COMMUNITY FIRST HEALTH PLANS

Updated September 2026

CHIP | TEXAS Health and Human Services

CHIP/CHIP PERINATE MEMBER HANDBOOK

MEMBER SERVICES 210-358-6300

TOLL-FREE 1-800-434-2347

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

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

CHIP/CHIP PERINATE MEMBER HANDBOOK

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

CHIP/CHIP PERINATE MEMBER SERVICES
Local 210-227-2347 | Toll-Free 1-800-434-2347

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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 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 our area offering the Children's Health Insurance Program (CHIP) and CHIP Perinatal Programs, 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 1-800-434-2347.

HOW TO READ THIS HANDBOOK

This Member Handbook has been divided into three sections so you can easily find the information that applies to you or your child's health plan.

SECTION I: CHIP/CHIP Perinate/CHIP Perinate Newborn: Section I has information that applies to CHIP, CHIP Perinate (expecting mothers and their unborn babies), and CHIP Perinate Newborn Members. Refer to Section I to review general information about any of the three health plans listed above, including important phone numbers, information about your Member ID card, and health and wellness programs available to you at no-cost.

SECTION II: CHIP/CHIP Perinate Newborn: Section II has information that applies to CHIP and CHIP Perinate Newborn Members only. Refer to Section II if you or your child is a CHIP or CHIP Perinate Newborn Member and you have specific questions about your or your child's health plan, including what is and is not covered by Community First.

SECTION III: CHIP Perinate: Section III has information specific to CHIP Perinate Members (expecting mothers and their unborn children). Refer to Section III if you are a CHIP Perinate Member and you have specific questions about your health plan, including what is and is not covered by Community First.

SYMBOLS

You will also see symbols used throughout this Member Handbook to help you identify what program the information you are reading applies to. **The symbols are only used in special cases.** If you do not see a symbol, then refer to the description of the section you are reading (Section I: CHIP/CHIP Perinate Newborn/CHIP Perinate, Section II: CHIP/CHIP Perinate Newborn, or Section III: CHIP Perinate) to find out what plan(s) the information applies to.

 Information applies to CHIP Members only.

 Information applies to CHIP Perinate Newborn Members only.

 Information applies to CHIP Perinate (expectant mothers and their unborn babies) only.

If you see more than one symbol grouped together, that means the information you are reading applies to more than one program.

Example:  = CHIP and CHIP Perinate Newborn Programs.

SECTION I

CHIP / CHIP PERINATE / CHIP PERINATE NEWBORN

References to “you,” “my,” and “I” apply if you are a CHIP Member.
References to “my child” apply if your child is a CHIP Member or a CHIP Perinate Newborn Member.

MEMBER SERVICES

Member Services can answer your questions, including how to get all covered services under your health care plan and what to do in an emergency or crisis. Our Member Services Representatives can also help you pick or change your primary care provider (PCP) or perinatal provider, get services that do not require a referral, send you a new Member ID card, and help resolve any problems or complaints.

CALL	1-800-434-2347, Monday through Friday, 8:00 a.m. to 5:00 p.m. (CST) (excluding state-approved holidays) Message service available on weekends and holidays. This call is free. We have free interpreter services for people who do not speak English. For emergency services, dial 911 or go to the nearest emergency department.
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 or your child needs help right away. You do not need a referral for mental health or substance misuse services. For a suicidal, substance use, or mental health crisis, call or text the 988 Suicide & Crisis Lifeline or go to the nearest emergency department.

CALL	1-877-221-2226, 24 hours a day, 7 days a week. This call is free. We have free interpreter services for people who do not speak English.
TTY	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	1-800-434-2347, 24 hours a day, 7 days a week. This call is free. We have free interpreter services for people who do not speak English.
TTY	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 CHIP and CHIP Perinate Newborn Members. Call Member Services for help finding a network vision provider near you.

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

DENTAL

Call your or your child's dental plan for information about preventive dental services, including routine cleanings.

CALL	**DentaQuest** 1-800-508-6775 **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 benefits.

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

OTHER HELPFUL NUMBERS

CHIP/CHIP Perinatal Programs Help Line	1-800-647-6558

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

COMMUNITY FIRST HEALTH PLANS WEBSITE

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

- Secure Member Portal
- Member resources and forms
- Events calendar
- Member e-newsletter sign up
- Value-Added Services available to you or your child
- Blog with information about different health topics
- Provider/Pharmacy Directory

COMMUNITY FIRST HEALTH PLANS LOCATIONS

Community First Health Plans has two locations to serve you:

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

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

Community Assistance Office at Vida
Community First Health Plans
3611 Jaguar Parkway, Suite 295
San Antonio, TX 78224

OFFICE HOURS

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

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 for each Member. If you do not receive a card, please call Member Services.

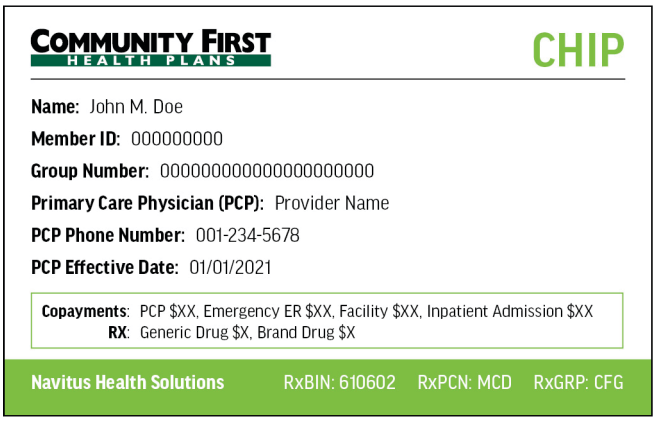
How do I use my Member ID Card?
Carry your or your child's Community First Member ID card with you at all times. Show this card to your doctor so that they know you are covered by a CHIP Program.

What if my card is lost or stolen?
If your or your child's card is lost or stolen, please call Member Services at 1-800-434-2347 and ask for a new one. You can also log in to our secure Member Portal at CommunityFirstMedicaid.com to print a temporary ID card and/or request a new one.

YOUR COMMUNITY FIRST MEMBER ID CARD - CHIP

The following information can be found on your or your child's CHIP Member ID card:

- Your or your child's name.
- Member ID number.
- Effective date (starting date of coverage under your health care plan).
- Your or your child's primary care provider's (PCP) name and phone number.
- Copayment and cost-sharing information.
- 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

CHIP

Name: John M. Doe
Member ID: 000000000
Group Number: 00000000000000000000
Primary Care Physician (PCP): Provider Name
PCP Phone Number: 001-234-5678
PCP Effective Date: 01/01/2021

Copayments: PCP $XX, Emergency ER $XX, Facility $XX, Inpatient Admission $XX
RX: Generic Drug $X, Brand Drug $X

Navitus Health Solutions RxBIN: 610602 RxPCN: MCD RxGRP: CFG


Directions for what to do in an emergency
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

Instrucciones en caso de emergencia
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

AVAILABLE 24 HOURS/7 DAYS A WEEK:

Member Services Department
Toll-Free: 1-800-434-2347

Behavioral Health Services
Toll-Free: 1-877-221-2226

Telecommunication Device for the Deaf
TDD: 711

DISPONIBLE 24 HORAS AL DÍA/7 DÍAS A LA SEMANA:

Departamento de Servicios para Miembros
Gratis: 1-800-434-2347

Servicios de Salud Mental
Gratis: 1-877-221-2226

Dispositivo de telecomunicaciones para sordos
Línea TDD: 711

FOR PROVIDERS

Notice to hospitals and other providers: All inpatient admissions require pre-authorization, except in the case of emergency. Please call Community First within 24 hours at 210-358-6050 or fax to 210-358-6040.

Submit professional/other claims to:
Community First Health Plans
PO Box 240969, Apple Valley, MN 55124

Submit electronic claims to Availity:
Payer ID = COMMF
Pharmacy Help Desk: 1-877-908-6023

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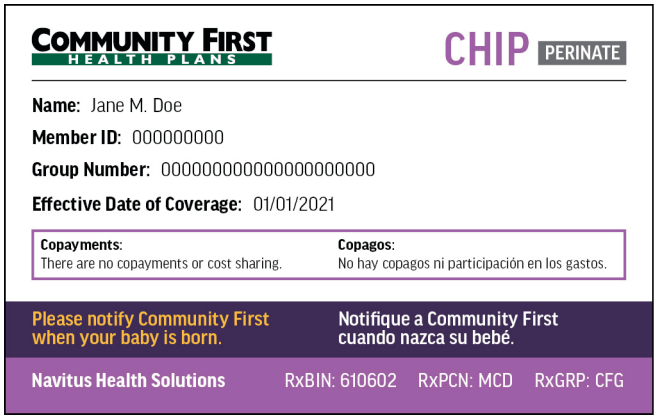
NAVITUS HEALTH SOLUTIONS

YOUR COMMUNITY FIRST MEMBER ID CARD - CHIP PERINATE

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

- Your name.
  - While the CHIP Perinate Member is your unborn child, for purposes of the Member ID card, your name and ID number must be used. At the time of birth, the CHIP Perinate Newborn Member (previously the CHIP Perinate Member) will receive their own ID card and ID number.
- Member ID number.
- Effective date (starting date of coverage under your health care plan).
- Copayment and cost-sharing information. (There are no copayments required for CHIP Perinate Members.)
- 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

CHIP PERINATE

Name: Jane M. Doe

Member ID: 000000000

Group Number: 00000000000000000000

Effective Date of Coverage: 01/01/2021

Copayments: There are no copayments or cost sharing.

Copagos: No hay copagos ni participación en los gastos.

Please notify Community First when your baby is born.

Notifique a Community First cuando nazca su bebé.

Navitus Health Solutions RxBIN: 610602 RxPCN: MCD RxGRP: CFG


Directions for what to do in an emergency
In case of emergency, call 911 or go to the closest emergency room.

AVAILABLE 24 HOURS/7 DAYS A WEEK:

Member Services Department
Toll-Free: 1-800-434-2347

Behavioral Health Services
Toll-Free: 1-877-221-2226

Telecommunication Device for the Deaf
TDD: 711

Instrucciones en caso de emergencia
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana.

DISPONIBLE 24 HORAS AL DÍA/7 DÍAS A LA SEMANA:

Departamento de Servicios para Miembros
Gratis: 1-800-434-2347

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Submit hospital claims to:
Texas Medicaid & Healthcare Partnership Claims
PO Box 200555, Austin, TX 78720-0555

Submit professional/other claims to:
Community First Health Plans
PO Box 240969, Apple Valley, MN 55124

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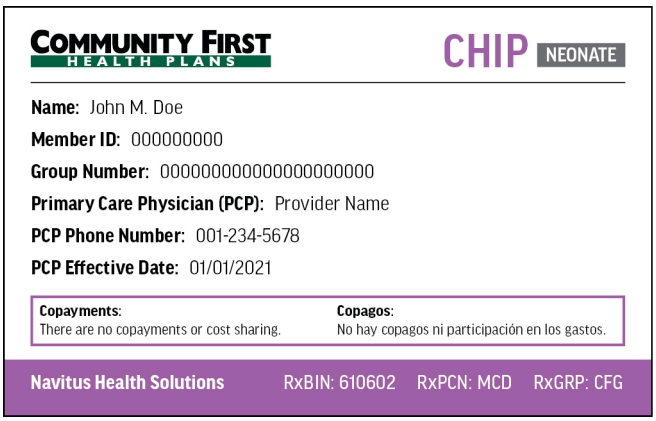
Submit electronic claims to Availity:
Payer ID = COMMF
Pharmacy Help Desk: 1-877-908-6023

NAVITUS HEALTH SOLUTIONS

YOUR COMMUNITY FIRST MEMBER ID CARD - CHIP PERINATE NEWBORN (NEONATE)

The following information can be found on your or your child's CHIP Neonate Member ID card:

- Your child's name.
- Member ID number.
- Effective date (starting date of coverage under your health care plan).
- Your child's primary care provider's (PCP) name and phone number.
- Copayment and cost-sharing information. (There are no copayments required for CHIP Neonate Members.)
- 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

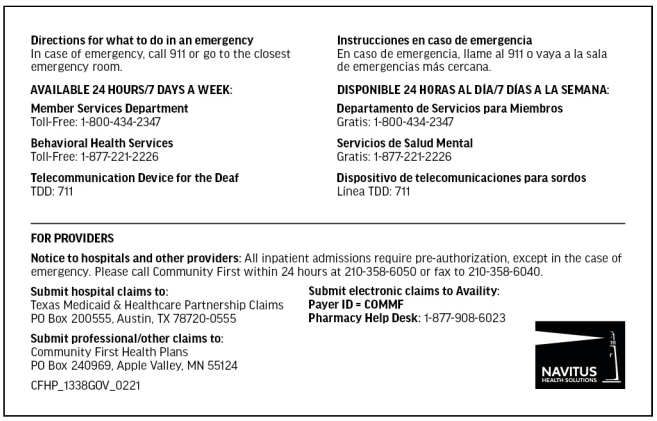
CHIP NEONATE

Name: John M. Doe
Member ID: 000000000
Group Number: 00000000000000000000
Primary Care Physician (PCP): Provider Name
PCP Phone Number: 001-234-5678
PCP Effective Date: 01/01/2021

Copayments:
There are no copayments or cost sharing.

Copagos:
No hay copagos ni participación en los gastos.

Navitus Health Solutions RxBIN: 610602 RxPCN: MCD RxGRP: CFG



Directions for what to do in an emergency
In case of emergency, call 911 or go to the closest emergency room.

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Member Services Department
Toll-Free: 1-800-434-2347

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En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana.

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Gratis: 1-877-221-2226

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Payer ID = COMMF
Pharmacy Help Desk: 1-877-908-6023

NAVITUS HEALTH SOLUTIONS

MEDICALLY NECESSARY

What does Medically Necessary mean?
Covered services for CHIP Members, CHIP Perinate Newborn Members, and CHIP Perinate Members must meet the CHIP definition of "Medically Necessary." **A CHIP Perinate Member is an unborn child.**

Medically Necessary means:

1. Health care services that are:
   a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life;
   b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
   c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
   d) consistent with the Member's diagnoses;
   e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   f) not experimental or investigative; and
   g) not primarily for the convenience of the Member or provider; and
2. 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.

HEALTH INSURANCE AND TRAVEL

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

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

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

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

SPECIALISTS AND REFERRALS

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

What is a referral?
A referral is a written order from your primary care or perinatal provider to see a specialist or get certain medical services. Your primary care or perinatal provider can help you make an appointment. If you need additional help, call Member Services.

What services do not need a referral?

- Behavioral health services
- OB/GYN services
- Vision exams from an optometrist
- Family planning services

Call Community First if you need help finding a network provider or to help you schedule an appointment for any of the services listed above.

How soon can I or my child expect to be seen by a specialist?
You or your child 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, please 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.

How do I get help if I have or my child has behavioral (mental) health or drug problems?
Call the Community First Behavioral Health Hotline at 1-877-221-2226 if you or your child has 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.

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.

Do I need a referral for behavioral health or substance use services?
You do not need a referral for mental health or substance use services. If you or your child has 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.

CASE MANAGEMENT

Who should I call if I have or my child has special health care needs and I need someone to help me?
Community First offers Case Management services to Members with special health care needs. Here are some examples of special needs Case Management can help with:

- High-risk pregnancy
- Neonatal care
- Organ transplant
- Oncology
- Emergency department intervention
- Serious illness
- Behavioral health or substance misuse

If you or your child have special health care needs and need help coordinating care, please contact Member Services. You can also learn more about Case Management on our website.

HEALTH & WELLNESS PROGRAMS

What health education classes does Community First Health Plans offer?
Community First Members have access to educational Health & Wellness Programs at no additional cost. Our Health & Wellness Programs can help provide the information, support, and resources you need to help manage your condition and lead a healthy, full life.

- **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 screenings, 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, 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 counseling, smoking cessation, and exercise classes.

- **Healthy Heart: Blood Pressure Management Program —** Participating Members will receive ongoing, age-appropriate education on high blood pressure; appropriate use of medication, exercise, and kidney disease. Members are also provided a list of community resources offering blood pressure, nutrition, and fitness programs.
- **Healthy Mind: Behavioral Health Management Program** — Participating Members will receive guidance to help decide 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.

You or your child's doctor may recommend that you or your child participate in one of Community First's Health & Wellness programs, or you can participate on your own.

If you are interested in participating or would like to learn more, please visit CommunityFirstHealthPlans.com/Health-And-Wellness-Programs and take our online Health Assessment, call 210-358-6055, or email healthyhelp@cfhp.com.

INTERPRETERS

Can someone interpret for me when I talk with my or my child's doctor or my perinatal provider?
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 1-800-434-2347. Interpreters can be scheduled to help you 24 hours a day, 7 days a week. This includes holidays and weekends.

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

COMPLAINT PROCESS

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us toll-free at 1-800-434-2347 to tell us about your problem.

Can someone from Community First help me file a complaint?
A Community First Member Services Representative can help you file a complaint. Just call 1-800-434-2347. Most of the time, we can help you right away or at the most within a few days. Community First cannot take any action against you as a result of your filing a complaint.

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?
If you file a written complaint, we will mail you a letter acknowledging that we have received your complaint within five days. Then, we will mail you our decision within 30 days.

If I am not satisfied with the outcome, who else can I contact?
If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance (TDI) by calling 1-800-252-3439 toll-free. If you would like to make your request in writing, send it to:

Texas Department of Insurance
Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091

If you can get on the Internet, you can send your complaint in an email to HHS.Texas.gov/Managed-Care-Help.

You can file a complaint with TDI at any time.

You can also file a complaint appeal in writing with Community First by contacting Member Services. If you file a complaint appeal, we will mail you a letter within five calendar days from the date we receive your form. We will then schedule an Appeal Panel hearing.

Do I have the right to meet with the complaint appeal panel?
Five calendar days before the hearing, you will receive a letter with important information about your appeal rights. You may appear before the appeal panel.

After the Appeal Panel hearing, we will send you our answer. We will mail the letter within 30 calendar days from when we received your written appeal.

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 denies or limits it?
Community First may 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 services are 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 our decision. You can also ask for an appeal if Community First denied payment of services in whole or in part.

What are the time frames for the appeal process?
You must request 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 days to tell you that we have received your appeal. We will then mail you our decision within 30 days.

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

Community First will resolve your appeal as soon as possible based on your health condition and no later than the 14-day extension. If you are not happy with the delay, you may file a complaint by calling Member Services at 1-800-434-2347.

How do I file an appeal? Does my request have to be in writing?
You may provide appeal information by phone, in writing, or in person.

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

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

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

EXPEDITED APPEAL PROCESS

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

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

What are the time frames for an expedited appeal?
If we have all the information we need, we will have an answer within one to three days after we receive your appeal.

Does my expedited appeal request have to be in writing?
You may ask for an expedited appeal by phone, in person, or in writing. You also have the right to ask for an extension of up to 14 days if you would like to provide additional information to support your expedited appeal.

What happens if Community First denies the request for an expedited appeal?
We will notify you if we deny your request for an expedited appeal. Your request will be moved to the regular appeal process and we will notify you of the change by mail within two calendar days.

INDEPENDENT REVIEW ORGANIZATION PROCESS

What is an Independent Review Organization?
An Independent Review Organization is a group of doctors who are not employees of Community First. A specialist will review your appeal and make a final decision.

How do I ask for a review by an Independent Review Organization?
Call us to request a review by an Independent Review Organization. You can also request a review in writing.

What are the time frames for this process?
We will mail you the final decision within 15 calendar days from when we received your request for an Independent Review Organization.

WASTE, ABUSE, AND FRAUD

REPORT CHIP WASTE, ABUSE, OR FRAUD

How do I report someone who is misusing or abusing the CHIP Program or services?
Let us know if you think a doctor, dentist, pharmacist at a drugstore, other health care provider, or a person getting CHIP 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 CHIP services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a CHIP ID.
- Using someone else's CHIP ID.
- Not telling the truth about the amount of money or resources someone has 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 and click the red "Report Fraud" box to complete the online form; or
- You can report directly to your health plan:

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

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

CHANGING HEALTH PLANS

CHANGING HEALTH PLANS FOR CHIP MEMBERS

What if I want to change health plans?
You are allowed to make health plan changes:

- for any reason within 90 days of enrollment in CHIP;
- for cause at any time;
- if you move to a different service delivery area; and
- during your annual CHIP re-enrollment period.

Who do I call?
For more information, call CHIP toll-free at 1-800-964-2777.

How many times can I change health plans?
CHIP Members can only change health plans during their first 90 days of enrollment.

When will my health plan change become effective?
Changes take between 15 and 45 days.

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.

CHANGING HEALTH PLANS FOR CHIP PERINATE NEWBORN AND CHIP PERINATE MEMBERS

Attention: If you meet certain income requirements, your baby will be moved to Medicaid and get 12 months of continuous Medicaid coverage from date of birth. Your baby will keep receiving services through the CHIP Program if you meet the CHIP Perinatal requirements. Your baby will get 12 months of continuous CHIP Perinatal coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

What if I want to change health plans?

- Once you pick a health plan for your unborn child, the child must stay in this health plan until the child's CHIP Perinatal coverage ends. The 12-month CHIP Perinatal coverage begins when your unborn child is enrolled in CHIP Perinatal and continues after your child is born.
- If you do not pick a plan within 15 days of getting the enrollment packet, the Texas Health and Human Services Commission (HHSC) will pick a health plan for your unborn child and send you information about that health plan. If HHSC picks a health plan for your unborn child, you will have 90 days from your effective date of coverage to pick another health plan if you are not happy with the plan HHSC chooses.
- The child or children must stay with the same health plan until the end of the CHIP Perinatal Member's enrollment period, or the end of the other child or children's enrollment period, whichever happens last. At that point, you can pick a different health plan.
- You can ask to change health plans:
  - for any reason within 90 days of enrollment in CHIP Perinatal;
  - if you move into a different service delivery area; and
  - for cause at any time.

Who do I call?
For more information, call toll-free at 1-800-964-2777.

How many times can I change health plans?
CHIP Perinatal Members can change their plans for their first 120 days of enrollment.

When will my health plan change become effective?
Changes take between 15 and 45 days.

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.

CHANGE OF ADDRESS

What do I have to do if I move/my child moves?
As soon as you have your new address, give it to HHSC by calling 211 or updating your account on YourTexasBenefits.com and call Community First Health Plans' Member Services Department at 1-800-434-2347.

Before you get CHIP 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.

SECTION II

CHIP / CHIP PERINATE NEWBORN

References to “you,” “my,” or “I” apply if you are a CHIP Member.
References to “my child” apply if your child is a CHIP Member or a CHIP Perinate Newborn Member.

PRIMARY CARE PROVIDER (PCP)

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

A PCP can be a:

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

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

CHOOSING A PRIMARY CARE PROVIDER

How can I or my child get a primary care provider?
You can choose a PCP from our CHIP Provider Directory at CommunityFirstMedicaid.com. You can also call Member Services if you need help. If you do not choose a PCP for you or your child, one will be selected for you.

When and why should my I or my child see a primary care provider?
Your or your child's PCP is your or your child's best resource for health advice. You or your child should see your or your child's PCP regularly, even if you or your child are healthy. Your or your child's PCP can provide needed preventive care and recommend certain screenings depending on health factors.

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

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

What if I choose to go to another doctor who is not my or my child's primary care provider?
If you go to another doctor, you might be asked to either pay the bill or sign a form that says you will pay the bill. For routine care, you should always go to your or your child's PCP.

How do I get medical care after my or my child's primary care provider's office is closed?
If you have an urgent problem, call your or your child's PCP first. You can leave a message and expect a callback. Your or your child's PCP or a doctor on-call is available to you, either in-person or by phone, 24 hours a day, 7 days a week.

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

CHANGING YOUR OR YOUR CHILD'S 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 PCP. Call Member Services toll-free at 1-800-434-2347.

You can also submit a request to change your or your child's 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 primary care providers in the Community First network, visit our CHIP Provider Directory at CommunityFirstMedicaid.com. You can also call Member Services if you have questions about your or your child's PCP's professional qualifications or for a current list of 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 PCP. You can change PCPs by calling Member Services toll-free at 1-800-434-2347.

You can also submit a request to change your or your child's 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

When will my or my child's primary care provider change become effective?
If you change your or your child's PCP, 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 or your child's PCP 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 PCP, please call Member Services and tell us the name of the doctor you want.

If you or your child is receiving medically necessary treatments, you might be able to stay with your or your child's current doctor, even if they leave our network, if the doctor is 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 or your child's doctor.

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

- The doctor you chose does not take patients with your or your child's needs.

- The doctor you chose is not accepting new patients.
- You or your child is in the hospital when you make the request.

Can my primary care provider move me or my child 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 you do not contact the doctor before a missed appointment.
- You do not follow the doctor's advice.
- You are rude, abusive, or do not work with the doctor or the doctor's staff.

PHYSICIAN INCENTIVE PLAN INFORMATION

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

MAKING AN APPOINTMENT

How do I make an appointment with my or my child's primary care provider?
Call your or your child's PCP to make an appointment. You can find their phone number on your Community First Member ID card. Tell your or your child's PCP's office that you are a Community First Health Plans CHIP Member and have your Community First Member ID 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
- Immunization (shot) records
- A list of all medications you or your child are currently taking
- Community First Health Plan's checkup checklist

We care about your health. Preventive care services like regular health checkups help your PCP get to know you or your child so they can recommend appropriate screenings and help plan for future health care needs.

COMMUNITY FIRST CHECKUP CHECKLIST

What To Ask At Your Health Checkup

5 questions to ask your Primary Care Provider (PCP)

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

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

TYPES OF MEDICAL CARE

ROUTINE MEDICAL CARE

What is routine medical care?

Routine medical care is the regular care you or your child gets from your or your child's primary care provider (PCP) to help keep you or your child healthy, such as regular checkups. You can call your or your child's PCP to make an appointment for routine medical care. Routine medical care includes:

- Regular checkups
- Immunizations
- 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 or your child's PCP to make an appointment for routine medical care including regular health checkups.

How soon can I or my child expect to be seen?

You can expect to be seen by your or your child's PCP within two weeks after requesting a routine appointment.

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/strains

What should I do if I or my child needs urgent medical care?
For urgent medical care, you should call your or your child's PCP's office, even on nights and weekends. Your or your child's doctor will tell you what to do. In some cases, your or your child's doctor may tell you to go to an urgent care clinic.

You also can call our 24-hour Nurse Advice Line at 1-800-434-2347 for help with getting the care you or your child needs.

How soon can I expect to be seen?
You or your child should be able to see your or your child's doctor within 24 hours for an urgent care appointment. If your or your child's doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. For a list of network urgent care clinics, please visit CommunityFirstMedicaid.com.

EMERGENCY MEDICAL CARE

What is an Emergency, an Emergency Medical Condition, and an Emergency Behavioral Health Condition?
Emergency care is a covered service. Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

"Emergency Medical Condition" is a medical condition characterized by sudden acute symptoms, severe enough (including severe pain) that would lead an individual with average knowledge of health and medicine, to expect that the absence of immediate medical care could result in:

- placing the Member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant CHIP Member, serious jeopardy to the health of the CHIP Member 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 an individual, possessing average knowledge of health and medicine:

- requires immediate intervention or medical attention without which the Member would present an immediate danger to themself or others; or
- renders the Member incapable of controlling, knowing, or understanding the consequences of their actions.

What is Emergency Services or Emergency Care?
"Emergency services" and "emergency care" mean health care services provided in an in-network or out-of-network hospital emergency department, free-standing emergency medical facility, or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize Emergency Medical Conditions or Emergency Behavioral Health Conditions. Emergency services also include any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency Medical Condition or an Emergency Behavioral Health Condition exists.

What is post-stabilization?
Post-stabilization care services are services covered by CHIP that keep the Member's condition stable following emergency medical care.

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

EMERGENCY DENTAL CARE

What do I do if I need 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 has closed, call us toll-free at 1-800-434-2347.

More information about routine dental care can be found in this Member Handbook.

WOMEN'S HEALTH SERVICES

OB/GYN CARE

ATTENTION MEMBERS

What if I or my child needs OB/GYN care? Do I or my child have the right to choose an OB/GYN?
You have the right to pick an OB/GYN for yourself or for your daughter without a referral from your or your daughter's primary care provider. An OB/GYN can give you:

- One well-woman checkup per year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to special doctor (specialist) within the network.

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.

How do I choose an OB/GYN?
You can find a list of available OB/GYN doctors from the CHIP Provider Directory at CommunityFirstMedicaid.com. You can also call Member Services at 1-800-434-2347 if you need help choosing an OB/GYN.

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

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

- If your OB/GYN is not in our network and you are **NOT** pregnant, you will have to pick a new OB/GYN from the CHIP 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.

How soon can I or my daughter be seen after contacting an OB/GYN for an appointment?
You or she should be able to get an appointment within two weeks of the request.

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, like 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.

CARE DURING PREGNANCY

What if I or my daughter is pregnant?
You or your daughter should make an appointment with a network OB/GYN. You or your daughter do not need a referral from your or her primary care provider, nor do you need to check first with Community First.

Who do I need to call?
Call Member Services if you need help choosing an OB/GYN.

What other services/activities/education does Community First offer pregnant women?
Community First Health Plans offers pregnant women access to a special maternity program called Healthy Expectations. Take our online Pregnancy Health Assessment to join, and you can earn giveaways and other products to help you throughout your pregnancy journey and after you welcome your new baby.

Healthy Expectations Maternity Program is offered at no-cost to Community First Members. Learn more about Healthy Expectations in this Member Handbook or visit CommunityFirstHealthPlans.com/Health-and-Wellness-Programs.

COST-SHARING

What is a copayment?
A copayment is a fixed amount (for example, $15) you pay for a covered health care service or prescription drug, usually when you or your child receives the service.

How much are they and when do I have to pay them?
The amount can vary by the type of covered health care service. Some services have no copayments. Your or your child's Community First Member ID card lists your copayment amount. Be sure to present the ID card when you seek services for your child.

Copayments do not apply, at any income level, to:

- Well-baby and well-child care services;
- Preventive services, including immunizations;
- Pregnancy-related services;
- Office visits and residential treatment services for mental health conditions and substance use disorders;
- Native Americans or Alaskan Natives*; and
- CHIP Perinatal Members [Perinates (unborn children) and Perinate Newborns].

*If you or your child is Native American or Alaskan Native, you are exempt from all cost-sharing obligations, including enrollment fees and copayments. If your or your child's Member ID card shows a copayment requirement and you or your child is Native American or Alaskan Native, call Community First Member Services and we will correct it for you.

MEMBER BILLING

What if I get a bill from my or my child's doctor?
As a CHIP Member, you may be responsible for a part of your bill called a copayment each time you get certain health care. You might also receive a bill if you go to a doctor who is not in the Community First network or 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?
If you feel you have a received a medical bill in error, please call Member Services. 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.

COPAYMENTS

There are some limits to how much you pay for copayments. See the following chart.

CHIP COST-SHARING	
	Effective January 1, 2014
ENROLLMENT FEES (FOR 12-MONTH ENROLLMENT PERIOD)	
	CHARGE
At or below 151% of FPL*	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
COPAYS (PER VISIT)	
AT OR BELOW 151% OF FPL	**CHARGE:**
Office Visit (non-preventative)	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Copay, Inpatient (per admission)	$35
Cost-sharing Cap	5% (of family's income)**
ABOVE 151% UP TO AND INCLUDING 186% FPL	**CHARGE**
Office Visit (non-preventative)	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Copay, Inpatient (per admission)	$75
Cost-sharing Cap	5% (of family's income)**
ABOVE 186% UP TO AND INCLUDING 201% FPL	**CHARGE**
Office Visit (non-preventative)	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Copay, Inpatient (per admission)	$125
Cost-sharing Cap	5% (of family's income)**

**The federal poverty level (FPL) refers to income guidelines established annually by the federal government.*

***Per 12-month term of coverage.*

CHIP 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. Please review the chart below to learn more about the Value-Added Services available to you as a Community First Member in the CHIP Program.

How can I get these benefits?
To learn how you can receive these added benefits as a Community First Member in the CHIP Program, please call 210-358-6055.

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
24-hour Nurse Advice Line staffed by registered nurses who are ready to answer your health-related questions every day, including weekends and holidays. Members can call the Nurse Advice Line at 1-800-434-2347. Deaf or hard of hearing can call 711.	
Extra Help Getting a Ride (bus passes) for Members, their siblings, and their parents or legal guardians to places, such as: • The doctor • The grocery store • Community-based services • Polling sites • Community First hosted events • Health education classes • Member Advisory Group meetings • WIC • Social Security Administration offices • Community offices that help find employment and housing • Social Security Administration-approved physician for appointments requested for disability determination and services	*Bus passes are not provided to children ages 0 through 18 unless they are with their parent or guardian. This service is available only for bus service routes within San Antonio, and routes are offered by VIA Metropolitan Transit.*
Extra Dental Services, including: • Low-cost dental exams, x-rays, and discounts on other dental/orthodontic services.	*Limited to 10% discount. No maximum benefit amount. For Members ages 21 through 999 and their family members with no dental coverage.*

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Extra Vision Services, including: • Up to $125 for frames or $75 for contact lenses	*Applies to either frames or contact lenses and must be medically necessary. Available every year for Members ages 0 through 18. Glasses or contacts can only be replaced when there is a change in vision. Lost or broken glasses or contacts may be replaced as allowed by the Benefit Program.*
Disease Management, including:	
• Diabetes Prevention Program: A no-cost, yearlong program that helps Members reduce their risk of type 2 diabetes through healthier eating, increased physical activity, and support from a Lifestyle Coach. Members complete a risk assessment, track nutrition and exercise, and participate in a diabetes evaluation. Members who attend at least four sessions receive a complimentary 4-month YMCA membership.	*Limited to Members age 18 at risk of developing type 2 diabetes. Community First Health Educators provide education, coaching, motivation, and ongoing support to help Members stay engaged, overcome barriers, and achieve their health goals throughout the program and four-month YMCA membership.*
• Weight Loss Program: A 10-week program that helps Members improve nutrition, increase physical activity, manage stress, and build healthier habits. Members who attend at least four sessions receive a complimentary 4-month YMCA membership.	*Limited to Members ages 13-18 (unless otherwise indicated in the program) with a signed release by the Member or by the Member's Legal Authorized Representative if under the age of 18. Community First Health Educators provide education, coaching, motivation, and ongoing support to help Members stay engaged, overcome barriers, and achieve their health goals throughout the program and four-month YMCA membership.*
• Blood Pressure Program: A program that helps Members build healthy blood pressure habits through self-monitoring, nutrition education, and support from a Lifestyle Coach. Members receive a free blood pressure cuff, and those who attend all four sessions earn a complimentary 4-month YMCA membership.	*Limited to Members age 18. Community First Health Educators provide education, coaching, motivation, and ongoing support to help Members stay engaged, overcome barriers, and achieve their health goals throughout the program and four-month YMCA membership.*
• Extra diabetes education through the Diabetes Garage series	*Diabetes Garage is limited to male Members ages 18 and up participating in the Diabetes in Control: Diabetes Management Program.*
• $50 gift card and health and wellness items for caregivers or Members who complete six in-person or virtual National Alliance on Mental Illness (NAMI) Basics classes about supporting a loved one with a mental health condition	*Limited to caregivers caring for Members or Members caring for their children, ages 0 through 18, with a diagnosed mental health condition.*

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Drug Store Services/Over-the-Counter Benefits • One-time $50 allowance for over-the-counter items, including household, personal care, oral care and children's items, for Members actively participating in Complex Case Management for more than 60 days	*Gift card excludes beer, wine, alcohol, cigarettes, and items covered in the plan's pharmacy benefit.*
Sports and School Physicals • One free physical per calendar year to be used for sports, school, or other physical activities	*For Members ages 0 through 18. Provider may perform the physical in conjunction with a CHIP well-child checkup or an acute care visit.*
Help for Members with Asthma who participate in Asthma Matters: Asthma Management Program, including: • 1 adult or child-size mask with an aerosol chamber each year, once CHIP benefit limit is reached • 1 allergy-free protector pillowcase each year • 1 mattress cover each year to protect against allergies and keep dust and pollen out • $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 for high-risk Members who participate in Community First Health & Wellness Programs, including Asthma Matters, Diabetes in Control, Healthy Mind, and Healthy Expectations	*Home visits are contingent upon medical necessary determination and vary from Member to Member.*

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Healthy Play and Exercise Programs, including: • Free virtual and in-person Zumba classes for Members and their families with a free fitness giveaway (choice of a frisbee, water bottle, or exercise band) • Free virtual and in-person breakdancing classes for Members and their families with a giveaway (choice of frisbee, water bottle, or exercise band) • Education on bicycle maintenance, safety tips, and giveaway through a free, local bike safety and repair program	
Health and Wellness Services, including: • Free toddler booster seat for children age 4 through 10 who are current with their CHIP well-child 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 • Free, local health education events (in-person and virtual) on topics including telehealth, healthy habits, and new benefits • GED program to help Members age 18 through 999 earn a GED certificate, plus extra academic and career support to empower Members entering the workforce	*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.* *Members in the GED program must:* • *Be legally able to work in the United States.* • *Have photo identification.* • *Take all program-related assessments.* • *Commit to completing the program.*
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 excludes beer, wine, alcohol, cigarettes, and items covered in the plan's pharmacy benefit.*

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Behavioral Health - Online Mental Health Resources • A webpage that helps Members find mental health care, covered services, community support, and rewards for staying active in their care. Visit at CommunityFirstMedicaid.com	
Gift Programs, including: • Up to $25 in gift cards for completing the Community First Health Assessment and receiving Meningococcal, Tdap, and HPV adolescent immunization series (for children ages 9 through 13) • $25 gift card for Members ages 6-24 months who get the full series of the flu vaccine and complete the Community First Health Assessment • $10 gift card for new Community First CHIP Members who complete the Community First Health Assessment and provide an email address • Up to $20 in gift cards for Members (ages 0 through 24 months) who complete a health survey and get recommended childhood vaccine series • Up to $20 in gift cards for completion of the Rotavirus immunization series for Members ages 42 days through 8 months old • Up to $90 in gift cards for completing Texas Health Steps checkups at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. ($10 gift card per checkup) • Up to $180 in gift cards for completing Texas Health Steps checkups at ages 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 ($10 gift card per checkup) and completing the Community First Health Assessment	*Gift card excludes beer, wine, alcohol, cigarettes, and items covered in the plan's pharmacy benefit.* *Recommended vaccine series includes:* • 4 DTaP • 3 IPV • 1 MMR • 3 HiB • 3 HepB • 1 VZV • 4 PCV • 1 HepA

CHIP VALUE-ADDED SERVICES	
VALUE-ADDED SERVICE	**RESTRICTIONS/LIMITATIONS**
Gift Programs, continued: • 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 • Up to $20 for Members (ages 1 through 17) in Community First's Healthy Mind: Behavioral Health Program who have filled two or more antipsychotics and get metabolic testing. • $25 gift card per year for Members ages 6 through 12 in Healthy Mind: Behavioral Health Program who follow up with their doctor within 30 days of starting ADHD medication	*Gift card excludes beer, wine, alcohol, cigarettes, and items covered in the plan's pharmacy benefit.*

CHIP PLAN BENEFITS

What are my or my child's health care benefits?
Use the chart beginning on the following page to review your or your child's covered benefits as a Community First Health Plans CHIP Member.

How do I get these services? How do I get these services for my child?
Your or your child's 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 or your child's doctor or referred by your or your child's doctor to another provider.

Are there any limits to any covered services?
Some covered services do have limitations. You can review limitations on covered services in the "Limitations" column in the chart below.

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
INPATIENT GENERAL ACUTE AND INPATIENT REHABILITATION HOSPITAL SERVICES Services include: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as approved by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications, and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to Texas Department of State Health Services (DSHS)-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for at least 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. • Hospital, physician, and related medical services, such as anesthesia, associated with dental care.	• **Requires authorization** for non-emergency care and care following stabilization of an emergency condition. • **Requires authorization** for in-network or out-of-network facilities and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarean section.	Applicable level of inpatient copayment per admission.

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ◦ dilation and curettage (D&C) procedures; ◦ appropriate provider-administered medications; ◦ ultrasounds; and ◦ histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and/or palate; or ◦ severe traumatic, skeletal and/or congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: ◦ all stages of reconstruction on the affected breast; ◦ surgery and reconstruction on the other breast to produce symmetrical appearance; and ◦ treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the Durable Medical Equipment (DME) 12-month period limit.		
SKILLED NURSING FACILITIES (INCLUDES REHABILITATION HOSPITALS) Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	• **Requires authorization** and physician prescription. • 60 days per 12-month period limit.	None

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
OUTPATIENT HOSPITAL, COMPREHENSIVE OUTPATIENT REHABILITATION HOSPITAL, CLINIC (INCLUDING HEALTH CENTER), AND AMBULATORY HEALTH CARE CENTER Services include, but are not limited to, the following services provided in a hospital clinic or emergency department, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ◦ dilation and curettage (D&C) procedures; ◦ appropriate provider-administered medications; ◦ ultrasounds; and ◦ histological examination of tissue samples.	**May require prior authorization** and physician prescription.	Applicable level of copayment for generic drugs and for brand drugs.

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and/or palate; or ◦ severe traumatic, skeletal and/or congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: ◦ all stages of reconstruction on the affected breast; ◦ surgery and reconstruction on the other breast to produce symmetrical appearance; and ◦ treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit		

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
PHYSICIAN OR PHYSICIAN EXTENDER PROFESSIONAL SERVICES Services include, but are not limited to the following: • American Academy of Pediatrics-recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Physician office visits, in-patient and outpatient services • Laboratory, X-rays, imaging, and pathology services, including technical component, and/or professional interpretation • Medications, biologicals, and materials administered in physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: ◦ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care ◦ Administration of anesthesia by physician (other than surgeon) or CRNA ◦ Second surgical opinions ◦ Same-day surgery performed in a hospital without an overnight stay ◦ Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician-performed technical and interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: ◦ all stages of reconstruction on the affected breast; ◦ surgery and reconstruction on the other breast to produce symmetrical appearance; and ◦ treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network physician services for a mother and her newborn(s) for at least 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section.	• **May require authorization** for specialty services.	Applicable level of copayment for office visits.

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
• Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation. • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: ◦ dilation and curettage (D&C) procedures; ◦ appropriate provider-administered medications; ◦ ultrasounds; and ◦ histological examination of tissue samples. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and/or palate; or ◦ severe traumatic, skeletal, and/or congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions, and/or tumor growth or its treatment.		
BIRTHING CENTER SERVICES	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery).	None
SERVICES RENDERED BY A CERTIFIED NURSE MIDWIFE OR PHYSICIAN IN A LICENSED BIRTHING CENTER	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.	None

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
DURABLE MEDICAL EQUIPMENT (DME), PROSTHETIC DEVICES, AND DISPOSABLE MEDICAL SUPPLIES Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to help in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe opthalmologic disease • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements	• **May require prior authorization** and physician prescription. • $20,000 per 12-month period limit for DME, prosthetics, devices, and disposable medical supplies (implantable devices, diabetic supplies, and equipment are not counted against this cap).	None

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
HOME AND COMMUNITY HEALTH SERVICES Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN) • Skilled nursing visits as defined for home health purposes (may include RN or LVN) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical, and occupational therapies	• **Requires prior authorization** and physician prescription. • Services are not intended to replace the child's caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on an intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services.	None
INPATIENT MENTAL HEALTH SERVICES Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state operated facilities, including but not limited to: • Neuropsychological and psychological testing.	• **Requires prior authorization** for non-emergency services. • Does not require PCP referral. • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code relating to court ordered commitments to psychiatric facilities, the court-ordered serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	None

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
OUTPATIENT MENTAL HEALTH SERVICES Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.	• **May require prior authorization.** • Does not require PCP referral. • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services per DSHS standards.	None

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
OUTPATIENT MENTAL HEALTH SERVICES, CONT'D	Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	
INPATIENT SUBSTANCE MISUSE TREATMENT SERVICES Inpatient substance misuse treatment services include, but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.	• **Requires prior authorization** for non-emergency services. • Does not require PCP referral.	None
OUTPATIENT SUBSTANCE MISUSE TREATMENT SERVICES Outpatient substance misuse treatment services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment, and referral for chemical dependency disorders. • Intensive outpatient services ◦ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. ◦ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training. • Partial hospitalization	• **May require prior authorization.** • Does not require PCP referral.	None

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
REHABILITATION SERVICES Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational, and speech therapy • Developmental assessment	**Requires prior authorization** and physician prescription.	None
HOSPICE CARE SERVICES Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services	• **Requires authorization** and physician prescription. • Services apply to the hospice diagnosis. • Up to a maximum of 120 days with a 6-month life expectancy. • Patients electing hospice services may cancel this election at any time.	None
EMERGENCY SERVICES, INCLUDING EMERGENCY HOSPITALS, PHYSICIANS, AND AMBULANCE SERVICES Covered services include: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	• **Requires authorization** for post-stabilization services. • Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.	Applicable level of copayment for non-emergency ER.

CHIP HEALTH CARE BENEFITS		
COVERED SERVICE	**LIMITATIONS**	**COPAYMENT**
TRANSPLANTS Covered services include: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow, and peripheral stem cell transplants, including donor medical expenses.	**Requires authorization.**	None
VISION BENEFIT Covered services include: • One examination of the eyes to see if there is a need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	• The health plan may reasonably limit the cost of the frames/lenses. • **Does not require authorization** for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	Applicable level of copayment for office visit.
CHIROPRACTIC SERVICES Covered services do not require physician prescription and are limited to spinal subluxation	• **Does not require authorization** for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit). • **Requires authorization** for additional visits.	Applicable level of copayment for office visit.

CHIP PERINATE NEWBORN PLAN BENEFITS

What are my newborn's health care benefits?
Use the chart on the following page to review your newborn's benefits as a CHIP Perinate Newborn Member.

How do I get these services for my child?
Your newborn's primary care provider will work with you to make sure your newborn gets the services they need. These services must be given by your newborn's doctor or referred by your newborn's doctor to another provider.

What benefits does my baby receive at birth?
Your newborn will receive benefits under the CHIP Perinate Newborn Program as outlined in the chart on the following page.

Are there any limits to any covered services?
Some covered services do have limitations. You can review limitations on covered services in the "Limitations" column in the chart on the following page.

What is a copayment? How much are they and when do I have to pay them?
Copayments do not apply, at any income level, to CHIP Perinate Newborn Members.

MEMBER BILLING

What if I get a bill from my child's doctor?
You should not get a bill from your child's doctor for any services covered under the CHIP Perinate Newborn Program. You might receive a bill if you go to a doctor who is not in the Community First network or if your child receives 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.

CHIP PERINATE NEWBORN HEALTH BENEFITS	
COVERED SERVICE	**LIMITATIONS**
INPATIENT GENERAL ACUTE AND INPATIENT REHABILITATION HOSPITAL SERVICES Covered services include, but are not limited to, the following: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as approved by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications, and biologicals • Blood or blood products that are not provided free of charge to the patient and their administration • X-rays, imaging, and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for at least 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section • Hospital, physician, and related medical services, such as anesthesia, associated with dental care • Surgical implants.	• **Requires authorization** for non-emergency care and care following stabilization of an emergency condition. • **Requires authorization** for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarean section.

CHIP PERINATE NEWBORN HEALTH BENEFITS	
COVERED SERVICE	**LIMITATIONS**
• Other artificial aids including surgical implants • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and/or palate; or ◦ severe traumatic, skeletal and/or congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	
SKILLED NURSING FACILITIES (INCLUDES REHABILITATION HOSPITALS) Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	• **Requires authorization** and physician prescription. • 60 days per 12-month period limit.

CHIP PERINATE NEWBORN HEALTH BENEFITS	
COVERED SERVICE	**LIMITATIONS**
OUTPATIENT HOSPITAL, COMPREHENSIVE OUTPATIENT REHABILITATION HOSPITAL, CLINIC (INCLUDING HEALTH CENTER) AND AMBULATORY HEALTH CARE CENTER Services include but are not limited to the following services provided in a hospital clinic or emergency department, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications, and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational, and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free of charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Surgical implants • Other artificial aids including surgical implants • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and/or palate; or ◦ severe traumatic, skeletal and/or congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	• **May require authorization** and physician prescription.

CHIP PERINATE NEWBORN HEALTH BENEFITS	
COVERED SERVICE	**LIMITATIONS**
PHYSICIAN/PHYSICIAN EXTENDER PROFESSIONAL SERVICES Services include, but are not limited to the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) • Physician office visits, in-patient and out-patient services • Laboratory, x-rays, imaging and pathology services, including technical component, and professional interpretation • Medications, biologicals, and materials administered in physician's office • Allergy testing, serum, and injections • Professional component (in/outpatient) of surgical services, including: ◦ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care ◦ Administration of anesthesia by physician (other than surgeon) or CRNA ◦ Second surgical opinions ◦ Same-day surgery performed in a Hospital without an over-night stay ◦ Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including physician-performed technical and interpretive components) • In-network and out-of-network physician services for a mother and her newborn(s) for at least 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. • Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ◦ cleft lip and/or palate; or ◦ severe traumatic, skeletal and/or congenital craniofacial deviations; or ◦ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	• **May require authorization** for specialty services.

CHIP PERINATE NEWBORN HEALTH BENEFITS	
COVERED SERVICE	**LIMITATIONS**
SERVICES RENDERED BY A CERTIFIED NURSE MIDWIFE OR PHYSICIAN IN A LICENSED BIRTHING CENTER	• Covers services rendered to a newborn immediately following delivery.
DURABLE MEDICAL EQUIPMENT (DME), PROSTHETIC DEVICES AND DISPOSABLE MEDICAL SUPPLIES Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness, injury, or disability; and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to help in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.	• **May require prior authorization** and physician prescription. • $20,000 12-month period limit for DME, prosthetics, devices, and disposable medical supplies (diabetic supplies and equipment are not counted against this cap).
HOME AND COMMUNITY HEALTH SERVICES Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (RN, LVN) • Skilled nursing visits as defined for home health purposes (may include RN, LVN). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies	• **Requires prior authorization** and physician prescription. • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on an intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services.

CHIP PERINATE NEWBORN HEALTH BENEFITS	
COVERED SERVICE	**LIMITATIONS**
REHABILITATION SERVICES Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational, and speech therapy • Developmental assessment	• **Requires prior authorization** and physician prescription.
HOSPICE CARE SERVICES **Services include, but are not limited to:** • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.	• **Requires authorization** and physician prescription. • Services apply to the hospice diagnosis. • Up to a maximum of 120 days with a six-month life expectancy. • Patients electing hospice services may cancel this election at any time.
EMERGENCY SERVICES, INCLUDING EMERGENCY HOSPITALS, PHYSICIANS, AND AMBULANCE SERVICES Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include but are not limited to the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.	• **Requires authorization** for post-stabilization services.
TRANSPLANTS Services include but are not limited to the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow, and peripheral stem cell transplants, including donor medical expenses.	**Requires authorization**.

CHIP PERINATE NEWBORN HEALTH BENEFITS	
COVERED SERVICE	**LIMITATIONS**
VISION BENEFIT Services include: • One examination of the eyes to see if there is a need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	• The health plan may reasonably limit the cost of the frames/lenses. • **Does not require authorization** for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.
CHIROPRACTIC SERVICES Covered services do not require physician prescription and are limited to spinal subluxation	• **Does not require authorization** for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit). • **Requires authorization** for additional visits.
CASE MANAGEMENT AND CARE COORDINATION SERVICES	• These services include outreach, informing, Care Management, Care Coordination and community referral.

HEALTH CARE SERVICES NOT COVERED

What services are not covered by CHIP/CHIP Perinate Newborn?
The following is a list of services NOT covered under either the CHIP or CHIP Perinate Newborn programs.

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e., cannot be prescribed for family planning).
- Personal comfort items, including but not limited to, personal care kits provided on inpatient admission, phone, television, newborn infant photographs, meals for guests of patient, and other articles that are not needed for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical, or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization.
- Treatment or evaluations needed by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance, or court.
- Dental devices solely for cosmetic purposes.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan.

HEALTH CARE SERVICES NOT COVERED

- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care and doctor, clinic, or primary care provider services for a mother and her newborn(s) for at least 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section.
- Services, supplies, meal replacements, or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy, and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses, or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment because of misuse, abuse, or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse that do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a physician/PCP.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

DURABLE MEDICAL EQUIPMENT

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

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

PRESCRIPTION DRUG BENEFITS

How do I get my or my child's medications?
CHIP covers most of the medicine your or your child's doctor says you need. Your or your child's doctor will write a prescription so you can take it to the drugstore, or they may be able to send the prescription to the drugstore for you.

Exclusions include contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain.

You may have to pay a copayment for each prescription filled depending on your income. **There are no copayments required for CHIP Perinate Newborn Members.**

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

What if I can't get my or my child's prescription approved?
If your or your child's doctor cannot be reached to approve a prescription, you or your child may be able to get a three-day emergency supply of your or your child's medication.

Call Community First Member Services at 1-800-434-2347 for help with your medication and refills.

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

NETWORK DRUG STORES

How do I find a network drugstore?
You can call Member Services for help finding a network drugstore. You can also find a list of network drugstores by using our Pharmacy Locator at CommunityFirstMedicaid.com.

What do I bring with me to the drugstore?
You should bring your or your child's Community First Health Plans Member ID card and your or your child's prescription.

What if I go to a drugstore not in-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 or my child's medications delivered to me or my child?
You may be able to get your or your child's medications delivered to you through the mail. Community First's partner for pharmacy benefits is Navitus. Their mail-order partner is H-E-B. Please call Member Services at 1-800-434-2347 if you'd like to see if your drugstore offers medication delivery by mail.

OVER-THE-COUNTER MEDICATION

What if I or my child needs over-the-counter medication?
The pharmacy cannot give you an over-the-counter medication as part of your or your child's CHIP or CHIP Perinate Newborn benefits. If you need or your child needs an over-the-counter medication, you will have to pay for it.

BIRTH CONTROL PILLS

What if I or my child needs birth control pills?
The drugstore cannot give you or your child birth control pills to prevent pregnancy. You or your child can only get birth control pills if they are needed to treat a medical condition.

VISION SERVICES

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

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

DENTAL SERVICES

EMERGENCY DENTAL SERVICES

How do I get dental services for my child?
Community First Health Plans will pay for some emergency dental services in a hospital or ambulatory surgical center. Community First will pay for the following:

- Treatment of a dislocated jaw.
- Treatment of 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.

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

The CHIP medical benefit provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth and removal of cysts; treatment of oral abscess of tooth or gum origin, treatment and devices for craniofacial anomalies, and drugs.

ROUTINE DENTAL SERVICES

Your child's CHIP dental plan provides all other dental services, including services that help prevent tooth decay and services that fix dental problems. You may pick the Dental Maintenance Organization (DMO) of your choice.

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

Call your child's CHIP dental plan to learn more about the dental services they offer. You can also call Member Services for help making a routine dental appointment or for more information.

EARLY CHILDHOOD INTERVENTION

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

Do I need a referral for this?
You can ask for a referral from your child's primary care provider for ECI services. However, a referral is not required. You can call ECI directly and 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.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment depending on your income. Copayments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. 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.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals, and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have the 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.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.
20. 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.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other provider's copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other Members, or health plans.
9. You must talk to your provider about your medications that are prescribed.

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

SECTION III

CHIP PERINATE

References to “you,” “my,” or “I” apply if you are a CHIP Member.
References to “my child” apply if your child is a CHIP Member or a CHIP Perinate Newborn Member.

PERINATAL AND PRIMARY CARE PROVIDERS

We care about your health and well-being and that of your unborn baby. Prenatal care is essential to helping create better health outcomes for you and your baby.

PERINATAL PROVIDERS

How do I choose a perinatal provider?
You can find a list of available perinatal providers from our online CHIP Perinate Provider Directory on our website, CommunityFirstMedicaid.com. If you need help choosing a perinatal provider, you can also contact Member Services for assistance.

Can a clinic (Rural Health Clinic/Federally Qualified Health Center) be my perinatal provider?
Yes. You may pick a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as your perinatal provider.

Do I need a referral?
You do not need a referral to see a perinatal provider.

What do I need to bring to my appointment?
You should bring your Community First Member ID card.

How soon can I be seen after contacting a perinatal provider for an appointment?
You expect to be seen for perinatal care within two weeks.

How do I get medical care after hours?
If you have an urgent problem, call your perinatal provider's office first. You can leave a message and expect a call back. Your perinatal provider or a doctor on-call is available either in-person or by phone, 24 hours a day, seven days a week.

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

Can I stay with my perinatal provider if they are not with Community First Health Plans?
You will need to choose a new perinatal provider from Community First if your current perinatal provider is not in our network. Call Member Services or pick a new perinatal provider online.

CHOOSING A PRIMARY CARE PROVIDER FOR YOUR BABY

Can I pick a primary care provider for my baby before the baby is born?
Yes. It is best to choose a primary care provider (PCP) before your baby is born. Your baby's PCP will check the baby while in the hospital and then take care of your baby's health care needs after you and your baby are discharged.

Who do I call? What information do I need?
To choose a PCP for your baby, call Member Services. A representative can help you choose a network PCP. Tell the representative either your due date or the baby's date of birth if you've already delivered. You can also choose a network PCP from our online Provider Directory.

If you do not choose a PCP, Community First will choose one for your baby.

TYPES OF MEDICAL CARE

ROUTINE MEDICAL CARE

What is routine medical care?

Routine medical care is the regular care you get from a provider to help keep you healthy, such as regular checkups. Routine medical care includes:

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

What should I do if I need routine medical care?

Contact your perinatal provider 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 by your perinatal provider within two weeks after requesting a routine appointment.

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/strains

What should I do if I need urgent medical care?

For urgent medical care, you should call your perinatal provider's office, even on nights and weekends. Your provider will tell you what to do. In some cases, your provider may tell you to go to an urgent care clinic.

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

How soon can I expect to be seen?

You should be able to see your perinatal provider within 24 hours for an urgent care appointment. If your provider tells you to go to an urgent care clinic, you do not need to call the clinic before going. For a list of network urgent care clinics, please visit CommunityFirstMedicaid.com.

EMERGENCY MEDICAL CARE

What is an Emergency and an Emergency Medical Condition?
A CHIP Perinate Member is defined as an unborn child. Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth. Emergency care is provided for the following Emergency Medical Conditions:

- Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child;
- Stabilization services related to the labor with delivery of the covered unborn child;
- Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit;
- Emergency ground, air, and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.

Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

What is Emergency Services or Emergency Care?
"Emergency Services" or "Emergency Care" are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition, including post-stabilization care services related to labor and delivery of the unborn child.

What is post-stabilization?
Post-stabilization care services are services covered by CHIP that keep the Member's condition stable following emergency medical care.

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

CHIP PERINATE HEALTH CARE BENEFITS

What are my unborn child's CHIP Perinate health care benefits?
Use the chart on the following page to review your unborn baby's benefits as a CHIP Perinate Member.

How do I get these services?
Call Member Services. We'll be happy to explain how you can get these services.

How much do I have to pay for my health care under CHIP Perinate?
Do I have a copayment?
Copayments, cost-sharing, and enrollment fees do not apply at any income level to CHIP Perinate Members.

What if I need services that are not covered by CHIP Perinate?
You will have to pay for any services you get if they are not covered under your plan. You can review a list of services not covered under CHIP Perinate in this Member Handbook.

CHIP PERINATE HEALTH CARE BENEFITS	
COVERED SERVICE	**LIMITATIONS**
INPATIENT GENERAL ACUTE Services include: • Covered medically necessary, hospital-provided services • Operating, recovery, and other treatment rooms • Anesthesia and administration (facility technical component) • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	• For CHIP Perinate Members with a family income at or below the Medicaid eligibility threshold (198 percent of the Federal Poverty Level [FPL]), the hospital/facility charges are not a covered benefit; however, professional service charges associated with labor and delivery are a covered benefit. *Note: Hospital/facility charges are paid through Emergency Medicaid. The hospital/facility will need to complete and submit an Emergency Medical Services Certification Form H3038 to establish Emergency Medicaid for labor and bill facility charges for both mother and newborn to TMHP.* • For CHIP Perinate Members with a family income above the Medicaid eligibility threshold (199 percent, up to and including 202 percent of the FPL), benefits are limited to the facility charges, professional service charges, and facility charges associated with labor and delivery up until birth. Services related to miscarriage and/or a non-viable pregnancy are also covered. *Note: Emergency Medicaid is not required for billing facility charges for CHIP Perinates in families with incomes at 199 – 202 percent of the FPL.* • Surgical services are limited to services that directly relate to the delivery of the unborn child. • Hospital/facility services are limited to labor with delivery until birth.
BIRTHING CENTER SERVICES	• Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery). • Applies only to CHIP Perinate Members (unborn child) with incomes at 186% FPL to 200% FPL.

CHIP PERINATE HEALTH CARE BENEFITS	
COVERED SERVICE	**LIMITATIONS**
COMPREHENSIVE OUTPATIENT HOSPITAL, CLINIC (INCLUDING HEALTH CENTER), AND AMBULATORY HEALTH CARE CENTER Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department, or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications, and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	• **May require prior authorization** and physician prescription. • Laboratory and radiological services are limited to services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinate until birth. • Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy. • Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT), and Ultrasonic Guidance for Cordocentesis and FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis. • Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.

CHIP PERINATE HEALTH CARE BENEFITS	
COVERED SERVICE	**LIMITATIONS**
COMPREHENSIVE OUTPATIENT HOSPITAL, CLINIC (INCLUDING HEALTH CENTER), AND AMBULATORY HEALTH CARE CENTER, CONT'D	• Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.
PHYSICIAN/PHYSICIAN EXTENDER PROFESSIONAL SERVICES Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. • Physician office visits, in-patient and out-patient services • Laboratory, x-rays, imaging, and pathology services, including technical component and/or professional interpretation • Medically necessary medications, biologicals, and materials administered in physician's office • Professional component (in/outpatient) of surgical services, including: ◦ Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. ◦ Administration of anesthesia by physician (other than surgeon) or CRNA. ◦ Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. ◦ Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Hospital-based physician services (including physician-performed technical and interpretive components) • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	• **May require authorization** for specialty services. • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.

CHIP PERINATE HEALTH CARE BENEFITS	
COVERED SERVICE	**LIMITATIONS**
SERVICES RENDERED BY A CERTIFIED NURSE MIDWIFE OR PHYSICIAN IN A LICENSED BIRTHING CENTER	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to a first visit and subsequent prenatal (antepartum) care visits that include: • (1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; (2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) one (1) visit per week from 36 weeks to delivery. • More frequent visits are allowed as Medically Necessary. Benefits are limited to: ◦ Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. • Visits after the first visit must include: ◦ interim history (problems, marital status, fetal status); ◦ physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).

CHIP PERINATE HEALTH CARE BENEFITS	
COVERED SERVICE	**LIMITATIONS**
PRENATAL CARE AND PRE-PREGNANCY FAMILY SERVICES AND SUPPLIES Covered services are limited to a first visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first 28 weeks or pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery. • More frequent visits are allowed as medically necessary.	• **Does not require prior authorization.** • Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. • Visits after the first visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).

CHIP PERINATE HEALTH CARE BENEFITS	
COVERED SERVICE	**LIMITATIONS**
EMERGENCY SERVICES, INCLUDING EMERGENCY HOSPITALS, PHYSICIANS, AND AMBULANCE SERVICES Health Plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. • Emergency services based on prudent layperson definition of emergency health condition. • Medical screening examination to see if there is an emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor and delivery of the covered unborn child. • Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit. • Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).	• For CHIP Perinate Members with a family income at or below the Medicaid eligibility threshold (198 percent of the Federal Poverty Level [FPL]), the hospital/facility charges are not a covered benefit; however, professional service charges associated with labor and delivery are a covered benefit. *Note: Hospital/facility charges are paid through Emergency Medicaid. The hospital/facility will need to complete and submit an Emergency Medical Services Certification Form H3038 to establish Emergency Medicaid for labor and bill facility charges for both mother and newborn to TMHP.* • For CHIP Perinate Members with a family income above the Medicaid eligibility threshold (199 percent, up to and including 202 percent of the FPL), benefits are limited to the facility charges, professional service charges, and facility charges associated with labor and delivery up until birth. Services related to miscarriage and/or a non-viable pregnancy are also covered. *Note: Emergency Medicaid is not required for billing facility charges for CHIP Perinates in families with incomes at 199 – 202 percent of the FPL.* • Emergency services that directly relate to the delivery of the covered unborn child until birth. • Post-delivery services or complications resulting in the need for emergency services for the mother are not a covered benefit.
CASE MANAGEMENT SERVICES Case management services are a covered benefit for the unborn child.	• These covered services include outreach informing, Case Management, Care Coordination and community referral.
CARE COORDINATION SERVICES Care coordination services are a covered benefit for the unborn child.	
DRUG BENEFITS Services include, but are not limited to the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	• Services must be medically necessary for the unborn child.

HEALTH CARE SERVICES NOT COVERED

What services are not covered under the CHIP Perinate Program?

- For CHIP Perinate families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false, or other labor not resulting in delivery are excluded services.
- Inpatient mental health services
- Outpatient mental health services
- Durable medical equipment or other medically related remedial devices
- Disposable medical supplies
- Home and community-based health care services
- Nursing care services
- Dental services
- Inpatient substance use disorder treatment services and residential substance use disorder treatment services
- Outpatient substance use disorder treatment services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the delivery of the covered unborn child
- Transplant services
- Tobacco Cessation Programs
- Chiropractic Services
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child
- Personal comfort items including, but not limited to, personal care kits provided on inpatient admission, phone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or postpartum care.
- Experimental and/or investigational medical, surgical, or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance, or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility

HEALTH CARE SERVICES NOT COVERED

- Mechanical organ replacement devices including, but not limited to, artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor and delivery of the covered unborn child
- Services, supplies, meal replacements, or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy, and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care (routine foot care does not include treatment of injury or complications of diabetes)
- Diagnosis and treatment of weak, strained, or flat feet, and the cutting or removal of corns, calluses, and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel).
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)

CHIP PERINATE 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. Please review the chart below to learn more about the Value-Added Services available to you as a Community First Member in the CHIP Perinate Program.

How can I get these benefits?
To learn how you can receive these added benefits as a Community First Member in the CHIP Perinate Program, please call 210-358-6055.

CHIP PERINATE VALUE-ADDED SERVICES	
VALUE-ADDED SERVICES	**RESTRICTIONS/LIMITATIONS**
Extra Help for Pregnant Women who participate in Healthy Expectations Maternity Program, including:	
• Mommy & Me Baby Shower with: ◦ 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 partners 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 safe sleep pack and play.*
• Maternal Community Health Club with: ◦ 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.*
• 4th Trimester class for moms on newborn care, breastfeeding, and postpartum self-care, plus a baby gift for each participating Member worth up to $30	*4th Trimester class limited to Members who complete a Community First postpartum assessment within 30 days after delivery.*
Home visits for high-risk Members who participate in Community First Health & Wellness Programs, including Asthma Matters, Diabetes in Control, Healthy Mind, and Healthy Expectations	*Home visits are contingent upon medical necessity determinations and vary from Member to Member.*

CHIP PERINATE VALUE-ADDED SERVICES	
VALUE-ADDED SERVICES	**RESTRICTIONS/LIMITATIONS**
24-hour Nurse Advice Line staffed by registered nurses who are ready to answer your health-related questions every day, including weekends and holidays. Members can call the Nurse Advice Line at 1-800-434-2347. Deaf or hard of hearing can call 711.	
Extra Help Getting a Ride (bus passes) for Members, their siblings, and their parents or legal guardians to places, such as: • The doctor • The grocery store • Community-based services • Community First hosted events • Health education classes • Polling sites • Member Advisory Group meetings • WIC • Social Security Administration offices • Community offices that help find employment and housing • Social Security Administration-approved physician for appointments requested for disability determination and services	*Bus passes are not provided to children younger than 18 unless they are with their parent or guardian. This service is available only for bus service routes within San Antonio, and routes are offered by VIA Metropolitan Transit.*
Disease Management • $50 gift card and health and wellness items for caregivers or Members who complete six in-person or virtual National Alliance on Mental Illness (NAMI) Basics classes about supporting a loved one with a mental health condition	*Limited to caregivers caring for Members or Members caring for their children, ages 0 through 19, with a diagnosed mental health condition.*

CHIP PERINATE VALUE-ADDED SERVICES	
VALUE-ADDED SERVICES	**RESTRICTIONS/LIMITATIONS**

Gift Programs, including:
 	
• Up to $150 for pregnant Members participating in Healthy Expectations Maternity Program:
  ◦ $30 for attending Mommy and 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 item, such as a pregnancy pillow
	Gift card excludes beer, wine, alcohol, cigarettes, and items covered in the plan's pharmacy benefit.
	
	Date of prenatal visit must occur in the first trimester or within 42 days of enrollment with Community First.
	
	Date of postpartum visit must occur prior to end of Member eligibility.
	
	Community First will reimburse for birthing classes at hospital that the Community First CHIP Perinate Member delivers their baby.

Extra Dental Services, including: • Low-cost dental exams, x-rays, and discounts on other dental/orthodontic services	*Limited to 10% discount. No maximum benefit amount. For Members ages 21 through 999 and their family members with no dental coverage.*
Behavioral Health- Online Mental Health Resources • A webpage that helps Members find mental health care, covered services, community support, and rewards for staying active in their care. Visit at CommunityFirstMedicaid.com	
Health and Wellness Services • 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 • GED program to help Members age 18 through 999 earn a GED certificate, plus extra academic and career support to empower Members entering the workforce	*Members in the GED program must:* • *Be legally able to work in the United States.* • *Have photo identification.* • *Take all program-related assessments.* • *Commit to completing the program.*

CARE DURING PREGNANCY

HEALTHY EXPECTATIONS MATERNITY PROGRAM

What services/activities/education does Community First offer pregnant women?
Healthy Expectations Maternity Program provides educational resources and support for expectant moms, including Mommy & Me Baby Showers, to help keep you and your newborn healthy both before and after delivery.

Healthy Expectations benefits include:

- Gift card upon completing pregnancy health assessment, joining the program, and agreeing to receive Health Baby text messages
- Gift card for receiving the flu shot
- Gift cards for completing prenatal and postnatal checkups
- One-on-one contact with a Health Educator
- Prenatal and postpartum education
- Reimbursement for birthing classes or toward a pregnancy pillow
- 24-hour Nurse Advice Line
- Home visits for high-risk pregnancies

Once enrolled, you'll also be invited to attend a Mommy & Me Baby Shower, a monthly gathering led by a Health Educator and experienced OB nurse where soon-to-be moms can learn about prenatal and postnatal care, breastfeeding, what to expect during labor and delivery, and newborn care.

Upon attendance, you may also be eligible to receive:

- Gift card for attending
- Diaper bag filled with baby wipes and other baby items
- Car seat or pack & play
- Gifts for dad who attend the baby shower along with mom

For more information or to join Healthy Expectations, please visit CommunityFirstHealthPlans.com/Health-and-Wellness-Programs and take the Pregnancy Health Assessment. You can also call 210-358-6055 to speak with a Health Educator who can help you sign up for this program.

PRESCRIPTION DRUG BENEFITS

What are my unborn child's prescription drug benefits?
CHIP Perinate covers most of the medicine your doctor says you need for your pregnancy. Your doctor will write a prescription so you can take it to the drugstore, or may be able to send the prescription to the drugstore for you.

There are no copayments required for CHIP Perinate Members.

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

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

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

NETWORK DRUG STORES

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

What do I bring with me to the drugstore?
You should bring your Community First Health Plans Member ID card and your prescription.

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.

MEDICATION DELIVERY

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

OVER-THE-COUNTER MEDICATION

What if I need over-the-counter medication?
The drugstore cannot give you an over-the-counter medication as part of your CHIP Perinate benefit. If you need an over-the-counter medication, you will have to pay for it.

CONCURRENT ENROLLMENT

If you are a CHIP Perinate Member and have children covered by CHIP, your children will keep getting CHIP benefits, but they will be moved to the same health plan that is providing your CHIP Perinate coverage.

- Copayments, cost-sharing, and enrollment fees still apply for children enrolled in the CHIP Program.
- An unborn child who is enrolled in CHIP Perinate will be moved to Medicaid for 12 months of continuous Medicaid coverage, beginning on the date of birth, if the child lives in a family with an income at or below the Medicaid eligibility threshold.

- An unborn child will keep getting coverage through the CHIP Program as a "CHIP Perinate Newborn" after birth if the child is born to a family with an income above the Medicaid eligibility threshold.

To read more about the CHIP Perinate Newborn Program and health benefits, please refer to Section II of this Member Handbook.

HEALTH CARE COVERAGE RENEWAL

When does CHIP Perinate coverage end?
You and your baby have 12 months of benefits. Benefits will start with the month you enroll yourself in CHIP Perinate. Your newborn baby's benefits (CHIP Perinate Newborn) will end 12 months from when you first enrolled.

Will the state send me anything when CHIP Perinate coverage ends?
Yes. You will receive a CHIP renewal packet during month 10 of your enrollment.

How does renewal work?
You will need to complete the renewal application you receive in the mail. Then, you will mail it to the enrollment address.

- If your baby qualifies, they will become a traditional CHIP Member.
- If your family is at or below 185% of the Federal Poverty Level (FPL), your baby will be moved to Medicaid for 12 months of continuous Medicaid coverage beginning on their date of birth.
- If your family is above the 185% to 200% of the FPL, your child will be eligible to receive the CHIP benefits outlined in this handbook.

MEMBER BILLING

What if I get a bill from my perinatal provider?
You should not get a bill from your perinatal provider for any services covered under the CHIP Perinate Program. You might receive a bill if you go to a doctor who is not in the Community First network or 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.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they

provide for your unborn child. You have a right to know about what those payments are and how they work.

3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your Perinatal provider in private and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group outside the health plan tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
13. 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.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.

4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other Members, or health plans.
7. You must talk to your provider about your medications that are prescribed.

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

COMMUNITY FIRST HEALTH PLANS

COMMUNITY FIRST INSURANCE PLANS

Non-Discrimination Notice

Community First Health Plans, Inc. and Community First Insurance Plans (Community First) comply with applicable federal civil rights laws and do 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 de no discriminación

Community First Health Plans, Inc. (Community First) y Community First Insurance Plans cumplen con las leyes federales de derechos civiles aplicables y no discriminan por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género u orientación sexual. Community First no excluye ni 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 lingüísticos gratuitos a personas cuyo idioma principal no es el inglés, como:

— Intérpretes calificados
— Información escrita en otros idiomas

Si usted necesita recibir estos servicios, comuníquese con Servicios para Miembros de Community First al número que aparece en el reverso de su tarjeta de Miembro o al 1-800-434-2347. Si tiene dificultades auditivas, por favor llame al 711. Si usted cree que Community First no le proporcionó servicios lingüísticos gratuitos o que fue discriminado/a de cualquier 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:

Coordinador de Cumplimiento Regulatorio de Community First
Teléfono: 210-227-2347 | TTY: 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 | TTY: 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 COMMUNITY FIRST INSURANCE PLANS

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-434-2347 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-434-2347 (TTY: 711) o hable con su proveedor.

پاملرنه: که چېرې تاسو په پښتو ژبه خبرې کوئ، په وړیا ډول د ژبې د مرستې خدمتونه ستاسو لپاره د لاسرسي وړ دي. د لاسرسي وړ بڼو کې د معلوماتو د وړاندې کولو لپاره مناسبې مرستې او خدمتونه په وړیا ډول د لاسرسي وړ دي. له 1-800-434-2347 (TTY: 711) شمېرې سره اړیکه ونیسئ یا د خپلو خدمتونو له چمتو کوونکي سره اړیکه ونیسئ.

تنبيه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-434-2347 (TTY: 711) أو تحدث إلى مزوّد الخدمة.

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-434-2347 (TTY : 711) ou parlez à votre fournisseur.

توجه: اگر به فارسی صحبت می کنید، خدمات رایگان کمک زبانی در دسترس شماست. کمک‌ها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس نیز به صورت رایگان در دسترس هستند. با شماره 1-800-434-2347 (TTY: 711) تماس بگیرید یا با ارائه دهنده خدمات خود صحبت کنید.

توجه: اگر شما دری صحبت می کنید، خدمات کمک زبان رایگان برای شما در دسترس است. کمک ها و خدمات کمکی مناسب برای ارائه معلومات در فارمت های قابل دسترس نیز به صورت رایگان در دسترس است. با 1-800-434-2347 (TTY: 711) تماس بگیرید یا با ارائه کننده خود صحبت کنید.

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-434-2347（文本电话：711）或咨询您的服务提供商。

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-434-2347 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ICYITONDERWA: Niba uvuga Ikinyarwanda, ufite serivisi z'ubufasha bw'ururimi ku buntu. Ibikoresho na serivisi byunganira bitangwa ku buntu kugira ngo amakuru atangwe mu buryo bworoshye kumva. Hamagara 1-800-434-2347 (TTY: 711) cyangwa uvugishe umuganga wawe.

DÍYAN DO: Zodi oñne Rohingya hotá hoo, toíle oñnolla maana zubani modot ókkol ase. Lootfaíbade formeth ót maalumat dibolla munasef modotgorede caíjjo adde hédmot oñnolla taíbo. Kool goró 1-800-434-2347 (TTY: 711) ót yá oñnor dekbal doya loí hotá hoo.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-434-2347 (TTY: 711) au zungumza na mtoa huduma wako.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-434-2347 (TTY: 711) o makipag-usap sa iyong provider.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-434-2347 (TTY: 711) или обратитесь к своему поставщику услуг.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-434-2347 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ኣስተውዕል፡- ትግርኛ ትዛረብ እንተ ኾንካ ብናጻ ናይ ቋንቋ ሓገዝ ኣገልግሎት ኪወሃበካ ይኽእል እዩ። ብተወሳኺ'ውን ብናጻ ሓበሬታ ንምሃብ ዘድሊ ሓጋዚ ረድኤትን ኣገልግሎታትን ብናጻ ይርከብ። ናብ 1-800-434-2347 (TTY፡ 711) ደውሉ ወይ ምስ ወሃቢ ኣገልግሎትካ ተዘራረብ።

CHIP/CHIP PERINATE MEMBER HANDBOOK

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