (TTY 711) to check on the status of your ride.

How do I change or cancel my ride?
You must notify MTM prior to the approved and scheduled trip if your medical appointment is canceled. To cancel your ride, call MTM at 1-888-444-0307 or log into the MTM Link Member Portal at MedicalTrip.net.

What if I have a complaint about the transportation program?
If you have any problems with Community First NEMT services, call MTM at 1-888-444-0824.

TELEHEALTH

What are telehealth services?
Most Community First Providers in our network offer telehealth services to STAR+PLUS Members for certain health care needs. Telehealth services are virtual health care visits with a provider through a mobile app, online video, or other electronic method.

Community First treats telehealth services with in-network providers the same way as face-to-face visits with in-network providers. A telehealth visit with an in-network Community First provider does not require prior authorization.

How do I make a telehealth appointment?
Call your doctor and ask if they offer telehealth services. You can make an appointment for a time that works with your schedule.

OTHER SERVICES

What other services can Community First Health Plans help me get?
Community First Health Plans can help Members get other services not covered under the STAR+PLUS program. These are called non-capitated services. STAR+PLUS Members may be eligible to receive non-capitated services from Texas Medicaid providers. We work with many services and agencies to help you get the care you need. Some of these services and agencies include:

- Hospice
- Public Health Departments
- Dental services for children
- Medical Transportation Service
- Early Childhood Intervention (ECI)
- Texas Health and Human Services Commission

Community First can help if you have questions about these or other non-capitated services. Please call Member Services at 1-844-382-2347 for more information.

MEMBER ADVOCATES

Community First Health Plans provides STAR+PLUS 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 functions and contact information for the HHSC Office of the Ombudsman,
3. The complaint process,
4. The appeal process,
5. Covered services available to them, including preventive services, and
6. 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 and Members' Legally Authorized Representatives (LARs) 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 and Members' LARs 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 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 available to meet Member needs that are not available from Community First as covered services.

Member Advocates must be trained to handle complaints regarding Service Coordination. Member Advocates must work with appropriate Community First personnel to address complaints about Service Coordinators, either by requesting reassignment or by working with the Member, the Service Coordinator, and other appropriate Community First staff to facilitate resolution.

Community First must ensure access to Spanish-speaking Member Advocates or Member Advocates who speak languages of other major population groups, if requested.

YOUR HEALTH CARE BENEFITS AND SERVICES

What are my 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 need. These services must be given by your doctor or referred by your doctor to another provider.

ACUTE CARE SERVICES

What are my acute care benefits? How can I get these services or learn more about them?
Acute care is a level of health care in which a patient is treated for short-term needs. Acute care is often performed in a hospital setting or doctor's office for quick, urgent treatment. To learn more about acute care services covered under your plan, call Member Services at 1-844-382-2347.

The acute care services listed below are covered under your plan.

- Ambulance services
- Audiology services, including hearing aids
- Behavioral health services, including:
  - Inpatient and outpatient mental health services
  - Outpatient chemical dependency services for children
  - Detoxification services
  - Psychiatry services
- Birthing services provided by a physician or certified midwife in a birthing center
- Chiropractic services
- Dialysis
- Durable Medical Equipment (DME)
- Emergency services
- Family planning services
- Home health care services (requires a referral)
- Hospital services, including inpatient and outpatient care
- Laboratory services
- Medical checkups
- Nursing facility care
- Optometry, including glasses and contact lenses if medically necessary

- Podiatry services
- Prenatal care
- Prescription medications
- Primary care services
- Radiology, imaging, and x-rays
- Specialty doctor services
- Therapies, including physical, occupational, and speech
- Transplantation of organs and tissues
- Vision services
- Wellness checkups

If you are a Community First STAR+PLUS Dual Eligible Member, these acute services are covered by Medicare. You can still go to your Medicare doctor for the services you need.

Will my STAR+PLUS benefits change if I am in a nursing facility?
If you go into a nursing facility, you will receive STAR+PLUS Nursing Facility Medicaid benefits. If you move from a nursing facility back into the community, you may be eligible for additional services through the STAR+PLUS home and community-based services program (HCBS). HCBS services may include:

- Assisted living
- Home therapies
- Personal Assistance Services (PAS)

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+PLUS Program or Community First Health Plans.

- Autopsies
- Acupuncture
- Sex-change surgery
- Out-of-area routine care
- Reversal of voluntary sterilization
- Services outside the United States
- Experimental surgery or procedures
- Abortions not covered by federal and state regulations
- Cosmetic or plastic surgery that is not medically necessary
- Eye surgery to correct nearsightedness, farsightedness, or blurred vision
- Infertility treatments, including artificial insemination and in-vitro fertilization

- Custodial care such as cooking, cleaning, bathing, and feeding that are not medically necessary
- Personal convenience items such as a television, phone or grooming supplies that are not medically necessary

You will be held responsible for non-Medicaid covered services. It is your responsibility to determine which services are covered or not. If you have questions about whether or not a service is covered, please call Community First Member Services at 1-844-382-2347.

LONG-TERM SERVICES AND SUPPORTS (LTSS)

What are my long-term services and supports (LTSS) benefits?
Long-term services and supports (LTSS) are benefits that help you stay safe and independent in your home or community. LTSS help you with functional needs like bathing, dressing, taking medicine, or preparing meals. They are just as important as acute care services.

Community First STAR+PLUS Members are eligible to receive:

- Personal Attendant Services (PAS)
- Day Activity and Health Services (DAHS)

There are other long-term care benefits that Community First Members can get based on their medical needs. These are called Home and Community Based Services (HCBS) STAR+PLUS Waiver and include:

- Adaptive aids and medical equipment
- Adult foster care
- Assisted living
- Cognitive Rehabilitation Therapy
- Consumer Directed Personal Attendant Services
- Emergency Response Services (ERS)
- Employment Assistance and Supported Employment
- Home delivered meals
- Medical supplies
- Minor home modifications
- Nursing services (in home)
- Personal Attendant Services (PAS)
- Physical, Occupational, and Speech Therapy
- Protective supervision
- Respite care
- Service responsibility choice for Personal Attendant Services
- Some dental care
- Transition Assistance Services

How can I get these services or learn more about LTSS?
Contact your Service Coordinator or call Community First Service Coordination at

210-358-6105 to find out more about LTSS benefits and delivery options. You can also call Community First Member Services for help.

LTSS SERVICE DELIVERY OPTIONS

For each LTSS service that has the option to be self-directed, you must choose one of the options below. You can choose a different option for each service, or the same option for them all. If you need help choosing, contact your Service Coordinator.

1. **Service Responsibility Option (SRO)**
   In the SRO model, an agency is the attendant's employer and handles the business details (e.g., paying taxes and doing the payroll). The agency also orients attendants to agency policies and standards before sending them to the Member's home.

2. **Consumer Directed Services (CDS)**
   Members who choose CDS are given the authority to self-direct certain services. CDS allows for more options and control. With CDS, you can find, screen, train, hire, and fire (if needed) the people who provide services to you (your staff). If you choose to be in CDS, you will contract with a Financial Management Services Agency (FMSA). FMSA will provide training, handle payroll, and file your taxes.

3. **Agency Option**
   Members who choose the agency model will select an agency from a list of Community First providers contracted to provide long-term services.

BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH AND SUBSTANCE USE DISORDERS)

How do I get help if I have behavioral (mental) health, alcohol, or drug problems?
Community First has a group of mental health and substance use disorder specialists to help you. Your Medicaid behavioral health benefits cover:

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

What should I do in a behavioral health emergency?
You should call 911 if you are having a life-threatening behavioral health emergency or go to the nearest emergency room.

You can also call the 988 Suicide and Crisis Lifeline for 24/7, confidential support for people in suicidal crisis or mental health-related distress. Call 988 if you are experiencing thoughts of suicide, a substance use crisis, or any other kind of emotional distress.

You do not have to wait for an emergency to get help. Call Community First's 24-hour Behavioral Health Crisis Line at 1-877-221-2226 to speak to someone who can help you with depression, mental illness, or a substance use disorder.

Do I need a referral for mental health or substance use services?
You do not need a referral to get these services. If you have a problem because of mental illness, alcohol, or drugs, please call us. You can call 24 hours a day, 7 days a week.

BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH AND SUBSTANCE USE DISORDERS)

Community First offers the following behavioral health services:

- Targeted Case Management
- Mental Health Rehabilitation
- Transitional health care services
- Referrals to other community resources
- Crisis services 24 hours a day, 7 days a week
- Outpatient mental health and substance use disorder services
- Medications for mental health and substance use disorder care
- Education, planning, and coordination of behavioral health services
- Psychiatric partial and inpatient hospital services (for Members 21 and over)
- Non-hospital and inpatient residential detoxification, rehabilitation and half-way house

Outpatient counseling services available include individual, couple, family, and group counseling. If you are in need of alternative treatment, the following services are available:

- Intensive outpatient
- Partial hospitalization
- Inpatient hospitalization
- Residential treatment

Please note: If you are a Community First STAR+PLUS Dual Eligible Member, Medicare pays for mental health care services. You can continue to see any Medicare provider. You do not have to use a Community First provider for these services.

How do I know if I need help?
You might need help if you:

- Can't cope with daily life.
- Are not sleeping or eating well.
- Feel very sad, stressed or worried.
- Are drinking or using other substances more.
- Are having problems at work, home, or school.
- Are troubled by strange thoughts (such as hearing voices).
- Want to hurt yourself or others or have thoughts about hurting yourself.

The most important thing to remember is that help is available and you are not alone.

What do I do if I am already in treatment?
If you are already getting care, call Community First Member Services. We will work with your provider to make sure you keep getting the care you need.

What are mental health rehabilitation services and mental health targeted case management? How do I get these services?
These are services that help Members with severe mental illness, behavioral, or emotional problems. We can help Members get access to care and community support through mental health rehabilitation and mental health targeted case management. To get help, please call 1-844-382-2347.

VIRTUAL MENTAL HEALTH CARE

Community First Health Plans has partnered with Charlie Health to offer Members ages 11-33 virtual mental heath services including individual, group, and family therapy. To learn more about Charlie Health or get these services, call 1-866-935-3297 or go to CharlieHealth.com.

SERVICE COORDINATION

What is Service Coordination?
Service Coordination is a special service for STAR+PLUS Members to help you manage your health, long-term service and supports, and behavioral health care needs. We will gather information and build an individual service plan (ISP) to address those needs, just for you. Service Coordination includes:

- Attention to addressing unique needs of Members;
- Assistance to ensure timely and a coordinated access to providers and services; and
- Coordination of Medicaid benefits with non-Medicaid services and supports, as necessary and appropriate.

How can I get these services?
All STAR+PLUS Members receive Service Coordination as a Member of our plan. You will be assigned a Community First Service Coordinator who will help you get the services you need.

What will a Service Coordinator do for me?
Service Coordinators are trained to meet the needs of those who need help the most, including people who have chronic or complex conditions. A Service Coordinator will work alongside your primary care provider and specialty care providers to make sure your needs are identified, a service plan is in place, you receive your services on time and at the right time, and your Community First-covered services are coordinated with social and community support services.

Community First Services Coordinators want you to be safe and healthy, involved in your service plan, and live where you choose.

How can I talk with a Service Coordinator?
Your Service Coordinator will provide you with a number to call them directly. If you have not been assigned a Service Coordinator or would like more information about Service Coordination, please call 210-358-6105.

VISION SERVICES

How do I get eye care services?
Community First Health Plans partners with Envolve to provide routine eye care services to our Members. You need to go to an Envolve vision care provider to get routine eye care. You do not need a referral from your primary care provider for routine eye care.

You can call Envolve Customer Relations at 1-800-334-3937 or Community First Member Services at 1-844-382-2347 for help finding an Envolve provider near you. You

can also look up Envolve providers by visiting VisionBenefits.EnvolveHealth.com.

If you have a medical problem with your eyes, you will need to call your primary care provider first. If your doctor cannot treat your medical problem, you will be referred to a special eye doctor who can.

What are my vision benefits?
STAR+PLUS Members can get a vision exam and medically necessary frames and certain plastic lenses every 24 months. Community First also offers STAR+PLUS Members extra vision benefits. Call 1-844-382-2347 or email healthyhelp@cfhp.com to learn more.

DENTAL SERVICES

How do I get dental services?
Your Medicaid dental plan provides routine dental services that help prevent tooth decay and services that fix dental problems. You may pick the Dental Maintenance Organization (DMO) of your choice.

DentaQuest: 1-800-516-0165
MCNA Dental: 1-855-691-6262
United Healthcare Dental: 1-877-901-7321

Call your Medicaid dental plan to learn more about the dental services they offer.

What do I do if I need emergency dental care?
During normal business hours, call your main dentist to find out how to get emergency services. If you need emergency dental services after the main dentist's office is closed, call Member Services at 1-844-382-2347, go to urgent care, or call 911.

Are emergency dental services covered by Community First?
Community First covers emergency dental services in a hospital or ambulatory surgical center, including 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 covers hospital, physician, and related medical services for the above conditions. This includes services the doctor provides and other services you might need, like anesthesia or other drugs.

Community First is also responsible for paying for treatment and devices for craniofacial anomalies.

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

HELP FOR SPECIAL HEALTH CARE NEEDS

Who do I call if I have special health care needs and I need someone to help?
If you have special health care needs, like a serious ongoing illness, disability or chronic or complex conditions, call Community First at 1-844-382-2347. We can help you make an appointment with one of our doctors that cares for patients with special needs. We will also refer you to one of our Care Managers who will:

- Help you get the care and services you need.
- Develop a plan of care with the help of you and your doctor.
- Follow your progress and make sure you are getting the care you need.
- Answer your health care questions

CASE MANAGEMENT

Community First has experienced nurses who can help you understand problems you may have, like:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Transplants
- Using the emergency room frequently
- Being in the hospital often
- Wounds that won't heal
- Multiple diseases or conditions

Our nurses will help you stay healthy. The goal of our Case Management program is to help you access services or support you need. We can help you find care close to you and we will work with your doctor to improve your health. We want to help you meet your goal to be more independent with your health. Please call Member Services to talk to a nurse. You can also reach a nurse 24 hours a day, 7 days a week by calling our Nurse Advice Line. A registered nurse can answer your health questions after hours and on weekends.

Also, a Community First nurse may contact you if your doctor asks us to call you, if you ask us to call you, or if Community First feels our Case Management program can help you.

- We may ask you questions about your health.
- We will give you information to help you understand how to get the care you need.
- We will talk to your doctor and other people who treat you, to get you care.

You should call us at 1-844-382-2347 if you want to talk to a nurse about being in this program. If you don't want to be in the Case Management program, you can opt out at any time by calling your nurse.

COMMUNITY FIRST CHOICE

Community First Choice (CFC) benefits provide home and community-based supports and services to eligible Medicaid members.

CFC helps Members with daily living needs. CFC services include:

- Personal Attendant Services (PAS): Help with daily living activities and health-related tasks.
- Habilitation: Services to help learn new skills and care for yourself.
- Emergency Response Services (ERS): Help if you live alone or are alone for most of the day.
- Support Management: Training on how to select, manage and dismiss attendants.

Your Service Coordinator will be able to help schedule an assessment for CFC if you think you need these services. For more information, call Member Services at 1-844-382-2347.

ELECTRONIC VISIT VERIFICATION (EVV)

What is Electronic Visit Verification (EVV)?

Texas Health and Human Services Commission (HHSC) implemented electronic visit verification (EVV) to verify that Members receive the services authorized for their support and for which the state is being billed. Time will be logged using an HHSC-approved EVV System and one of three EVV time recording methods. These methods include:

1. Mobile telephone application
2. Member's home landline telephone
3. Approved small alternative device

Approved small alternative device EVV is required for home care services and verifies when service visits occur. It also documents the exact time service begins and ends.

EVV is required for Members using the consumer directed services (CDS) option and for certain home and community-based services provided by Community First, including:

- Personal Attendant Services (PAS)
- Community First Choice Personal Attendant Services or Habilitation
- Protective Supervision
- In-home Respite
- In-home Nursing visits
- Physical Therapy visits in the home
- Occupational Therapy visits in the home
- Speech Therapy
- Cognitive Rehabilitation Therapy
- Employment Assistance and Supported Employment
- Support Consultation

How does EVV work?

Your service provider will clock in using one of the HHSC approved time recording methods when they begin providing your services. They will then clock out when the services are completed. EVV will help make sure you, as a Member, get all your authorized services.

What if I don't have a home landline phone?
If you don't have a landline phone in your home and the service provider does not have access to the mobile phone application, please tell the agency that provides your services. The agency will install a small alternative device in your home so your service provider can accurately record the time services begin and end. If you are unsure if your phone is a landline, please request a small alternative device. Member's personal cell phones are not an acceptable replacement for a home landline.

The small alternative device can be installed anywhere in the home that is convenient for access to the service provider. The device must remain inside the home at all times. If the device breaks or gets lost, please let your service provider know as soon as possible. They can then request a replacement from the selected EVV vendor and the SAD will be re-installed.

Only CDS employers have the option to allow their employees to use the CDS employer's personal cell phone. If a CDS employer chooses to let their CDS employees use the CDS employer's personal cell phone for EVV, the CDS employer will be responsible for cell phone charges. CDS employers must document their request to use the CDS employer's personal cell phone or to request additional landline numbers for the EVV system.

Please note, the use of a Member's personal cell phone is not allowed and your service provider should never ask to use your cell phone to call in and out.

Do I have to participate in EVV?
Yes, EVV is required for certain home and community-based services. You must do one of the following:

1. Let your service provider use your home landline phone if they do not have access to the mobile phone application to access the EVV system; or
2. Let the agency that provides your services install the small alternative device. That way, your service provider can use the device to record a timestamp for when they begin and end their authorized services for you.

How do I find out more about EVV?
If you have any questions about EVV, please contact your Community First Service Coordinator or contact Member Services. You can also find more information about EVV at CommunityFirstMedicaid.com. You can also visit the HHSC EVV website at www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification-evv.

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 they are 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. They 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 that you participate in one of Community First's Health & Wellness programs. If you are interested or would like to learn more about these programs, please visit CommunityFirstMedicaid.com or email healthyhelp@cfhp.com.

VALUE-ADDED SERVICES

What extra benefits do I get as a Member of Community First Health Plans?
As a Member of Community First, you are able to get extra benefits in addition to your regular benefits. These are called Value-Added Services.

STAR+PLUS VALUE-ADDED SERVICES (MEDICAID ONLY)

The following Value-Added Services are available to Community First STAR+PLUS Medicaid Only Members. If you are a a Community First STAR+PLUS Dual Eligible Member (you have Medicare and Medicaid), please see the Value-Added Services chart beginning on page 47.

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
24-hour Nurse Advice Line staffed by registered nurses who are ready to answer your health-related questions every day, including weekends and holidays. Members can call the Nurse Advice Line at 1-800-434-2347. Deaf or heard of hearing can call 711.	
Extra Help Getting a Ride, for Members, their siblings, and their parent or legal guardian, to places such as: • The grocery store • Community-based services • Community First hosted events • Health education classes • Member Advisory Group meetings • WIC • Social Security Administration offices to submit applications for employment and housing • Voter polling sites to vote in local and national elections • Social Security Administration-approved physician for appointments requested for disability determination and services	*Bus passes are not provided to children younger than 18 unless they are with their parent or guardian. For non-medical related use only. This service is available only for bus service routes within San Antonio and routes are offered by VIA Metropolitan Transit.*

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Health & Wellness Programs that provide outreach, education and more, including but not limited to: • Healthy Expectations Maternity Program • Diabetes in Control: Diabetes Management Program • Healthy Mind: Behavioral Health Program • Healthy Living: Lifestyle Management Program • Healthy Joints: Arthritis Management Program • Healthy Lungs ○ Asthma Matters: Asthma Management Program ○ Chronic obstructive pulmonary disease (COPD) Management Program • Healthy Heart ○ Blood Pressure Management Program ○ Congestive Heart Failure (CHF) Management Program ○ Coronary Artery Disease Management Program	
YMCA Programs • Y Weight Loss Program - 16 Weeks to Wellness: a no-cost program for individuals interested in implementing and maintaining a healthy lifestyle. Program includes a free 4-month YMCA membership for two adults and up to 4 children • YMCA Diabetes Prevention Program: a no-cost, year-long, evidence-based program to help individuals at risk of developing Type 2 Diabetes. Program includes a free 4-month YMCA membership for two adults and up to 4 children	*For ages 21 and older. Must attend education sessions 1-4 to receive YMCA membership.*
Extra Dental Services, including: • Up to 50% off dental & orthodontic services • Price match guarantee (terms apply) • Free exams and x-rays every 6 months	*For Members ages 21 and up and their family members who do not have dental coverage.*

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Extra vision services, including up to $125 for frames or $75 for contact lenses	*Either frames or contact lenses must be medically necessary. Available every year for Members ages 21 and younger and every other year for Members ages 22 and older. Glasses or contacts can only be replaced when there is a change in vision. Lost or broken glasses or contacts may be replaced as allowed by the Benefit Program.*
Drug Store Services/Over-the-Counter Benefits Up to 80% discount on prescription medicines for Member's family members who do not have Medicaid or CHIP coverage	
Help for Members with Asthma who participate in Asthma Matters: Asthma Management Program, including: • 1 adult or child size mask with aerosol chamber each year • $10 gift card for completing asthma education • $10 gift card for receiving a flu shot • 1 allergy-free protector pillowcase each year	*Gift cards must not be used to purchase beer, wine, alcohol, cigarettes, or over-the-counter drugs.*

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Extra Help for Pregnant Women who participate in Healthy Expectations Maternity Program, including: • Mommy and Me Baby Shower • Free baby car seat or Pack and Play portable play yard • Free diaper bag with baby supplies, including baby wipes and other baby items • Free gifts for fathers who attend Mommy and Me Baby Shower with mom For pregnant Members who participate in both Healthy Expectations and the Maternal Community Health Club: • A Health Educator assigned to you to help find health services, community resources, and guide you through pregnancy and beyond • Pregnancy, birthing, postpartum, and baby education • Free baby car seat or Pack & Play portable play yard, whichever was not received the Mommy and Me Baby Shower	*Limited to one baby shower per pregnancy, unless having more than one baby (i.e., twins). Members will receive one diaper bag and a choice of a car seat or safe sleep pack and play.*
Home visits for high-risk Members who participate in Community First Health & Wellness Programs, including Asthma Matters, Diabetes in Control, Healthy Mind, and Healthy Expectations • One home-delivered package of 10 prepared meals after discharge from nursing facility or inpatient stay • Up to 8 hours of in-home respite care services per year, for non-HCBS waiver Members	

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Health and Wellness Services, including: • Free, personalized support and the tools and strategies to keep you motivated and help you become tobacco-free by phone or online. Includes coaching, education, activities and more • Free notary services for documents such as medical power of attorney, health agent of record, and living wills • Opportunity to attend in-person and virtual seasonal and community Health Education Special Events at no-cost where Members may receive health education on topics such as telehealth, healthy habits, new benefits, and more • Online social services resource directory available at CommunityFirstResources.com to find community resources such as housing, food and nutrition, education, and more	*To receive notary services, Members must have a valid, state-issued identification card or driver's license.*
Healthy Play and Exercise Programs, including: • Free Zumba classes for Members and their family with a free fitness giveaway, including the choice of a frisbee, water bottle, or exercise bands • Free Bike Safety and Repair Program with free giveaway • For Members participating in Healthy Living: Lifestyle Management Program: ○ One exercise kit that includes a towel, water bottle, and exercise bands	

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Gift Programs, including: • **Up to $90 for pregnant Members participating in Healthy Expectations Maternity Program**: ○ $10 for attending Mommy and Me Baby Shower ○ $20 for completing the Community First maternity assessment and agreeing to receive health education text messages ○ $20 for completing a prenatal visit ○ $20 for receiving the flu shot during pregnancy. ○ $20 for completing a postpartum visit between 7 and 84 days after delivery ○ Up to $30 reimbursement for birthing classes or pregnancy-related items, such as a pregnancy pillow • **Up to $70 in gift cards for Members with diabetes participating in Diabetes in Control: Diabetes Management Program:** ○ $20 gift card for completing the Community First diabetes assessment ○ $10 gift card for completing diabetes education ○ $10 gift card for receiving a dilated eye exam ○ $10 gift card once every six months for submitting A1c results • **Up to $35 allowance for a seat attachment that fits on a walker** for Members who use a walker and participate in a Community First Health and Wellness program • **One adult activity book (word search, crossword puzzle), coloring book, and colored pencils in a tote** for Members 65 years and older participating in Healthy Living: Lifestyle Management Program • **One insulated insulin cooler bag** for Members with diabetes who participate in Diabetes in Control: Diabetes Management Program • **One pill organizer** for Members participating in any Community First Health and Wellness Program	*Date of prenatal visit must occur in the first trimester or within 42 days of enrollment with Community First.* *Date of postpartum visit must occur prior to end of Member eligibility.* *Community First will reimburse for birthing classes at hospital that the Community Firs STAR+ PLUS Medicaid Member delivers their baby.* *Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.* *Walker allowance is one-time only.* *One pill organizer per year upon request.* *One insulated cooler bag per year.*

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Extra Foot Doctor (Podiatry) Services • Two pairs of full-length foot insoles for Members with diabetes who participate in the Diabetes Management Program	*For Members 21 years or older. Two pairs per year.*
Emergency Response Services (ERS) • Access to rapid response services for eligible non-STAR+PLUS Waiver Members up to six months follow a transition from an institutional setting	
Online Mental Health Resources • A dedicated page for resources and information at CommunityFirstMedicaid.com	

STAR+PLUS VALUE-ADDED SERVICES (DUAL-ELIGIBLE)

The following Value-Added Services are available to Community First STAR+PLUS Dual Eligible Members only. If you are a Community First STAR+PLUS Medicaid Only Member, please see the Value-Added Services chart beginning on page 40.

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (DUAL-ELIGIBLE)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
24-hour Nurse Advice Line staffed by registered nurses who are ready to answer your health-related questions every day, including weekends and holidays. Members can call the Nurse Advice Line at 1-800-434-2347. Deaf or heard of hearing can call 711.	
Extra Help Getting a Ride, for Members, their siblings, and their parent or legal guardian, to places such as: • The grocery store • Community-based services • Community First hosted events • Health education classes • Member Advisory Group meetings • WIC • Social Security Administration offices to submit applications for employment and housing • Voter polling sites to vote in local and national elections • Social Security Administration-approved physician for appointments requested for disability determination and services	*Bus passes are not provided to children younger than 18 unless they are with their parent or guardian. For non-medical related use only. This service is available only for bus service routes within San Antonio and routes are offered by VIA Metropolitan Transit.*

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (DUAL-ELIGIBLE)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Health & Wellness Programs that provide outreach, education and more, including but not limited to: • Healthy Expectations Maternity Program • Diabetes in Control: Diabetes Management Program • Healthy Mind: Behavioral Health Program • Healthy Living: Lifestyle Management Program • Healthy Joints: Arthritis Management Program • Healthy Lungs ○ Asthma Matters: Asthma Management Program ○ Chronic obstructive pulmonary disease (COPD) Management Program • Healthy Heart ○ Blood Pressure Management Program ○ Congestive Heart Failure (CHF) Management Program ○ Coronary Artery Disease Management Program	
YMCA Programs • Y Weight Loss Program - 16 Weeks to Wellness: a no-cost program for individuals interested in implementing and maintaining a healthy lifestyle. Program includes a free 4-month YMCA membership for two adults and up to 4 children • YMCA Diabetes Prevention Program: a no-cost, year-long, evidence-based program to help individuals at risk of developing Type 2 Diabetes. Program includes a free 4-month YMCA membership for two adults and up to 4 children	*For ages 21 and older. Must attend education sessions 1-4 to receive YMCA membership.*
Extra Dental Services, including: • Up to 50% off dental & orthodontic services • Price match guarantee (terms apply) • Free exams and x-rays every 6 months	*For Members ages 21 and up and their family members who do not have dental coverage.*

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (DUAL-ELIGIBLE)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Help for Members with Asthma who participate in Asthma Matters: Asthma Management Program, including: • 1 adult or child size mask with aerosol chamber each year • $10 gift card for completing asthma education • $10 gift card for receiving a flu shot • 1 allergy-free protector pillowcase each year	*Gift cards must not be used to purchase beer, wine, alcohol, cigarettes, or over-the-counter drugs.*
Extra Help for Pregnant Women who participate in Healthy Expectations Maternity Program, including: • Mommy and Me Baby Shower • Free baby car seat or Pack and Play portable play yard • Free diaper bag with baby supplies, including baby wipes and other baby items • Free gifts for fathers who attend Mommy and Me Baby Shower with mom For pregnant Members who participate in both Healthy Expectations and the Maternal Community Health Club: • A Health Educator assigned to you to help find health services, community resources, and guide you through pregnancy and beyond • Pregnancy, birthing, postpartum, and baby education • Free baby car seat or Pack & Play portable play yard, whichever was not received the Mommy and Me Baby Shower	*Limited to one baby shower per pregnancy, unless having more than one baby (i.e., twins). Members will receive one diaper bag and a choice of a car seat or safe sleep pack and play.*
Home visits for high-risk Members who participate in Community First Health & Wellness Programs, including Asthma Matters, Diabetes in Control, Healthy Mind, and Healthy Expectations • One home-delivered package of 10 prepared meals after discharge from nursing facility or inpatient stay • Up to 8 hours of in-home respite care services per year, for non-HCBS waiver Members	

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (DUAL-ELIGIBLE)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Health and Wellness Services, including: • Free, personalized support and the tools and strategies to keep you motivated and help you become tobacco-free by phone or online. Includes coaching, education, activities and more • Free notary services for documents such as medical power of attorney, health agent of record, and living wills • Opportunity to attend in-person and virtual seasonal and community Health Education Special Events at no-cost where Members may receive health education on topics such as telehealth, healthy habits, new benefits, and more • Online social services resource directory available at CommunityFirstResources.com to find community resources such as housing, food and nutrition, education, and more	*To receive notary services, Members must have a valid, state-issued identification card or driver's license.*
Healthy Play and Exercise Programs, including: • Free Zumba classes for Members and their family with a free fitness giveaway, including the choice of a frisbee, water bottle, or exercise bands • Free Bike Safety and Repair Program with free giveaway • For Members participating in Healthy Living: Lifestyle Management Program: ○ One exercise kit that includes a towel, water bottle, and exercise bands	

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (DUAL-ELIGIBLE)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Gift Programs, including: • **Up to $90 for pregnant Members participating in Healthy Expectations Maternity Program**: ○ $10 for attending Mommy and Me Baby Shower ○ $20 for completing the Community First maternity assessment and agreeing to receive health education text messages ○ $20 for completing a prenatal visit ○ $20 for receiving the flu shot during pregnancy. ○ $20 for completing a postpartum visit between 7 and 84 days after delivery ○ Up to $30 reimbursement for birthing classes or pregnancy-related items, such as a pregnancy pillow • **Up to $70 in gift cards for Members with diabetes participating in Diabetes in Control: Diabetes Management Program:** ○ $20 gift card for completing the Community First diabetes assessment ○ $10 gift card for completing diabetes education ○ $10 gift card for receiving a dilated eye exam ○ $10 gift card once every six months for submitting A1c results • **Up to $35 allowance for a seat attachment that fits on a walker** for Members who use a walker and participate in a Community First Health and Wellness program • **One adult activity book (word search, crossword puzzle), coloring book, and colored pencils in a tote** for Members 65 years and older participating in Healthy Living: Lifestyle Management Program • **One insulated insulin cooler bag** for Members with diabetes who participate in Diabetes in Control: Diabetes Management Program • **One pill organizer** for Members participating in any Community First Health and Wellness Program	*Date of prenatal visit must occur in the first trimester or within 42 days of enrollment with Community First.* *Date of postpartum visit must occur prior to end of Member eligibility.* *Community First will reimburse for birthing classes at hospital that the Community Firs STAR+ PLUS Medicaid Member delivers their baby.* *Gift card restrictions include no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.* *Walker allowance is one-time only.* *One pill organizer per year upon request.* *One insulated cooler bag per year.*

COMMUNITY FIRST STAR+PLUS VALUE-ADDED SERVICES (DUAL-ELIGIBLE)	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Extra Foot Doctor (Podiatry) Services • Two pairs of full-length foot insoles for Members with diabetes who participate in the Diabetes Management Program	*For Members 21 years or older. Two pairs per year.*
Emergency Response Services (ERS) • Access to rapid response services for eligible non-STAR+PLUS Waiver Members up to six months follow a transition from an institutional setting	
Online Mental Health Resources • A dedicated page for resources and information at CommunityFirstMedicaid.com	

Limitations or restrictions to Value-Added Services may apply. Please call 210-358-6105 or email healthyhelp@cfhp.com to see if you qualify for specific Value-Added Services.

How can I get these benefits?
To learn how you can receive these benefits as a Community First Health Plans Member in the STAR+PLUS Medicaid Only or STAR+PLUS Dual Eligible program, please call 210-358-6105.

PHARMACY SERVICES

PRESCRIPTION DRUG BENEFITS

What are my prescription drug benefits?
You get unlimited prescriptions through your Medicaid coverage if you go to a drug store that takes Community First Members. There are some medications that may not be covered through Medicaid. The drug store can let you know which medications are not covered, or help you find another medication that is covered. You can also ask your doctor or clinic about what medications are covered, and what is best for you. Call Community First Member Services at 1-844-382-2347 if you have questions.

How do I get my medications?
Medicaid pays for most medications your doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or your doctor may be able to send the prescription to the drug store for you. All prescriptions you get from your doctor can be filled at any drug store that takes your Community First Member ID card. If you need help finding a pharmacy, please call Member Services or use our Pharmacy Locator located at CommunityFirstMedicaid.com.

How do I find which medications are on the formulary?
In order to be covered, a medication should be included on the Texas Medicaid Formulary. The formulary is listed on the Texas Vendor Drug website at www.txvendordrug.com/formulary. You can request a paper copy of the formulary at no cost and we will send one to you within five (5) business days of your request. Please call Member Services at 1-844-382-2347 if you have any questions.

Who do I call if I have problems getting my medications?
If you have problems getting your covered medications, please call Member Services at 1-844-382-2347. 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 medication. Call Community First Member Services at 1-844-382-2347 for help with your medications and refills.

What if I lose my 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 1-844-382-2347.

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.

How do I get my medications if I am in a nursing facility?
If you are in a nursing facility, your drugs will be provided to you by the nursing facility. The pharmacy that is used by your nursing facility will continue to bill your Medicare plan (if you have Medicare) and will bill Navitus, Community First's partner for pharmacy benefits, for your Medicaid covered drugs.

What if I also have Medicare?
If you have Medicare and Medicaid (you are dual eligible), your prescription drugs are now paid by a Medicare drug plan. Under Medicare, you have choices. Make sure the Medicare drug plan you are with meets your needs. If you have questions or want to change plans you can call 1-800-633-4227 (1-800-MEDICARE).

Remember, under Medicare:

- You have a choice of prescription drug plans.
- Plans may require you to pay a copay for each prescription.
- There's no limit on the number of prescriptions you can fill each month.

NETWORK DRUG STORES

How do I find a network drug store?
Call Member Services for help finding a network drug store. You can also find a list of network drug stores using the Pharmacy Locator at CommunityFirstMedicaid.com.

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.

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.

MEDICATION DELIVERY

What if I need my medications delivered to me?
Community First offers many medications by mail. Some Community First drug stores offer home delivery services. Call Member Services at 1-844-382-2347 to learn more about mail order prescriptions or to find a drug stores that may offer home delivery service in your area.

MEDICAID LOCK-IN PROGRAM

What is the Medicaid-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 1-844-382-2347.

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 1-844-382-2347 for more information about these benefits.

CHANGING HEALTH PLANS

What if I want to change health plans? Who do I call?
You can change your health plan by calling the Texas STAR+PLUS Program Helpline at 1-800-964-2777.

How many times can I change health plans?
You can change health plans as often as you want. If you are in the hospital, a residential Substance Use Disorder (SUD) treatment facility or a residential detoxification facility for SUD, you will not be able to change health plans until you have been discharged.

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

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

Can Community First Health Plans ask that I leave the plan?
Yes, for the following reasons:

- Fraud or abuse by a Member
- Threats or physical acts leading to the harm of Community First staff or provider
- Making threats or mistreating a staff person
- Sending digital communication that is inappropriate, threatening, or graphic
- Theft
- Letting someone use your Community First Member ID card
- Repeatedly missing appointments

Community First will not ask you to leave our plan without trying to work with you first. If you have any questions about this process, call Member Services at 1-844-382-2347. Texas Health and Human Services Commission (HHSC) will decide if a Member can be told to leave the program.

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 health care plan and 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.
   c) Be given information about your health, plan, services, and providers.
   d) Be told about your rights and responsibilities.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   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 provider 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, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services provided to you. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have the right to make recommendations to your health plan's Member Rights and Responsibilities

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 and Medicaid's policies and procedures. That includes the responsibility to:
   a) Learn and follow your health plan's rules and Medicaid rules.
   b) Choose your primary care provider quickly.
   c) Make any changes in your health plan and 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 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 while using NEMT services:
When requesting non-emergency medical transportation (NEMT) services, you must:

a) Provide the information requested by the person arranging or verifying your transportation.
b) Follow all rules and regulations affecting your NEMT services.
c) Return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
d) Not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
e) Not lose bus tickets or tokens and 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.
f) Only use NEMT services to travel to and from your medical appointments.
g) Contact the person who helped you arrange your NEMT transportation or service as soon as possible if something changes and you no longer need that service.

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.

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 to 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 911 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.

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 and are unable to make or communicate decisions yourself. Community First has a booklet with information about advance directives that we can send to you, free-of-charge. Call Member Services at 1-844-382-2347 to request this booklet.

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. Remember to always show Your Texas Benefits Medicaid ID card and Community First Member ID card before you get health care services.

Who do I call? What information will they need?
If you get a bill from a Medicaid provider, call Member Services at 1-844-382-2347. We can help you figure out what to do. Be sure to have the following information when you call:

- Date of service
- Your patient account number
- Name of provider
- Phone number on the bill
- Total amount of bill

Please note: If you go to a doctor who is not in the Community First network, you may

get billed for services. You will also need to pay for services not covered by Medicaid. It is your responsibility to determine which services are covered and which are not.

If you are covered by both Medicare and Medicaid (dual-eligible), you cannot be billed for Medicare "cost-sharing," which includes deductibles, coinsurance or copayments that are covered by Medicaid. Those expenses should be billed to and reimbursed by your Medicare Advantage Plan (MAP) if you have a managed Medicare plan, or Texas Medicaid & Healthcare Partnership (TMHP) if you have traditional Medicare coverage. There are also some Medicare non-covered acute care services and supplies that are covered by Medicaid, and should be billed to and reimbursed by TMHP.

Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid?
You cannot be billed for Medicare "cost-sharing," which includes deductibles, coinsurance, and co-payments that are covered by Medicaid.

If you are covered by both Medicare and Medicaid (dual eligible), you cannot be billed for Medicare "cost-sharing," which includes deductibles, co-insurance or co-payments that are covered by Medicaid. Those expenses should be billed to and reimbursed by your Medicare Advantage Plan (MAP) if you have a managed Medicare plan, or TMHP if you have traditional Medicare coverage. There are also some Medicare non-covered acute care services and supplies that are covered by Medicaid, and should be billed to and reimbursed by TMHP.

COMPLAINT PROCESS

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us toll-free at 1-844-382-2347 to tell us about your problem.

You can also file a complaint by writing to us at:

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

Can someone from Community First help me file a complaint?
Yes. A Community First Health Plans Member Services Representative can help you file a complaint. Just call 1-844-382-2347. Most of the time, we can help you right away or at the most within a few days.

Your Legally Authorized Representative can file a complaint for you as well.

Once you have gone through the Community First complaint process, you can complain 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, Texas 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 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?
Community First will send you a letter telling you if a service or medicine has been denied. You will also receive an appeal form. If you disagree with the decision, you may file an appeal.

When do I have the right to ask for an appeal?
You have the right to appeal Community First's decision if Medicaid-covered services are denied, reduced, suspended, or ended. You can also ask for an appeal if Community First denied payment of services in whole or in part. Community First's denial is called an "Adverse Benefit Determination." You can appeal if you think Community First:

- Is stopping coverage for care you think you need.
- Is denying coverage for care you think should be covered.
- Provides a partial approval of a request for a covered service.

Please note, if you are a Community First STAR+PLUS Dual Eligible Member, most of the acute care services you get such as doctor's visits, lab and x-ray services and medications, are Medicare covered services. The appeal process for these services may have different timeframes. Medicare covered services would follow the grievance and appeal process for Medicare covered services that are provided to you by your Medicare plan. Please contact your Medicare plan to get information about your Medicare grievance and appeal process.

APPEAL PROCESS

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 their name to Community First. A doctor or other medical provider may be your representative.

For more information, call Member Services at 1-844-382-2347.

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 Community First Notice of Adverse Benefit Determination letter 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

Community First will mail a letter to you within five business (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 1-844-382-2347.

Can I still keep getting medical services while Community First is processing my appeal?
You can ask to continue current authorized services when you appeal Community First's Adverse Benefit Determination. To continue receiving a service that is being ended, suspended or reduced, your request to continue a service must be made within ten (10) days of the date of Community First's Notice of Adverse Benefit Determination letter, or before the date the currently authorized services will be discontinued, whichever is later.

Community First will keep providing the benefits while your appeal is being reviewed, if all of the following are met:

- Your appeal is sent in the needed time frame.
- Your appeal is for a service that was denied or limited that had been previously approved.
- Your appeal is for a service ordered by a Community First-approved provider.

If Community First continues or reinstates benefits at your request and the request for continued services is not approved on appeal, Community First will not pursue recovery of payment for those services without written permission from HHSC.

EMERGENCY APPEAL PROCESS

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

How do I ask for an Emergency Appeal and who can I ask for help?
A Community First Member Services Representative can help you file an Emergency Appeal. Call Member Services at 1-844-382-2347 for assistance.

Does my request for an Emergency Appeal have to be in writing?
Your request does **NOT** have to be in writing. You may provide Emergency Appeal information orally by phone, in writing, or in person, within the limited time of the emergency appeal.

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

Please note: If you are eligible for both Medicare and Medicaid and need to request an emergency appeal for Medicare acute care services, please follow the emergency review process for your Medicare Plan/Program.

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

What happens if Community First denies my request for an Emergency Appeal?
We will notify you if we deny your request for an Emergency Appeal. Your request will then be moved to the regular appeal process. If Community First thinks your appeal does not need to be expedited, we will let you know right away. We will still work on the appeal, but the resolution may take up to 30 days.

EXTERNAL APPEAL PROCESS

What if I am not satisfied with Community First's decision?
After a Medicaid Member has completed the internal Community First appeal process related to an Adverse Benefit Determination, more appeal rights are available if the Member is not satisfied with the health plan's appeal decision. After the health plan's appeal decision is completed, Members have additional external appeal rights, including a State Fair Hearing, with or without an External Medical Review. The details for both the State Fair Hearing and External Medical review appeal rights and process are included in the sections below.

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 1-844-382-2347 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 I ask for an External Medical Review?
If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed before the State Fair Hearing occurs.

The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent them. 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 their 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 1-844-382-2347; 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. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with the 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.

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. 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 Community First Health Plans at 1-844-382-2347 or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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.

ABUSE, NEGLECT, AND EXPLOITATION

You have the right to respect and dignity, including freedom from Abuse, Neglect, and Exploitation.

What are Abuse, Neglect, and Exploitation?

- **Abuse** is mental, emotional, physical, or sexual injury, or failure to prevent such injury.
- **Neglect** results in starvation, dehydration, overmedicating or under medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care, and personal hygiene.
- **Exploitation** is misusing the resources of another person for personal or monetary gain. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

REPORTING ABUSE, NEGLECT, AND EXPLOITATION

The law requires that you report suspected Abuse, Neglect, or Exploitation that occurs within the delivery of long-term services and supports. Community First and our network of providers are also responsible for identifying and reporting suspected abuse or neglect of people who are older or who have disabilities.

Report to the Health and Human Services Commissions (HHSC) if the victim is an adult or child who resides in or receives services from:

- Nursing facility;
- Assisted living facility;
- Home and Community Support Services Agency (HCSSA)
- Adult day care center;
- Licensed adult foster care provider

Report to HHSC by calling 1-800-458-9858. If it's an emergency, call 911.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
  - Home and Community Support Services Agencies (HCSSAs)
  - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
  - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), community center, or Mmntal health facility operated by the Department of State Health Services;
  - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
  - A managed care organization;
  - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed

Services option

Report to DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org.

Report to Local Law Enforcement
If you suspect Abuse, Neglect, or Exploitation, but you are not sure who to report it to, contact your local law enforcement agency and DFPS.

Helpful Information for Filing a Report
When reporting abuse, neglect, or exploitation, it is helpful to have the names, ages, addresses, and phone numbers of everyone involved.

Will anyone know I made the report?
HHSC keeps your name and that of the other person confidential, unless required to release it by law. However, if you choose to remain anonymous, HHSC has no way to let you know the results of the investigation. HHSC may also forward your report to another agency if it should be reported to or investigated by that agency.

WASTE, FRAUD, AND ABUSE

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 they have to get benefits.

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit oig.hhs.texas.gov and click on "Report Fraud" to complete the online form; or
- You can report directly to your health plan by calling Community First Health Plans at 1-844-382-2347 or writing to the following address:

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

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 services covered by Medicaid

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 PHI. An employee may only access PHI when they have an appropriate reason to do so. Each employee must sign a statement that they understand 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 CommunityFirstMedicaid.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 auxiliary aids and services to people with disabilities to communicate effectively with our organization, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, and other written formats)

Community First Health Plans also 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 auxiliary services, please contact Community First Member Services at 1-800-434-2347. TTY (for hearing impaired) at 210-358-6080 or toll free 1-800-390-1175.

If you wish to file a complaint regarding claims, eligibility, or authorization, please contact Community First Member Services at 1-800-434-2347.

If you feel that Community First Health Plans failed to provide free language services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can contact the Chief Compliance & Quality Officer by phone, fax, or email at:

Susan Lomba
Chief Compliance & Quality Officer
Phone: 210-510-2463, TTY number: 1-800-390-1175
Fax: 210-358-6014
Email: slomba@cfhp.com

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

You may also file a complaint 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
Phone: 1-800-368-1019, TDD number: 1-800-537-7697

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

Aviso de no discriminación

Community First Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual. Community First Health Plans no excluye o trata de manera diferente a las personas debido a raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual.

Community First Health Plans proporciona asistencia y servicios gratuitos a personas con discapacidades para comunicarse efectivamente con nuestra organización, como:

- Intérpretes calificados de lenguaje de señas
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Community First Health Plans también ofrece servicios gratuitos lingüísticos a personas cuyo idioma principal no es el inglés, como:

- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita recibir estos servicios auxiliares, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347. TTY (para personas con problemas auditivos) al 210-358-6080 o al número gratuito 1-800-390-1175.

Si desea presentar una queja sobre reclamos, elegibilidad, o autorización, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347.

Si cree que Community First Health Plans no proporcionó servicios lingüísticos gratuitos o fue discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual, puede comunicarse con la directora del calidad y cumplimiento por teléfono, fax, o correo electrónico al:

Susan Lomba
Directora de calidad y cumplimiento
Teléfono: 210-510-2463, línea de TTY gratuita: 1-800-390-1175
Fax: 210-358-6014
Correo electrónico: slomba@cfhp.com

También puede presentar un queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del portal de quejas de derechos civiles, disponible en:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

También puede presentar una queja por correo o por teléfono al:

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

Los formularios de queja están disponibles en:
http://www.hhs.gov/ocr/office/file/index.html.

COMMUNITY FIRST
HEALTH PLANS

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.

رق م 1-800-434-2347 ق م ب ر ات ص ل باﻟ مجان . ل ك ف ت وت ى ة الﻟ غ وع دة الﻟ م اس خدمات ف إن الﻟ
ل غة،اذا ك ر ت تحدث ك نت إذا م لحوظة : 1-800-390-1175 :واﻟ الﻟ مص هات

ک الﻟ ـ ہ ی ں د س ت ای ب م ی ں م فت خدمات ک ی مدد ک ی زب ان ک و آپ ت و ہ ی ں،ل تے ب و دو را آپ
ا گ ر دار : خ 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 हदी 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,ການບລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-434-2347 (TTY: 1-800-390-1175).

STAR+PLUS MEMBER HANDBOOK

COMMUNITY FIRST HEALTH PLANS

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