COMMUNITY FIRST HEALTH PLANS

Updated June 2025

TEXAS STAR Kids Your Health Plan ★ Your Choice

TEXAS Health and Human Services

STAR KIDS MEMBER HANDBOOK

MEMBER SERVICES 210-358-6403

TOLL-FREE 1-855-607-7827

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

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

STAR KIDS MEMBER HANDBOOK

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

STAR KIDS MEMBER SERVICES
1-855-607-7827

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INTRODUCTION

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

As the only local, non-profit health care plan in this area's State of Texas Access Reform (STAR) Kids Program, we know 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 get 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 help you in both English and Spanish. You can also get this handbook in other formats, such as large print, braille, or audio. We will mail you a copy free of charge within five business days of your request and update your personal record with your preferred language or format. In the future, when you contact us, we will verify this information. You may ask us to update it at any time.

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

MEMBER SERVICES

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

CALL	1-855-607-7827 Monday through Friday, 8 a.m. to 5 p.m. (CST) Message service available on weekends and holidays. This call is free. For emergency services, dial 911 or go to the nearest emergency department. We have free interpreter services for people who do not speak English.
TTY	711, 24 hours a day, 7 days a week. This call is free. This number requires special phone equipment and is only for people who have problems hearing or speaking.

MENTAL HEALTH AND SUBSTANCE USE SERVICES

Call toll-free to talk to someone if you need help right away. You do not need a referral for mental health or substance use services. For a suicidal, substance use, or a mental health crisis, call or text the 988 Suicide & Crisis Lifeline or go to the nearest emergency department.

CALL	1-844-541-2347 24 hours a day, 7 days a week. This call is free. We have free interpreter services for people who do not speak English.
TTY	711, 24 hours a day, 7 days a week. This call is free. This number requires special phone equipment and is only for people who have problems hearing or speaking.

SERVICE COORDINATION

STAR Kids Members can also speak to a Service Coordinator for help with benefits. We have dedicated Service Coordinators who can help you know the STAR Kids Program, covered services, and resources.

CALL	1-855-607-7827 Monday-Friday, 8:00 a.m. to 5:00 p.m. This call is free. We have free interpreter services for people who do not speak English.
TTY	711, 24 hours a day, 7 days a week. This call is free. This number requires special phone equipment and is only for people who have problems hearing or speaking.

NURSE ADVICE LINE

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

CALL	1-855-607-7827, 24 hours a day, 7 days a week. This call is free. We have free interpreter services for people who do not speak English.
TTY	711, 24 hours a day, 7 days a week. This call is free. This number requires special phone equipment and is only for people who have problems hearing or speaking.

VISION

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

CALL	1-855-607-7827 Monday-Friday, 8:00 a.m. to 5:00 p.m.

DENTAL

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

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

PRESCRIPTION DRUG MEDICATIONS

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

CALL	1-855-607-7827 Monday-Friday, 8 a.m. to 5 p.m.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

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

CALL	**Member Reservation Line:** 1-855-932-2335 Monday-Friday, 8 a.m. to 6 p.m. **Where's My Ride?:** 1-855-932-2335 Monday through Saturday, 4 a.m. to 8 p.m. This call is free. Information available in both English and Spanish. Interpreter services available.
TTY	711 This number requires special phone equipment and is only for people who have problems hearing or speaking.

OTHER HELPFUL NUMBERS

Ombudsman Managed Care Assistance Team	1-866-566-8989
STAR Kids Program Help Line	1-877-782-6440
Texas Health Steps Outreach and Information Hotline	1-877-847-8377

For emergency services, dial 911 or go to the nearest emergency department.

COMMUNITY FIRST HEALTH PLANS WEBSITE

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

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

COMMUNITY FIRST HEALTH PLANS LOCATIONS

Community First Health Plans has two locations to serve you:

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

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

OFFICE HOURS

8:30 a.m. to 5:00 p.m., Monday through Friday, except state-approved holidays.

MEMBER IDENTIFICATION (ID) CARDS

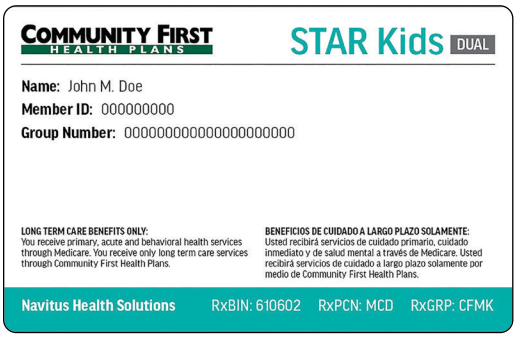
When you sign up to become a Community First Health Plans Member, you will receive a Community First Member ID card. If you do not receive a card, please call Member Services.

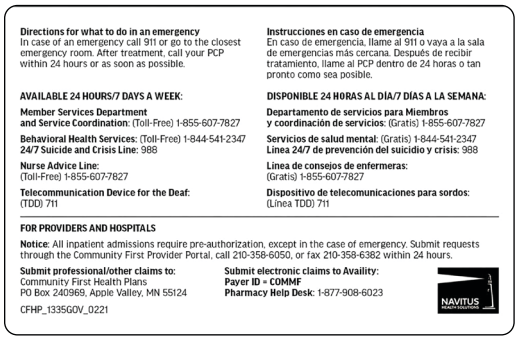
YOUR COMMUNITY FIRST MEMBER ID CARD

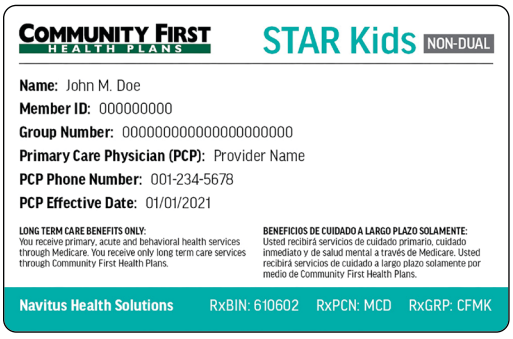
The following information can be found on your Member ID card:

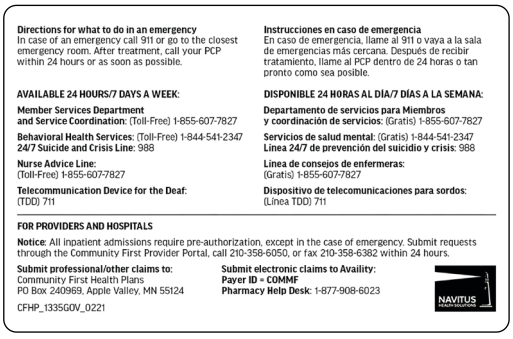
- Your name
- Member ID number
- Effective date (starting date of coverage under your health care plan)
- Your primary care provider's (PCP) name and phone number
- What to do in the event of an emergency
- How to reach Member Services
- How to get help in Spanish or another language

Community First Health Plans Member ID Card - STAR Kids









How do I use my Member ID Card?
Carry your Community First Member ID card with you at all times. Show this card to your doctor so they know you are covered by a Medicaid program.

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

What if my Community First Member ID Card is lost or stolen?
If your Member ID Card is lost or stolen, please call Member Services at 1-855-607-7827 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 ask for a new one.

YOUR TEXAS BENEFITS (YTB) MEDICAID CARD

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

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

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 1-800-252-8263. You can also call 211. First pick a language and then pick option 2.

Your health information is a list of medical services and medicines 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.

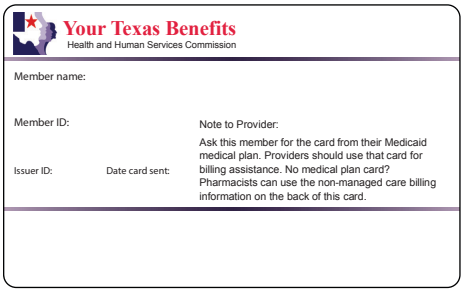
The YTB Medicaid card has these facts printed on the front:

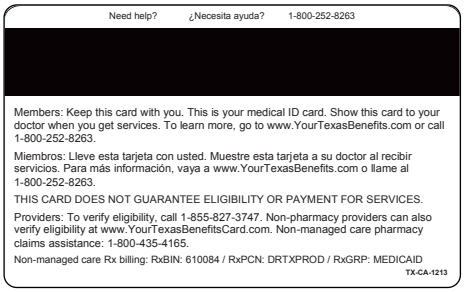
- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - Medicare (QMB, MQMB);
  - Healthy Texas Women Program (HTW);
  - Hospice;
  - STAR Health;
  - Emergency Medicaid; or
  - Presumptive Eligibility for Pregnant Women (PE).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

MEMBER IDENTIFICATION (ID) CARDS

Your Texas Benefits Medicaid Card





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

The YourTexasBenefits.com Medicaid Client Portal

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

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

To access the portal, go to 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.

What if my Texas Benefits Medicaid Card is lost or stolen?

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

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

PRIMARY CARE PROVIDER (PCP)

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

A PCP can be a:

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

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

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

CHOOSING A PRIMARY CARE PROVIDER

How can I or my child get a primary care provider?
You can choose a primary care provider from our STAR Kids Provider Directory at CommunityFirstMedicaid.com. You can also call Member Services at 1-855-607-7827 if you need help. If you do not choose a primary care provider, one will be selected for you.

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

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

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

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

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

You can also call our 24/7 Nurse Advice Line at 1-855-607-7827. The nurse might give you at-home medical advice or refer you to an urgent care center or hospital emergency department, if needed.

CHANGING YOUR PRIMARY CARE PROVIDER

How can I change my or my child's primary care provider?
A Member Services Representative can help you choose a new primary care provider. Call Member Services toll-free at 1-855-607-7827.

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

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

For a list of PCPs in the Community First network, visit our STAR Kids Provider Directory at CommunityFirstMedicaid.com.

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

How many times can I change my or my child's primary care provider?
There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling Member Services toll-free at 1-855-607-7827.

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

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

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

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

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

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

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

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

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

MAKING AN APPOINTMENT

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

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

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

PHYSICIAN INCENTIVE PLAN INFORMATION

Community First Health Plans cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary covered services to Members. You have the right to find out if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to find out how the plan works. You can call 1-855-607-7827 to learn more about this.

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

COMMUNITY FIRST CHECKUP CHECKLIST

What To Ask at Your Health Checkup

5 questions to ask your Primary Care Provider (PCP)

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

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

TEXAS HEALTH STEPS

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

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

- Free regular medical checkups starting at birth.
- Free dental checkups starting at six months of age.
- A Case Manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:

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

When to set up a checkup:

- You will get a letter from Texas Health Steps telling you when it's time for a checkup. Call your child's doctor or dentist to set up the checkup.
- Set up the checkup time that works best for your family.

If the doctor or dentist finds a health problem during a checkup, your child can get the care they need, such as:

- Eye tests and eyeglasses.
- Hearing tests and hearing aids.
- Other health and dental care.
- Treatment for other medical conditions.

Call Community First Health Plans toll-free at 1-855-607-7827 or Texas Health Steps toll-free at 1-877-847-8377 (1-877-THSTEPS) if you:

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

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

Do I have to have a referral for a Texas Health Steps checkup?
You do not need a referral to receive a Texas Health Steps checkup.

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

What if I am out of town and my child is due for a Texas Health Steps checkup?
If you have moved or are out of town when your child's Texas Health Steps exam is due, call Member Services at 1-855-607-7827 for help.

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

HAVE QUESTIONS ABOUT TEXAS HEALTH STEPS?

CALL MEMBER SERVICES AT 1-855-607-7827 OR TEXAS HEALTH STEPS AT 1-877-847-8377 (1-877-THSTEPS) TOLL-FREE IF YOU:

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

If you can't get your child to their checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital, or drugstore. Please call 1-855-932-2335 for non-emergency medical transportation help.

TEXAS HEALTH STEPS MEDICAL CHECKUPS

During a Texas Health Steps medical checkup, you or your child will receive the following:

- Physical exam, measuring height and weight
- Health and developmental history
- Hearing and eye check
- Checking for good diet
- Vaccines (when needed)
- Blood tests (when needed)
- TB (tuberculosis) screening

TEXAS HEALTH STEPS DENTAL CHECKUPS

Your child can begin to get dental checkups every six months at age 1 through 20. Your child can see any dentist who takes Medicaid. You do not need a referral for dental care. During a Texas Health Steps dental checkup, you or your child will receive the following:

- Exam and teeth cleaning (once every six months)
- Emergency care (when needed)
- Fluoride treatments to prevent tooth decay
- Braces (when medically necessary)

These are services your dentist will provide in their office. The dentist may need to provide added services in a hospital or some other place that is not their office. You will need approval from Community First for those added services.

TYPES OF MEDICAL CARE

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:

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

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

Contact your PCP to make an appointment for routine medical care including regular health checkups.

How soon can I expect to be seen?

You can expect to be seen for routine medical care within two weeks.

URGENT MEDICAL CARE

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

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

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

For help, call Community First Member Services toll-free at 1-855-607-7827. You also can call our 24-hour Nurse Advice Line at 1-855-607-7827 for help with getting the care you need.

How soon can I or my child expect to be seen?
You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Community First Health Plans Medicaid.

EMERGENCY MEDICAL CARE

What is emergency medical care?
Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

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

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

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

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

Emergency Services and Emergency Care mean:
Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services that are needed to evaluate or stabilize an Emergency Medical Condition or Emergency Behavioral Health Condition, including post-stabilization care services.

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

What do I do in case of a true emergency?

- Go to the nearest emergency department.
- Call 911 if you need help getting to the hospital.
- Call your personal doctor as soon as possible after your emergency care.
- Your personal doctor will give you follow-up care.

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

What do I do if my child needs emergency dental care?
During normal business hours, call your child's dentist to find out how to get emergency services. If your child needs emergency dental services after the dentist's office has closed, call us toll-free at 1-855-607-7827 or call 911.

Are emergency dental services covered by my health plan?
Community First covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

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

What if I or my child gets sick when I or my child are out town or traveling?
If you or your child need medical care when traveling, call us toll-free at 1-855-607-7827 and we will help you find a doctor. If you or your child need emergency services while traveling, go to a nearby hospital, then call us toll-free at 1-855-607-7827.

What if I am out of the state?
We cover true emergencies anywhere in the United States.

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

SPECIALISTS AND REFERRALS

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

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

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

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

What services do not need a referral?

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

YOUR PLAN BENEFITS

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

BENEFITS CHART

BENEFIT	DESCRIPTION
Ambulance services	Emergency and non-emergency
Audiology services	Includes hearing aids for children and adults
Behavioral Health Services	• Inpatient mental health services for children (birth through age 20) • Acute inpatient mental health services for adults • Outpatient mental health services • Psychiatry services • Mental Health Rehabilitative (MHR) services • Counseling services for adults (21 years of age and over) • Outpatient substance use disorder treatment services including: ◦ Assessment ◦ Detoxification services ◦ Counseling treatment ◦ Medication assisted therapy • Residential substance use disorder treatment services including: ◦ Detoxification services ◦ Substance use disorder treatment (including room and board)
Birthing services	Provided by a doctor, primary care provider, or certified nurse midwife (CNM) in a licensed birthing center
Cancer services	Screening, diagnostic, and treatment
Chiropractic services	
Dialysis	
Durable Medical Equipment (DME) and supplies	
Early Childhood Intervention (ECI) services	
Emergency services	
Family planning services	
Home health care services	

BENEFIT	DESCRIPTION
Hospital services	Inpatient and outpatient hospital services including: • Inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital instead of an acute care inpatient hospital setting • Substance use disorder treatment services in a chemical dependency treatment facility instead of an acute care inpatient hospital setting • Drugs and biologicals provided in an inpatient setting
Laboratory services	
Mastectomy, breast reconstruction, and related follow-up procedures	Inpatient and outpatient services including: • Services provided at an outpatient hospital and ambulatory health care center as clinically appropriate • Doctor, primary care provider, and professional services provided in an office, inpatient, or outpatient setting for: ◦ All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed ◦ Surgery and reconstruction on the other breast to produce symmetrical appearance ◦ Treatment of physical complications from the mastectomy and treatment of lymphedemas ◦ Prophylactic mastectomy to prevent the development of breast cancer • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
Medical checkups and Comprehensive Care Program (CCP) services	For children (birth through age 20) through the Texas Health Steps Program including: • Private duty nursing • Prescribed Pediatric Extended Care Center (PPECC) services • Certified respiratory care practitioner services • Therapies ◦ Speech ◦ Occupational ◦ Physical
Oral evaluation and fluoride varnish	In conjunction with Texas Health Steps medical checkup for children (ages 6 months through 35 months)
Outpatient drugs and biologicals	Including drugstore-dispensed and provider-administered outpatient drugs and biologicals
Podiatry	

BENEFIT	DESCRIPTION
Prenatal care	Provided in a licensed birthing center by a: • Doctor or primary care provider • Certified nurse midwife (CNM) • Nurse practitioner (NP) • Clinical nurse specialist (CNS) • Physician assistant (PA)
Primary care services	
Preventive services	Includes once a year adult well check for patients 21 years of age and over
Radiology, imaging, and X-rays	
Specialty physician services	
Mental Health Targeted Case Management (TCM)	
Mental Health Rehabilitative (MHR) services	
Therapy	Includes physical, occupational, and speech
Transplantation of organs and tissues	
Vision	Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.
Telemedicine	
Telemonitoring	To the extent covered by Texas Government Code §531.01276
Telehealth	

How can I find out more about these services?
To learn more about your or your child's benefits as a Community First Member, please call Member Services at 1-855-607-7827.

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 Kids Program or Community First Health Plans.

- Out-of-area routine care
- Services outside the United States
- Experimental surgery or procedures
- Eye surgery to correct nearsightedness, farsightedness, or blurred vision

- Abortions not covered by federal and state regulations
- Acupuncture
- Infertility treatments, including artificial insemination and in-vitro fertilization
- Reversal of voluntary sterilization
- Custodial care, such as cooking, cleaning, bathing, and feeding, which are not medically necessary
- Personal convenience items such as a television, phone, or grooming supplies, which are not medically necessary
- Cosmetic or plastic surgery that is not medically necessary
- Sex-change surgery
- Autopsies

If you have questions about whether or not a service is covered, please call Member Services at 1-855-607-7827.

VALUE-ADDED SERVICES

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

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

VALUE-ADDED SERVICE	RESTRICTIONS/LIMITATIONS
Extra Help Getting a Ride (bus passes) for Members, their siblings, and their parents or legal guardians to places, such as: • The grocery store • Community-based services • Community First hosted events • Health education classes • Member Advisory Group meetings • WIC • Social Security Administration offices to submit applications for employment and housing • Voter polling sites to vote in local and national elections • Social Security Administration-approved doctor or primary care provider for appointments requested for disability determination and services	*Bus passes are not provided to children younger than 18 unless they are with their parent or guardian. For non-medical related use only. This service is available only for bus service routes within San Antonio and routes are offered by VIA Metropolitan Transit.*

VALUE-ADDED SERVICES

VALUE-ADDED SERVICE	RESTRICTIONS/LIMITATIONS
Disease Management • Y Weight Loss Program - 16 Weeks to Wellness: a no-cost program for individuals ages 13 and older interested in starting and maintaining a healthy lifestyle. Program includes a free 4-month YMCA membership for two adults and up to 4 children. • YMCA Diabetes Prevention Program: a no-cost, year-long, evidence-based program to help individuals at risk of developing Type 2 Diabetes. Program includes a free 4-month YMCA membership for two adults and up to 4 children.	*Must attend education sessions 1-4 to receive YMCA membership.* *Members must be 18 or older to participate in the YMCA Diabetes Prevention Program and 13 or older to participate in the Y Weight Loss Program.*
Extra Vision Services, including up to $125 for frames or $75 for contact lenses	*Applies to either frames or contact lenses and only if they are medically necessary. Available every year for Members ages 20 and younger. Glasses or contacts can be replaced when there is a change in vision. Lost or broken glasses or contacts may be replaced as allowed by the Benefit Program.*
Drugstore Services/Over-the-Counter Benefits, including • One $30 allowance per quarter for over-the-counter products for the Member's family, to include household, personal care, oral care, and children's items • Up to 80% discount on prescription medicines for Member's family members who do not have Medicaid or CHIP coverage	*Allowance excludes beer, wine, alcohol, cigarettes, and items covered in the plan's pharmacy benefits.*
Sports and School Physicals One free physical per calendar year to be used for sports, school, or other physical activities	*For Members age 20 and younger. Provider may perform the physical in conjunction with a Texas Health Steps visit, well child exam, or an acute care visit.*

VALUE-ADDED SERVICE	RESTRICTIONS/LIMITATIONS

Help for Members with Asthma who participate in Asthma Matters: Asthma Management Program, including:
 	
• 1 adult or child-size mask with aerosol chamber each year
• 1 allergy-free protector pillowcase each year
• $10 gift card for completing asthma education
• $10 gift card for receiving a flu shot
• Up to $80 in gift cards for completing home visits with San Antonio Kids BREATHE
  ◦ $35 for first visit
  ◦ $10 for second visit
  ◦ $35 for third visit
	Gift cards must not be used to purchase beer, wine, alcohol, cigarettes, or over-the-counter drugs.

Home Visits • One home-delivered package of 10 prepared meals after a hospital stay	
Phone Assistance for STAR Kids Members who qualify for the Federal Lifeline Program, including: • Free smartphone with minutes, text, storage and international calling as determined by vendor • Unlimited calls to Member Services, Member Advocates, and Service Coordinators through our toll-free line and free health education text messages	*Limited to one smartphone per household. Members can get a free cell phone or use their own from the following plan options depending on coverage area: SafeLink Wireless and Life Wireless.*

VALUE-ADDED SERVICES

VALUE-ADDED SERVICE	RESTRICTIONS/LIMITATIONS
Extra Help for Pregnant Women who participate in Healthy Expectations Maternity Program, including: • Mommy & Me Baby Shower • Free baby car seat or Pack & Play portable play yard • Free diaper bag with baby supplies, including baby wipes and other baby items • Free gifts for fathers who attend Mommy & Me Baby Shower with mom	*Limited to one baby shower per pregnancy, unless having more than one baby (i.e., twins). Members will receive one diaper bag and a choice of a car seat or Pack & Play.*
For pregnant Members who participate in both Healthy Expectations and the Maternal Community Health Club: • A Health Educator assigned to you to help find health services, community resources, and guide you through pregnancy and beyond • Pregnancy, birthing, postpartum, and baby education • Free baby car seat or Pack & Play portable play yard, whichever was not received the Mommy & Me Baby Shower	*The Maternal Community Health Club is limited to pregnant Members who are also in the Healthy Expectations program.*
Health and Wellness Services, including: • Free toddler booster seat for children age 4 through 10 who are current with their Texas Health Steps checkups • 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 • Chance to attend in-person and virtual seasonal and community Health Education Special Events at no-cost where Members may receive health education on topics such as telehealth, healthy habits, new benefits, and more	*Toddler booster seat to be used according to safety guidelines.* *To receive notary services, Members must have a valid, state-issued identification card or driver's license.*

VALUE-ADDED SERVICE	RESTRICTIONS/LIMITATIONS
Healthy Play and Exercise Programs, including: • Up to $150 allowance each year for a camp of the Member's choice. • Free Zumba classes for Members and their families with a free fitness giveaway, including the choice of a frisbee, water bottle, or exercise bands • Free Bike Safety and Repair Program with free giveaway	*Valid for Members ages 3 through 20. Camp must be approved by Community First Service Coordination Department 30 days before or within 30 days after the camp start date. Allowance will be paid directly to the camp provider. Member must be up to date with Texas Health Steps checkups. Members receiving a same or similar service in a HHSC waiver and/or from a federal, state government, or community resource are not eligible.*
Respite Services • Up to 8 hours of in-home respite care services per year for non-waiver STAR Kids Members	
Inpatient Follow-up Incentive Program for Members who participate in Healthy Mind: Behavioral Health Program • $25 gift card for completing a follow-up visit with a behavioral health provider within 7 days of discharge from a mental health hospital or facility upon request	*Gift card restrictions include: no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.*
Online Mental Health Resources • A dedicated page for resources and information at CommunityFirstMedicaid.com	

VALUE-ADDED SERVICES

VALUE-ADDED SERVICE	RESTRICTIONS/LIMITATIONS
Gift Programs including: • Up to $90 in gift cards for completing Texas Health Steps checkups and the Community First Health Assessment at ages 2 months through 30 months • Up to $180 in gift cards per child for completing Texas Health Steps checkups and the Community First Health Assessment at ages 3 through 20 years • Up to $25 in gift cards for completing the Community First Health Assessment and receiving meningococcal, Tdap, and HPV series adolescent immunizations (for children ages 9-13) • $10 gift card for new Community First STAR Kids Members who complete the Community First Health Assessment and provide an email address • Up to $20 in gift cards for completion of the Rotavirus Immunization series for Members ages 42 days through 8-months-old • Up to $60 in gift cards for Members with diabetes participating in Diabetes in Control: Diabetes Management Program: ◦ $20 gift card for completing the Community First diabetes assessment ◦ $10 gift card for completing diabetes education ◦ $10 gift card for receiving a dilated eye exam ◦ $10 gift card once every six months for submitting A1C results	*Gift card restrictions include: no beer, wine, alcohol, cigarettes, or over-the-counter drugs may be purchased.*
• Up to $150 for pregnant Members participating in Healthy Expectations Maternity Program: ◦ $30 for attending Mommy & Me Baby Shower ◦ $30 for completing the Community First maternity assessment and agreeing to receive health education text messages ◦ $30 for completing a prenatal visit ◦ $30 for receiving the flu shot during pregnancy ◦ $30 for completing a postpartum visit between 7 and 84 days after delivery • Up to $30 reimbursement for birthing classes or pregnancy-related items, such as a pregnancy pillow	*Date of prenatal visit must happen in the first trimester or within 42 days of enrollment with Community First.* *Date of postpartum visit must happen before the end of Member eligibility.* *Community First will reimburse for birthing classes at the hospital where the Community First STAR Kids Member delivers their baby.*

*Limitations or restrictions may apply. Please call 210-358-6055 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 Kids Program, please call 210-358-6055.

HEALTH EDUCATION PROGRAMS

What health education classes does Community First Health Plans offer?
Besides 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 know 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 reduce the frequency and severity of flare-ups, how to have more restful sleep, and increase your quality of life.
- **Healthy Expectations Maternity Program** - Participating Members will receive ongoing information about prenatal health, a baby shower with gifts, home visits for high-risk pregnancies, information about how to care for your baby after they are born, information on getting a lactation consultant, and more.
- **Healthy Living: Healthy Lifestyle Management Program** - Participating Members will receive ongoing, age-appropriate information on stress management; quitting smoking; exercise; a heart-healthy lifestyle; and a list of community resources offering nutrition, smoking cessation, and exercise classes.
- **Healthy Heart: Blood Pressure Management Program** - Participating Members will receive ongoing, age-appropriate education on high blood pressure; appropriate use of medication; exercise; and kidney disease. They are also provided a list of community resources offering blood pressure, nutrition, and fitness programs.
- **Healthy Mind: Behavioral Health Management Program** - Participating Members will receive guidance to help determine the type of behavioral health assistance needed and information to help you choose a professional counselor or doctor or other mental health services, including outpatient counseling services; individual, family, and group counseling; and alternative treatments.

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

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

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

- Member health risk assessments
- Flu shot reminders

- Women's health reminders
- Medical checkup reminders

LONG-TERM SERVICES AND SUPPORTS (LTSS)

Long-Term Services and Supports (LTSS) are benefits that help you stay safe and independent in your home or community. LTSS help you with functional needs like bathing, dressing, taking medicine, or preparing meals.

STAR Kids Members who have an assessed need for LTSS, identified by the STAR Kids Screening and Assessment Instrument (SK-SAI), may receive the services listed below.

LONG-TERM SERVICES AND SUPPORTS (LTSS) CHART

LTSS	DESCRIPTION
Day activity health services (DAHS) for Members ages 18 through 20	DAHS includes: • Nursing and personal care services • Therapy extension services • Nutrition services • Transportation services • Other supportive services
Personal care services (PCS)	Services which provide assistance with activities of daily living (ADLs)
Prescribed pediatric extended care center (PPECC)	PPECC is a facility that provides basic services outside the home including: • Medical, nursing, psychosocial, therapeutic, and developmental services to Members under the age of 21 (up to 12 hours per day)
Private duty nursing (PDN)	PDN is nursing services for Members who: • Meet medical necessity criteria, and • Require individualized, continuous skilled care

STAR Kids Members who have an assessed need for LTSS, and who meet an institutional level of care (LOC), may receive the following services through Community First Choice.

COMMUNITY FIRST CHOICE (CFC) SERVICES CHART

LTSS	DESCRIPTION
Personal assistance services (PAS)	Services which provide assistance with activities of daily living (ADLs)
Habilitation	Services that provide acquisition, maintenance, and enhancement of skills necessary for Members to accomplish activities of daily living
Emergency response services (ERS)	Electronic back-up systems and supports
Support management	Training provided to Members, legally authorized representatives (LARs), or authorized representatives (ARs) on how to manage and dismiss their attendants

MEDICALLY DEPENDENT CHILDREN PROGRAM ADDITIONAL SERVICES

STAR Kids Members in the Medically Dependent Children Program (MDCP) are eligible for more services as a cost-effective alternative to living in a nursing facility. Receipt of MDCP services does not impact a Member's eligibility for other LTSS available to STAR Kids. More services available to STAR Kids Members in MDCP include:

- Adaptive aids
- Employment assistance
- Financial management services
- Flexible family support services
- Minor home modifications
- Respite services
- Supported employment
- Transition assistance services

LTSS SERVICE DELIVERY OPTIONS

How can I or my child receive LTSS benefits?

STAR Kids Members may choose from three service delivery options for the delivery of their LTSS.

1. **Agency Option**
   Members who choose the agency model will pick an agency from a list of Community First providers contracted to provide long-term services.
2. **Consumer Directed Services (CDS)**
   Members who choose CDS are given the authority to self-direct certain services. CDS allows for more choices and control. With CDS, you can find, screen, train, hire, and fire (if needed) the people who provide services to you (your staff). If you choose to be in CDS, you will contract with a Financial Management Services Agency (FMSA). FMSA will provide training, handle payroll, and file your taxes.
3. **Service Responsibility Option (SRO)**
   In the SRO model, an agency is the attendant's employer and handles the business details (e.g., paying taxes and doing the payroll). The agency also orients attendants to agency policies and standards before sending them to the Member's home.

Contact your Service Coordinator or call Community First Service Coordination at 1-855-607-7827 or 210-358-6403 to find out more about LTSS benefits and delivery options.

How can I get these services or learn more about LTSS?
To get services or learn more about LTSS, call Member Services at 1-855-607-7827.

LTSS AND STATE-PLANS

I am in the Medically Dependent Children Program (MDCP). How will I receive my LTSS?
State-plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN), and Community First Choice (CFC), in addition to other MDCP services, will all be delivered through Community First Health Plans STAR Kids. Please contact your Community First Health Plans Service Coordinator if you need assistance with accessing these services.

I am in the Youth Empowerment Services (YES) program. How will I receive my LTSS?
State-plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN), and Community First Choice (CFC) will be delivered through Community First Health Plans STAR Kids. Your YES waiver services will be delivered through the Department of State Health Services. Please contact your Community First Service Coordinator if you need assistance with accessing these services. You can also contact your Local Mental Health Authority (LMHA) Case Manager for questions specific to YES waiver services.

I am in the Community Living Assistance and Support Services (CLASS) waiver. How will I receive my LTSS?
State-plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN), and Community First Choice (CFC) will be delivered through Community First Health Plans STAR Kids. Your CLASS waiver services will be delivered through the Texas Health and Human Services Commission (HHSC). Please contact your Community First Service Coordinator if you need assistance with accessing these services. You can also contact your CLASS Case Manager for questions specific to CLASS waiver services.

I am in the Deaf Blind with Multiple Disabilities (DBMD) waiver. How will I receive my LTSS?
State-plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN), and Community First Choice (CFC) will be delivered through Community First Health Plans STAR Kids. Your DBMD waiver services will be delivered through the Texas Health and Human Services Commission (HHSC). Please contact your Community First Service Coordinator if you need assistance with accessing these services. You can also contact your DBMD Case Manager for questions specific to DBMD waiver services.

I am in the Home and Community-Based Services (HCS) waiver. How will I receive my LTSS?
State-plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN), and Community First Choice (CFC) will be delivered through Community First Health Plans STAR Kids. Your HCS waiver services will be delivered through the Texas Health and Human Services Commission (HHSC). Please contact your Community First Service Coordinator if you need assistance with accessing these services. You can also contact

your HCS Service Coordinator at your local intellectual and developmental disability authority (LIDDA) for questions specific to HCS waiver services.

I am in the Texas Home Living (TxHmL) waiver. How will I receive my LTSS?
State-plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN), and Community First Choice (CFC) will be delivered through Community First Health Plans STAR Kids. Your TxHmL waiver services will be delivered through the Texas Health and Human Services Commission (HHSC). Please contact your Community First Service Coordinator if you need assistance with accessing these services. You can also contact your TxHmL Service Coordinator at your local intellectual and developmental disability authority (LIDDA) for questions specific to TxHmL waiver services.

Will my STAR Kids benefits change if I or my child is in a nursing facility?
No. Your STAR Kids benefits and services will not change if you enter a nursing facility.

Will I or my child keep receiving STAR Kids benefits in a nursing facility?
A STAR Kids Member who enters a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) will stay a STAR Kids Member. Community First Health Plans must provide Service Coordination and any covered services that happen outside of the nursing facility or ICF/IID when a STAR Kids Member is a nursing facility or ICF/IID resident. Throughout the duration of the nursing facility or ICF/IID stay, Community First must work with the Member and the Member's Legally Authorized Representative (LAR) to identify Community-Based Services and LTSS programs to help the Member return to the community.

ACUTE CARE SERVICES

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 below are covered under your plan.

ACUTE CARE SERVICES CHART

ACUTE CARE SERVICES	DESCRIPTION
Ambulance services	
Audiology services	Includes hearing aids
Behavioral health services	Includes the following services: • Inpatient and outpatient mental health services • Outpatient chemical dependency services for children • Detoxification services • Psychiatry services
Birthing services	Provided by a doctor, primary care provider, or certified midwife in a birthing center
Chiropractic services	
Dialysis	

ACUTE CARE SERVICES	DESCRIPTION
Durable medical equipment (DME) and supplies	
Early Childhood Intervention (ECI) services	
Emergency services	
Family planning services	
Home health care services	
Hospital services	Includes both inpatient and outpatient services
Laboratory services	
Medical checkups and Comprehensive Care Program (CCP) services	Includes Texas Health Steps for children ages 20 and younger
Oral evaluation and fluoride varnish	In conjunction with Texas Health Steps medical checkup for children ages six months through 35 months
Optometry	Includes glasses and contact lenses, if medically necessary
Podiatry	
Prenatal care	
Primary care services	
Radiology, imaging, x-rays	
Specialty physician services	
Therapies	Includes physical, occupational, and speech
Transplantation of organs and tissues	
Vision services	

STAR Kids Members who have other insurance, like Medicare or private insurance, will receive most of their acute care services through their primary insurance. Members receive dental care through their primary insurer, through their selected Medicaid dental maintenance organization (DMO), or through a Medicaid fee-for-service model.

How can I get Acute Care Services or learn more about them?
To learn more about acute care services covered under your plan, call Member Services at 1-855-607-7827.

BEHAVIORAL HEALTH AND SUBSTANCE USE

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

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

Call the STAR Kids Behavioral Health Hotline at 1-844-541-2347 if you have an urgent problem. You can call for help 24 hours a day, seven days a week.

For a suicidal, substance use, or a mental health crisis, call or text the 988 Suicide & Crisis Lifeline or go to the nearest emergency department.

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

What are mental health rehabilitation services (MHR) and mental health-targeted case management (TCM)? 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 MHR and mental health TCM. To get help, please call 1-855-607-7827.

IN LIEU OF SERVICES

As a Community First Medicaid Member, you have the right to receive the medically necessary **in lieu of service (ILOS)** specific to behavioral health and substance use disorders. You also have the right to refuse these services.

What are ILOS?
ILOS are different services that you or your child can get to treat a behavioral health condition or substance use disorder in a setting approved by Texas Health and Human Services Commission (HHSC) in lieu of (instead of) a hospital. ILOS may work better for you or your child and your personal health care needs.

These services include:

- Partial Hospitalization Program (PHP) – an outpatient program that offers a structured day of behavioral health services, like group therapy, medication management, and nursing services.
- Intensive Outpatient Program (IOP) – an outpatient program that offers structured therapy, educational services, and life skills training.
- Coordinated Specialty Care (CSC) – a team-based approach to treat people with a newly diagnosed psychosis disorder.

How can I get these services?
If your behavioral health provider recommends ILOS, they can refer you to a qualified provider once the request is approved.

Note: ILOS do not replace regular services or specific treatments covered by Community First. However, if you think ILOS would be a better option for you or your child, please talk to your provider.

VIRTUAL MENTAL HEALTH CARE

Community First Health Plans has partnered with Charlie Health to offer Members ages 11-33 virtual mental health 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.

APPLIED BEHAVIORAL ANALYSIS

Applied Behavioral Analysis (ABA) is a treatment approach for children diagnosed with Autism Spectrum Disorder (ASD). Licensed behavior analysts (LBAs) can provide ABA services if your child has been diagnosed with ASD. ABA can help encourage positive and adaptive behaviors and apply skills across everyday settings, helping to improve your child's health, safety, or independence. To ask for an evaluation to see if your child qualifies for Medicaid ABA services, call:

- Your child's primary care provider; or
- Community First Member Services at 1-855-607-7827.

HELP ACCESSING HEALTH CARE

OTHER SERVICES

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

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

Community First can help if you have questions about these or other non-capitated services. Please call Member Services at 1-855-607-7827 to learn more.

INTERPRETERS

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

Who do I call for an interpreter? How far in advance do I need to call?
Call Member Services at least 24 hours before your medical visit at 1-855-607-7827.

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

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

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

What are NEMT services?

NEMT services provide transportation to non-emergency health care appointments for Members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, drugstore, and other places you get Medicaid services. These trips do NOT include ambulance trips. Community First's partner for NEMT services is SafeRide Health.

What services are part of NEMT services?

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

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

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

How do I get a ride?

Community First Health Plans will provide you with information on how to ask for NEMT services. You should ask for NEMT services as early as possible, and at least 48 hours before you need the NEMT service. In certain circumstances you may ask for the NEMT service with less than 48 hours notice. These circumstances include:

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

You must notify Community First before the approved and scheduled trip if your medical appointment is canceled.

To schedule a ride, please call:

NEMT Member Reservation Line: 1-855-932-2335 (TTY 711)
Monday through Friday, from 8 a.m. to 6 p.m.
Information available in both English and Spanish. Interpreter services available.

When you call, please be ready to provide:

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

You can also reserve a ride online at CommunityFirst.Member.SafeRideHealth.com/login.

Your driver will call, give you your pickup time, and provide you with their direct phone number. Keep this number with you.

If you need help after hours or are unable to contact your driver, please call:

Where's My Ride?: 1-855-932-2335 (TTY 711)
Monday through Saturday, 4 a.m. to 8 p.m.
Information available in both English and Spanish. Interpreter services available.

PRESCRIPTION DRUG BENEFITS

HOW TO GET YOUR OR YOUR CHILD'S MEDICATIONS

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

If you need assistance with finding a drugstore, please call Member Services at 1-855-607-7827 or visit CommunityFirstMedicaid.com to use the Pharmacy Locator.

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

Who do I call if I have problems getting my medications?
If you have problems getting your covered medications, please call Member Services at 1-855-607-7827. We can work with you and your drugstore to make sure you get the medication(s) you need.

What if I can't get the medication my doctor ordered approved?
If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your or your child's medication. Call Community First Member Services at 1-855-607-7827 for help with your medications and refills.

What if I lose my medication(s)?
If you lose your medications, call your doctor for help. If your doctor's office is closed, the drugstore where you got your medications may be able to help you. You can also call Member Services for help at 1-855-607-7827.

NETWORK DRUGSTORES

How do I find a network drugstore?
Call Member Services for help finding a network drugstore. You can also find a list of network drugstores at CommunityFirstMedicaid.com.

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

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

1. Call the new network drugstore you'd like to transfer your prescription(s) to and give the needed information to the pharmacist; or
2. Bring your prescription container to the new network drugstore.

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

MEDICATION DELIVERY

What if I need my medications delivered to me?
You may be able to have your medications delivered to you through the mail. Community First's partner for pharmacy benefits is Navitus. Their mail order partner is H-E-B. Please call Member Services at 1-855-607-7827 if you'd like to see if your drugstore offers medication delivery by mail.

COPAY

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

What if I paid out of pocket for a medicine and want to be reimbursed?
If you had to pay for a medicine, please contact Member Services at 1-855-607-7827 for assistance with reimbursement.

MEDICARE AND PRESCRIPTION DRUG BENEFITS

What if I also have Medicare?
If you have both Medicare and Medicaid, your prescription drugs are paid by a Medicare Rx plan. If you have questions or want to change Medicare Rx plans, please call 1-800-633-4227.

Under Medicare Rx:

- You have a choice of prescription drug plans.
- All plans require you pay $1 to $5 for each prescription.
- There is no limit on the number of prescriptions you can fill each month.

How do I get my medications if I am in a nursing facility?
If you are in a nursing facility, your drugs will be provided to you by the nursing facility. The drugstore that is used by your nursing facility will keep billing your Medicare plan (if you have Medicare) and will bill Navitus, Community First's partner for pharmacy benefits, 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 drugstore services. Your Medicaid benefits stay 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 drugstore 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 1-855-607-7827.

DURABLE MEDICAL EQUIPMENT (DME)

What if I need durable medical equipment (DME) or other products normally found in a drugstore?
Some durable medical equipment (DME) and products normally found in a drugstore are covered by Medicaid. For all Members, Community First Health Plans pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), Community First Health Plans also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call Member Services at 1-855-607-7827 to learn more about these benefits.

VISION SERVICES

How do I or my child get eye care services?
Community First Health Plans partners with Envolve to provide routine eye care services to our Members. You can call Member Services at 1-855-607-7827 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 or my child's vision benefits?
Community First STAR Kids Members ages birth through 20 receive one vision exam yearly. Members 21 and over receive one vision exam every two years.

You must get your eye care services from Community First network eye care providers. If you need help finding a provider, call Member Services at 1-855-607-7827.

DENTAL SERVICES

How do I or my child get dental services?
Community First covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

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

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

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

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

What do I do if I or my child needs emergency dental care?
During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office is closed, call Member Services at 1-855-607-7827 or call 911.

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

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

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

FAMILY PLANNING SERVICES

How do I get family planning services? Do I need a referral for this?
For family planning services, you can go to any provider that accepts Medicaid. You do not need a referral from your primary care provider. You should also talk to your doctor about family planning. They can help you pick a family planning provider. You can also call Member Services at 1-855-607-7827.

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 1-855-607-7827 for help finding a family planning provider.

EARLY CHILDHOOD INTERVENTION

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

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

Where do I find an ECI provider?
You can search for an ECI provider in your area by using the ECI Program Search Tool at Citysearch.HHSC.State.TX.us. You can also call the Office of the Ombudsman at 1-877-787-8999, select a language, and then select Option 3.

SERVICE COORDINATION

What is Service Coordination?
Service Coordination allows Community First to work together with you and your care team to best identify and address your needs. We will gather information and build an individual service plan (ISP) to address those needs, just for you. Service Coordination includes:

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

SERVICE COORDINATOR

What can a Service Coordinator do for me or my child?
Service Coordinators are trained to meet the needs of those who need help the most, including people who have long-lasting 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. If you have not been assigned a Service Coordinator or would like more information about Service Coordination, please call 1-855-607-7827.

STAR KIDS SCREENING AND ASSESSMENT INSTRUMENT

What is the STAR Kids Screening and Assessment Instrument (SK-SAI)?
All STAR Kids Members receive a comprehensive assessment of their physical and functional needs by a Service Coordinator using the STAR Kids Screening and

Assessment Instrument (SK-SAI) once a year. If you or your child has a significant change in condition, Community First will reassess and update your individual service plan (ISP) and authorize necessary services, if needed.

TRANSITION SPECIALIST

What is a Transition Specialist? What will a Transition Specialist do for me or my child?
A Transition Specialist is a specially trained Service Coordinator who will help you, your family, and your Community First Service Coordinator plan for your future. Starting as early as age 10, but regularly at age 15, you, your family, and your caregiver team will meet and set your goals and objectives for that year. Each year, until you reach the age of 21, your team is with you. They will help you plan for the transition from child health care and services to adult health care and services.

How can I talk to a Transition Specialist?
You can talk to a Transition Specialist by calling your personal Service Coordinator. You can also call 1-855-607-7827.

HEALTH HOME

What is a Health Home?
A Health Home is a person-based approach to holistically meet your needs. It provides services and support beyond what your primary care provider can provide. STAR Kids Health Homes operate through a primary care practice or specialty care practice and use a team approach. The goal is to provide quality care that is easy to get and coordinated between providers.

PRESCRIBED PEDIATRIC EXTENDED CARE CENTER

What is a Prescribed Pediatric Extended Care Center (PPECC)?
Prescribed Pediatric Extended Care Centers allow children and youth from ages birth through 20 with medically complex conditions to receive daily medical care in a non-residential setting. Members who qualify can attend a PPECC up to a maximum of 12 hours per day to receive medical, nursing, psychosocial, therapeutic, and developmental services for their medical conditions and developmental status.

WOMEN'S HEALTH SERVICES

OB/GYN CARE

ATTENTION FEMALE MEMBERS

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

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

- One well-woman checkup per year.
- Care related to pregnancy.

- Care for any female medical condition.
- Referral to a special doctor within the network.

How do I choose an OB/GYN?
You can find a list of available OB/GYN doctors from the STAR Kids Provider Directory at CommunityFirstMedicaid.com. You can also call Member Services at 1-855-607-7827 if you need help choosing an OB/GYN.

If I don't choose an OB/GYN, do I or my child 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 do not need a referral.

How soon can I be seen after contacting my OB/GYN for an appointment?
You will be seen within two weeks.

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

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

MOBILE WOMEN'S HEALTH CARE

Community First partners with Betty's Co. to offer health care services for girls and young women ages 13-45 in mobile, boutique clinics stationed across Bexar County and surrounding areas. Betty's care model is built on trust and inclusivity and removes barriers to care, such as a lack of transportation. Every visit includes gynecology, mental health, and wellness care. To learn more or make an appointment, call 210-572-4931 or go to BettysCo.com.

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

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

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

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

Who can get a Case Manager?
Children, teens, young adults (birth through age 20), and pregnant women who get Medicaid and:

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

What do Case Managers do?
A Case Manager will visit with you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?
Case Managers can help you:

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

How can you get a Case Manager?
Contact Community First Health Plans at 1-855-607-7827 to learn more or call Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8:00 a.m. to 8:00 p.m.

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

CARE DURING PREGNANCY

What if I am pregnant? Who do I need to call?
Call Member Services at 1-855-607-7827 and we can help you pick an OB/GYN. It is very important to start your prenatal care right away.

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

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

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

Learn more about Healthy Expectations by reviewing the Health & Wellness Programs section in this Member Handbook. You can also visit CommunityFirstHealthPlans.com/Health-And-Wellness-Programs, call 210-358-6055, or email healthyhelp@cfhp.com to learn more.

NOTIFYING YOUR HEALTH PLAN AFTER GIVING BIRTH

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

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

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

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

Who do I call if I or my child has special health care needs and I need someone to help?
Community First offers Case Management and Service Coordination services to Members with special health care needs. Please call Member Services at 1-855-607-7827 if you need help.

SPECIAL HEALTH PROGRAMS

How can I receive health care after my baby is born (and I am no longer covered by Medicaid)?
After your baby is born you may lose Medicaid coverage. You may be able to get some health care services through the Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for services and are approved.

HEALTHY TEXAS WOMEN PROGRAM

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

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

DSHS PRIMARY HEALTH CARE PROGRAM

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

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

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

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

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

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

Website: HHS.Texas.gov/Services/Health/Primary-Health-Care-Services-Program
Phone: 512-776-7796
Email: PrimaryHealthCare@hhs.texas.gov

DSHS EXPANDED PRIMARY HEALTH CARE PROGRAM

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

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

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

Website: HHS.Texas.gov/Services/Health/Primary-Health-Care-Services-Program
Phone: 512-776-7796
Fax: 512-776-7203
Email: PrimaryHealthCare@hhs.texas.gov

DSHS FAMILY PLANNING PROGRAM

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

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic locator at 211Texas.org.

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

Website: HHS.Texas.gov/Providers/Health-Services-Providers/Womens-Health-Services/Family-Planning
Phone: 512-776-7796
Fax: 512-776-7203
Email: famplan@hhs.texas.gov

ADVANCE DIRECTIVES

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

What are advance directives? How do I get an advance directive?
Advance directives are written instructions to your family about what to do if you become very sick. Community First has a booklet with information about advance directives that we can send to you free of charge. Call Member Services at 1-855-607-7827 to ask for this booklet.

RENEWING YOUR HEALTH CARE COVERAGE

You must renew you or your child's Medicaid coverage every year. In the months before your or your child's coverage is due to end, HHSC will send you a renewal packet in the mail. The renewal packet has an application. It also includes a letter asking for an update on your family's income and cost deductions. Instructions and more information can also be found at YourTexasBenefits.com. Here you can:

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

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

What happens if I lose my Medicaid coverage?
If you lose Medicaid coverage but get it back again within six months, you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same primary care provider you had before.

MEMBER BILLING

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

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

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.

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

CHANGE OF ADDRESS

What do I have to do if I move?
As soon as you have your new address, give it to the local HHSC benefits office and Community First Health Plans Member Services Department at 1-800-607-7827. Before you get Medicaid services in your new area, you must call Community First, unless you need emergency services. You will keep getting care through Community First until HHSC changes your address.

MEDICALLY NECESSARY

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

1. For Members birth through age 20, the following Texas Health Steps services are considered medically necessary:
   a) screening, vision, and hearing services; and
   b) other Health Care Services, including Behavioral Health Services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
      i) must comply with the requirements of the *Alberto N., et al. v. Janek, et al.* partial settlement agreements; and
      ii) may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.
2. For Members over age 20, non-behavioral health-related health care services that are:
   a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
   b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
   c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
   d) consistent with the diagnoses of the conditions;
   e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   f) are not experimental or investigative; and
   g) are not primarily for the convenience of the Member or provider; and
3. For Members over age 20, behavioral health services that:
   a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
   b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
   c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
   d) are the most appropriate level or supply of service that can safely be provided;
   e) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
   f) are not experimental or investigative; and
   g) are not primarily for the convenience of the Member or provider.

CHANGING HEALTH PLANS

What if I want to change health plans?
You can change your health plan by calling the Texas STAR, STAR Kids, or STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want.

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

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

Can Community First Health Plans ask that I get dropped from their health plan (for non-compliance, etc.)?
Yes, for the following reasons:

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

MEMBER RIGHTS AND 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 primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a) Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b) Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a) Work as part of a team with your provider in deciding what health care is best for you.
   b) Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the Managed Care Organization and through Medicaid; and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   a) Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   b) Get a timely answer to your complaint.
   c) Use the plan's appeal process and be told how to use it.
   d) Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   e) Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a) Have phone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b) Get medical care in a timely manner.
   c) Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d) Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e) Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services provided to your child. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

MEMBER RESPONSIBILITIES

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a) Learn and understand your rights under the Medicaid program.
   b) Ask questions if you do not understand your rights.
   c) Learn what choices of health plans are available in your area.

2. You must abide by the health plan's policies and procedures and Medicaid policies and procedures. That includes the responsibility to:
   a) Learn and follow your health plan's rules and Medicaid rules.
   b) Choose your primary care provider quickly.
   c) Make any changes in your 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.
5. When requesting non-emergency medical transportation (NEMT) services, you have the responsibility to:
   a) Provide the information requested by the person arranging or verifying your transportation.
   b) Follow all rules and regulations affecting your NEMT services.
   c) Return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
   d) Not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
   e) Not lose bus tickets or tokens and return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
   f) Only use NEMT services to travel to and from your medical appointments.
   g) Contact the person who helped you arrange your NEMT transportation or service as soon as possible if something changes and you no longer need that service.

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

UTILIZATION MANAGEMENT PROCESS

Utilization Management (UM) decision making is based only on appropriateness of care and service and existence of coverage. Community First Health Plans does not award providers or other individuals for issuing denials of coverage. Utilization Management decision makers are not awarded financially to make decisions that result in underutilization.

To make UM decisions, Community First Health Plans uses the requesting practitioner's recommendation and nationally recognized criteria and guidelines, and applies the criteria in a fair, impartial, and consistent manner that serves the best interest of our Members. To make sure that Members receive the most appropriate health care, Community First Health Plans reviews your care before, during, and after you receive it to make sure it is covered.

Pre-service review happens before you receive care. Post-service review happens before the claim is paid when you receive care that was not authorized in advance. Generally, your practitioner requests prior authorization from Community First Health Plans before you receive care; however, it is the Member's responsibility to make sure that they are following Community First Health Plans rules for accessing care.

If you are obtaining care from an out-of-network provider, call Member Services at 1-855-607-7827 to ask for Community First's review of your care. Out-of-network care that is not approved in advance by Community First is not covered.

We also review your care while you are in the hospital and work with the hospital staff to help make sure you have a smooth transition to home or your next care setting. Our experienced clinical staff reviews all requests. Member needs that fall outside of standard criteria are reviewed by our physician staff for plan coverage and medical necessity. Community First Health Plans approves or denies services based upon whether or not the service is medically needed and a covered benefit.

How to obtain information about the UM process and authorization of care:
UM staff are available to help you with any questions or concerns you may have about the UM process and the authorization of care. You may speak with a UM staff member by calling Member Services at 1-855-607-7827 during normal business hours, Monday through Friday from 8:30 a.m. to 5:00 p.m. On-call UM staff can be reached for urgent issues after hours, weekends, and holidays by calling the same phone number and advising the answering service of your need to speak with a UM staff member.

COMPLAINT PROCESS

What should I do if I have a complaint?
We want to help. If you have a complaint, please call us toll-free at 1-855-607-7827 to tell us about your problem. A Community First Health Plans Member Services Representative can help you file a complaint. Just call 1-855-607-7827. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the Community First complaint process, you can file a complaint to the Health and Human Services Commission (HHSC) by calling toll-free

1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

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

If you can get on the Internet, you can submit your complaint at HHS.Texas.gov/Managed-Care-Help.

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

How long will it take to process my complaint?
We will mail you a letter within five (5) days to tell you we have received your complaint. Then, we will mail you our decision within 30 days.

APPEAL PROCESS

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

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

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

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

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

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

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

To learn more, call Member Services at 1-855-607-7827.

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

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

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

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

Community First will resolve your appeal as soon as possible based on your health condition and no later than the 14 day extension. If you are not happy with the delay, you may file a complaint by calling Member Services at 1-855-607-7827.

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

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

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

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

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

EXPEDITED APPEAL PROCESS

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

How do I ask for an Expedited Appeal and who can I ask for help?
A Community First Member Services Representative can help you file an Expedited Appeal. Call Member Services at 1-855-607-7827 for assistance.

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

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

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

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

STATE FAIR HEARING

Can I ask for a State Fair Hearing?
If you, as a Member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter with the internal appeal decision. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either call 1-855-607-7827 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 ask for 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 phone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Can I ask for an emergency State Fair Hearing?
If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling Community First Health Plans. To qualify for an emergency State Fair Hearing through HHSC, you must first complete Community First Health Plans' internal appeals process.

EXTERNAL MEDICAL REVIEW

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

The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent them. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose their right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative may either:

- Fill out the "State Fair Hearing and External Medical Review Request Form" provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Community First Health Plans by using the address or fax number at the top of the form;
- Call Community First Health Plans at 1-855-607-7827; 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 ask for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also ask for the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting Community First Health Plans at 1-855-607-7827 or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can I ask for an emergency External Medical Review?
If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health or your ability to attain, maintain, or regain maximum function, you, your parent, or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Community First Health Plans. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete Community First Health Plans' internal appeals process.

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, over medicating 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, including unapproved use of restraints or isolation that is committed by a provider. Call 911 for life-threatening or emergency situations.

Report by phone (non-emergency)

You can call toll free 24 hours a day, 7 days a week.

Report to the Health and Human Services Commission (HHSC) by calling 1-800-458-9858 if the person being abused, neglected, or exploited lives in or receives services from a:

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

Suspected Abuse, Neglect, or Exploitation by an HCSSA must also be reported to the Department of Family and Protective Services (DFPS). If it's an emergency, call 911.

Report all other suspected abuse, neglect, or exploitation to DFPS by calling 1-800-252-5400.

Report Electronically (Non-Emergency)

Go to TXAbuseHotline.org. This is a secure website. You will need to create a password-protected account and profile.

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.

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.

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 stay anonymous, HHSC has no way to tell you 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, Fraud, and Abuse?

Let us know if you think a doctor, dentist, pharmacist at a drugstore, 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 Office of Inspector General (OIG) Hotline at 1-800-436-6184;
- Visit OIG.HHS.Texas.gov
  - Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan by calling 1-855-607-7827 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

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, phone numbers, and languages spoken (other than English) for each Network Provider, plus identification of providers that are not accepting new patients, and, when applicable, professional qualifications, specialty, medical school attended, residency completion, and board certification status.
- Any limits on your freedom of choice among Network Providers.
- Your rights and responsibilities.
- Information on complaint, appeal, External Medical Review, and State Fair Hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers, and/or limits to those benefits.
- How to get after hours and emergency coverage and/or limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services, and post-stabilization services.
  - The fact that you do not need prior authorization from your primary care provider for emergency care services.
  - How to get emergency services, including instructions on how to use the 911 phone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have the right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your primary care provider.
- Community First Health Plan's practice guidelines.

MEMBER ADVOCATES

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

Member Advocates must tell Members of the following:

1. Their rights and responsibilities;
2. The roles 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 help Members and Members' 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 help 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 about 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 help with resolution.

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

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 get your medical records. You have the right to agree 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 get PHI when they have an appropriate reason to do so. Each employee must sign a statement that they know 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 people 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 get 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, Inc. (Community First) 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 does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Community First provides free 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 formats)

Community First 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 services, please contact Community First Member Services at the number on the back of your Member ID card or 1-800-434-2347. If you're deaf or hard of hearing, please call 711.

If you feel that Community First failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a complaint with Community First by phone, fax, or email at:

Community First Compliance Coordinator
Phone: 210-227-2347 | TTY: 711
Fax: 210-358-6014
Email: DL_CFHP_Regulatory@cfhp.com

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

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

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 | TTY: 1-800-537-7697

Complaint forms are available at:
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Aviso sobre no discriminación

Community First Health Plans, Inc. (Community First) 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 no excluye o trata de manera diferente a las personas debido a su raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual.

Community First 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, y otros formatos)

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

- Intérpretes calificados
- Información escrita en otros idiomas

Si usted necesita recibir estos servicios, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347. TTY (para personas con problemas auditivos) al 711.

Si usted cree que Community First no proporcionó servicios lingüísticos gratuitos o se siente que fue discriminado/a de otra manera por motivos de su raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual, usted puede comunicarse con Community First por teléfono, fax, o correo electrónico a:

Community First Compliance Coordinator
Teléfono: 210-227-2347 | Línea de TTY gratuita: 711
Fax: 210-358-6014
Correo electrónico: DL_CFHP_Regulatory@cfhp.com

Si usted necesita ayuda para presentar una queja, Community First está disponible para ayudarlo. Si usted desea presentar una queja sobre reclamos, elegibilidad o autorización, comuníquese con Servicios para Miembros de Community First llamando al 1-800-434-2347.

Usted también puede presentar una 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 TTY gratuita: 1-800-537-7697

Los formularios de queja están disponibles en:
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

COMMUNITY FIRST
HEALTH PLANS

Language Assistance

ENGLISH: ATTENTION: Free language assistance services are available to you. Call 1-800-434-2347 (TTY: 711).

SPANISH: ATENCIÓN: Si habla español, usted tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-434-2347 (TTY: 711).

VIETNAMESE: 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: 711).

CHINESE: : 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: 711).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-434-2347 (TTY: 711)번으로 전화해 주십시오.

ARABIC: رق م 1-800-434-2347 ق م ب ر اتـ ص ل باﻟ مجا ن . ل ك ف ت وت ى ة اﻟ ل وغ عدة اﻟ م اس خدمات ف إن اﻟ ل غة،اذا ك ر ت حدث ك نت اذإ م لحوظة : 711 او: ل اﻟ مصاهـ ات

URDU: ک ا ل ۔ ہ ی د س ت ای ب م ی ں م ف ت خدمات ک ی ددم ک ی ز ب ان ک و آپ ت و ہ ی ں،ل ے ب و دو ا ر آپ ا گ ر اد ر : خ رب 1-800-434-2347 (TTY: 711).

TAGALOG: 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: 711).

FRENCH: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-434-2347 (ATS: 711).

HINDI: ध्यान द: यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-434-2347 (TTY: 711) पर कॉल कर।

PERSIAN: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان ب ارای شما تامین گردیده. 1-800-434-2347 (TTY: 711) فراهم می باشد. اب

GERMAN: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-434-2347 (TTY: 711).

GUJARATI: ध्यान दे: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 1-800-434-2347 (TTY: 711) पर कॉल करे।

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-434-2347 (телетайп: 711).

JAPANESE: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:711)まで、お電話にてご連絡ください.

LAOTIAN: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-800-434-2347 (TTY: 711).

STAR KIDS MEMBER HANDBOOK

COMMUNITY FIRST HEALTH PLANS

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

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