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

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

COMMUNITY FIRST HEALTH PLANS

The first choice for your family

A prescription discount card your whole family can use

Additional eight hours of respite care services for non-waiver STAR Kids members

Gift programs for health-related items to keep your family healthy

STAR and STAR Kids Member Handbook

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827
12238 Silicon Drive, Ste.100 San Antonio, TX 78249

Covering Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson counties.

JANUARY 2019

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WELCOME TO COMMUNITY FIRST HEALTH PLANS!

Welcome to Community First Health Plans. We are happy you chose us.

We are the only local, non-profit health plan in this area's STAR Medicaid Program and STAR Kids Program. Our employees live and work here. We can help you find doctors, hospitals and providers. We can help you or your children get the health care services you need.

We serve people of all backgrounds. We work hard to understand and respect your needs. We work hard to make sure your personal information is secure at Community First. We want you to be satisfied with your health plan.

Please read this handbook for information about your benefits.

What if I need help understanding or reading the Member handbook?
You can ask to get a handbook –

- with larger print
- in Braille
- in another language
- on an audio cassette or CD

Our Member Services Advocates can answer your questions about the handbook. A paper copy of this handbook can be mailed to you within 5 business days, free of charge. Call us for help:

STAR Medicaid: (210) 358-6060 or toll-free at 1-800-434-2347
STAR Kids: (210) 358-6403 or toll-free at 1-855-607-7827

What can a Member Services Advocate do for me?
We can help you in many ways. We can:

- Speak to you in English or Spanish, or we can get an interpreter who speaks your language.
- Answer your questions about benefits or where to go for services.
- Help you find services that don't need a referral from your Primary Care Provider, like vision, behavioral health, and family planning.
- Help you pick or change your Primary Care Provider. You can choose a different doctor for each Member in your family, if you want.
- Send you a new Member ID card if it is lost or stolen.
- Help you solve problems or complaints.

If you have any questions, call us. Community First Member Services staff can take your call from 8 a.m. to 5 p.m. You can reach a nurse 24 hours a day, 7 days a week. They can answer your health questions after hours, weekends, and holidays. Our staff is bilingual in English and Spanish. If you speak another language or are hearing impaired, call Member Services. STAR Kids Members can speak to a Service Coordinator for help with benefits. Nurses can help STAR Kids Members with information about the STAR Kids program, covered services, and provider resources. We are here for you!

For Emergency Services dial 9-1-1 or go to the nearest emergency room!

Community First Member Services:

STAR Medicaid
Local .... (210) 358-6060
Toll-free 1-800-434-2347

STAR Kids
Local .... (210) 358-6403
Toll-free 1-855-607-7827
TTY (for hearing impaired) .... (210) 358-6080
Outside Bexar County TTY (toll-free) 1-800-390-1175

Eye Care:
STAR Medicaid .... (210) 358-6060
STAR Kids .... (210) 358-6403

Behavioral Health & Substance Abuse Services Crisis Hotline:
Toll-free 1--877-221-2226

Nurse Advice Line (toll-free):
STAR Medicaid 1-800-434-2347
STAR Kids 1-855-607-7827
TTY (for hearing impaired) .... (210) 358-6080
Outside Bexar County TTY (toll-free) 1-800-390-1175

OTHER HELPFUL NUMBERS:
Medical Transportation Program .... (210) 949-2020
Toll-free 1-877-MED-TRIP (1-877-633-8747)
Ombudsman Managed Care Assistance Team 1-866-566-8989
STAR Program Helpline 1-800-964-2777
STAR Kids Program Helpline 1-877-782-6440
TTY (for hearing impaired) 1-800-267-5008
Texas Health Steps Outreach and Information Hotline 1-877-847-8377

Medicaid Dental :
DentaQuest 1-800-516-0165
MCNA 1-800-494-6262

ADDRESSES:

Community First Health Plans has two offices where we can help you:

Main Office at The Oaks - Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

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

OFFICE HOURS:
Office hours are 8:30 a.m. to 5 p.m.
Monday to Friday, except state-approved holidays

Visit our website at: www.cfhp.com.

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ABOUT YOUR HEALTH PLAN

What services do I get with Community First?

- Your own personal doctor, called a Primary Care Provider
- A large network of quality specialists and hospitals
- Caring Member Services Advocates to help you get the health care you need

How do I get the services I need?
Your personal doctor will take care of most of your health care needs. If you need to see a specialist or go to the hospital, your personal doctor will send you.

HERE IS WHAT YOU WILL NEED TO VISIT YOUR PERSONAL DOCTOR:

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

You will be issued only one card, and you will receive a new card only if your card was lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free 1-800-252-8263.

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

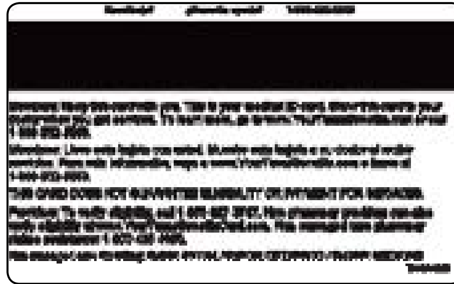
The Your Texas Benefits Medicaid card has these facts printed on the front:

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

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

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

Your Texas Benefits Card



COMMUNITY FIRST MEMBER ID CARD

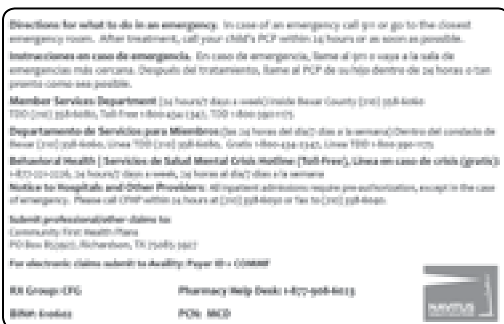
You will get a Community First ID card for each person enrolled in the plan. If you do not get a card, call Member Services. We will send you a card. Your card will list:

- Your name
- Your Medicaid number
- Your start date
- Your Primary Care Provider's name, address, and phone number
- What to do in an emergency
- How to reach Member Services
- How to get help in Spanish

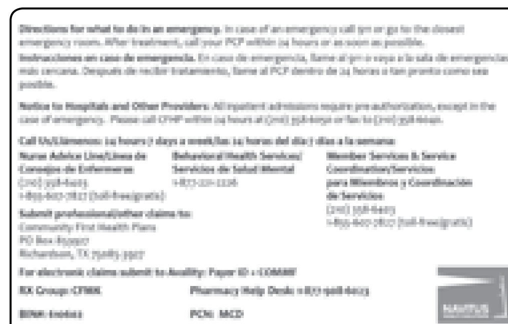
Carry this card with you at all times. Show the ID card to your doctor so they know you are covered by the Medicaid program.

You must take both the Your Texas Benefits Medicaid Card and your Community First ID card when you get health care services. If you lose the Your Texas Benefits Medicaid Card, call or visit your local HHSC Benefits Office to get another one. You can ask the HHSC eligibility office for a Form 1027-A as a verification form. Dial 2-1-1 on your phone and select option 2 to get the location of your closest HHSC office.

STAR Medicaid ID Card



STAR Kids ID Cards



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What if my Community First ID card is lost or stolen?
Call Member Services and ask for a new one. You can also go online on the Community First website, www.cfhp.com, to request a new card.

PRIMARY CARE PROVIDERS

What do I need to bring with me to my doctor's appointment?
Bring to every visit --

- Your Community First Member ID card
- Your Texas Benefits Medicaid Card
- A list of all medicines you are taking

What is a Primary Care Provider?
A Primary Care Provider is your own doctor or clinic. The Primary Care Provider will take care of your medical needs. If a specialist or tests are needed, the Primary Care Provider will ask for them. Your Primary Care Provider must be available, in person or by phone, 24 hours a day, seven days a week. Or they must have a doctor on call.

Note: STAR Kids Members who are covered by Medicare will not have a Primary Care Provider.

Can a specialist ever be considered a Primary Care Provider?
If you have a very serious medical condition, you may ask for a specialist to be the Primary Care Provider. The specialist must be approved by Community First. The specialist must also be willing to be your Primary Care Provider.

How can I change my Primary Care Provider?
For a list of physicians and doctors in the Community First network, visit our website at www.cfhp.com. You can also call Member Services if you have questions about a physician's professional qualifications or for the most current information about the provider network. Call us:

STAR Medicaid: (210) 358-6060 or toll-free at 1-800-434-2347
STAR Kids: (210) 358-6403 or toll-free at 1-855-607-7827
Visiting: www.cfhp.com

A Member Service Advocate can help you pick a new Primary Care Provider. You can also ask to change your Primary Care Provider through our secure Member portal on Community First's website at www.cfhp.com. Click on "Member Login." Click on "Contact Us," then on "Send a secure request to Member Services." Fill out the "Member Contact Us" form and hit "submit."

Can a clinic (RHC/FQHC) be my Primary Care Provider?
Yes. You may pick one of the Federally Qualified Health Centers or Rural Health Clinics from our STAR or STAR Kids Provider Directory.

How many times can I change my/my child's Primary Care Provider?
There is no limit on how many times you can change your or your child's Primary Care Provider. You can change Primary Care Providers by calling us toll-free at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

or writing to:

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

You may also request a change through our secure Member portal on our website at www.cfhp.com.

When will my Primary Care Provider change become effective?
Here is an example:

- If you change by May 15, you can see your new doctor on June 1.
- If you change after May 15, you have to wait until July 1 to see your new doctor. Until then, your old doctor can see you.

Are there reasons why my request to change Primary Care Provider may be denied?
Community First might deny your Primary Care Provider request if:

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

Can my Primary Care Provider move me to another Primary Care Provider for non-compliance?
Yes, for these reasons:

- You miss three appointments in a row during a six-month period and do not call ahead of time.
- You do not follow the doctor's advice.
- You are rude, abusive, or do not work with your doctor or the doctor's staff.

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

How do I get medical care after my Primary Care Provider's office is closed?
If you have an urgent problem, call your doctor's office first. Your doctor's phone is answered 24 hours a day, 7 days a week. You can also call Member Services. We have nurses to help you 24 hours a day, 7 days a week. The nurse might refer you to an urgent care center or to the hospital emergency room. The nurse might also give you home advice.

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

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

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

To learn more, call Community First Health Plans.

PHYSICIAN INCENTIVE PLANS

Community First Health Plans cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. You have the right to know if your Primary Care Provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

to learn more about this.

CHANGING HEALTH PLANS

What if I want to change health plans? Who do I call? How many times can I change health plans? When will my health plan change become effective?
You can change your health plan by calling the Texas STAR, STAR Kids, or STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want.

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

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

Can Community First ask that I get dropped from their health plan (for non-compliance, etc.)?
We can ask to drop you if you do any of these things:

- Move out of our service area.
- Enter a hospice or long-term care facility.
- You do not follow Community First policies and procedures.
- Let someone else use your Community First Member ID card.
- You are rude, abusive or you do not work with Community First staff, Primary Care Providers, other providers, or their staff.
- You are non-compliant or do not follow your doctor's medical advice.

BENEFITS

What are my health care benefits?
Here are many of the benefits Medicaid covers:

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral Health Services, including:
  - Inpatient mental health services for Children (birth through age 20)
  - Acute inpatient mental health services for Adults
  - Outpatient mental health services
  - Psychiatry services
  - Mental Health Rehabilitative Services
  - Counseling services for adults (21 years of age and over)
  - Outpatient substance use disorder treatment services including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication assisted therapy
  - Residential substance use disorder treatment services including:
    - Detoxification services
    - Substance use disorder treatment (including room and board)
- Birthing services provided by a physician and certified nurse midwife (CNM) in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
  - The MCO may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
  - The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - surgery and reconstruction on the other breast to produce symmetrical appearance;
    - treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - prophylactic mastectomy to prevent the development of breast cancer.
  - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed

- Medical checkups and Comprehensive Care Program (CCP) Services for children (birth through age 20) through the Texas Health Steps Program, including private duty nursing, Prescribed Pediatric Extended Care Center (PPECC) services, certified respiratory care practitioner services, and therapies (speech, occupational, physical)
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Mental Health Targeted Case Management
- Mental Health Rehabilitative Services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
- Telemedicine
- Telemonitoring, to the extent covered by Texas Government Code §531.01276
- Telehealth

How do I get these services?

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

Are there any limits to any covered services?

There may be limits to some covered services based on your age. Call Member Services at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

if you have a question about limits.

What are my Long-Term Services and Supports (LTSS) benefits? (STAR Kids only)

Long term care services are benefits to help you stay safe and independent in your home or community. Long term care services help you with functional needs like bathing, dressing, taking medicine or preparing meals. They are just as important as acute care services.

The following are long-term service benefits that all STAR Kids Members can get based on their individual medical and functional need:

- Personal attendant services (PAS)
- Private duty nursing (PDN) services
- Prescribed pediatric extended care center (PPECC) services

- Day activity and Health services (DAHS) (age restriction of 18 and older)
- Financial Management Services (available to members who select the CDS service delivery model)

For certain qualified STAR Kids Members these long- term service benefits are also available based on an individual member who meet medical necessity or level of care requirements:

- Flexible family support services
- Minor home modifications
- Adaptive aids
- Transition assistance services
- Respite care (in the home, in a facility, at a camp)
- Employment assistance and supported employment services
- Community First Choice (CFC) - Personal Attendant Services
- Community First Choice (CFC) -Habilitation Services
- Community First Choice (CFC) - Emergency Response Services (ERS) – emergency call button

Long term care service benefits can be provided in three ways. As a STAR Kids member, you can choose any one of the options listed below:

Agency Option
CFHP will provide the member with a list of Agencies to provide LTSS services. The member chooses will provide the Long-term service employee to the Member and manage all employment functions.

Self - Responsibility Option (SRO)
CFHP will provide the member with a list of Agencies contracted to provide long-term services. The Agency will provide a selection of long-term service employees for the Member/LAR to interview, and select. The member/LAR will have input in the management of that employee's time and attendance in the Member's home.

How do I get these services? What number do I call to find out about these services? (STAR Kids only)
To get these services, call Member Services at 1-855-607-7827.

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

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

I am in the Community Living Assistance and Support Services (CLASS) waiver. How will I receive my LTSS? (STAR Kids only)
State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through Community First Health Plans STAR Kids. Your CLASS waiver

services will be delivered through the Department of Aging and Disability Services. Please contact your Community First Health Plans service coordinator if you need assistance with accessing these services.You can also contact your CLASS case manager for questions specific to CLASS waiver services.

I am in the Deaf Blind with Multiple Disabilities (DBMD) waiver. How will I receive my LTSS? (STAR Kids only)
State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through Community First Health Plans STAR Kids. Your DBMD waiver services will be delivered through the Department of Aging and Disability Services. Please contact your Community First service coordinator if you need assistance with accessing these services. You can also contact your DBMD case manager for questions specific to DBMD waiver services.

I am in the Home and Community-based Services (HCS) waiver. How will I receive my LTSS? (STAR Kids only)
State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through Community First Health Plans STAR Kids. Your HCS waiver services will be delivered through the Department of Aging and Disability Services. Please contact your Community First Health Plans service coordinator if you need assistance with accessing these services. You can also contact your HCS service coordinator at your local intellectual and developmental disability authority (LIDDA) for questions specific to HCS waiver services.

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

Will my STAR Kids benefits change if I am in a Nursing Facility? (STAR Kids only)
No. Your STAR Kids benefits and services will not change if you go into a nursing facility.

Will I continue to receive STAR Kids benefits if I go into a Nursing facility?
A STAR Kids Member who enters a Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) will remain a STAR Kids Member. Community First Health Plans must provide Service Coordination and any Covered Services that occur outside of the Nursing Facility or ICF/IID when a STAR Kids Member is a Nursing Facility or ICF/IID resident. Throughout the duration of the Nursing Facility or ICF/IID stay, Community First Health Plans must work with the Member and the Member's Legally Authorized Representative (LAR) to identify Community-Based Services and LTSS programs to help the Member return to the community.

What are my Consumer Directed Services (CDS)?
Consumer Directed Services (CDS) gives you a way that you can have more choice and control over some of the long- term support services you get.

With CDS you can:

- Find, screen, hire and fire (if needed) the people who provide services to you (your staff)
- Train and direct your staff

These are the services you can manage in CDS:

- Personal Care Services

- CFC Attendant care Services
- Respite care in the home
- CFC Habilitation Services

If you choose to be in CDS, you will contract with a Financial Management Services Agency (FMSA). The FMSA will help you get started and give you training and support if you need it. The FMSA will do your payroll and file your taxes. Contact your Service Coordinator to find out more about CDS. You can call Community First's Service Coordination team at 210-358-6403.

What are my Acute Care benefits? How do I get these services? (STAR Kids only)
Acute care benefits are things such as doctors, hospitals and labs. They provide services for you when you are sick or trying to prevent getting sick. Your doctor will work with you to make sure you get the services you need. Here are some medical services that are covered:

- Ambulance services, emergency and non-emergency
- Audiology services (including hearing aids)
- Behavioral health services
- Birthing center services
- Cancer screening, diagnostic, and treatment service
- Chiropractic services
- Dialysis
- Drugs and biologicals provided in an inpatient setting
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency services
- Family planning services
- Home health care services
- Hospital services, inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures
- Medical checkups (including Texas Health Steps for children ages 20 and younger)
- Mental health rehabilitation services
- Mental health targeted case management
- Nursing facility care
- Optometry services
- Oral evaluation and fluoride varnish
- Optometry, glasses, and contact lenses
- Outpatient drugs and biologicals
- Podiatry services
- Prenatal care
- Primary care services
- Radiology, imaging, x-rays
- Specialty doctor services
- Telemonitoring
- Telehealth
- Therapies – physical, occupational, and speech
- Transplants of organs and tissues
- Vision services

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

What number do I call to find out about these services? (STAR Kids only)
To learn more about your acute care benefits, call Member Services at 1-855-607-7827.

Extra Benefits for Pregnant Women
Did you know that Community First offers extra benefits for pregnant women? Our members have access to baby showers, free toddler booster seat, gift cards, home visits for high-risk pregnant women, and more to help take care of your new bundle of joy.

What services are not covered?

Some services are not covered, such as --

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

What are my prescription drug benefits?
Most prescription medicines your doctor says you need are covered. Your prescription must be filled by a drug store that takes Medicaid. If you have problems getting your prescriptions filled, call us:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

A Member Services Advocate will help you.

What extra benefits do I get as a Member of Community First?
Community First offers the following extra benefits to our STAR Kids and STAR Medicaid Members:

- Extra vision benefits
- A prescription discount card your whole family can use
- Free sports physicals
- 24-hour Nurse Advice Line
- Bus tokens for doctor, behavioral health visits and health classes
- Weight management program
- Smoking cessation program

- Asthma kit
- Asthma pillow cover
- Healthy Expectations Prenatal Program
- Diabetes Program
- Adult healthy lifestyle classes.
- Mommy and Me baby shower
- Low-cost dental referrals
- Free samrt phone *
- Post-discharge incentives
- Free baby car seat
- Free toddler booster seat
- Free safe sleep player
- Bike safety & repair class
- Notary services
- Zumba classes
- Free gift for attending classes for new fathers

For Pregnant Women Only

- Free birthing classes
- Additional dental services
- Home visits for high-risk pregnant women
- Prenatal gift program with up to $150 in gift cards. *

Community First offers the following extra benefits to our STAR Kids Members:

- Eight hours of in-home respite care services for non-waiver STAR Kids Members per year.
- Up to $100 allowance for specialized therapies
- Pre-vocational assistance
- Discount prescription card
- Free smart phone *
- Asthma kit and asthma pillow cover
- Free toddler booster seat
- Help to quit smoking class and support
- Weight management program
- Gift programs for health-related items for disease management
- Notary services

How can I get these benefits?
Call Member Services to ask about any of these special services.

What health education classes does Community First offer?
We can help you find health education classes to help you stay healthy. We can also send you many types of information. We have special programs including:

- Diabetes in Control Program
- Asthma Matters Program
- Healthy Expectations Prenatal Program
- Chronic Disease Program
- Preventive health programs such as Member health risk assessment, personalized health program, flu shot reminders, women's health reminders, and medical checkup reminders.

Call Member Services with your questions or visit www.cfhp.com. You will also get health education at all of your Texas Health Steps checkups.

* Limitations or restrictions may apply.

What other services can Community First help me get (non-capitated services)?
Community First can help you with a referral for non-capitated services.
Some of these services include:

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

If you have questions about these or other non-capitated services, call Member Services.

HEALTH CARE AND OTHER SERVICES

What does "Medically Necessary" mean?

Medically Necessary means:

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

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What is routine medical care?
Routine medical care is:

- regular checkups
- treatment when you are sick
- follow-up care when you have medical tests
- prescriptions

How soon can I expect to be seen?
For routine visits, your personal doctor will see you within two weeks.

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

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

You also can call our 24-hour Nurse Advice Line at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

for help with getting the care you need.

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

What are Long-Term Services and Supports (LTSS)? (STAR Kids only)
Long term care services are benefits to help you stay safe and independent in your home or community. Long term care services help you with functional needs like bathing, dressing, taking medicine or preparing meals. They are just as important as acute care services.

How do I get these services?
To get these services, call Member Services at 1-855-607-7827.

EMERGENCY MEDICAL CARE

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

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

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

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

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

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

What do I do in case of a true emergency?
- Go to the nearest emergency room.
- Call 9-1-1 if you need help to get to the hospital.
- Call your personal doctor as soon as possible after your emergency care.
- Your personal doctor will give you follow-up care.

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

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

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

What do I do if 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:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

or call 9-1-1.

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

How do I get medical care after my Primary Care Provider's office is closed?
If you have an urgent problem, call your doctor's office first. Your doctor's phone is answered 24 hours a day, 7 days a week. You can also call Member Services. We have nurses to help you 24 hours a day, 7 days a week. The nurse might refer you to an urgent care center or to the hospital emergency room. The nurse might also give you home advice.

What if I get sick when I am out of town or traveling?
If you need medical care when traveling, call us toll-free at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

and we will help you find a doctor.

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

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

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

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

How soon can I expect to be seen by a specialist?
You should be seen within two weeks. If you have an urgent problem, the specialist should see you within 48 hours. If you cannot get an appointment within these time frames, call Member Services for help.

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

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

What services do not need a referral?
Here are some services that do not need a referral:

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

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

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

Call the Community First Behavioral Health Hotline if you have an urgent problem like severe depression or you feel like you might harm yourself. You can call for help anytime.

Behavioral Health Hotline: 1-877-221-2226

Do I need a referral for this?
You do not need a referral for this. If you have a problem because of mental illness, alcohol, or drugs, please call us. You can call 24 hours a day, 7 days a week. Someone will be there to help you find professionals close to you.

What are mental health rehabilitation services and mental health targeted case management? How do I get these services?
These are services that help Members with severe mental illness, behavioral or emotional problems. We can help Members get access to care and community support through Mental Health Targeted Case Management. To get help, call us:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

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Referrals
CFHP does not require a referral to see a specialist. Some specialists and PCP offices require or prefer to have a "Referral." You should ask your PCP to confirm with the specialist if a referral is needed from the PCP for you to be seen.

If the specialist is not in-network, CFHP will try to recruit the provider. A Letter of Agreement (LOA)/ Single Case Agreement can be signed by the provider if needed. These LOA/Single Case Agreements can be for one or several visits and lengths of time.

Authorizations
CFHP needs authorization for some services **before** they are done. The provider will call CFHP to request the services. They will provide the information about your medical case. You should check with your provider to see if an authorization is needed. You should ask if they have the approval before the services are done.

Continuity of Care

1. Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months after November 1, 2016, until the authorization expires, or until the health plan conducts a new assessment.
2. Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months after November 1, 2016 or until the health plan conducts a new assessment.
3. You may continue to see non-physician providers where you have an existing relationship with that provider, even if they are out of network and/or out of the Bexar Service Area, for up six (6) months after November 1, 2016. Authorization(s) for new services may be required depending on the service or procedure being performed.
4. You may continue to see physician and specialists where you have an existing relationship with that primary care or specialist physician, even if they are out of network and/or out of the Bexar Service Area, for up to twelve (12) months after November 1, 2016 without need for an authorization to pay the provider's claim.

How do I get my medications?
Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

If you need assistance with finding a pharmacy, please call Member Services at 1-855-607-7827 or visit www.cfhp.com.

How do I find a network drug store?
You can call Member Services for help to find a network drug store. You can also find a list of drug stores in the Community First network on our website. Visit our website at www.cfhp.com. Click on "Find a Provider," then click on "STAR/Medicaid or STAR Kids," then click on "Pharmacy Locator."

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

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

What if I need my medications delivered to me?
You may be able to have your medications brought to you through mail order. Community First's partner for pharmacy benefits is Navitus. Their mail order partner is Wellpartner. You may also be able to have your medications delivered to you at home. This can be done by some pharmacies. Please call Member Services at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

to learn more.

Who do I call if I have problems getting my medications?
If you have problems getting your Community First-covered medications, please call Community First Member Services at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827.

We can work with you and your pharmacy to make sure you get the medicine you need.

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

Call Community First Health Plans at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

for help with your medications and refills.

What if I lose my medication(s)?

If you lose your medications, call your doctor for help. If your doctor is closed, the pharmacy where you got your medications may be able to help you. You can also call Member Services for help at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

What if I also have Medicare? How do I get my medications if I am in a Nursing Facility?
If you have Medicare and Medicaid, your prescription drugs are paid by a Medicare Rx plan. If you have questions or want to change Medicare Rx plans, call
1-800-633-4227. Under Medicare Rx:

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

If you are in a nursing facility, your drugs will be provided to you by the nursing facility. The pharmacy that is used by your nursing facility will continue to bill your Medicare plan if you have Medicare and will bill Navitus for your Medicaid covered drugs.

How Do I Find Out What Drugs Are Covered?
Community First Health Plans uses the state Vendor Drug Program (VDP) list of drugs that your doctor can choose from. It includes all medicines covered by Medicaid and CHIP. To view the Texas Formulary Drug Search, go to
www.txvendordrug.com/formulary/formulary-search.asp. When there is a generic drug available, it will be covered if it is on the VDP formulary. Generic drugs are equal to brand-name drugs as approved by the Food and Drug Administration (FDA).

Some prescriptions require prior approval. A prior approval drug requires your provider to submit clinical data to support the need for the drug. The pharmacist will notify you if a drug your doctor prescribed requires prior approval. If this happens, contact your provider and ask him/her to submit the request for the medication and the clinical data to Community First.

Some drugs require step edits. A step edit requires the trial and failure of another drug(s) prior to approving the requested drug. If the pharmacist notifies you that your drug requires step edits, contact your provider and ask if about trying the other medications first.

Your prescription will be filled with a 30-day supply.

How Do I transfer My Prescriptions to a Network Pharmacy?
If you need to transfer your prescriptions, all you need to do is:

- Call the nearest network pharmacy and give the needed information to the pharmacist; or
- Bring your prescription container to the new pharmacy, and they will handle the rest.

Will I Have a Copay?
Medicaid Members do not have a copay for prescription drugs.

How Do I Get My Medicine If I Am Traveling?

Community First Health Plans has network pharmacies in all 50 states. If you need a refill while on vacation, call your doctor for a new prescription to take with you.

What If I Paid Out of Pocket For a Medicine and Want To Be Reimbursed?
If you had to pay for a medicine, please contact Member Services at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

for assistance with reimbursement.

How do I get family planning services? Do I need a referral for this?
You can go to any provider that accepts Medicaid. You do not need a referral from your Primary Care Provider. You should talk to your doctor about family planning. Your doctor will help you pick a family planning provider. If you do not feel comfortable talking to your doctor, call Member Services at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

Where do I find a family planning services provider?
You can find the locations of family planning providers near you online at http://www.dshs.state.tx.us/famplan/, or you can call Community First Health Plans at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

for help in finding a family planning provider.

Call Community First 24 Hours a Day
Do you have health questions? Call Community First's Nurse Advice Line 24 hours a day, 7 days a week. Just call:

STAR: 1-800-434-2347
STAR Kids: 1-855-607-7827

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

What is Case Management for Children and Pregnant Women (CPW)?
Need help finding and getting services? You might be able to get a case manager to help you.

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

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

What do case managers do?
A case manager will visit with you and then:

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

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

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

How can you get a case manager?
Call the Texas Health Steps at 1-877-847-8377 (toll-free),
Monday to Friday, 8 a.m. to 8 p.m.

To learn more, go to: www.dshs.state.tx.us/caseman

Community First Health Plans Case Management: 1-855-607-7827
Community First Health Plans Website: www.cfhp.com

What is a Early Childhood Intervention (ECI)?
ECI is a statewide program for families with children, 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?
Yes, your PCP can refer you to an ECI services.

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

SERVICE COORDINATION

What is Service Coordination? (STAR Kids only)

The Community First Service Coordination program looks at all of your needs. It focuses on your health, well-being, and independence. The program allows Community First to work with you and your care team. We will gather information about you and your needs. We will build an individual plan of care and services just for you. This is called Person Centered or Person Directed planning.

What will a Service Coordinator do for me?

Community First Service Coordinators will help you get all the health care services you need. They will help you stay healthy and independent. Our Service Coordinators will work with your Primary Care Physician (PCP) and specialty care providers. They make sure you get all your covered services. In some cases non-covered services may be covered.

Here are some services they will assist you with:

- Utilization Management
- Case management
- Behavioral Health
- Substance Abuse
- Texas Heath Steps

Service Coordinators know how to meet the needs of people that need the most help. They help with people who have chronic or complex conditions. They are dedicated to serving STAR Kids Members.

How can I talk with a Service Coordinator?

Your Service Coordinator will provide you with a number to call them directly. If you have not been assigned a Service Coordinator you can contact Community First at (210) 358-6403, or toll-free 1-855-607-7827.

What is a Transition Specialist? What will a Transition Specialist do for me? (STAR Kids only)

A Transition Specialist is a specially trained Service Coordinator who will help you, your family and your Community First Service Coordinator plan for your future. Starting as early as age ten (10), but regularly at age fifteen (15), you, your family and care giver team will meet and set your goals and objectives for that year. Each year until you reach the age of twenty-one (21), your team is with you. They will help you plan for the move from child care and services to adult care and services.

How can I talk to a Transition Specialist?

You can talk to a Transition Specialist by calling your personal Service Coordinator. You can call us at 1-855-607-7827.

What is a Health Home? (STAR Kids only)

A health home is a person-based approach to holistically meet your needs. It provides services and support beyond what a PCP is supposed to do. STAR Kids Health Homes operate through a primary care practice or specialty care practice through a team-approach. The goal is to provide care that is easy to access, is coordinated between providers, and provide quality of care.

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

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

Texas Health Steps gives your child:

- Free regular medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.
- A case manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:

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

When to set up a checkup:

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

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

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

Call Community First Health Plans at:
STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827
or Texas Health Steps 1-877-847-8377 (1-877-THSTEPS) (toll-free) if you:

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

If you can't get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital, or drug store.

- Houston/ Beaumont area: 1-855-687-4786.
- Dallas/ Ft. Worth area: 1-855-687-3255.
- All other areas: 1-877-633-8747 (1-877-MED-TRIP).

How and when do I get Texas Health Steps medical and dental checkups for my child?
Medical Checkups -- Call us to see if your personal doctor does Texas Health Steps medical checkups. If so, you can call your doctor to make an appointment. If your doctor does not do Texas Health Steps medical checkups, call us to find out where you can go at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827.

We can help you find a doctor close to your home.

In a Texas Health Steps checkup, your child will receive the following:
- Physical exam, measuring height and weight
- Health and developmental history
- Hearing and eye check
- Checking for a good diet
- Vaccines (when needed)
- Blood tests (when needed)
- TB (tuberculosis) screening

Your doctor can tell you when you your child is due for a Texas Health Steps medical checkup.

Dental Checkups - Your child can begin to get dental checkups every 6 months when he or she turns 1. The age limit is 20 years old. Your child can see any dentist who takes Medicaid. You do not need a referral for dental care.

- Exam and teeth-cleaning once every 6 months
- Emergency care
- Fluoride treatments to prevent tooth decay
- Fixing tooth decay
- Braces (but not for cosmetic reasons)
- Other services as needed
- Ask about dental sealants for your child. A dental sealant is a plastic material put on the back teeth that can help prevent tooth decay.

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

Does my doctor have to be part of the Community First network for a Texas Health Steps exam?
You can use any Texas Health Steps provider in the state for a Texas Health Steps exam.

Do I need to have a referral?
You do not need a referral from your personal doctor. If you need help to find a doctor, call us at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827.

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

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

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

If you need help to find a Texas Health Steps doctor, call Member Services at 1-855-607-7827 or visit www.cfhp.com.

MEDICAL TRANSPORTATION PROGRAM (MTP)

What is MTP?
MTP is an HHSC program that helps with non-emergency transportation to healthcare appointments for eligible Medicaid clients who have no other transportation options. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?
- Passes or tickets for transportation such as mass transit within and between cities
- Air travel
- Taxi, wheelchair van, and other transportation
- Mileage reimbursement for enrolled individual transportation participant (ITP). The enrolled ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals at a contracted vendor (such as a hospital cafeteria)
- Lodging at a contracted hotel and motel
- Attendant services (responsible party such as a parent/guardian, etc., who accompanies the client to a healthcare service)

How to get a ride?
Call **MTP**
Phone Reservations: 1-877-633-8747 (1-877-MED-TRIP).
All requests for transportation services should be made within 2-5 days of your appointment.
Exceptions may be authorized in the event of an emergency.

How do I get eye care services?
Envolve provides routine eye care services to our Members. Call Member Services at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

for help finding an Envolve provider near you. You can also look up Envolve providers under the Envolve link on our website at www.cfhp.com. Click on "Find a Provider," then click on "STAR/ Medicaid" or "STAR Kids" then click on "Envolve" link.

- Ages 0-20 years of age receive one vision exam yearly
- Members 21 and over receive one vision exam every two years
- Members under 21 years of age can get prescription eye-glasses

If you need medical services from an ophthalmologist, you need a referral from your Primary Care Provider. These providers are listed as specialists in the STAR and STAR Kids Provider Directory. You can find them in the provider look-up on our website at www.cfhp.com.

What dental services does Community First cover for children?
Community First covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

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

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

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

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

Can someone interpret for me when I talk with my doctor?
Yes. Member Services will get someone to speak to you in your language.

Who do I call for an interpreter? How far in advance to I need to call?
Call Member Services at least 24 hours before your medical visit at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

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

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

ATTENTION FEMALE MEMBERS

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

You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

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

How do I choose an OB/GYN?
You can find a list of available OB/GYN doctors from the STAR or STAR Kids Provider Directory. Or you can view our website at www.cfhp.com, click on "Find a Provider," then click on "STAR/ Medicaid" or "STAR Kids." You can also call us at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

so we can help you pick a doctor.

If I don't choose an OB/GYN, do I have direct access to an OB/GYN without a referral?
Yes, you still have direct access without a referral if you don't pick an OB/GYN.

Will I need a referral?
You do not need a referral from your personal doctor. You do not need to check first with Community First.

Can I stay with my OB/GYN if they are not with Community First?
You will have to pick a new OB/GYN from the STAR or STAR Kids Provider Directory if you are not pregnant and your OB/GYN is not in our network. If you are pregnant and your OB/GYN is not in our network, call us for assistance.

What if I am pregnant? Who do I need to call?
Call us and we can help you pick an obstetrician. It is very important to start your prenatal care right away.

How soon can I be seen after contacting my OB/GYN for an appointment?
You should be able to get an appointment within two weeks of the request. If you cannot get an appointment within two weeks, call us:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

What other services/activities/education does Community First offer pregnant women?
Community First has a special prenatal program called Healthy Expectations. There are gifts for women who enroll in the program and complete education classes. Call Member Services to learn more.

Where can I find a list of birthing centers?
To find a list of participating hospitals to give birth, please see our provider directory. You can visit our website at www.cfhp.com or call us:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

Can I pick a Primary Care Provider for my baby before the baby is born? (STAR Medicaid only)
Yes. It will be much easier if you do.

For Pregnant Women Only

- Free birthing classes
- Additional dental services
- Home visits for high-risk pregnant women

How and when can I switch my baby's Primary Care Provider? (STAR Medicaid only)
The rules for infants are the same as for other children. Just call Member Services and if you ask before the 15th of the month, the change will be made for the first of the next month. Requests made after the 15th of the month will be effective the first of the month following the next month.

Can I switch my baby's health plan? (STAR Medicaid only)
For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at 1-800-964-2777.

You cannot change health plans while your baby is in the hospital.

How do I sign up my newborn baby? How and when do I tell my health plan?
You should pick a Primary Care Provider for your baby before the baby is born. Just call Member Services for help.

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

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

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

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

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

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

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

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

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

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

DSHS Expanded Primary Health Care Program

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

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

http://txclinics.com/.

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

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

DSHS Family Planning Program

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

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

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

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

How and when do I tell my caseworker?
Call your Medicaid caseworker as soon as possible after your baby is born. That way, the baby can get a Medicaid number and benefits right away.

Who do I call if I have special health care needs and need someone to help me?
We offer case management services or service coordination services to Members with special health care needs. Member Services can help you get in touch with a case manager.

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

What are advance directives? How do I get an advance directive?
They are written instructions to your family about what to do if you become very sick. Community First has a booklet about Advance Directives. We will be happy to send you one. Call Member Services to ask for the booklet.

What do I have to do if I need help with completing my renewal application?
Families must renew their Children's Medicaid coverage every year. In the months before a child's coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family's income and cost deductions. The family needs to:

- Look over the information on the renewal application.
- Fix any information that is not correct.
- Sign and date the application.
- Look at the health plan options, if Medicaid health plans are available.
- Return the renewal application and documents of proof by the due date.

Once HHSC receives the renewal application and documents of proof, staff checks to see if the children in the family still qualify for their current program or if they qualify for a different program. If a child is referred to another program (Medicaid or CHIP), HHSC sends the family a letter telling them about the referral and then looks to see if the child can get benefits in the other program. If the child qualifies, the coverage in the new program (Medicaid or CHIP) begins the month following the last month of the other program's coverage. During renewal, the family can pick new medical and dental plans by calling the CHIP/Children's Medicaid call center at 1-800-964-2777.

Completing the Renewal Process
When children still qualify for coverage in their current program (CHIP or Medicaid), HHSC will send the family a letter showing the start date for the new coverage period. If the children qualify for CHIP and an enrollment fee is due, the family must pay the enrollment fee by the due date or risk losing the coverage.

What happens if I lose my Medicaid coverage?
If you lose Medicaid coverage but get back in again within six (6) months you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same Primary Care Provider you had before.

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

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

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

What do I have to do if I move? (STAR & STAR Kids only)
As soon as you have your new address, give it to the local HHSC benefits office and Community First Health Plans Member Services Department at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827.

Before you get Medicaid services in your new area, you must call Community First Health Plans, unless you need emergency services. You will continue to get care through Community First Health Plans until HHSC changes your address.

What if I need to update my address or phone number? (AAPCA Only)
- The adoptive parent or permanency care assistance caregiver should contact the DFPS regional adoption assistance eligibility specialist assigned to his or her case
- If the parent or caregiver doesn't know who the assigned eligibility specialist is, they can contact the DFPS hotline, 1-800-233-3405, to find out.
- The parent or caregiver should contact the adoption assistance eligibility specialist to assist with the address change.

MEDICAID AND PRIVATE INSURANCE

What if I have other health insurance in addition to Medicaid?
You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if

- Your private health insurance is canceled.
- You get new insurance coverage.
- You have general questions about third party insurance.

You can call the hotline toll-free at 1-800-846-7307.

If you have other insurance, you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a) Be treated fairly and with respect.
   b) Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a) Be told how to choose and change your health plan and your Primary Care Provider.
   b) Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan.
   c) Change your Primary Care Provider.
   d) Change your health plan without penalty.
   e) Be told how to change your health plan or your Primary Care Provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a) Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated, regardless of cost or what your benefits cover.
   b) Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a) Work as part of a team with your provider in deciding what health care is best for you.
   b) Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
   a) Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
   b) Get a timely answer to your complaint.
   c) Use the plan's appeal process and be told how to use it.
   d) Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a) Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.

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b) Get medical care in a timely manner.
c) Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
d) Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
e) Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals and others cannot require you to pay copayments or any other amounts for covered services.
10. You have a right to make recommendations about the health plan's Member rights and responsibilities policy.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a) Learn and understand your rights under the Medicaid program.
   b) Ask questions if you do not understand your rights.
   c) Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a) Learn and follow your health plan's rules and Medicaid rules.
   b) Choose your health plan and a Primary Care Provider quickly.
   c) Make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan.
   d) Keep your scheduled appointments.
   e) Cancel appointments in advance when you cannot keep them.
   f) Always contact your Primary Care Provider first for your non-emergency medical needs.
   g) Be sure you have approval from your Primary Care Provider before going to a specialist.
   h) Understand when you should and should not go to the emergency room.
3. You must share information about your health with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:
   a) Tell your Primary Care Provider about your health.
   b) Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c) Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   a) Work as a team with your provider in deciding what health care is best for you.
   b) Understand how the things you do can affect your health.

c) Do the best you can to stay healthy.
d) Treat providers and staff with respect.
e) Talk to your provider about all of your medications.

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

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

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

for more information about these benefits.

UTILIZATION MANAGEMENT PROCESS

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

To make UM decisions, Community First Health Plans uses the requesting practitioner's recommendation and nationally recognized criteria and guidelines, and applies the criteria in a fair, impartial, and consistent manner that serves the best interest of our Members. To ensure that Members receive the most appropriate healthcare, Community First Health Plans reviews your care before, during, and after you receive it to ensure it is covered. Pre-service review occurs before you receive care and post-service review occurs before the claim is paid when you receive care that was not authorized in advance. Generally, your practitioner requests prior authorization from Community First Health Plans before you receive care; however, it is the Member's responsibility to make sure that they are following Community First Health Plans rules for accessing care. If you are obtaining care from a non-network provider, call:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

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

How to Obtain Information About the UM Process and Authorization of Care:

Utilization management staff are available to assist you with any questions or concerns you may have regarding the UM process and the authorization of care. You may speak with a UM staff member by calling:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

during normal business hours, Monday through Friday, 8:30 a.m. to 5 p.m. On-call UM staff can be reached for urgent issues after hours, weekends, and holidays by calling the same phone numbers and advising the answering service of your need to speak with a UM staff member.

COMPLAINT PROCESS

What should I do if I have a complaint? Who do I call? Can someone from Community First help me file a complaint?
We want to help. If you have a complaint, please call Member Services toll-free at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

to tell us about your problem. A Community First Health Plans Member Services Advocate can help you file a complaint. Just call:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

Most of the time, we can help you right away or at the most within a few days.

How long will it take to process my complaint? What are the requirements and timeframes for filing a complaint?
You can file a complaint with Community First at any time. We will mail you a letter within 5 days to tell you we received your complaint. Then we will mail you our decision within 30 days.

What if I want to file a complaint with HHSC, once I have gone through the Community First complaint process?
Once you have gone through the Community First Health Plans complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
MCCO Research and Resolution
P.O. Box 149030, MC:0210
Austin, TX 78714-9030
ATTN: Resolution Services

If you can get on the Internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us.

APPEAL PROCESS

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

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

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

How will I find out if services are denied?
You will receive a letter telling you about this. You will also get an appeal form.

When does a Member have the right to ask for an appeal?
You can appeal if you are not happy with the decision. You may also ask for an appeal if Community First denied payment of services in whole or in part. You may name someone to represent you by writing a letter to the health plan telling them that name of the person you want to represent you. A doctor or other medical provider may be your representative. Just call:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

You may also fill out the appeal form and send it back to Community First. If you request an appeal by phone, an appeal form will be mailed to you. You must fill out and sign the form and return it to Community First.

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

What are the timeframes for the appeal process?
You must request an appeal within 60 days from the date on you notification of the denial, reduction or suspension of previously authorized services, or by the effective date of the action. A letter will be mailed to you within 5 days to tell you we received your appeal. We will mail you our decision within 30 days. You have the right to ask for an extension up to 14 days if you want to provide more information. You may provide appeal information by phone, in writing or in person.

If Community First needs more information, we might ask for an extension. If we need an extension, we will call you as soon as possible to explain the reason for the delay. We will also send you a letter within two days. We will tell you the reason for the delay and how this will help you. Community First will resolve your appeal as soon as possible based on your health condition and no later than the 14 days extension. If you are not happy with the delay, you may file a complaint. Just call:

STAR Medicaid: 1-800-434-2347

STAR Kids: 1-855-607-7827

You have the right to keep getting any current medical services Community First already approved while we process your appeal if you file your appeal on or before:

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

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

What if I am not happy with the answer to my appeal? Can I request a State Fair hearing?
Call us to ask for a State Fair Hearing if you are not satisfied with the CFHP decision on you appeal.

EXPEDITED HEALTH PLAN APPEAL

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. For emergencies, hospital admissions or to continue current prescriptions and intravenous medications, or for denial of step therapy medication protocol exeption, you can request an Expedited Appeal.

What are the timeframes 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.

How do I ask for an expedited appeal? Who can help me in filing an expedited appeal? Does my request have to be in writing?
Call us. Our Member Service Advocates can help you. Your request does not have to be in writing. You have the right to ask for an extension up to 14 days if you want to provide more information. You may provide appeal information by phone, in writing or in person, within the limited time of the expedited appeal.

What happens if Community First denies my request for an Expedited Appeal?
We will tell you. Your request will be moved to the regular appeal process and we will notify you of the change by mail within 2 calendar days.

STATE FAIR HEARING

Can I ask for a State Fair Hearing?
If you, as a Member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may request a standard or expedited fair hearing after exhausting the CFHP appeal process. You are not required to pay for the cost of the fair hearing. If CFHP does not answer your standard or expedited appeal within the timelines given, you may request a fair hearing without waiting for the answer to your appeal.

You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 120 days of the date on the health plan's letter with the decision. If you do not ask for the fair hearing within 120 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should either send a letter to the health plan at 12238 Silicon Drive, Suite 100, San Antonio, TX 78249 or call:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827.

You have the right to keep getting any service the health plan denied or reduced at least until the final hearing decision is made if you ask for a fair hearing by the later of:

- 10 calendar days following Community First's mailing of the notice of the Action, or
- the day the health plan's letter says your service will be reduced or end.

If you do not request a fair hearing by this date, the service the health plan denied , reduced or suspened will be stopped. If the services that are the subject of the fair hearing are not approved during the fair hearing, you may be responsible for the cost of the services you received during the fair hearing appeal.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

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

NEW MEDICAL TECHNOLOGY

The Community First Medical Director and participating providers review and evaluate new medical advances in technology (or the new application of existing technology). This is done for medical procedures, behavioral health procedures, pharmacy management, and devices on an individual basis to determine if they are appropriate for covered benefits. Scientific literature and government approval are reviewed for determining if the treatment is safe and effective. The new medical advance or treatment (or new application of existing technology) must provide equal or better outcomes than the existing covered benefit or therapy for it to be considered for coverage.

For more information about how Community First reviews new medical technology, please call us. We can be reached at:

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827.

REPORTING ABUSE, NEGLECT, AND EXPLOITATION (STAR Kids only)

How do I report suspected abuse, neglect, or exploitation?
You have the right to respect and dignity, including freedom from Abuse, Neglect, and Exploitation.

What are Abuse, Neglect, and Exploitation?
Abuse is mental, emotional, physical, or sexual injury, or failure to prevent such injury.

Neglect results in starvation, dehydration, over medicating or under medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care, and personal hygiene.

Exploitation is misusing the resources of another person for personal or monetary gain. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Reporting Abuse, Neglect, and Exploitation
The law requires that you report suspected Abuse, Neglect, or Exploitation, including unapproved use of restraints or isolation that is committed by a provider.

Call 9-1-1 for life-threatening or emergency situations.

Report by Phone (non-emergency); 24 hours a day, 7 days a week, toll-free
Report to the Department of Aging and Disability Services (DADS) by calling 1-800-647-7418 if the person being abused, neglected, or exploited lives in or receives services from a:

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

Suspected Abuse, Neglect or Exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

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

Report Electronically (non-emergency)
Go to: https://txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

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

FRAUD AND ABUSE

Do you want to report Waste, Abuse, or Fraud?
Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ Under the box lebeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249
STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827

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

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

INFORMATION THAT MUST BE MADE AVAILABLE ON AN ANNUAL BASIS

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

- Information about network providers - at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services and post-stabilization services.
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - How to get emergency services, including instructions on how to use of the 911 telephone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have the right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- Community First Health Plan’s practice guidelines.

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CONFIDENTIALITY

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

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

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

Find us on Facebook
Community First is committed to you and your wellness. Our Facebook page has information such as health tips and other helpful information.
Check us out and like us!

Extra Benefits for Members
Community First members can get extra benefits in addition to their regular benefits. These are called value-added services. We offer the most value-added services in the Bexar service delivery area. More information about these benefits is located on page 17. Ask us about how you can get these benefits.

CFC: Community First Choice

CFHP: Community First Health Plans

CLASS waiver: Community Living Assistance and Support Services

DBMD: Deaf Blind with Multiple Disabilities

DME: Durable Medical Equipment

DSHS: Department of State Health Services

FQHC: Federally Qualified Health Center

HHSC: Health and Human Services Commission

LAR: Legally Authorized Representative

LMHA: Local Mental Health Authority

LTSS: Long Term Services and Supports

MCO: Managed Care Organization

MTP: Medical Transportation Program

PCP: Primary Care Physician

PCS: Personal Care Services

PDN: Private Duty Nursing

RHC: Rural Health Clinic

TxHmL: Texas Home Living

UM: Utilization Management

YES Waiver: Youth Empowerment Services Waiver

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

Community First Health Plans provides free auxiliary aids and services to people with disabilities to communicate effectively with our organization, such as:

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

Community First Health Plans also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

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

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

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

(210) 510-2482
TTY number: 1-800-390-1175
Fax: (210) 358-6014
E-mail: lketterman@cfhp.com

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019
1-800-537-7697 (TDD)

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

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-434-2347（TTY：1-800-390-1175）。

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

رقم 1-800-434-2347 قم رب اتصلابالمجان.
نإف تامدخ اسملا ةدع وغللا ةى وتت ف لك
اللغة،اذك رت تتحدث كنت إذا ملحوظة: 1-800-
390-1175 :والا لصم اهات

یک تامدخ تفم ںیم بایتسد ںیہ ۔ لاک
ود وب ےتل،ںیہ وت پآ وک نابز ی ک ددم
ار پآ رگا راد: ربخ 1-800-434-2347 (TTY:
1-800-390-1175) ک

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

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

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

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد. 1-800-434-2347 (TTY: 1-800-390-1175)

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

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

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

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

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

COMMUNITY FIRST
HEALTH PLANS

12238 Silicon Drive, Ste. 100 • San Antonio, Texas 78249

www.cfhp.com

STAR Medicaid: 1-800-434-2347
STAR Kids: 1-855-607-7827