COMMUNITY FIRST
HEALTH PLANS

September 1, 2024

TEXAS STAR+PLUS
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

STAR+PLUS NURSING FACILITY 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 NURSING FACILITY MEMBER HANDBOOK

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

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

TEXAS
Health and Human
Services

TEXAS
STAR PLUS
Your Health Plan ★ Your Choice

TABLE OF CONTENTS

INTRODUCTION **1**

NUMBERS TO REMEMBER **2**
- Member Services 2
- Emergency services 3
- Mental Health, Substance Use, And Crisis Services 3
- Service Coordination 3
- TTY 3
- Nurse Advice Line 3
- Vision Care 4
- Prescription Drug Medications 4
- Non-Emergency Medical Transportation 4

MEMBER IDENTIFICATION (ID) CARDS **6**

MEDICAID **8**
- Your Texas Benefits (YTB) Medicaid Card 8
- The YourTexasBenefits.com Medicaid Client Portal 9
- Medicaid and Private Insurance 9
- Change of Address 10

PRIMARY CARE PROVIDER (PCP) **11**
- Changing Your Primary Care Provider 12
- Making an Appointment 13
- Community First Checkup Checklist 13

SPECIALISTS **13**

WOMEN'S HEALTH SERVICES **15**
- OB/GYN Care 15

FAMILY PLANNING SERVICES **15**

CARE DEFINED **16**
- Routine Medical Care 16
- Urgent Medical Care 16
- Emergency Medical Care 17
- Medically Necessary 18

HELP ACCESSING HEALTH CARE **18**
- Interpreters 19
- Transportation Services 19
- Telehealth 19

MEMBER ADVOCATES **19**

YOUR HEALTH CARE BENEFITS AND SERVICES **20**
- Acute Care Services 20
- Limits To Covered Services 22
- Services Not Covered 22

LONG-TERM SERVICES AND SUPPORTS (LTSS) **22**

VALUE-ADDED SERVICES **24**
- STAR+PLUS Nursing Facility Value-Added Services (Medicaid Only) 24

STAR+PLUS Nursing Facility Value-Added Services (Dual-Eligible) 26
HEALTH EDUCATION PROGRAMS 27
BEHAVIORAL HEALTH & SUBSTANCE USE 28
Virtual Mental Health Care 28
PHARMACY SERVICES 29
Prescription Drug Benefits 29
Network Drug Stores 29
Medication Delivery 30
Medicare And Prescription Drug Benefits 30
Medicaid Lock-in Program 30
VISION SERVICES 30
DENTAL SERVICES 31
FAMILY PLANNING SERVICES 31
SERVICE COORDINATION 32
Service Coordinator 32
ADVANCE DIRECTIVES 33
MEMBER BILLING 33
CHANGING HEALTH PLANS 34
MEMBER RIGHTS & RESPONSIBILITIES 34
Information Available To Members 37
COMPLAINT PROCESS 38
APPEAL PROCESS 38
EMERGENCY APPEAL PROCESS 40
EXTERNAL APPEAL PROCESS 41
State Fair Hearing 41
External Medical Review 42
REPORTING ABUSE, NEGLECT, AND EXPLOITATION 43
Reporting Abuse, Neglect, and Exploitation 43
WASTE, FRAUD, AND ABUSE 44
CONFIDENTIALITY 46
GLOSSARY OF TERMS 47

INTRODUCTION

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

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

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

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

If you prefer this handbook in an alternate format or would like a printed copy, please contact Member Services toll free at 1-844-382-2347.

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 Nursing Facility Program Helpline...1-800-964-2777 or 211
Pharmacy Benefits/Prescription Drugs (Navitus)............1-844-268-9789
Non-Emergency Medical Transportation 1-888-444-0307
Vision Services (Envolve)...1-800-334-3937
Dental Care...1-844-382-2347

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 Nursing Facility Members can get 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 32.

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 210-358-6105 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.

NUMBERS TO REMEMBER

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.

PRESCRIPTION DRUG MEDICATIONS

Community First's partner for pharmacy benefits is Navitus. Communicate with your nursing facility to get your prescription medications. Call Navitus Customer Care at 844-268-9789 or call Community First Member Services for more information about your prescription drug medication benefits.

NON-EMERGENCY MEDICAL TRANSPORTATION

Your nursing facility can help you get to and from your health care appointments. Contact your nursing facility staff for non-emergency transportation services. If medically necessary, Community First provides non-emergency ambulance transportation for Members that require this service. Read more on page 19.

COMMUNITY FIRST HEALTH PLANS LOCATIONS

Community First Health Plans 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)

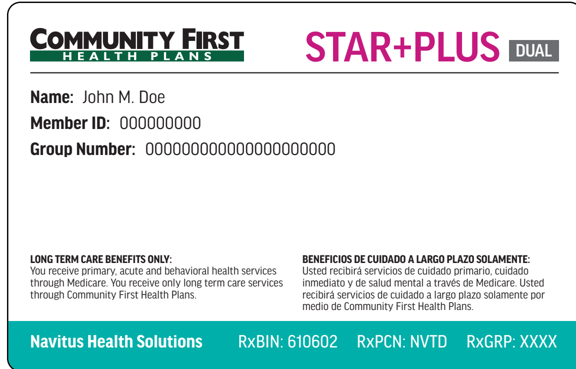
Our Avenida Guadalupe Community Office provides in-person assistance for questions about your health care coverage, renewing your plan, local community resources, and more. Walk-ins are welcome. We also can also help you in-person at our location at the MAC by appointment only.

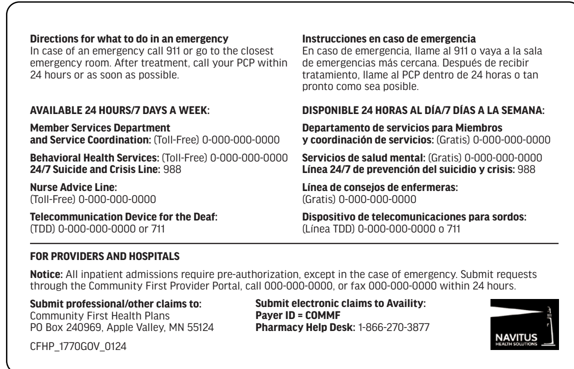
To make an appointment at either location, please go to CommunityFirstMedicaid.com and click on Community Office under the Contact dropdown menu or call 210-358-6105.

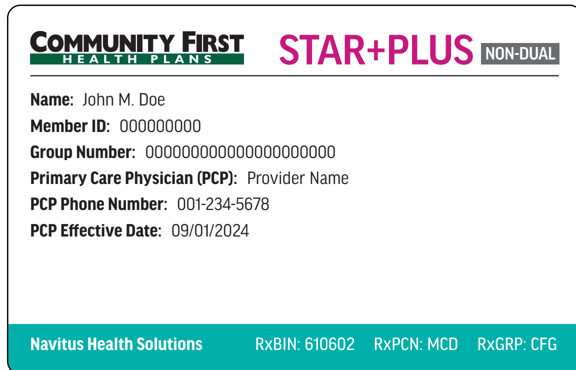
MEMBER IDENTIFICATION (ID) CARDS

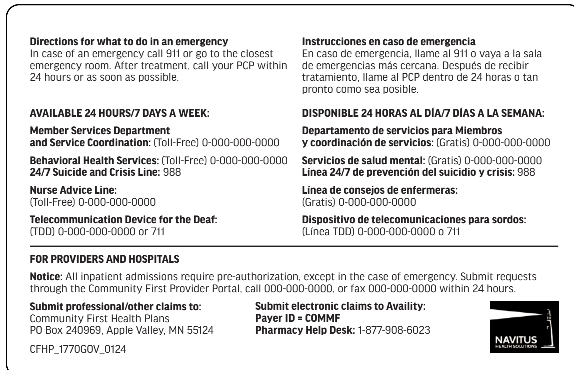
When you sign up to become a Community First Health Plans Member, you will receive a Community First Member ID card. If you do not receive a card, please call Member Services. Here's what the front and back of your Community First Member ID card will look like.

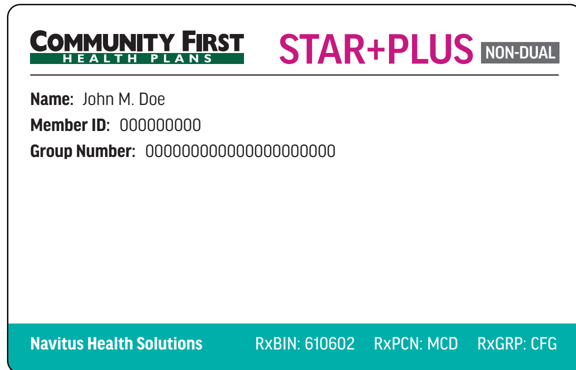
Examples of Community First Health Plans STAR+PLUS Nursing Facility Member ID Cards

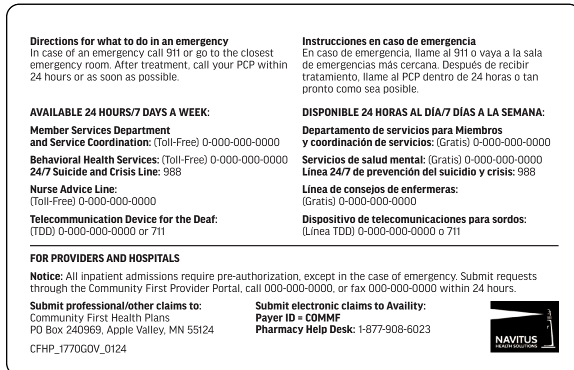












How do I use my Member ID Card?

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

NOTE: If you are dual eligible (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.

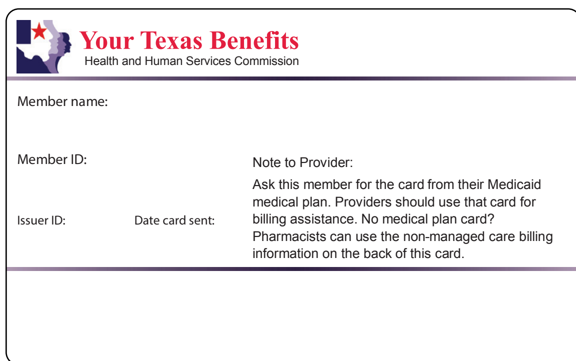
The YTB Medicaid card has these facts printed on the front:

- 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



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.

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 Nursing Facility 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 or your nursing facility 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.

Will I be assigned a doctor if I have Medicare?
If you are dual eligible, you do not need to choose a PCP. You can keep seeing the Medicare doctor you have been seeing for your health care.

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 see my PCP if they do not visit my nursing home?
Your nursing facility will provide you with transportation to and from your appointments if you need to leave the facility. A Service Coordinator can also assist you if you need assistance with transportation.

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 210-358-6105. 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 the facility and traveling out of town?
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 change your PCP through our secure Member Portal. You can access the Member Portal and create an account at CommunityFirstMedicaid.com. Or, you can 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 Nursing Facility 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.

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, 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.

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 doctor 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.

SPECIALISTS

If you are dual eligible, 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
- 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 dual eligible, 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 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. 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.

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 at 210-358-6105 for help finding a family planning provider.

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 may also contact 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. The urgent care clinic must take Community First Health Plans Medicaid.

EMERGENCY MEDICAL CARE

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

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.

Do I need prior authorization?

You do not need prior authorization from your primary care provider (PCP) for emergency medical care

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?
Covered services for STAR+PLUS Nursing Facility Members must meet the STAR+PLUS Nursing Facility definition of "medically necessary."

Medically necessary means:

1. For Members age 21 or over, 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) not experimental or investigative; and
   g) not primarily for the convenience of the Member or provider; and
2. 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.

   Community First will determine medical necessity for Nursing Facility Add-on Services and Acute Care Services only. Nursing Facility Add-on Services include, but are not limited to emergency dental services, physician-ordered rehabilitative services, customized power wheelchairs, and audio communication devices.

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.

TRANSPORTATION SERVICES

What transportation services does Community First offer?

The nursing facility is responsible for providing routine non-emergency transportation services. If medically necessary, Community First can provide non-emergency ambulance transportation for Members who require this service.

How do I get this service? Who do I call?

To get non-emergency ambulance transportation, your provider must contact Community First to request authorization for these services. You can also contact your Service Coordinator at 210-358-6105 for help.

TELEHEALTH

What are telehealth services?

Most Community First Providers in our network offer telehealth services to STAR+PLUS Nursing Facility 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.

MEMBER ADVOCATES

Community First Health Plans provides STAR+PLUS Nursing Facility 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?
Community First Health Plans covers many benefits for our Members who live in a nursing facility. Your STAR+PLUS Nursing Facility benefits include basic health services (acute care) and long-term services and supports (LTSS). Residents who get Medicaid and Medicare (dual eligibles) will get their basic health services through Medicare and their long-term services through STAR+PLUS Medicaid.

What number can I call to find out about these services?
To learn more, review the covered services and benefits listed in this section. If you have questions about covered services, please call Member Services at 1-844-382-2347.

ACUTE CARE SERVICES

What are my acute care benefits?
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. Your doctor will work with you to make sure you get the services you need. The acute care services listed in the chart 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

In addition, there are other services you can get through Medicaid including:

- Transportation to doctor visits
- Women, Infants and Children (WIC) services

If you are dual eligible, your acute services are covered by Medicare. You can still go to your Medicare doctor for the services you need.

How can I get acute care services or learn more about them?
Call your PCP and let them know what service you need. Your doctor will help you get it. For some services, you can go directly to the provider who gives them. If you need more help, call your Service Coordinator at 210-358-6105 or Member Services at 1-844-382-2347.

LIMITS TO COVERED SERVICES

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

SERVICES NOT COVERED

What services are not covered?
The following is a list of some of the services **NOT** covered by the STAR+PLUS Nursing Facility 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

What services can I still get through regular Medicaid but are not covered by Community First Health Plans?

- **Hospice:** This program provides Members who are terminally ill with care to relieve pain or other medical problems.
- **Preadmission Screening and Resident Review PASRR:** PASRR is a federal requirement to help determine whether an individual is not inappropriately placed in a nursing home for long term care.

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 Member Services at 1-844-382-2347.

LONG-TERM SERVICES AND SUPPORTS (LTSS)

What are Long-Term Services and Support (LTSS)?
Long-term services and supports (LTSS) are benefits that help people live outside of a nursing facility and stay safe and independent in their home or community. LTSS help you with functional needs like bathing, dressing, taking medicine, or preparing meals. If you ever leave a nursing facility and want to live independently in your community, you may be able to get these services to help you to live with more independence.

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) or STAR+PLUS Waiver Services 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 directly or call Community First Service Coordination at 210-358-6105 to find out more about LTSS benefits a. You can also call Community First Member Services for help.

What are my Nursing Facility LTSS benefits?
When you are in a nursing facility, all of your self-care needs are provided by the facility where you live.

How will my benefits change if I move back into the community?
If you choose to move back into the community, you will be assessed for all of the services listed above based on your medical need. You can contact Member Services at 1-844-382-2347 or your Service Coordinator for help at 210-358-6105.

VALUE-ADDED SERVICES

What extra benefits do I get as a Member of Community First Health Plans?
At Community First Health Plans, we are committed to getting you the Value-Added Services (extra benefits), care, and support you need to stay healthy.

STAR+PLUS NURSING FACILITY VALUE-ADDED SERVICES (MEDICAID ONLY)

The following Value-Added Services are available to Community First STAR+PLUS Nursing Facility Medicaid Members only. If you are a STAR+PLUS Nursing Facility Dual Eligible Member, please see the Value-Added Services chart beginning on page 27.

STAR+PLUS NURSING FACILITY VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**LIMITATIONS OR RESTRICTIONS**
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 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*
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.*
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 • 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.*

STAR+PLUS NURSING FACILITY VALUE-ADDED SERVICES (MEDICAID ONLY)	
VALUE-ADDED SERVICE	**LIMITATIONS OR RESTRICTIONS**
Gift Programs, including: • A Welcome Kit, including: ○ Adult activity books (word search, crossword puzzle), coloring book, and colored pencils ○ One pair of skid-proof socks ○ One shower cap ○ One lap blanket • Personalized labels to identify personal belongings, including clothing and shoes	*Welcome Kit available to new Members only as a one-time gift.* *Personalized labels available upon request every two years.*
Alzheimer's Care • One personal remembrance photo album	*One-time gift upon request only.*
Online Mental Health Resources • A dedicated page for resources and information at CommunityFirstMedicaid.com	

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

The following Value-Added Services are available to Community First STAR+PLUS Nursing Facility Dual-Eligible Members only. If you are a STAR+PLUS Nursing Facility Medicaid Member, please see the Value-Added Services chart beginning on page 24.

STAR+PLUS NURSING FACILITY VALUE-ADDED SERVICES (DUAL-ELIGIBLE)	
VALUE-ADDED SERVICE	**LIMITATIONS OR RESTRICTIONS**
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 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*
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 • 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.*
Gift Programs, including: • A Welcome Kit, including: ○ Adult activity books (word search, crossword puzzle), coloring book, and colored pencils ○ One pair of skid-proof socks ○ One shower cap ○ One lap blanket • Personalized labels to identify personal belongings, including clothing and shoes	*Welcome Kit available to new Members only as a one-time gift.* *Personalized labels available upon request every two years.*

STAR+PLUS NURSING FACILITY VALUE-ADDED SERVICES (DUAL-ELIGIBLE)	
VALUE-ADDED SERVICE	**LIMITATIONS OR RESTRICTIONS**
Alzheimer's Care • One personal remembrance photo album	*One-time gift upon request only.*
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 Nursing Facility Medicaid or STAR+PLUS Dual Eligible program, please call 210-358-6105.

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 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.

If you would like to learn more about these programs, please call 1-844-382-2347, visit CommunityFirstMedicaid.com, or email healthyhelp@cfhp.com.

BEHAVIORAL HEALTH & SUBSTANCE USE

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.

Please note: If you are dual eligible, 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.

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.

PHARMACY SERVICES

PRESCRIPTION DRUG BENEFITS

What are my prescription drug benefits?
You get unlimited prescriptions through your Medicaid coverage when the nursing facility uses a drug store that generally services nursing facilities and is in the Community First network.

There are some medications that may not be covered through Medicaid. The pharmacy will work with the doctor and nursing facility to let them know which medications are not covered, or help them find another medication that is covered. You can also call Member Services at 1-844-382-2347 if you have questions about your prescription drug benefits.

How do I get my medications?
Medicaid pays for most medication your doctor says you need. Your doctor will write a prescription and send the prescription for you by calling, faxing or submitting by electronic means to the nursing facility to order, fill, dispense and administer to you.

Who do I call if I have problems getting my medications?
The drug store that services your nursing facility will work with your doctor and/or the pharmacy if there are problems getting your medications. They will do this for you.

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)?
It is not normal for a nursing facility to lose your medication. However, if your medication is lost, Community First would work with the nursing facility and drug store to help you. If you are not currently in a nursing facility and you lose your medications, call your doctor or clinic for help. If your doctor or clinic is closed, the drug store where you got your medication should be able to help. You can also call Community First Member Services at 1-844-382-2347.

NETWORK DRUG STORES

How do I find a network drug store?
If you are not in a nursing facility and need help finding a drug store, call Member Services. 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. Your nursing facility will also need a copy of the same Community First Member ID card and your Medicaid ID card to share with the pharmacy that services the nursing facility.

What if I go to a drug store not in the network?
Community First has many contracted drug stores that can fill your medications, including those which service nursing facilities. It is important that you show your

Community First Member ID card to your nursing facility. The nursing facility will share this information with the drug store.

If you are not currently in a nursing facility and the drug store tells you they do not take Community First Members, you can call Member Services at 1-844-382-2347. We can help you find a drug store that can fill your medications for you.

If you choose to have the drug store fill your medications and they do not take Community First Members, you will have to pay for the medication.

MEDICATION DELIVERY

What if I need my medications delivered to me?
Drug stores that service nursing facilities arrange the delivery of medications directly to the facility. If you are not currently in a nursing facility, Community First can send you 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 or to find a drug store that may offer home delivery service in your area.

MEDICARE AND PRESCRIPTION DRUG BENEFITS

What if I also have Medicare?
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 for your Medicaid covered drugs.

MEDICAID LOCK-IN PROGRAM

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

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

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

To learn more, call Community First Health Plans at 1-844-382-2347.

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 can call Member Services at 1-844-382-2347 for help finding an Envolve provider near you.

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

What are my vision benefits?
Community First STAR+PLUS Nursing Facility Members ages 21 and over receive one vision exam every two years.

You must get your eye care services from Community First network eye care providers. If you need help finding a Provider, call Member Services at 1-844-382-2347.

DENTAL SERVICES

Are emergency dental services covered?
Community First covers limited emergency dental services for the following:

- Dislocated jaw.
- Traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Drugs for any of the above conditions.

Community First is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs).

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- Open or closed reduction of fracture of the maxilla or mandible;
- Repair of laceration in or around oral cavity;
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- Incision and drainage of cellulitis;
- Root canal therapy. Payment is subject to dental necessity review and pre- and post-operative x-rays are required; and
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Are non-emergency dental services covered?
Community First is not responsible for paying for routine dental services provided to Medicaid Members. Community First is responsible, however, for paying for treatment and devices for craniofacial anomalies.

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 at 210-358-6105 for help finding a family planning provider.

SERVICE COORDINATION

What is Service Coordination?
Service Coordination allows Community First to work together with you and your care team in order to best identify and address your needs. A Service Coordinator will work with your nursing facility to get you specialized services/care process that include, but are not limited to:

- Identifying the physical, mental, or long term needs of the Member
- Addressing any unique needs of the Member that could improve outcomes and health/well-being
- Assisting the Member to ensure timely & coordinated access to array of services and/or covered Medicaid eligible services
- Partner with nursing facility to ensure best possible outcomes for the Member's health and safety
- Coordinate the delivery of services for Members who are transitioning back to the community

Community First wants you to be safe and healthy, to be involved in your service plan, and to live where you choose. We will assign a Service Coordinator to all Community First STAR+PLUS Nursing Facility Members.

SERVICE COORDINATOR

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 you get all your covered services. In some cases, services that are usually not covered may also be covered.

How can I talk with a Service Coordinator?
Your Service Coordinator will provide you with a number to call them directly. You can also call 210-358-6105. Our staff is available from 8 a.m. to 5 p.m., Monday through Friday, except for state-approved holidays. You can also speak with a registered nurse 24 hours a day, 7 days a week by calling this number. They can answer your health questions after hours and on weekends.

How often will I talk with a Service Coordinator?
You will receive a letter in the mail from your Service Coordinator. The letter will detail how often and what type of contact you will have, based on your health care needs. It will also give you the name and direct phone number of your coordinator. Your Service Coordinator will come visit with you within the first 30 days you are in your nursing facility. They will come back every quarter after that.

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. Your nursing facility should make sure that all of the doctors who provide your care in the nursing facility are enrolled in Texas Medicaid. If you see a provider outside of the nursing facility, they should be enrolled in Texas Medicaid and also in the Community First Health Plans network.

Note: If you see a provider who is not enrolled with Texas Medicaid and/or is not signed up as a Community First provider, Community First may not pay that doctor and you may get billed for the services.

What if I get a bill from my nursing facility? Who do I call? What information will they need?
If you get a bill from your nursing facility for covered services, call the nursing facility business office and make sure they have your Medicaid and/or Medicare information and any other insurance policy information.

You can also get help from Member Services. If you need help you with your nursing facility bill, be prepared to provide this information:

1. The name of the patient
2. The patient's Medicaid ID number
3. The date of service
4. The name of the nursing facility sending you the bill
5. The amount you are being billed for

What is applied income, and what are my responsibilities?
Applied income is the Member's personal income that the Member must provide to the nursing facility as part of their cost sharing obligation as a Medicaid beneficiary. Any time Medicaid is billed by the nursing facility, the Member must give their applied income to the facility. The amount is determined by the total amount of monthly income divided by the number of days the Member resides in the facility each month. The Member is allowed to keep $60 for themselves for personal needs.

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.

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 Nursing Facility 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, but not more than once a month. 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 get dropped from their health plan (for non-compliance, etc.)?
Yes, for the following reasons:

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

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.

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 Providers and when talking to your health plan. Interpreters include people who can speak in your native

   language, help someone with a disability, or help you understand the information.
   e) Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, 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.

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, languages spoken (other than English) and qualifications for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal and fair hearing procedures.
- A hard copy of Community First's Quality Improvement program. Call Member Services at 1-844-382-2347.
- Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits available. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits, including authorization requirements.
- How members can get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services and post-stabilization services.
  - The fact that you do not need prior authorization from your PCP for emergency care services.
  - How to get emergency services, including instructions on how to use 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 PCP.
- Community First's practice guidelines.

COMPLAINT PROCESS

What should I do if I have a complaint? Who do I call? Can someone from Community First help me file a complaint?
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. 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.

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

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.

Community First will send you a letter if a requested service is denied or limited. If you disagree with the decision, you may file an appeal.

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

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

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 appeals 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 1-844-382-2347for 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 210-358-6105 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 you, 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 with State Fair Hearing. 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 210-358-6105; 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 210-358-6105 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.

REPORTING 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 210-358-6105 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.

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.

ال إن ف تامدخ اس م ل ا ةدع وغ ل ل ا ة ى وت ت ف ك ل . ناجملاب ل ص تا ر ب م ق 1-800-434-2347 م قر
تاه مص ل ا لاو: 1-800-390-1175 : ةظوحلم اذإ تن ك ثدحت ت ر كذا،ةغ ل

پآ را ود و ب ےت ل،ںی ہ و ت پآ و ک نا بز ی ک ددم ی ک تامدخ تف م ںی م بای ت س د ںی ہ ۔ ل ا ک
اگ ر داد : خ رب 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।

امش یارب ناگیار تروصب ینابز تالیهست ،دینک یم وگتفگ یسراف نابز هب رگا :هجوت
اب .دشاب یم مهارف (TTY: 1-800-390-1175) 1-800-434-2347 .دیریگب سامت

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

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-434-2347 (TTY: 1-800-390-1175).

STAR+PLUS NURSING FACILITY MEMBER HANDBOOK

COMMUNITY FIRST
HEALTH PLANS

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

CFHP_1766GOV_1223