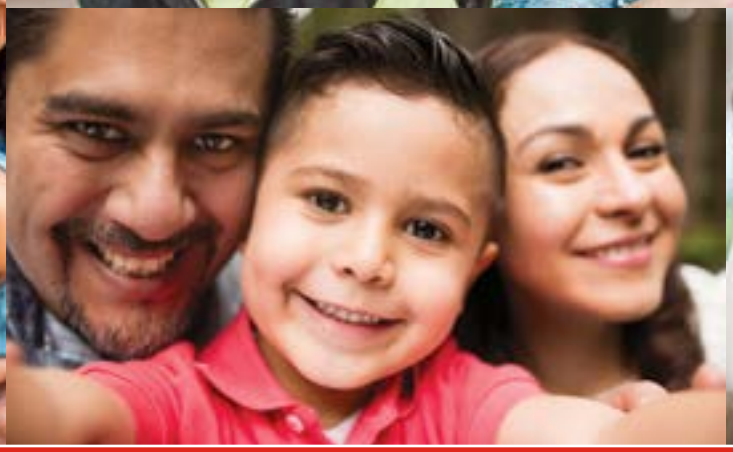
STAR Member Handbook

For Harris and Jefferson Service Delivery Areas

TEXAS STAR
Your Health Plan ★ Your Choice

TEXAS
Health and Human Services



Texas Children's®
Health Plan

866-959-2555
texaschildrenshealthplan.org

January 2023
MS-2203-213

Texas Children's Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Texas Children's Health Plan Member Services Department at 866-959-2555 (STAR), 866-959-6555 (CHIP), 800-659-5764 (STAR Kids) (TTY 7-1-1)

Texas Children's Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Texas Children's Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If you believe that Texas Children's Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Texas Children's Health Plan Member Services Department. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you at:

Texas Children's Health Plan
866-959-2555 (STAR), 866-959-6555 (CHIP), 800-659-5764 (STAR Kids) (TTY 7-1-1)
HealthPlan@texaschildrens.org
Attn: Civil Rights Coordinator
P.O. Box 301011, WLS 8314
Houston, Texas 77230-1011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or 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
800-368-1019, 800-537-7697 (TTY)

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

Communication is important to us. Language assistance services, free of charge, are available to you.
Call 866-959-2555 (STAR), 866-959-6555 (CHIP), 800-659-5764 (STAR Kids) (TTY 711).

Spanish: La comunicación es importante para nosotros: tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-866-959-2555 (TTY 711).

Vietnamese: Giao tiếp là quan trọng đối với chúng tôi: Dịch vụ trợ giúp ngôn ngữ, miễn phí, có sẵn cho bạn. Hãy gọi 1-866-959-2555 (TTY 711)

Chinese (Simplified): 我们非常重视沟通：您可以免费获得语言援助服务。请致电 1-866-959-2555 (TTY 711)

Korean: 귀하나 귀하의 자녀 (스등)은 커뮤니케이션을 중요합니다: 무료 언어지원 서비스가 이용가능합니다. 1-866-959-2555 번으로 전화 주시기 바랍니다. (TTY 711)

Arabic: التواصل يهمنا: خدمات الدعم اللغوي متاحة لك مجانا. اتصل بالرقم 1-866-959-2555 (TTY 711)

Urdu: مواصلات ہمارے لئے اہم ہے: زبان میں معاونت کی خدمات آپ کو مفت دستیاب ہیں 1-866-959-2555 پر کال کریں (TTY 711)

Tagalog: Mahalagang makipag-ugnayan tayo: Kung hindi kayo marunong mag-Ingles, maaaring makakuha ng libreng mga serbisyong makakatulong sa inyong umunawa. Tumawag lamang sa 1-866-959-2555. (TTY 711)

French: La communication nous tient à coeur : des services gratuits d'aide linguistique sont à votre disposition. Il vous suffit de composer le 1-866-959-2555. (TTY 711)

Hindi: संचार हमारे लिए ज़रूरी है: आपके संबंधी सेवाएँ निःशुल्क प्राप्त करने के लिए 1-866-959-2555 पर कॉल करें (TTY 711)

Farsi (Persian): برقراری ارتباط برای ما حائز اهمیت است: خدمات کمک زبانی به صورت رایگان در دسترس شما است. به شماره 1-866-959-2555 تماس بگیرید (TTY 711)

German: Kommunikation ist für uns wichtig: Fremdsprachliche Hilfe steht Ihnen kostenlos zur Verfügung. Bitte rufen Sie 1-866-959-2555 an. (TTY 711)

Gujarati: કમ્યુનિકેશન એ અમારા માટે મહત્વનું છે ભાષા સહાયતા સેવાઓ, તમારા માટે વિનામૂલ્ય ઉપલબ્ધ છે. સંપર્ક 1-866-959-2555 (TTY 711)

Russian: Общение важно для нас: вы можете воспользоваться бесплатной службой языковой поддержки - звоните по номеру 1-866-959-2555 (TTY 711)

Japanese: コミュニケーションは私たちにとって大切です：無料の言語サポートサービスをご利用いただけます。1-866-959-2555 までお電話ください。(TTY 711)

Laotian: ການສື່ສານແມ່ນສິ່ງທີ່ສຳຄັນສຳລັບພວກເຮົາ: ພວກເຮົາມີບໍລິການຊ່ວຍດ້ານພາສາຟຣີໃຫ້ກັບທ່ານ. ໂທ 1-866-959-2555 (TTY 711)

Quick Guide – Who to call

If you need:	Please call:
Texas Children's Health Plan	Member Services, call 866-959-2555 or TTY 800-735-2989 (Texas Relay) or 7-1-1 to find out how to get covered services for you or your child. Member Services is ready 8 a.m. to 5 p.m. Monday through Friday Central Time, excluding state-approved holidays. After hours, on weekends and holidays, our answering service is ready to help you and/or take your messages. A Member Services Advocate will return your call the next business day. In case of an emergency, go to your nearest in-network emergency room or call 9-1-1. You can talk to a Member Advocate in English or Spanish. Interpreters who speak 140 different languages are also available by phone.
A doctor's care	Your primary care provider's phone number is on your ID card. Your primary care provider is available 24 hours a day, 7 days a week.
Behavioral (mental) health or substance abuse treatment	Behavioral Health/Substance Abuse Hotline, at 800-731-8529 to find out how to get services. You can call 24 hours a day, 7 days a week. No primary care provider referral is needed. The hotline has people who speak English and Spanish. Interpreters who speak 140 different languages are also available by phone. If you have an emergency and need treatment immediately, call 9-1-1 or go to the nearest emergency room.
Nurse Help Line	800-686-3831 or TTY 800-735-2989 (Texas Relay). Registered nurses are ready 24 hours a day, 7 days a week. (Note: This is not an emergency care line.) The help line is staffed with individuals who speak English and Spanish, are knowledgeable about the STAR Program, covered services, the STAR population, and provider resources. Interpreters who speak 140 different languages are also ready by phone
Case Management	To sign up for case management, contact us directly at 832-828-1430 or you can reach us at 844-780-1154.
Emergency care	Go to an in-network hospital emergency room. If the situation is life-threatening, go to the nearest emergency facility. You do not need a primary care provider referral.
Urgent care	Your primary care provider or the Texas Children's Health Plan Nurse Help Line at 800-686-3831, TTY 800-735-2989 or 7-1-1.
Hospital care	Your primary care provider, who will arrange the care you need.
Family planning	Your primary care provider, a network OB/GYN, or a Medicaid family planning provider. You do not need a primary care provider referral.
Vision care	Envolve Vision, call 844-683-2305. No primary care provider referral is needed.
Prescriptions	Call Member Services at 866-959-2555 for the names of participating pharmacies or for help with getting a prescription filled. Member Services is ready 8 a.m. to 5 p.m. Monday through Friday Central Time, excluding state-approved holidays.
Dental care* (for children under age 21)	Your child's Medicaid dental plan. Your child will have one of the following dental plans. • DentaQuest 800-516-0165 • MCNA Dental 800-494-6262 • UHC Dental 800-964-2777 It is also listed on your child's Your Texas Benefits Medicaid Card. If you don't know who your child's Medicaid dental plan is, call the STAR Help Line at 800-964-2777.
Adult dental care	FCL Dental, dental care for adults ages 21 and older, call at 866-548-8123.
Transportation to the doctor	Non-Emergency Medical Transportation Services (NEMT), at 888-401-0170 or TTY 800-735-2989 (Texas Relay) or 7-1-1. NEMT services for trip scheduling are available 8 a.m. - 5 p.m. Monday - Friday. Where's My Ride services for trip updates are available 5 a.m. - 7 p.m. Monday - Saturday. All numbers have individuals who speak English and Spanish. Interpreters who speak 140 different languages are also available by phone.
Medicaid enrollment information	STAR Help Line, call 800-964-2777.
Medicaid eligibility and renewal	Your Health and Human Services Commission (HSSC) Caseworker, dial 2-1-1.
Ombudsman Managed Care Assistance Team	Call 866-566-8989, TTY 866-222-4306.
Women, Infants, and Children (WIC)*	Call 800-942-3678.

*Texas Children's Health Plan does not cover these services. You can get them directly from a Medicaid provider by using Your Texas Benefits Medicaid Card.

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Welcome to Texas Children's Health Plan

We are happy that you chose Texas Children's Health Plan for your family. Texas Children's Health Plan was founded in 1996 by Texas Children's Hospital. Texas Children's Health Plan is the nation's first managed care organization (MCO) created just for children. Texas Children's Health Plan has more than 500,000 members. The staff and group of over 1,200 provider groups, over 500 specialists and over 150 hospitals provide excellent service and patient care to our members. Texas Children's Health Plan also offers great services to pregnant women and adults. As a member, you will have use of programs for pregnant women and our disease management program for members with special health care needs. In addition, we offer exclusive benefits and rewards for our members to enjoy with their families, such as reward cards for staying on top of their health, special events, a 24-hour nurse help line, and much more.

This handbook will help you know how your health plan works. It tells you what to expect and how to get the most out of your coverage. It includes information on:

- How to get care when you are sick.
- How to change your doctor.
- What to do if you get sick while out of town or when your doctor's office is closed.
- Your rights and responsibilities as a plan member.
- How to call the health plan when you have questions or need help.
- What benefits and services are covered.
- Extra services offered by Texas Children's Health Plan.

Please take a few minutes and read this handbook carefully. If you have trouble understanding, reading, or seeing the information in this handbook, our Member Services Representatives can offer you special services to meet your needs. Call Member Services at 866-959-2555. If needed, this handbook can be given to you in audio, larger print, Braille, and other languages.

It is important to us to keep you healthy. That is why we want you to get regular well-child checkups and immunizations. It is also important to start and keep a relationship with a primary care provider. A primary care provider can be a doctor or clinic that gives you most of your health care. You and your doctor should work together to help keep you healthy and take care of you when you are not well. Here are 4 important things you need to do to get the most from your health coverage:

1. Always carry your Texas Children's Health Plan Member ID card and Your Texas Benefits Medicaid Card with you. Your Texas Children's Health Plan Member ID card and your Your Texas Benefits Medicaid Card are the keys to getting care. Show them every time you visit a doctor, hospital, or get a prescription filled. Do not let anyone else use your card.
2. Stay focused on prevention. As a new member, you should have your first checkup within 90 calendar days after joining Texas Children's Health Plan. Newborns should be seen by a doctor 3 to 5 days after birth. During your first visit, your primary care provider will learn about your health care needs to help keep you healthy.
3. Call your primary care provider first for non-emergency care. Always call your doctor first, unless it is an emergency. That way, they can help you get the care you need.
4. Keep this handbook and the other information in your packet for future use.

We are glad you chose Texas Children's Health Plan. It is our pleasure to serve you. If you have any questions, please call Member Services at 866-959-2555, TTY 800-735-2989 (Texas Relay), or 7-1-1. We are available from 8 a.m. to 5 p.m. Monday through Friday. After hours, on weekends and holidays, our answering service is ready to help you and/or take your messages. A Member Services Representative will return your call the next business day.

How the Plan Works

Texas Children's Health Plan STAR plan gives you a wide choice of doctors, hospitals, and other health services providers. We also give you the support and help you need to make the most of your plan.

Your primary care provider

What is a primary care provider?

When you joined the plan, you picked or were given a primary care provider. This will be your main doctor for regular medical care.

Think of your primary care provider as your medical home. If you are sick, need a checkup, or if you have a medical question, call your primary care provider.

Having a good relationship with your primary care provider will help keep you healthy. They will know about any issues you may be having and be able to help you choose what is the right care for you.

If you need to see a specialist or hospital, your primary care provider will give you a referral when needed. A referral is when your primary care provider arranges for you to go to another doctor. They will tell you exactly what kind of specialist or tests you need for your illness or condition.

Most of the time, you will need to get a referral to go to another doctor. If you do not get a referral, you will have to pay for the services yourself.

You can get more information on getting care from specialists or hospitals in the Specialty Care and Referrals section later in this handbook.

How do I find out who my primary care provider is?

Your primary care provider is listed on your member ID card. You can also call us at 866-959-2555 to find out.

How can I pick a primary care provider?

You can pick any primary care provider in the Texas Children's Health Plan network to be your main doctor. Each person living in your home who is a member can pick the same or a different primary care provider. You can easily search for a doctor at our website: texaschildrenshealthplan.org/doctor.

We can help you find a doctor. Call us at 866-959-2555.

Can a clinic be a primary care provider?

Yes. Primary care providers can be:

- Family doctors
- Pediatricians (for children and adolescents)
- General practice doctors
- Internal medicine doctors
- Advanced Nurse Ppractitioners (ANPs)
- Federally Qualified Health Clinics (FQHCs)
- Rural Health Clinics (RHCs)
- Community-based clinics

It is important that you get to know your primary care provider. It also is important to tell the doctor as much as you can about your health. Your primary care provider will get to know you, give you regular checkups, and treat you when you are sick. It is important that you follow your primary care provider's advice and take part in decisions about your health care.

It is not good to wait until you are sick to meet your primary care provider. Schedule your first Texas Health Steps checkup or adult wellness checkup right away. You should get this checkup within the first 90 days (about 3 months) of you joining Texas Children's Health Plan. Member Services can help you schedule your visit. We can also help you get transportation to your doctor's office. Call our transportation line at 346-232-4130, or at 888-401-0170.

Can a Specialist ever be considered a Primary Care Provider?

There are times when Texas Children's Health Plan will allow a specialist to be your primary care provider. Call Member Services at 866-959-2555 for more information. Your primary care provider or another doctor working with him or her is available 24 hours a day, 7 days a week.

Changing your primary care provider

You can always choose to change your primary care provider.

How do I find a new doctor?

You can easily find a doctor using our online Find a doctor tool. Just visit texaschildrenshealthplan.org/doctor.

You can also call Member Services at 866-959-2555. We will be glad to help you pick a new primary care provider or send you a copy of our provider directory.

Our Member Services Representatives can tell you the:

- Doctor's office hours.
- Languages spoken by the doctor and staff in the office.
- Doctor's specialty.
- Patient age limits.
- Restrictions on accepting new patients.

Do not change to a new primary care provider without telling us. If you go to a new primary care provider without telling us, you may have to pay for the services.

Are there any reasons why a request to change a primary care provider may not be approved?

Sometimes you might not be able to have the primary care provider you chose. This happens when the primary care provider you chose:

- Cannot see more patients.
- Does not treat patients your age.
- Is no longer part of Texas Children's Health Plan.

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 at 866-959-2555 or writing to:

Texas Children's Health Plan
Member Services Department
PO Box 301011, NB 8360
Houston, TX 77230

When will my primary care provider change become effective?
When you change your primary care provider, the change will take effect immediately. A new Member ID card will be mailed to you. The ID card will have your new primary care provider's name and phone number. Be sure to have your medical records sent to your new doctor.

You do not have to change health plans to change your primary care provider.

What if I want to know more about my doctor?
You can learn more about your doctor such as their specialty or whether they offer telemedicine services by clicking on the "Find a doctor" link on our website texaschildrenshealthplan.org.

Your primary care provider also can ask for changes

Can my primary care provider move me to another primary care provider for non-compliance?
Your primary care provider can ask that you pick another primary care provider if:

- You miss visits without calling to say you will not be there.
- You often are late for your visits.
- You do not follow your primary care provider's advice.
- You do not get along with the primary care provider's office staff.

If your primary care provider asks you to change to a new primary care provider, we will send you a letter. The letter will tell you that you need to pick a new primary care provider. If you do not choose a new primary care provider, one will be chosen for you.

If your primary care provider leaves Texas Children's Health Plan

What if my primary care provider leaves?
If your primary care provider decides to end his or her participation with Texas Children's Health Plan, we will tell you within 15 days (about 2 weeks) of finding out about the doctor's decision. You may also pick another primary care provider. Call Member Services at 866-959-2555. A Member Advocate will help you make the change.

If you are getting medically necessary treatments, you might be able to stay with that doctor if they are willing to see you. When we find you a new primary care provider on our list who can give you the same type of care, we will change your primary care provider.

What if I choose to go to another doctor who is not my primary care provider?
Always call Member Services to change your primary care provider before setting up a visit with another doctor. If you choose to go to another doctor who is not your primary care provider, the doctor might refuse to see you, or you might have to pay.

Your Texas Children's Health Plan Member ID Card

You and each person in your family covered by Texas Children's Health Plan will have a personal Member ID card.

What do I need to bring to my doctor's appointment?
Always carry this card with you. You will need to show it to all health care providers before you get medical services. It tells the providers what Texas Children's Health Plan you have. If you do not show your ID card, the doctor might refuse to see you, or you might have to pay for the services you get.

Call Member Services at 866-959-2555 if you need to see your primary care provider before you get your new ID card. We will call and tell your doctor you are a member of the Texas Children's Health Plan.

A copy of the Member ID card is shown below. The front shows valuable information about you. It also has your Medicaid ID number and the name and phone number of your primary care provider. The bottom-front section of the Member ID card has important phone numbers for you to call if you need help using health services.

How to read your ID card

The front and back of your ID card shows:

- Your name and ID number.
- Your date of birth.
- Your primary care provider's name and phone number.
- The Member Services telephone number.
- The Behavioral Health/Substance Abuse phone number.
- The Vision Care phone number.
- The Nurse Help Line phone number.

As soon as you receive the Member ID card, check to make sure your information is correct. Call Member Services if you find an error. We will correct the information and send you a new card.

Do not let other people use your Member ID card. If the card is lost or stolen, call Member Services. A Member Advocate will send you a new card.

How to use your ID card

- Always carry your Member ID card and Your Texas Benefits Medicaid Card with you.
- Show your Member ID card and Your Texas Benefits Medicaid Card every time you go to a provider's office.
- Do not let other people use your card.
- Call Member Services at 866-959-2555 if you do not have a Member ID card.
- Call Member Services at 866-959-2555 if your Member ID card is lost or stolen.
- Call Member Services at 866-959-2555 if you move or change your phone number

Your Texas Benefits (YTB) Medicaid Card

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

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

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

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

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

If you lose your Texas Benefits Medicaid card and need quick proof of eligibility, the Health and Human Services Commission (HHSC) can still give you a Temporary Medicaid Eligibility Verification Form (Form 1027-A). You must apply for the temporary form in person at an HHSC benefits office. To find the nearest office call 2-1-1 (choose a language and then choose option 2).

You must take your Form 1027-A or your YTB ID card with you when you get any health care services.

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

The YourTexasBenefits.com Medicaid Client Portal

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

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

To access the portal, go to www.YourTexasBenefits.com.

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

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

Benefits and Services

STAR Covered Services

What are my health care benefits?

The following is a list of many of the medically necessary Care Covered Services included under the Medicaid STAR Program.

The services listed below are subject to modification based on changes in Federal and State laws, regulations, and policies.

For more information or if you have questions, call Member Services at 1-866-959-2555.

STAR Covered Services include Medically Necessary:

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids
- Autism Benefit Therapy, Applied Behavior Analysis (ABA) evaluation and treatment of the Texas Health StepsComprehensive Care Program (THSteps-CCP) Member must be 20 years of age or younger. Requires approval ahead of time
- 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)
  - Collaborative Care Model services
  - 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 provided in accordance with 42 C.F.R. § 440.70, and as directed by HHSC
- Hospital services, including inpatient and outpatient
- 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)
- Nonemergency Medical Transportation Services, including:
  - Demand response transportation services, including Nonmedical Transportation prearranged rides, shared rides, and public transportation services;
  - Mass transit;
  - Individual transportation participant mileage reimbursement;
  - Meals;
  - Lodging;
  - Advanced funds; and
  - Commercial airline transportation services, including out of state travel.
- 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

STAR Program benefits are subject to benefit limits and exclusions. For a complete listing of the limitations and exclusions that apply to each Medicaid benefit category, you can review the current *Texas Medicaid Provider Procedures Manual*, which can be accessed online at: http://www.tmhp.com.

Are there any limits to any covered services? What number do I call to find out about these services?
There may be limits on some services. Questions? Call 866-959-2555.

What are 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, from 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 or dentist 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 they need, such as:
- Eye tests and eyeglasses.
- Hearing tests and hearing aids.
- Dental care.
- Other health care.
- Treatment for other medical conditions.

Call Texas Children's Health Plan 866-959-2555 or Texas Health Steps at 877-847-8377 (877-THSTEPS) if you:
- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps.
- Need help finding and getting other services.

Get rewarded for completing your well-child checkups!
- Complete 3 well-child checkups by the age of 15 months and get a $50 reward card.
- Complete 6 well-child checkups by the age of 15 months and get an additional $100 reward card.
- Rewards can be requested up to 30 days after the end of the eligible year.

Visit healthyrewardsprogram.org or call Member Services for more information.

Texas Children's Health Plan covers hospitals, primary care providers, 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. Texas Children's Health Plan 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.

Does my doctor have to be part of the Texas Children's Health Plan network? Do I have to have a referral?
You may see any doctor or dentist who gives Texas Health Steps services. The doctor does not have to be in the Texas Children's Health Plan network. You do not need a referral to receive Texas Health Steps services from a Texas Health Steps provider who is not your primary care provider.

Call Member Services at 866-959-2555 or Texas Health Steps at 877-847-8377 for the names of doctors and dentists who give Texas Health Steps services.

What if I am out of town and my child is due for a Texas Health Steps checkup?
Office visits for Texas Health Steps services when your child is out of town but within the Texas Health and Human Services will be covered if you get services from a Texas Health Steps provider.

How and when do I get Texas Health Steps medical and dental checkups for my child?

We will help you keep track of the services your child needs to stay healthy. When a Texas Health Steps checkup or an immunization is due for your child, we will send you a postcard or call to remind you to make an appointment. We can also help you get transportation. Call our transportation line at 346-232-4130, or at 888-401-0170.

Texas Health Steps medical and dental checkups can help find and treat health problems before they get worse. Children's dental services are paid for by the Texas Department of State Health Services so you will need Your Texas Benefits Medicaid Card to receive services. Dental checkups are due every 6 months beginning at 12 months of age.

What if I need to cancel an appointment?

If you cannot keep a visit for Texas Health Steps services, call the doctor's office as far in advance as possible to let them know. It is best to tell the office at least 24 hours before your appointment.

If you do not keep your or your children's Texas Health Steps checkups and immunizations up to date, your Temporary Assistance for Needy Families (TANF) check could be reduced.

Services that are not covered

What services are not covered?

Some services that are not covered include:

- Infertility treatment
- Autopsies
- Experimental and investigational services, including drugs and equipment
- Any service received outside of the United States and its territories
- Cosmetic surgery
- Sex-change operations
- Sterilization reversal
- Health care performed by a doctor or provider who does not take Texas Medicaid
- Services that are not medically necessary

You can call Member Services for a complete list of services that are not covered.

You have a right to know the cost of any service that is not covered before you receive that service. If you agree to get services that we do not cover, you might have to pay for them.

This notice applies to all Texas Children's Health Plan STAR members 20 years old or younger.

The Health and Human Services Commission (HSSC) has settled a lawsuit that affects private duty nursing, home health skilled nursing, durable medical equipment and supplies, and personal care services for Medicaid beneficiaries 20 years old or younger. You can get a copy of the Settlement Agreement by visiting www.hhsc.state.tx.us and www.advocacyinc.org. If you have any questions, call Advocacy, Inc. at 713-974-7691 and 800-880-0821.

Migrant farm workers

What is a migrant farm worker?

A migrant farm worker is a person who works on farms as a field worker or as a food packer during certain times of the year. Migrant farm workers move from place to place to follow the crops. We have extra services for migrant farm workers and their children. Call Member Services at 866-959-2555 if you are a migrant farm worker family. We will:

- Help you choose a primary care provider.
- Help you set up your appointments.
- Help you get transportation to the doctor.
- Let your primary care provider know your children need to be seen before they leave Texas for your next farm job.

What if I am a migrant farm worker?

You can get your checkup sooner if you are leaving the area.

Extra benefits offered to Texas Children's Health Plan members

What extra benefits does a member of Texas Children's Health Plan get? How can I get these benefits for me or my child?

Good health starts here! When joining Texas Children's Health Plan, you or your child have access to the exclusive benefits of our Healthy Rewards Program. These benefits are value-added services that Medicaid does not cover, and that Texas Children's Health Plan offers for your family to enjoy as we help you plan for a healthy future.

Healthy Rewards Program benefits are divided in four categories:

Healthy Pregnancy

- **Basic baby care and birth classes:** Participate in a variety of online classes through the INJOY app to learn more about pregnancy, childbirth, breastfeeding, postpartum health and baby care, newborn care, and more. Printed materials provided upon request.
- **Meals for Moms:** Inform Texas Children's Health Plan of your pregnancy and receive one healthy meal at no cost for a family of four delivered once a month, starting in the second trimester of your pregnancy and for two months after giving birth, for a total of eight months.
- **Portable crib/playpen:** Notify Texas Children's Health Plan within 14 days of giving birth and receive a portable crib that doubles as a playpen at no cost. Reward can be requested up to 15 days after the end of the eligible year.
-  **Prenatal visit reward:** Complete at least one prenatal visit during your pregnancy and receive a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year.
-  **Postpartum visit reward:** Complete at least one postpartum visit within 42 days of giving birth and receive a $25 reward card. Reward can be requested up to 60 days after the end of the eligible year.

Health and Wellness

-  **Cervical cancer screening reward:** Complete a cervical cancer screening during your yearly well-woman

exam and get a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year. Ages 21-64.

- **Diabetes Management Reward (Type 1 or 2):**
  - Complete a diabetic (retinal or dilated) eye exam once a year and get a $25 reward card.
  - Complete an HbA1c blood test every 6 months and get a $50 reward card. $100 max reward per year.

  Rewards can be requested up to 30 days after the end of the eligible year. Ages 18 and older.
- **Health education special events:** Learn about healthy habits while having family fun with your family at our special events, such as seasonal activities and community events.
- **Mental health follow-up visit reward:** Complete a mental health follow-up visit within 7 days after discharge from a mental health hospital or facility and get a $25 reward card. Ages 6 and older.
- **Vision Benefit:** Receive an allowance towards upgrades of $110 for framed glasses or $90 for contact lenses and contact fittings. Ages 18 and younger.
- **Well-child checkups reward:**
  - Complete 3 well-child checkups by the age of 15 months and get a $50 reward card.
  - Complete 6 well-child checkups by the age of 15 months and get an additional $100 reward card.

  Rewards can be requested up to 30 days after the end of the eligible year.
- **Young adult wellness visit reward:** Complete a yearly wellness visit and get a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year. Ages 18-21.

Healthy Play and Exercise

- **Boys & Girls Clubs of America memberships:** Enjoy summer and school-year memberships at no cost at participating Boys & Girls Clubs of America. Ages 6-17.
- **Extracurricular activity fee assistance:** Sign up for an extracurricular activity through a school or community program and get a reward card for up to $50. Reward can be requested up to 30 days after the end of the eligible year. Ages 5-21.
- **Sports and school physicals:** Get one yearly sports or school physical exam at no cost with your primary care provider. Must have completed a well-child checkup in the last 12 months. Ages 5-19.
- **Sports Clinics:** Get active and attend a variety of sports clinics at no cost. Sports clinics include soccer, taekwondo, ballet, baseball, football, basketball, and bike safety. Registration on a first-come, first served basis. Harris county only. Ages 3-18.

Extra Help for Families

- **24-Hour Nurse Help Line:** Our nurses are available over the phone 24 hours a day, 7 days a week to help you with advice about your symptoms and medical concerns.
- **Dental services:** Benefits include a complete oral exam, 2 routine exams, 2 cleanings, x-rays, fillings, routine extractions, and emergency exams per year. Ages 21 and older.
- **Transportation services:** Get a ride at no cost to Texas Children's Health Plan classes or events. Transportation to medical appointments and the pharmacy are already covered services for STAR members.

Restrictions and limitations may apply. Age range may vary. Extra benefits valid from September 1, 2022 to August 31, 2023. Visit healthyrewardsprogram.org for more details.

How to redeem your rewards

For rewards with this icon :

- **Option 1:** Login on your MyChart account. Head to "Resources" and click on "Healthy Connections" to sign up and access your rewards balance.
  New to MyChart? Set up an account at texaschildrenshealthplan.org/mychart
- **Option 2:** Call Healthy Connections at 866-475-1619 (TTY 711)

For all other benefits and more information:

- Visit healthyrewardsprogram.org or call Member Services at the number on the back of your member ID card.

Getting care

Setting up your visit

To get care, the right place to start is with a call to your primary care provider's office. The phone number is listed on your Member ID card. They can help you set up a visit. If you need medical care the same day, call your primary care provider as early in the day as possible. Remember that your primary care provider or another doctor working with can be reached 24 hours a day, 7 days a week.

You should not have to wait more than 14 days (about 2 weeks) to see your primary care provider. If your primary care provider cannot see you within 14 days (about 2 weeks) or if you have problems with your primary care provider, call Member Services at 866-959-2555.

When you call:

- Have your Member ID card with you.
- Be ready to tell the doctor your health problem or the reason for the visit.
- Write down the day and time for your visit.

What to bring with you to your visit:

- Your Member ID card and Your Texas Benefits Medicaid Card.
- Prescription drugs you are taking.
- Something to write with, to take notes on the information you get from the doctor.

If it is your first visit to this doctor, also bring the name and address

of your previous doctor. Children should bring their vaccination records.

What if I cannot make the appointment?
Call your doctor's office as soon as possible if you are not able to keep your visit or will get there late. They will help you change the visit to a different day or time. Also, remember to change or cancel your ride if one is scheduled. Calling to cancel a visit is sometimes hard to remember. It is important to cancel your visit so that others who need visits can get them.

Routine care

What is routine medical care? How soon can I expect to be seen?
Your primary care provider will give you regular checkups and treat you when you are sick. This is called routine care. Most routine visits, including well-child checkups, are scheduled within 14 days (about 2 weeks) of your asking. Adult checkups are scheduled within 4 weeks.

When you need routine care, call your primary care provider's phone number on the front of your ID card. Someone in the doctor's office or clinic will set up a visit for you.

Urgent medical care

What is urgent medical care?
Another type of care is urgent care. There are some injuries and illnesses that are 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, call your doctor's office even on nights and weekends. 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 do not need to call the clinic before going. You need to go to a clinic that takes Texas Children's Health Plan Medicaid. For help, call us at 866-959-2555. You can also call our 24-hour Nurse Help Line at 800-686-3831 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 Texas Children's Health Plan Medicaid.

Care after office hours

How do I get medical care after my primary care provider's office is closed?
To get medical care outside of regular working hours, you should still call your primary care doctor. They or another doctor working with them can be reached 24 hours a day, 7 days a week. You can find their number on your ID card.

Your doctor's answering service will take a message and a doctor or nurse will call you back. Call again if you do not hear from a doctor or nurse within 30 minutes. Some primary care provider's phones are answered by an answering machine or a recorded voice outside of working hours. The recording will tell you what number to call to reach your doctor.

Do not wait until the evening to call if you can take care of a medical problem during the day. Most illnesses tend to get worse as the day goes on. You also can call the Texas Children's Health Plan's Nurse Help Line and talk to a nurse at 800-686-3831. Nurses are ready to help you decide what to do 24 hours a day, 7 days a week. If you have a life-threatening emergency, call 9-1-1 right away or go to the nearest emergency room.

Emergency Medical Care

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

What is an emergency medical condition?
An emergency medical condition includes severe and sudden symptoms (including severe pain), such that a reasonable person with average knowledge of health and medicine, could know immediately that medical care is necessary and the situation:

- places the patient's health in serious jeopardy;
- may result in serious damage to bodily functions;
- may result in serious issues of any bodily organ or part;
- may result in serious disfigurement; or
- in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Emergencies can be things like:

- A badly injured arm, leg, hand, foot, tooth, or head.
- Severe burns.
- Bad chest pains.
- Heavy bleeding.
- Criminal attack (raped, mugged, stabbed, gunshot).
- A severe allergic reaction or have been bitten by an animal.
- Choking, passing out, having a seizure, or not breathing.
- Acting out of control and a danger to self or others.
- Poisoned or overdosed on drugs or alcohol.

What is an emergency behavioral health condition?
Any condition, regardless of nature or cause of the condition, which in the opinion of a layperson, with average knowledge of medicine and health:

- Requires immediate intervention or medical attention without which the member would present an immediate danger to themselves, or others.
- Which renders the member incapable of controlling 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 and that are

needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition, including post-stabilization care services.

How soon can I expect to be seen?
If you believe the situation is life-threatening, go to the nearest hospital emergency room or call 9-1-1 for help.

If you are sure your situation is not life-threatening but are not sure if you need emergency care, call your primary care provider.

After you receive care, call your primary care provider within 48 hours (about 2 days) or as soon as possible. Your primary care provider will offer or arrange any follow-up care you may need. If you get follow-up care from a provider other than your primary care provider without your primary care provider's approval, Texas Children's Health Plan might not pay for the care.

You might have to pay the bill if you go to the emergency room for a condition that is not urgent or an emergency.

Remember to show your Member ID card and Your Texas Benefits Medicaid Card to the emergency room staff.

Are emergency dental services for children covered by the health plan?
Texas Children's Health Plan covers 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.
- 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 at 866-959-2555 or call 9-1-1.

Post-stabilization care

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

Care when you are away from home

What if I get sick when I am out of town or traveling?
If you need medical care when traveling, call us at 866-959-2555 and we will help you find a doctor.

If you need emergency services while traveling, go to a nearby hospital, then call us at 866-959-2555.

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

What if I am out of state?
When you are out of state, if you get sick or injured and you are not in serious danger, call your primary care provider for what to do. You can also call the Texas Children's Health Plan Nurse Help Line at 800-686-3831 and a nurse will help you decide what to do.

If you have a life-threatening emergency, go to the nearest emergency room, or call 9-1-1 for help. Call your primary care provider or Member Services within 48 hours (about 2 days) of receiving emergency care. Your primary care provider must arrange for any follow-up care received while you are out of town.

Specialty Care, Referrals, and Prior Authorization

What if I need to see a specialist? What is a referral?
Your primary care provider will take care of your most health care needs.

If you have a special health problem, your primary care provider might ask you to see another doctor or have special tests done. This is called a referral. Your primary care provider will refer you to a participating specialist or other provider who is in the Texas Children's Health Plan network. Specialists include doctors such as cardiologists (heart), dermatologists (skin), or allergists.

Your primary care provider makes sure that you see the right specialist for your condition or problem. They will discuss with the specialist the need for further treatment, special tests, or hospital care.

What if I get care with another doctor without a referral?
In most cases, you must get a referral before you get care with another doctor. If you choose to go to another doctor who is not your primary care provider, the doctor might refuse to see you, or you might have to pay the cost of that care yourself.

How soon can I expect to be seen by a specialist?
Expect visits with specialists to happen within 21 days (about 3 weeks) of your request.

If you see a specialist without being referred to by your primary care provider, the specialist might refuse to see you, except in an emergency. Always check with your primary care provider before you go anywhere else for care.

Texas Children's Health Plan will not cover the costs of medical care from non-participating health care providers.

If your doctor thinks there is not a doctor in our network that can give you the care you need, they can send us an authorization request. They can ask our Utilization Management department for the authorization of medically necessary services that you cannot get from any other doctor or other provider in the Texas Children's Health Plan network.

Second opinions

How can I ask for a second opinion?
You have the right to a second opinion to find out about the use of any health care. Tell your primary care provider if you want a

second opinion about a treatment recommended by a provider. Your primary care provider will set up a visit or refer you to another doctor in the Texas Children's Health Plan network. If no other doctor is available in the network, he or she will set up a visit for you to see a doctor that is not in the Texas Children's Health Plan network. You will not have to pay for these services. Call Member Services at 866-959-2555 if you need help making a request or picking a doctor for a second opinion.

Listed below are some of the reasons why you may want to have a second opinion:

- You are not sure if you need the surgery your doctor is planning to do.
- You are not sure of your doctor's diagnosis or care plan for a serious or difficult medical need.
- You have done what the doctor asked, but you are not getting better.

Services that do not require a referral from your primary care provider

What services do not need a referral?

Texas Children's Health Plan does not require a referral for you to see a provider in-network. To see a provider out of network, the visit must be authorized.

Texas Children's Health Plan's network providers are listed in the provider directory. Most of our OB/GYN doctors give family planning services. There is also a list of Medicaid family planning providers in this handbook. Call Member Services at 866-959-2555 for help in finding participating doctors.

Prior Authorization Process

What services do not need a referral?

Some services need approval or authorization from Texas Children's Health Plan. Your doctor will submit a request for authorization. That means we must review the request to make sure you are getting the right care you need. We also want to make sure the care you are getting is covered by your plan. Your doctor will submit an authorization request, in writing, to the Utilization Management department to get approval of medical services that you can't get from any other doctor or other provider in the Texas Children's Health Plan network.

Texas Children's Health Plan may extend the timeframe for a standard authorization decision by up to 14 calendars days if the member or provider asks for an extension or if additional information is needed and the extension is in the member's best interest.

If you would like to see the prior authorization list, please log on to the Texas Children's Health Plan member portal or contact member services or your service coordinator.

OB/GYN care

What if I need OB/GYN care? Will I need a referral?

ATTENTION FEMALE MEMBERS:

Texas Children's Health Plan lets you pick an OB/GYN. But this doctor must be in the same network as your primary care provider.

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

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

Do I need a referral for OB/GYN care?

No. You do not need a referral for OB/GYN Care. The OB/GYN provider must be in the same network as your primary care provider.

How do I find an OB/GYN provider?

You can easily find an OB/GYBN using our online Find a doctor tool. Just visit texaschildrenshealthplan.org/doctor.

You can also call Member Services at 866-959-2555. We will be glad to help you pick a new OB/GYN or send you a copy of our provider directory.

Most of our OB/GYN doctors also give family planning services. There is also a list of Medicaid family planning providers in this handbook. Call Member Services at 866-959-2555 for help in finding participating doctors.

How soon can I be seen after contacting the OB/GYN for a visit?

You should be seen within 14 days (about 2 weeks) of asking for an appointment.

Can I stay with my OB/GYN if they are not with Texas Children's Health Plan?

If you are pregnant and have 16 or fewer weeks before your delivery due date when you join our health plan, you can still go to your current OB/GYN. You can also choose a different OB/GYN who is in-network if he or she agrees to treat you. Call Member Services if you need help making changes.

Do I need a referral for other women's health services?

In addition to access to OB/GYN care, TCHP offers direct access to other women's health specialists including Certified Nurse Midwives.

Direct access means that no authorization or referral is needed to receiving services from specialists in the TCHP network.

Members have direct access to other routine preventative health care services including breast exams, mammograms, and pap tests.

What if I am pregnant?

Who do I need to call?

If you are pregnant, call Member Services at 866-959-2555. We can help you pick an OB/GYN participating in the Texas Children's Health Plan network. A Maternal Care Outreach Specialist will give you information on all the maternity benefits and services available. They will be ready throughout your pregnancy to help you with getting prenatal (before the baby is born) care visits and transportation to visits and tests.

Member Services can help with:

- Scheduling visits for pregnancy checkups.
- Questions you might have about your health coverage.
- Arranging for transportation to doctor visits.
- Prenatal classes (classes to prepare you for the birth).
- Information on the Women, Infants, and Children (WIC) program.
- Scheduling visits for well-baby checkups.
- Information on Texas Health Steps and the Healthy Texas Women program.

Where can I find a list of birthing centers?
A list of birthing centers may be found on our website at texaschildrenshealthplan.org/doctor or by calling Member Services at 866-959-2555.

What other services/activities does Texas Children's Health Plan offer pregnant women?
Texas Children's Health Plan has a Case Management program to help you or your daughter have a healthy pregnancy. Our dedicated team of Care Coordinators are here to help pregnant members throughout their pregnancy and postpartum recovery. They work together with members, doctors, and medical staff to make sure that the member receives the best possible care each step of your pregnancy. Our Case Management program offers important services and resources such as:

- Pick an OB/GYN.
- Schedule visits to the doctor for mom and baby.
- Learn about the Women, Infants, and Children (WIC) program.
- Find parenting resources.
- Healthy Pregnancy Website with helpful pregnancy-related information at healthypregnancies.org

To learn more about how to get these services, call our Care Coordination line at 832-828-1430.

A Healthy Pregnancy with the Healthy Rewards Program

This program offers pregnant members extra benefits, such as:

- **Basic baby care and birth classes** through the INJOY app to learn more about pregnancy, childbirth, breastfeeding, postpartum and baby care, newborn care and more.
- **Meals for Moms:** Inform Texas Children's Health Plan of your pregnancy and receive a healthy meal at no cost for a family of 4 delivered once a month, starting in the second trimester of your pregnancy and for two months after giving birth, for a total of eight months.
- **Portable Crib:** Notify us within 14 days of welcoming your new baby and get a portable crib that doubles as a playpen at no cost. Reward can be requested up to 15 days after the end of the eligible year.
- **Prenatal visit reward:** Complete at least one prenatal visit during your pregnancy and receive a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year.
- **Postpartum visit reward:** Complete at least one postpartum visit within 42 days of giving birth and receive a $25 reward card. Reward can be requested up to 60 days after the end of the eligible year.
- **24-Hour Nurse Help Line:** Our 24-hour nurse help line is available day or night to offer you advice with your symptoms, understand doctor's instructions, and more.
- **Transportation services:** Need a ride to a Texas Children's Health Plan class or event? We provide transportation services for you at no cost! Transportation to medical appointments and the pharmacy are already covered services for STAR members.

Restrictions and limitations may apply. Age range may vary. Extra benefits valid from September 1, 2022 to August 31, 2023. Visit healthyrewardsprogram.org for more details.

How to redeem your rewards

For rewards with this icon :

- **Option 1:** Login on your MyChart account. Head to "Resources" and click on "Healthy Connections" to sign up and access your rewards balance.
  New to MyChart? Set up an account at texaschildrenshealthplan.org/mychart
- **Option 2:** Call Healthy Connections at 866-475-1619 (TTY 711)

For all other benefits and more information:

- Visit healthyrewardsprogram.org or call Member Services at the number on the back of your member ID card.

Newborn care

Can I pick a primary care provider for my baby before the baby is born?
Finding the right doctor for your unborn child is important. You can choose a primary care provider before your baby is born.

You can easily find a primary care provider for your newborn using our online Find a doctor tool. Just visit texaschildrenshealthplan.org/doctor.

You can also call Member Services at 866-959-2555. We will be glad to help you pick a new primary care provider or send you a copy of our provider directory.

Get rewarded for completing your well-child checkups!

- Complete 3 well-child checkups by the age of 15 months and get a $50 reward card.
- Complete 6 well-child checkups by the age of 15 months and get an additional $100 reward card.
- Rewards can be requested up to 30 days after the end of the eligible year.

Visit healthyrewardsprogram.org or call Member Services for more information.

How and when can I switch my baby's primary care provider?

You can always pick a new primary care provider for your baby.

You can easily find a primary care provider for your newborn using our online Find a doctor tool. Just visit texaschildrenshealthplan.org/doctor.

Once you pick out a primary care provider, you should call Member Services at 866-959-2555. Be sure to have your baby's member ID number ready.

Can I switch my baby's health plan?

For at least 90 days (about 3 months) from the date of birth, your baby will be covered by the same health plan that you joined. You can ask for a health plan change before the 90 days (about 3 months) is up if both your current health plan and your new health plan agree with the transfer.

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

If your baby is not in the hospital, you can change their health plan by calling the Texas STAR Help Line at 800-964-2777.

How do I sign up my newborn baby? How and when do I tell my caseworker?

As soon as your baby is born, call the Health and Human Services Commission (HHSC) benefits office at 2-1-1 to sign your baby up for coverage. Also, be sure to call your caseworker. They can answer any questions about your baby's coverage.

How and when do I tell my health plan?

It is also important that you call Member Services as soon as your baby is born so we can help you get health services for your baby.

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

Healthy Texas Women

Healthy Texas Women's Health Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 (15-17 with parental permission) 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, you can get through the Healthy Texas Women Program, write, call or visit the program's website:

Healthy Texas Women's Family Program
P.O. Box 14000
Midland, TX 79711-9902
Phone: 800-335-8957
Website: healthytexaswomen.org
Fax: 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.

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: hhs.texas.gov/services/health/primary-health-care-services-program
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: hhs.texas.gov/services/health/primary-health-care-services-program
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

Family planning services
How do I get family planning services? Do I need a referral?
Family planning services help you plan or prevent a pregnancy. They are for men and women. You can get family planning services from your primary care provider. You can also see any Medicaid Family Planning Provider. A referral is not needed for family planning services. If you are 20 years old or younger, you do not have to get your parents to agree to you getting family planning services or supplies.

The family planning services you get include:

- A yearly checkup.
- An office or clinic visit for a problem, counseling, or advice.
- Laboratory tests.
- Prescriptions and contraceptive devices such as birth control pills, diaphragms, and condoms.
- Pregnancy tests.
- Sterilization services (only if you are 21 years old or older; Federal Sterilization Consent Form is needed).
- Checkup and treatment of sexually transmitted diseases such as herpes and syphilis.

Where do I find a family planning services provider?
You can find the locations of family planning providers near you online at healthytexaswomen.org/ or you can call Texas Children's Health Plan at 866-959-2555 for help in finding a family planning provider.

Hospital services
Your primary care provider or a specialist may decide if you need care at a hospital. The doctor will arrange for care at a hospital that is in the Texas Children's Health Plan's network. Your coverage includes both outpatient and inpatient services. Your primary care provider or specialist will need to approve or refer you for these services.

Home health services
Sometimes a sick or injured person needs medical care at home. Home care can follow an inpatient stay or be provided to prevent an inpatient stay. If you need home health services, your primary care provider will talk to Texas Children's Health Plan so that you can get the right care.

Ambulance services
Covered services include services from a licensed ambulance company in case of an emergency, or for non-emergencies only with prior authorization. You may have to pay for an ambulance for non-emergency services.

Audiology services
Hearing aids are covered for members 21 years and older when medically necessary. Hearing tests are only covered for members 21 years old or older. Hearing aids and hearing tests for children are provided through the Program for Amplification for Children of Texas (PACT). You can call PACT at 800-252-8033.

Mental health and drug abuse services
How do I get help if I have mental health, alcohol, or drug problems? Do I need a referral?
You can get mental or drug abuse services when needed. You do not need a referral from your primary care provider. These services include:

- Counseling services.
- Inpatient and outpatient care.
- Detoxification and treatment for drug addiction and alcoholism.

You can get mental or drug abuse services by:

- Calling Texas Children's Health Plan's Mental Health/Drug Abuse Hotline at 800-731-8529. You can call the hotline 24 hours a day, 7 days a week.
- Choosing a mental or drug abuse provider from the Texas Children's Health Plan provider network.

Mental Health Follow-up Visit Reward:
Complete a mental health follow-up visit within 7 days after discharge from a mental health hospital or facility and get a $25 reward card (ages 6 and older):

If you have an emergency and need mental or drug abuse treatment immediately, go to the nearest emergency room or call the Mental Health/Drug Abuse Hotline at 800-731-8529. Someone will help you get care right away. Once you are able, you, or someone on your behalf, will need to call the hotline and let them know you had an emergency.

Other Medicaid services or programs
What other services can Texas Children's Health Plan help me get?
Medicaid covers some services that Texas Children's Health Plan does not. You may be able to get these services and programs.

What is Early Childhood Intervention (ECI)?
Early Childhood Intervention (ECI) program. ECI provides

information on services available to help children, from birth to three years old, who may have a disability or developmental delay. ECI is a statewide program for families with children, from birth to three years old, with disabilities and developmental delays. ECI supports families to help their children reach their potential through developmental services. Services are provided by a variety of local agencies and organizations across Texas.

Do I need a referral for this?
You do not need a referral from your primary care provider. Call Member Services at 866-959-2555 for help with using these services and programs.

Where do I find an ECI provider?
Find your nearest ECI program:
https://dmzweb.dars.state.tx.us/prd/citysearch.

Other programs

- Mental Health or Mental Retardation (MHMR) case management.
- Mental Retardation Diagnostic Assessment (MRDA) program.
- Case Management for Children and Pregnant Women (CPW).
- Mental Health Rehabilitation (MHR) program.
- Texas School of Health and Related Services (SHARS). These services are available only to members 20 years old and younger with certain disabilities. Services include therapies, counseling, special transportation, hearing, and school health services.
- Texas Commission for the Blind (TCB) program.
- Tuberculosis (TB) clinic services.
- Women, Infants, and Children (WIC) program. WIC is a nutrition program for women, infants, and children. WIC helps pregnant women and new mothers learn more about food, formulas, nutrition, healthy eating, and offer breastfeeding support.

Prescription Drug Benefits

What are my prescription drug benefits?
Your prescription medicines are a benefit through your Texas STAR coverage. You will need to obtain the medication through a drug store in Texas Children's Health Plan network. Always bring your prescription, your Texas Children's Health Plan ID card and your Texas Medicaid ID card with you to the drug store.

You can contact our Member Services Team if you have questions about your prescription drug benefits. You can also search our website or use our online portal to view and manage your benefits at texaschildrenshealthplan.org.

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. You or your child's doctor can choose from a list of medications approved by the Texas Vendor Drug Program (VDP). If you need help finding a drug store near you or one that can deliver medications directly to your home, call us at 866-959-2555.

How much will my medications cost?
You do not have a copayment for prescription medications covered under the Medicaid benefit.

How do I find a network drug store?
You can call Member Services at 866-959-2555 to find a drug store in our network. We can help you find pharmacies that deliver medications for free, open 24 hours a day 7 days a week, are handicap accessible, or speak different languages. You can request a printed copy of the pharmacies in our network or visit our website at texaschildrenshealthplan.org to use our online search tool.

What if I or my child go to a drug store not in the network?
If you go to a drug store that is not in the network, you may not be able to fill your medications, or may have to pay out of pocket yourself. You can ask for an exception for emergency situations.

What is a drug formulary?
Medications included in you or your child's prescription benefit are part of the Texas Medicaid/CHIP formulary. The formulary is a list of brand and generic medicines based on quality and value. The formulary also identifies which medications require prior authorization, and which medications are on a preferred drug list (PDL). The Texas Health and Human Services (HHSC) creates and maintains the drug formulary for Medicaid. The PDL is updated every 6 months in January and July.

Who decides what drugs are on the formulary?
A group of doctors and pharmacists from the Texas Drug Utilization Review board review the formulary on an ongoing basis. Only drugs that are safe, effective and affordable are included. The formulary, PDL list, and prior authorization criteria are all decided by the Texas Vendor Drug Program (VDP) at the Texas Health Human and Services (HHSC).

Where can I go to find out what drugs are covered and/or require pre-approval?
You can review the list of medications by visiting https://www.txvendordrug.com/. There is a tool to search medications by brand or generic name. The tool also identifies if a medication requires prior authorization requirements. You can also contact Texas Children's Health Plan to speak to a pharmacist if you have any questions about your medications and benefits. Contact Member Services at 866-959-2555 if you need help.

What is a Pharmacy Benefit Manager (PBM)? Who is the PBM for Texas Children's Health Plan?
A PBM is a company that manages drug store benefits. Navitus is Texas Children's Health Plan's PBM. Navitus is responsible for:

- Maintaining Texas Children's Health Plan's network of drug stores.
- Helping drug store process claims.
- Making sure only claims covered under the Texas STAR

and CHIP drug formulary are processed.

- Reviewing prior approval requests from doctors for drugs that require pre-approval.
- Reviewing exceptions for quantity limits or high doses.

How much medicine can I pick up for myself or my child?
Texas Children's Health Plan allows up to 34-days' supply of medicines per fill. You may request an exception for a refill by contacting Member Services at 866-959-2555.

What if my or my child's medication requires prior authorization?
Some medicines need a pre-approval before you can fill them at a drug store. Pre-approvals make sure that the drug is safe and effective and/or drugs not on the preferred drug list. Your doctor must submit a prior authorization request. We work with Navitus Health Solutions, a pharmacy benefit manager (PBM) to review prior authorization requests. Decisions are made within 72 hours. A list of prior authorization forms may be found on your online member portal, or at txstarchip.navitus.com under "Prior Authorization Forms."

Where do I find the Texas Children's Health Plan clinical criteria for pre-approval?
The Texas Children's Health Plan Medicaid Prior Authorization clinical criteria is available from the Navitus pharmacy benefit manager (PBM) website: https://txstarchip.navitus.com under "Clinical Edits."

Where do I find the Medicaid Preferred Drug List (PDL)?
You can search for the preferred drug list (PDL) by visiting the Texas Health and Human Services (HHSC) Vendor Drug website at txvendordrug.com. The PDL is controlled by HHSC. Texas Children's Health Plan is required to follow PDL requirements. The PDL is updated every 6 months in January and July. Texas Children's will notify you directly if there are negative changes that impact your ability to obtain your medications. We also provide information on our website before a change.

Can I ask for an exception?
If your pre-approval will be denied based on the criteria, your doctor may request an exception by appealing the pre-approval denial. Your doctor may also submit a separate "exception to request" prior authorization form for high dose drugs, or for requests beyond standard quantity limits. The Exception to Coverage form can be found at txstarchip.navitus.com under "Prior Authorization Forms."

If you are out of state, or need a drug not on the drug list, or have any other problem getting your or your child's medications, you or your doctor may call Member Services at-866-959-2555. Your provider can also appeal a pre-approval denial if you and your provider believe you need the medication.

How do I file a complaint or an appeal for medications ordered by my or my child's doctor?
If you or your doctor does not agree with a pre-approval request decision, you have the right to submit an appeal. Texas Children's Health Plan reviews all appeal requests. Instructions on how to appeal are included in the prior authorization denial letter. If you have a concern about a drug store benefit, claim, or other service, please call Member Services at 866-959-2555.

What if I can't get the medication my or my child's doctor ordered approved?
If your or your child's doctor cannot be reached to approve a prescription, you or your child may be able to get a three-day (72- hour) emergency supply of your or your child's medication. Ask your drug store about providing you or your child an emergency supply. You can also call Texas Children's Health Plan at 866-959-2555 for help.

What if I need my or my child's medications delivered to me?
If you need your medication(s) delivered, you can use a pharmacy in our network that provides delivery services. You can search for a pharmacy that provides delivery services using our online website, or you can call Member Services at 866-959-2555.

What if I lose my or my child's medication(s)?
If you lose your medications, you should call your doctor or clinic for help. If your doctor or clinic is closed, the drug store may be able to provide an emergency 72-hour supply. Sometimes, you may need special permission from the Texas Children's Health Plan for an early refill. You can call Member Services at 866-959-2555 for help.

What if I need/my child needs an over-the-counter (OTC) medication?
The pharmacy cannot give you an over-the-counter medication as part of your/your child's Medicaid benefit. If you need/your child needs an over-the-counter medication, you will have to pay for it unless it is on the formulary and the provider writes a prescription for it.

What if I need or my child needs more than 34 days of a prescribed medication?
The drug store can only give you an amount of a medication that you need/your child needs for the next 34 days. For exception requests, please call Texas Children's Health Plan at 866-959-2555.

How are generic substitutes or therapeutic interchanges handled?
Generic substitution is when the benefit will require members to only use a generic drug. Therapeutic interchange is when the doctor prescribes a drug, but the pharmacy gives one that is chemically different but works the same. Any changes to your medicine should only be made with your doctor's consideration.

Texas Children's Health Plan will not deny any coverage of any product covered under Medicaid/CHIP benefits. This includes brand or generic drugs on the formulary. Texas Children's Health Plan will only process claims as written by your doctor.

Emergency Prescription Supply

You may receive a 72-hour (3-day) emergency supply of a prescribed drug if a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to analysis for getting your money back. The pharmacist at your pharmacy

will decide in the end if they want to give out the 3-day supply or not. The choice is up to the pharmacist.

The 72-hour emergency supply should be given out any time a PA cannot be fixed within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the provider cannot be reached or is unable to ask for a PA, the drug store should submit an emergency 72-hour prescription.

A drug store can give a product that is packaged in a form that is fixed and unbreakable, such as an albuterol inhaler, as a 72-hour emergency supply.

For more information, please call Member Services at 866-959-2555.

Medicaid Lock-In Program

What is Medicaid Lock-In Program?

The Lock-In Program ("LP") is designed to both manage the inappropriate use of medical services and to promote safety.

You may be put in the Lock-in Program if you do not follow Medicaid rules. It checks how you use Medicaid drug store services.

This can include activity that can be considered dangerous, excessive, or potentially fraudulent.

If you are selected for the lock-in program, you must get all of your medications from a single drug store. You will get a letter from the Office of Inspector General notifying you of the drug store you are locked into and the start date. Lock-ins may range from 36 to 60 months.

Your Medicaid benefits will remain the same. Changing to a different health plan will not change the Lock-In status.

If you are locked into a drug store but have an urgent/immediate medication need that the locked-in drug store cannot meet, please contact Member Services immediately. We will review your request on a case-by-case basis.

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

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

To learn more, call Member Services at 866-959-2555 and ask to speak to a pharmacist about the Medicaid Lock-In Program.

Dental services

What dental services does Texas Children's Health Plan cover for children?

Texas Children's Health Plan covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

- Treatment of dislocated jaw.
- Treatment for traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Texas Children's Health Plan 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.

Texas Children's Health Plan 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.

Vision care

How do I get eye care services?

To get eye checkups or eyewear, call Envolve Vision at 844-683-2305. They can help you pick a provider near you and how to get eyeglasses. You do not need a referral from your primary care provider to get routine eye checkups from ophthalmologists or optometrists in Envolve Vision's provider network.

Covered eye care services are different for adults and children.

If you are 20 years old or younger:

- You can get an eye checkup once every 12 months.
- Eyewear may be replaced every 12 months.

If you are 21 years old or older:

- You can get an eye checkup once every 24 months (about 2 years).
- Eyewear may be replaced every 24 months (about 2 years).

Non-Emergency Medical Transportation (NEMT) Services

What are NEMT Services?

NEMT services provide rides to non-emergency health care appointments for members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

What services are part of NEMT Services?

- Passes or tickets for mass transportation within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb rides in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an Individual Transportation Participant (ITP) for a completed ride to a covered health care service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance

trip to obtain health care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.

- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services.

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

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

How to get a ride?
You can contact Veyo, our transportation provider, at 888-401-0170 or for TTY (800-735-2989). Offices are open Monday- Friday, 8 a.m. - 5 p.m. CT. Help can be provided in English and Spanish. We also have interpreters available by phone who speak 140 different languages.

Be sure to call early. Rides must be set up at least two business days before you need the ride service. Sometimes you can ask for the ride with less notice. These situations include being picked up after being discharged from a hospital; trips to the drug store to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

What is Case Management?

How do I get care management?
Case management is a covered benefit for all STAR members. Members can join our Case Management programs by calling 832-828-1430. You can also be referred to Case Management by your health care provider for certain conditions, or by meeting certain criteria. Our case management programs include:

- Asthma
- Diabetes
- Behavioral Health
- High Risk Pregnancy
- Nurse Family Partnership
- Frequent Emergency Room Use

What do case managers do?
Once you are signed up, you will work with one of our case managers, who will help you:

- Set goals and help you meet your goals.
- Provide education and resources to help you control a chronic condition.
- 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.
- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

What are mental health rehabilitation services and mental health targeted case management?
These are services that help Members with severe mental illness, behavioral or emotional problems. Texas Children's Health Plan can also help Members get better access to care and community support services through Mental Health Targeted Case Management.

How do I get these services?
To get these services, call Case Management at 832-828-1430, Member Services at 866-959-2555, or you may contact the Local Mental Health Authority (LMHA) in your county.

Members with special health care needs

Who do I call if I have or my child has special health care needs and I need someone to help me?
If you have or your child has special health care needs, such as developmental delays, diabetes, or asthma, call Member Services at 866-959-6555 to get more information on how to get help. Texas Children's Health Plan has a Case Management program that offers families help with you or your child's special needs. The services range from simple outreach and information to intensive care management. They also include coordination with and referral to community resources to help families with transportation and basic living needs. Your information will be given to a case manager. The case manager will call you within 15 business days to assess your needs. The case manager will work with you to develop a service plan within 30 business days. You can decline or opt out of Case Management at any time.

A case manager is a nurse or social worker who can help you:

- Find services in your community.
- Make appointments with special doctors.
- Learn more about your or your child's medical condition.
- Explain covered benefits and services.
- Create a plan of care just for you or your child.
- Work with your or your child's doctors to get medically necessary care for you or your child.

Be sure to tell the case manager about any special providers you have or your child has been seeing. It is also important to tell your or your child's primary care provider that you have or your

child has special health care needs. The best way to tell your or your child's doctor is to schedule a visit to see them.

Case Management for Children and Pregnant Women (CPW)

What is Case Management for Children and Pregnant Women (CPW)?

Case Management for Children and Pregnant Women (CPW) is a benefit at Texas Children's Health Plan for members with STAR Kids and STAR coverage. Members birth to 20 years-old with a health condition, health risk or high risk pregnancy receive case management services. CPW services help clients gain access to needed medical, social and/or educational services.

Need help finding and getting services?

You might be able to get a case manager to help you.

Who can get a case manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- have health problems, or
- are at a high risk for getting health problems.

What do case managers do?

A case manager will visit with you and then:

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

What kind of help can you get?

Case managers can help you:

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

How can you get a case manager?

Contact Texas Children's Health Plan for more information or call Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8 a.m. to 8 p.m.

- Texas Children's Health Plan Case Management
  Phone: 832-828-1430
- Website: texaschildreshealthplan.org

Member Services

Member Services

If you have questions about your coverage or need help, please call Member Services at 866-959-2555. The phone number is also at the bottom on the front of your Texas Children's Health Plan Member ID card. You will need your member ID number when you call.

With the help of interpreters, Member Services Representatives can speak to you in 140 languages. You can reach Member Services Representatives 24 hours a day, 7 days a week.

Call Member Services if you:

- Need to pick a primary care provider.
- Need to know what services are covered.
- Have questions about specialists, hospitals, and other providers.
- Get a bill from a provider.
- Have a complaint.
- Move or change your phone number.
- Need an interpreter for a medical visit.
- Need to replace an ID card.
- Don't understand something you get in the mail.
- Need to get a ride to the doctor.
- Have any questions.
- Have problems getting your prescription filled.

Member Services can also give you materials about:

- Mental health care.
- Diabetes care.
- Dental care.
- Asthma care.
- Self-care.
- Preventive care.
- Social workers.

Supporting our diverse membership

We have a wide range of ways we can communicate so we best meet your needs. From translating documents, to proving materials in other formats we are here to help.

Our Member Service team is fluent in English and Spanish. Our team can also use interpreters to speak with you in 140 languages.

Interpreter and translation services

Can someone interpret for me when I talk with my doctor?
We can get you face-to-face sign and language interpretation for doctor visits.

Who do I call for an interpreter?
Call Member Services at 866-959-2555 to ask for an interpreter.

How far in advance do I need to call?
Please let us know if you need these services at least 48 hours (about 2 days) before your visit. Call Member Services at 866-959-2555, TTY 800-735-2989 (Texas Relay) or 7-1-1.

How can I get a face-to-face interpreter in the doctor's office?
Call us from any doctor's office. We will find someone who speaks your language. Call Member Services at 866-959-2555.

Help for the visually impaired

If you have a visual impairment, Texas Children's Health Plan will give you health plan materials in large print, Braille, or on audiotapes. Call Member Services to discuss your special needs.

Phone device for the deaf (TTD) services for members with hearing or speech impairments

Texas Children's Health Plan uses Relay Texas TTY services for members and their parents or guardians who have hearing or speech impairments. For TTY, call 800-735-2989 or 7-1-1.

Member materials in English and Spanish

This member handbook and all other materials included in your member packet are provided in English and Spanish. We can also give you many of the other health educational materials in Spanish. If you need another language, just give us a call and ask.

Changes to your plan

What do I do if I move?
As soon as you have your new address, give it to the local Health and Human Services Commission (HSSC) benefits office and Texas Children's Health Plan Member Services at 866-959-2555. Before you get Medicaid services in your new area, you must call Texas Children's Health Plan unless you need emergency services. You will keep getting care through Texas Children's Health Plan until HHSC changes your address.

What if I get a bill from my doctor? Who do I call?

If you get a bill for a Texas Children's Health Plan covered benefit or service, call Member Services at 866-959-2555.

What information will they need?
Have the bill available so you can tell us the:

- Doctor's name.
- Date services were received.
- Doctor's phone number.
- Amount of the claim.

Member Services will call the doctor.

Changes in Texas Children's Health Plan

Sometimes Texas Children's Health Plan might make some changes in the way it works, the services it covers, or its network of doctors and hospitals. We will mail you a letter when we make changes to the services.

Changing health plans

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

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

What happens if I lose my Medicaid coverage?
If you lose Medicaid coverage but get it back again within 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.

Your health plan also can ask for changes

Can Texas Children's Health Plan ask that I get dropped from their health plan (for non-compliance, etc.)?
Texas Children's Health Plan also might request from HHSC that you be dropped from our plan if:

- You often do not follow your doctor's advice.
- You keep going to the emergency room when you do not have an emergency.
- You keep going to another doctor or clinic without first getting approval from your primary care provider.
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition.
- You often miss visits without letting your doctor know in advance.
- You let someone else use your ID card.

Renew your Medicaid benefits on time

Do not lose your medical benefits. Every 6 months you will need to renew your benefits. The Health and Human Services Commission (HHSC) will send you a letter telling you it is time to renew your Medicaid benefits. The letter will have a local HHSC office phone number for you to call. You will need to call and set up a meeting with your caseworker to renew your health care benefits.

The letter will also list any paperwork you need to bring to your caseworker. If you do not renew your eligibility by the date in the letter, you will lose your health care benefits.

How to renew

Online: yourtexasbenefits.com

By mail: Texas Health and Human Services Commission
PO Box 149024
Austin, TX 78714-9968

By phone: 2-1-1 (Press option 2)

Renewal Assistance: To schedule an appointment call 888-559-7526.

What do I do if I need help completing my renewal application?
If you need help with your renewal packet, call one of our Application Assistance Specialists at 888-559-7526 to schedule an appointment or visit texaschildrenshealthplan.org/renew to learn more on how to renew.

Families must renew their children's Medicaid coverage every year. In the months before a child's coverage ends, 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, and if you can sign up for a Medicaid health plan.
- 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), 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) 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 Children's Medicaid call center at 800-964-2777.

Completing the Renewal Process
When children still qualify for coverage in their current program (Medicaid), HHSC will send the family a letter showing the start date for the new coverage period.

Adoption Assistance and Permanency Care Assistance (AAPCA)

How do I get AAPCA for my child?

- The adoptive parent or permanent care assistance caregiver should contact the Department of Family and Protective Services (DFPS) regional adoption assistance eligibility specialist assigned to their case.
- If the parent or caregiver does not know who the assigned eligibility specialist is, they can contact the DFPS hotline at 800-233-3405, to find out.
- The parent or caregiver should contact the adoption assistance eligibility specialist to help with the address change.

Rights and Responsibilities

New medical procedures review

You have benefits as a member. One of them is that we look at new medical advances. Some of them are new equipment, tests, and surgery. Each situation is looked at on a case-by-case basis. Sometimes we use a special review to make sure that it is right for you. Questions? Call 866-959-2555.

Advance Directives

This section applies to adults 18 years and older.

What if I am too sick to decide about my medical care?

When you need medical care, you have the right to make decisions about the care you will receive and to talk these decisions to your doctors. If you are too sick decide about your medical care, an advance directive will let your doctor know what kind of care you want or name someone to make decisions about your medical care for you.

What are advance directives?

An advance directive is a legal document that allows you to tell your doctor and family your preferences for medical treatment before you need care. If you become too sick to make decisions about your health care, your doctor and family will know what kind of care you do or do not want. An advance directive can also say who can make decisions for you if you are not able to.

There are 4 types of advance directives under Texas law:

- Directive to Physicians and Family or Surrogates (Living Will) – A living will allow you to make medical decisions ahead of time so your doctor can know your wishes for treatment if you are in a terminal or irreversible condition and become unable to talk or make informed decisions.
- Out-of-Hospital Do-Not-Resuscitate (DNR) Order – This is a form you complete with your doctor, and it allows you to refuse life-saving treatments outside of a hospital.
- Medical Power of Attorney – A medical power of attorney lets you choose someone you trust to make health care decisions on your behalf in case you become unable to do so.
- Declaration for Mental Health Treatment – This type of advance directive lets you make decisions about your mental health treatment in case you become unable to make treatment decisions.

How do I get an advance directive?

Any person 18 years or older can make an advance directive. If you already have an advance directive, please let your primary care provider know. If you want information about how to put your instructions in writing, call Member Services at 866-959-2555.

Release of information

Texas Children's Health Plan is not permitted to give any information to anyone other than the person that filled out the Medicaid application for enrollment. If you filled out the application for enrollment and want to give information to someone other than yourself, call Member Services at 866-959-2555.

Information you can ask for and receive from Texas Children's Health Plan each year

As a member of Texas Children's Health Plan, you can ask for and receive the following information each year:

- Information about network providers—at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, phone numbers, and languages spoken (other than English) for each network provider plus identification of providers that are not accepting new patients.
- Any limits on the member's 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 to make sure you know 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 benefits, including:
  - What makes up emergency medical conditions, emergency services, and post-stabilization services.
  - The fact that you do not need prior authorization from your primary care provider for emergency care services.
  - How to get emergency services, including instructions on how to use the 9-1-1 phone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have a 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.
- Texas Children's Health Plan's practice guidelines.

Medicaid and private insurance

What if I have other health insurance in addition to Medicaid?

You must tell Medicaid staff about any other health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

- Your other health insurance is canceled.
- You get new insurance coverage.
- You have general questions about other insurance.

You can call the hotline at 800-846-7307.

If you have other insurance, you may still be able to get 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 other health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your other health insurance company.

Physician incentive plans

Texas Children's Health Plan has a physician incentive plan for STAR and OB providers. Texas Children's Health Plan cannot make payments under a doctors' 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 doctors' incentive plan. You also have a right to know how the plan works. You can call Member Services at 866-959-2555 to learn more about this.

Your privacy

Texas Children's Health Plan takes the confidentiality of your personal health information—information from which you can be identified—very seriously. In addition to meeting the program rules with all applicable laws, we carefully handle your Personal Health Information (PHI) in accordance with our confidentiality policies and procedures. We are committed to protecting your privacy in all settings.

We use and share your information only to give you health benefits.

Our Notice of Privacy Practices has information about how we use and share our members' PHI. A copy of our Notice of Privacy Practices is included with your Member Handbook and is on our website at texaschildrenshealthplan.org. You may also get a copy of our Notice of Privacy Practices by calling Member Services at 866-959-2555. If you have questions about our notice, call Member Services.

When you are not satisfied or have a complaint

What is a complaint?

A complaint is when you are not happy with your health care or services provided by your doctor, their office staff, or the Texas Children's Health Plan staff.

What should I do if I have a complaint?

We want to help. If you have a complaint, please call us at 866-959-2555 to tell us about your problem. Member Services can help you file a complaint. Just call Member Services at 866-959-2555. Most of the time, we can help you right away or at the most within a few days.

Can someone from Texas Children's Health Plan help me file a complaint?

A Texas Children's Health Plan Member Advocate can help you file a complaint. Just call us at 866-959-2555. Most of the time, we can help you right away or at the most within a few days.

If you would like to make your complaint in writing, send it to:

Texas Children's Health Plan
Attention: Member Services Complaints
P.O. Box 301011 WLS 8360
Houston, TX 77230-1011

Be sure to include your name and member ID number from your Member ID card.

What are the requirements and how long does it take to file a complaint?

You can file a complaint at any time. You will get a letter within 5 business days telling you your complaint was received.

How long will it take to work on my complaint?

Within 5 business days of receiving your oral or written complaint, Member Services will send you a letter. It will confirm the day we received your complaint. Texas Children's Health Plan will review the facts and act within 30 calendar days of receiving your complaint. A resolution letter will be sent to you.

The letter will:

- Describe your complaint.
- Tell you what has been or will be done to solve your problem.
- Tell you how to ask for a second review of your complaint.

Once you have gone through Texas Children's Health Plan's complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling 866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

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

If you can get on the Internet, you can submit your complaint at hhs.texas.gov/managed-care-help.

Appeals

If you would like to file an appeal regarding an action made by Texas Children's Health Plan, including a denial of payment of service in whole or in part, you must tell us within 60 days of the date on your decision letter.

What is an appeal?

An appeal is the process you or someone acting on your behalf can ask for when you are not satisfied with Texas Children's Health Plan's action, and you want a review. An action means the denial or limited authorization of a requested service. It includes the:

- Denial in whole or part of payment for a service.
- Denial of a type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Failure to give services in a timely manner.
- Failure to act within regulatory timeframes.

How will I find out if services are denied?
We will send you a letter if a covered service requested by your doctor is denied, delayed, limited, or stopped.

What can I do if my doctor asks for a service or medicine for me that is covered but Texas Children's Health Plan denies it or limits it? Can someone from Texas Children's Health Plan help me file an appeal?
You have the right to ask for an appeal if you are not satisfied or disagree with the action. Call Member Services at 866-959-2555. A Member Advocate can help you file your request for an appeal.

You can request an appeal orally or in writing. If you make a written request for an appeal, you can send the appeal letter to the Utilization Management Appeals Department address:

Texas Children's Health Plan
Attention: Member Services Complaints
PO Box 301011 WLS 8360
Houston, TX 77230-1011

You can also allow someone like a friend, family member, or your doctor to ask for an appeal on your behalf. You will need to give your consent in writing to have them act on your behalf. Your request for an appeal must be filed within 60 calendar days from the date of the notice of the action.

To keep receiving authorized services, you must file the appeal within 10 business days from the date of the denial letter or the start date of the proposed adverse benefit determination, whichever is later. You can ask that your services keep going until a decision is made. If the final decision is to uphold Texas Children's Health Plan's action, then you can be asked to pay back what it costs to keep getting your services. Please note: if the denial is upheld, you may be responsible for any cost for the services after the date of the original denial. Texas Children's Health Plan must have written permission from the Health and Human Services Commission (HHSC) to recover cost of services from the member.

Each appeal is promptly investigated. Texas Children's Health Plan will send you a letter within 5 business days to let you know that we received your appeal request. The letter will list all the information we will need to receive to review the appeal. If you make a written request for an appeal, you can send the appeal letter to the Utilization Management Appeals Department address:

Texas Children's Health Plan
Attn: UM Appeals Department
P.O. Box 301011, WLS 8390
Houston, TX 77230-1011

Texas Children's Health Plan must complete the entire standard appeal process within 30 days after receipt of the initial written or oral request for appeal. This deadline may be extended for up to 14 Days at the request of a Member; or Texas Children's Health Plan shows that there is a need for more information and how the delay is in the Member's interest. If Texas Children's Health Plan needs to extend, the Member must receive written notice of the reason for delay.

If your appeal is not approved, the answer will explain the reason it was not approved and tell you how to appeal to ask for an External Medical Review and State Fair Hearing or only a State Fair Hearing.

What is an emergency appeal?
An emergency appeal is when the health plan must decide quickly based on the condition of your health and taking the time for a standard appeal could put your life or health at risk.

What happens if the health plan denies the request for an emergency appeal? How long does an emergency appeal take?
Requests for emergency appeals can be oral or written. When we get your request for an emergency appeal, we will decide if your appeal requires a fast review. If we decide that your appeal does not need a fast review, we will let you know by phone or mail within 2 calendar days. Your appeal will then be a regular appeal. That means we will finish reviewing it in 30 days (about 4 and a half weeks). If we decide that your appeal does need an expedited review, a decision will be made within 72 hours (about 3 days) after receipt of the request.

If you are currently hospitalized or experiencing a medical or dental emergency, a decision will be made within one business day after receipt of the request. You or your representative can ask for an extension of 14 days (about 2 weeks). Texas Children's Health Plan can also ask for an extension if we need to get additional information. An extension is not applicable to cases of an ongoing emergency or denials of continued hospitalization. We will call you promptly with the decision. We will also send you a letter within 2 business days of the decision.

How do I ask for an emergency appeal?
You can call Member Services at 866-959-2555 and ask for help requesting an appeal. A Member Services Representative is ready to help you.

Does my request have to be in writing?
Appeals must be accepted orally or in writing.

Who can help me in filing an emergency appeal?
Your and your child's doctor can ask for this type of appeal on your behalf.

Can I request an External Medical Review and State Fair Hearing?
You have the option to request an External Medical Review and State Fair Hearing no later than 120 days after the date that Texas Children's Health Plan mails the appeal decision notice.

Can I request a State Fair Hearing only?
You have the option to request only a State Fair Hearing Review no later than 120 days after Texas Children's Health Plan mails the appeal decision notice.

What is a State Fair Hearing?

A State Fair Hearing is a chance for you to tell the reasons why you think the services you asked for, but did not get, should be allowed.

Can I ask for a State Fair Hearing?
If you, as a Member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a State

Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter with the internal appeal decision. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the health plan or call:

Texas Children's Health Plan
Member Services WLS 8360
P.O. Box 301011
Houston, TX 77230-1011
866-959-2555
TTY: 800-735-2989 (Texas Relay) or 7-1-1

You have the right to keep getting any service the health plan denied or reduced, based on previously authorized services, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of: (1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or (2) the day the health plan's internal appeal decision letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped.

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

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

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

If you need help filing a request for a State Fair Hearing you can call Member Services at 866-959-2555 and ask a Member Advocate to help you.

If you need oral interpretation or written translation of materials, please call STAR Member Services at 866-959-2555, TTY 800-735-2989 (Texas Relay) or 7-1-1. If you have a visual impairment, Texas Children's Health Plan will provide you with health plan materials in large print, Braille, or on audiotapes. Call Member Services to discuss your needs. Texas Children's Health Plan uses Relay Texas TTY services for members and their parents or guardians who have hearing or speech impairments. For TTY, call 800-735-2989 or 7-1-1.

External Medical Review Information

Can a Member ask for an External Medical Review?
If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed before the State Fair Hearing occurs. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Texas Children's Health Plan by using the address or fax number at the top of the form.
- Call Texas Children's Health Plan at 866-959-2555.

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

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

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting Texas Children's Health Plan at 866-959-2555 or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is

final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

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

What are my rights and responsibilities?

Member rights

1. You have the right to respect, dignity, privacy, confidentiality, and non-discrimination. That includes the right to:
   - Be treated fairly and with respect.
   - Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable chance 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 an easy manner. That includes the right to:
   - Be told how to choose and change your health plan and primary care provider.
   - Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   - Change your primary care provider.
   - Change your health plan without penalty.
   - 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:
   - 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.
   - Be told why care or services were not approved and not given.
4. You have the right to agree to or refuse treatment and be involved in treatment decisions. That includes the right to:
   - Work as part of a team with your provider in deciding what health care is best for you.
   - 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 Texas Children's Health Plan and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews, and State Fair Hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your Provider, or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive 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:
   - Have phone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   - Get medical care in a timely manner.
   - 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.
   - 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.
   - Receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities.
   - 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 the right to know the 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 the right to receive information on Texas Children'sHealth Plan, its services, the doctors, hospitals, and others whocare for you can advise you about your health status, medicalcare and treatment, and your rights and responsibilities.

11. You have the right to be treated with dignity and respect.
12. You have the right to a candid discussion of treatment options regardless of cost or benefit coverage.
13. You have the right to make recommendations to the rights and responsibility policy.

Member responsibilities

1. You must learn and know each right you have under the Medicaid program. That includes the responsibility to:
   - Learn and understand your rights under the Medicaid program.
   - Ask questions if you do not understand your rights.
   - Learn what choices of health plans are available in your area.
2. You must follow the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   - Understand and know your responsibility to follow plans and instructions for care.
   - Learn and follow your health plan's rules and Medicaid rules.
   - Choose your health plan and a primary care provider quickly.
   - Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   - Keep your scheduled appointments.
   - Cancel appointments in advance when you cannot keep them.
   - Always contact your primary care provider first for non-emergency medical needs.
   - Be sure you have approval from your primary care provider before going to a specialist.
   - 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:
   - Tell your primary care provider about your health.
   - Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   - 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:
   - Work as a team with your provider in deciding what health care is best for you.
   - Understand how the things you do can affect your health.
   - Do the best you can to stay healthy.
   - Treat providers and staff with respect.
   - Talk to your provider about your medications.
5. You must follow plans and instructions for care that you have agreed to with your provider.

Additional Member responsibilities while using NEMT Services

1. When asking for NEMT Services, you must provide the information requested by the person arranging your ride.
2. You must follow all rules and regulations related to your NEMT services.
3. You must return unused advance funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) at 800-368-1019. You also can 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 drug store?

Some DME and products normally found in a drug store are covered by Medicaid. For all members, Texas Children's Health Plan pays for nebulizers, ostomy supplies and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), Texas Children's Health Plan also pays for medically necessary prescribed over-the-counter drugs, diapers, formula and some vitamins and minerals. Questions? Call 866-959-2555.

For members 21 years of age and older, Texas Medicaid is obligated to consider coverage of medically necessary Durable Medical Equipment (DME) and supplies under the provision called the Home Health DME and Supplies Exceptional Circumstances. This includes items listed as non-covered services in the Texas Medicaid Provider Procedures Manual (TMPPM) or any item of DME and supplies that is not considered a benefit of Medicaid. Home Health DME and Supplies Exceptional Circumstances requests must be pre-authorized. Requests for medically necessary DME and supplies not covered as a benefit under Texas Medicaid should be submitted through the Home Health DME and Supplies Exceptional Circumstances process.

Fraud and abuse

Do you want to report waste, abuse, or fraud?

Let us know if you think a doctor, dentist, pharmacist at a drugstore, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For

example, tell us if you think someone is:

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

To report waste, abuse, or fraud:

- You can report directly to your health plan:
  Texas Children's Health Plan
  Fraud and Abuse Investigations
  PO Box 301011, WLS 8302
  Houston, TX 77230-1011
  832-828-1320 or Member Services Hotline 866-959-2555
  Email: TCHPSIU@texaschildrens.org
- or call the Office of Inspector General (OIG) Hotline at 800-436-6184 or visit https://oig.hhs.texas.gov/ and click on "Report Fraud"

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 the 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 the 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.
- Details about the waste, abuse, or fraud.

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:

– must comply with the requirements of the *Alberto N., et al. v. Traylor, et al.* partial settlement agreements; and

– 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, 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.

As a Member of Texas Children's Health Plan 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, External Medical Review and State Fair Hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from Out-of-Network providers and limits to those benefits.
- How you get after hours and emergency coverage and limits to those kinds of benefits, including:
  - What makes up Emergency Medical Conditions, Emergency Services, and Post-Stabilization Services.
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - How to get Emergency Services, including instructions on how to use the 911 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 a 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.
- Texas Children's practice guidelines.

Terms and Definitions

Appeal - A request for your managed care organization to review a denial or a grievance again.

Complaint - A grievance that you communicate to your health insurer or plan.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Durable Medical Equipment (DME) - Equipment ordered by a health care provider for everyday or extended use. Coverage for DME may include but is not limited to oxygen equipment, wheelchairs, crutches, or diabetic supplies.

Emergency Medical Condition - An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.

Emergency Medical Transportation - Ground or air ambulance services for an emergency medical condition.

Emergency Room Care - Emergency services you get in an emergency room.

Emergency Services - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services - Health care services that your health insurance or plan doesn't pay for or cover.

Grievance - A complaint to your health insurer or plan.

Habilitation Services and Devices - Health care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.

Health Insurance - A contract that requires your health insurer to pay your covered health care costs in exchange for a premium.

Home Health Care - Health care services a person receives in a home.

Hospice Services - Services to provide comfort and support for people in the last stages of a terminal illness and their families.

Hospitalization - Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care - Care in a hospital that usually does not require an overnight stay.

Medically Necessary - Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-participating Provider - A provider who does not have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.

Participating Provider - A Provider who has a contract with your health insurer or plan to provide covered services to you.

Physician Services - Health-care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Plan - A benefit, like Medicaid, which provides and pays for your health-care services.

Pre-authorization - A decision by your health insurer or plan that a health-care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision or approval, sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization is not a promise your health insurance or plan will cover the cost.

Premium - The amount that must be paid for your health insurance or plan.

Prescription Drug Coverage - Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs - Drugs and medications that by law require a prescription.

Primary Care Physician - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health-care services for a patient.

Primary Care Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health-care services.

Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health-care professional, or health-care facility licensed, certified, or accredited as required by state law.

Rehabilitation Services and Devices - Health-care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

Skilled Nursing Care - Services from licensed nurses in your own home or in a nursing home. Specialist - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

24-Hour Nurse Help Line

We have answers around the clock.

Whenever you need answers, the Texas Children's Health Plan 24-Hour Nurse Help Line is here. Don't wait until your child gets worse. Call when the symptoms first appear! You can call us **24 hours a day, 7 days a week.** Our nurses are ready to help with your health concerns and make informed decisions about your or your child's health. Call us when you:

- Are not sure if you need to make an appointment with a doctor
- Need information about medications, medical tests or procedures
- Want to know how to care for bug bites and rashes, and how to know if you should see a doctor
- Are at home and don't feel well, but don't need to see a doctor
- Have general questions and more

Texas Children's® Health Plan

Call the 24-Hour Nurse Help Line to speak with a nurse:

800-686-3831

texaschildrenshealthplan.org

Texas Children's® Health Plan

Good health starts here!

HEALTHY REWARDS PROGRAM

Healthy Rewards Program

At Texas Children's Health Plan, we go far beyond our members' medical needs. Our general approach to their well-being includes extra services, activities and rewards so they can start –and continue– living healthy lifestyles.

- **Healthy Pregnancy:** Services and rewards to help our members give their baby a healthy start!
- **Health and Wellness:** Members can get rewards just for taking care of their well-being!
- **Healthy Play and Exercise:** Benefits and rewards to help members get stronger and take control of their health.
- **Extra Help for Families:** With services like transportation help and a 24-hour nurse help line, we go the extra mile to show that we truly care for our members.

Learn about these new benefits and more at healthyrewardsprogram.org

CHIP | TEXAS STAR Your Health Plan • Your Choice | TEXAS STAR Kids Your Health Plan • Your Choice | TEXAS Health and Human Services

The Healthy Rewards Program is only available to active Texas Children's Health Plan members. Restrictions and limitations may apply. Age range may vary by plan.