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 (CHP), 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 (CHP), 800-659-5764 (STAR Kids) (TTY 7-1-1)

HealthPlan@texaschildrens.org
Attn: Civil Rights Coordinator
PO 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://portal.hhs.gov/ocr, 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
1-800-368-1019, 1-800-537-7697 (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 1-866-959-2555 (STAR), 866-959-6555 (CHP), 800-659-5764 (STAR Kids) (TTY 7-1-1).

Spanish: La comunicación es importante para nosotros. Tiene a su disposición servicios gratuitos de interpretación y traducción.
Llame al 1-800-659-5764 (TTY 7-1-1), 866-959-6555 (TTY 7-1-1), o 800-659-5764 (TTY 7-1-1)

Vietnamese: Giao tiếp là yếu tố quan trọng. Chúng tôi cung cấp dịch vụ dịch và giải trình miễn phí cho người nói tiếng Việt.
Lh萎缩 vi 800-659-5764 (TTY 7-1-1), 866-959-6555 (TTY 7-1-1)

Korean: 의사소통은 매우 중요합니다. 여러분이 한국어로 문의해 주시면 우리 직원이 도움을 드리겠습니다.
1-800-659-5764 (TTY 7-1-1)

Arabic: الاتصال هو مسألة مهمة بالنسبة لنا. لدينا خدمات مجانية للتأويل والترجمة.
للاستفسار 1-800-659-5764 (TTY 7-1-1), 866-959-6555 (TTY 7-1-1)

Tagalog: Mahalagang masanang mag-usap tayo. Kaalikesan kami nang magbigay ng mga serbisyo na makatulong sa iyong unang sitwasyon. Tamaan ang lahat ng 1-800-659-5764 (TTY 7-1-1)

French: La communication est importante. Nous offrons des services gratuits d’aide linguistique à votre disposition. Vous pouvez nous joindre au 1-800-659-5764 (TTY 7-1-1).

Hindi: वायरस और इलाज के लिए की जा रही है हस्ताक्षर और इलाज के लिए भी है 1-800-659-5764 (TTY 7-1-1)

Punjabi: ਇਕੱਤੀ ਸੰਤੁਸ਼ਤੀ ਹੋਵੇਗਾ ਦੇ ਸੰਸਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ ਭਾਸ਼ਾ ਅਧਾਰ ਵਿੱਚ ਹਿੱਸਾਵਾਂ ਦੇ ਲੌਚ ਕੀਤੇ ਗਏ ਹਨ। 1-800-659-5764 (TTY 7-1-1)

German: Kommunikation ist für uns wichtig. Fremdsprachliche Hilfe steht Ihnen kostenlos zur Verfügung. Bitte rufen Sie 1-800-659-5764 (TTY 7-1-1), 866-959-6555 (TTY 7-1-1) oder 800-659-5764 (TTY 7-1-1).

If you speak a language other than English, Spanish, or French, you may need to choose another language.

You can get help by calling 1-800-659-5764 (TTY 7-1-1), 866-959-6555 (TTY 7-1-1), or 800-659-5764 (TTY 7-1-1).

You may also present a complaint online, by email, or through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

You can also file a complaint with the Department of Health and Human Services by calling 1-800-659-5764, 866-959-6555, or 800-659-5764, or by email to HealthPlan@texaschildrens.org.

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

For more information, visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need to reach us after business hours, you can call the Women, Infants, and Children (WIC) Behavioral Health/Substance Abuse Hotline, at 844-818-0125 to find out how to get services. Ready 24 hours a day, 7 days a week. No primary care provider referral is needed. The hotline is staffed with individuals who speak English and Spanish. Interpreters who speak 140 different languages are also available by phone.

You can get help by calling 1-800-659-5764 (TTY 7-1-1), 866-959-6555 (TTY 7-1-1), or 800-659-5764 (TTY 7-1-1).

You may also present a complaint online, by email, or through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
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- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
- Information written in other languages
Welcome to Texas Children’s Health Plan

Thank you for choosing Texas Children’s Health Plan for your family. Texas Children’s Health Plan was founded in 1996, by Texas Children’s Hospital as the nation’s first managed care organization (MCO) created just for children. Texas Children’s Health Plan also offers services to pregnant women and members with special health care needs. As a member, you will have access to a wide network of doctors, hospitals, and specialists providing excellent patient care. 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. We look forward to serving you!

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 services to help you. Call Member Services at 800-659-5764. If needed, this handbook can be given to you in audio, larger print, Braille and other languages.

It is important for us to keep you healthy. That is why we want you to get regular well 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 three 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 Texas Benefits Medicaid Card are the keys to getting care. Show these Cards every time you visit a doctor, hospital, or get a prescription. Do not let anyone else use your card.

2. Call your primary care provider first if your problem is not an emergency. Except in the case of an emergency, always call your doctor first. That way, he or she can help you get the care you need.

3. Keep this handbook and the other information in your packet for future use.

We are glad you picked Texas Children’s Health Plan. It is our pleasure to serve you. If you have any questions, please call Member Services at 800-659-5764, 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 take your messages. A Member Advocate will return your call the next business day.

Texas Children’s Health Plan STAR Kids health coverage is designed to give you use of a network of doctors, hospitals, and other health services providers who are committed to giving good medical care. Our health plan was founded on the belief that you and your primary care provider are the two best qualified to care for your health. Think of your primary care provider as your main doctor. If you are sick, need a checkup, or if you have a medical question, call your primary care provider.

Remember—always take your Texas Children’s Health Plan Member ID card and Your Texas Benefits Medicaid Card with you each time you get health care.

How the Plan Works

Your primary care provider

What is a primary care provider?

Your primary care provider is considered your main doctor. He or she helps take care of all your health care needs. He or she keeps your medical records for you, and knows your medical history. A good relationship with your primary care provider helps you stay healthy.

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. If you have a primary care provider through another insurance, you may keep seeing your primary care provider. Each person living in your home who is a member can pick the same primary care provider or a different one. You should pick a doctor with an office location and office hours that are convenient for you. The names, addresses, and phone numbers of primary care providers can be found in the Texas Children’s Health Plan Provider Directory. For a current directory, please call Member Services at 800-659-5764.

If you like your current doctor, you can continue to see them if they are listed in the directory. If you have trouble picking a primary care provider, call us. We will be glad to help. You can request a printed copy of the Provider Directory or, you can easily search ‘Find a Provider’ on our website, texaschildrenshealthplan.org/find-a-provider.

Can a clinic be a primary care provider?

Yes. Primary care providers can be:

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

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 visit right away. 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 free-of-charge at 888-401-0170.

When you call:

- Have your Member ID card with you. The phone number is listed on your Member ID card. If you need medical care the same day, call your primary care provider as early in the day as possible.
- Be ready to tell the doctor your health problem or the reason for the visit.
- Write down the day and time for your visit.

When you go for your visit:

- Take your Member ID card and Your Texas Benefits Medicaid Card.
- Know the medicines you are taking.
- Take notes on the information you get from the doctor.

What do I need to bring with me to my doctor’s visit?

If it is your first visit to this doctor, also bring the name and address of your previous doctor. Children should also bring their vaccination records.

Be on time for your doctor visits. 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 it can get it.

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 800-659-5764 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

Your relationship with your doctor is very important. If you decide the primary care provider you picked does not meet your needs, or if you are told that he or she is no longer part of Texas Children’s Health Plan, it is your right to change to another doctor.

You may also want to change your primary care provider if:

- You are not happy with the care he or she gives.
- You need a different kind of doctor.
- Your primary care provider’s office is too far away from you because you have moved.

How can I change my primary care provider?

The names, addresses, and phone numbers of the primary care providers in the Texas Children’s Health Plan network can be found in the provider directory. To get a provider directory or help picking a new primary care provider, call Member Services at 800-659-5764. Or you can easily search ‘Find a Provider’ on our website, texaschildrenshealthplan.org/find-a-provider.
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 you to pick another primary care provider:
• 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 pick a new primary care provider, one will be picked for you.

If your primary care provider leaves Texas Children’s Health Plan
What if my primary care provider leaves?
We will tell you if your primary care provider decides to end his or her participation with Texas Children’s Health Plan. You will be assigned a new primary doctor. If your primary care provider is a Texas Children’s doctor, we will assign a new one. Call Member Services at 800-659-5764 to make the change.
If you are getting medically necessary treatments, you might be able to stay with that doctor until we find you a new doctor.

When will my primary care provider change become effective?
When you change your primary care provider, the change will take effect the next day. 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 his or her specialty or whether he or she offers telemedicine services by clicking on the “Find a Provider” link on our website: texaschildrenshealthplan.org/find-a-provider.
HOW THE PLAN WORKS

Medicaid Temporary ID Form 1027-A
If you lose the Your Texas Benefits Medicaid card and need quick proof of eligibility, the Health and Human Services Commission (HHSC) staff can still generate 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 211 (pick a language and then pick option 2). You must take your Form 1027-A with you when you get any health care services.

Specialty Care and Referrals
What if I need to see a doctor for a special problem (specialist)?
Your primary care provider is usually the doctor who coordinates your health care. Your primary care provider might ask you to see another doctor or have special tests done. This is called a referral. Texas Children’s Health Plan does not require referral or approval to see an in-network specialist. Specialists include doctors such as cardiologists (for heart), dermatologists (for skin), or allergists (for bad reactions).

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

How soon can I expect to be seen by a specialist?
Expect visits with specialists to happen within 21 days of your request. If you see a specialist without being referred by your primary care provider, the specialist might refuse to see you, except in an emergency situation. We recommend always checking with your primary care provider before you go anywhere else for care.

Unless needed for continuity of care, Texas Children’s Health Plan will not cover the costs of medical care from non-participating health care providers without approval. However, there may be times when your doctor believes it is critical for you to receive care from a non-participating doctor or other provider. In these cases, your doctor will work with Texas Children’s Health Plan. He or she will submit a request in writing to our Utilization Management Department for the authorization of medically necessary services that aren’t available from any other doctor or other provider in the Texas Children’s Health Plan network.

Other services that do not require a referral from your primary care provider
What services do not need a referral?
There are other certain types of health care that you can get without being referred by your primary care provider.

Those services include (when given by a Texas Children’s Health Plan network provider):
• Emergency care.
• OB/GYN care.
• Prenatal care.
• Behavioral health services or drug and alcohol treatment.
• Texas Health Steps medical and dental checkups.
• Family planning services.
• Vision care.
• Mental health or substance use services.

Texas Children’s Health Plan’s network providers are listed in the provider directory. Most of our OB/GYN doctors give family planning services. Call Member Services at 800-659-5764 for help in finding participating doctors.

Continuity of care
If you are new to Texas Children’s Health Plan, we will help coordinate your care to prevent any delay in services. This may include continuing to see a non-participating doctor for a period of time to allow for continuity of care. Contact your service coordinator or Member Services for more information.

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 recommended treatment. 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 800-659-5764 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.

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

ATTENTION FEMALE MEMBERS:
Texas Children’s Health Plan allows you to pick an OB/GYN but this doctor must be in the same network as your primary care provider.

You have the right to pick an OB/GYN without a referral from your primary care provider. An OB/GYN can give you:
• One well-woman checkup each year.
• Care related to pregnancy and postpartum.
• Care for any female medical condition.
• Referral to a special doctor within the network.

Do I have the right to choose an OB/GYN?
Texas Children’s Health Plan allows you to pick an OB/GYN but this doctor must be in the same network as your primary care provider.

How do I choose an OB/GYN?
Check our provider directory to find an OB/GYN. You can also call Member Services at 800-659-5764. We will be happy to help you pick a doctor. Or, you can easily find ‘a Provider’ on our website: texasciftedhealthplan.org/find-a-provider.

If I do not choose an OB/GYN, do I have direct access?
You may contact any OB/GYN in the Texas Children’s Health Plan network directly to get services.

Can I stay with my OB/GYN if they are not with Texas Children’s Health Plan?
If you are pregnant and have 16 weeks or less before your delivery date when you join our health plan, you can still go to your current OB/GYN. If you want, you can choose another OB/GYN who is in-network as long as 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 800-659-5764. We can help you pick an OB/GYN participating in the Texas Children’s Health Plan network, and help you with getting prenatal care visits and transportation to visits and tests.

How soon can I be seen after contacting my OB/GYN for an appointment?
Expect visits with your OB/GYN to be scheduled within 14 days of your request.

What other services/activities does Texas Children’s Health Plan offer pregnant women?
Texas Children’s Health Plan has a Service Coordination 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 Service Coordination 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 resources for parents.
This program offers pregnant members extra benefits, such as:

• Option 1: Login on your MyChart account. Head to “Resources” and click on “Healthy Connections” to sign up and access your rewards balance. Now to MyChart! Set up an account at texascare.onhealthplan.org/primary.html.

• Option 2: Call Healthy Connections at 866-475-1619 (TTY 711)

For all other benefits and more information:
Visit healthylifeprogram.org or call Member Services at 1-800-659-5764.

WHERE CAN I FIND A LIST OF BIRTHING CENTERS?

To learn more about how to get these services, make a free call to Member Services at 800-659-5764.

A Healthy Pregnancy with the Healthy Rewards Program

This program offers pregnant members extra benefits, such as:

1. 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.

2. Basic baby care and online birth classes: Join a variety of online classes through INJOY to learn more about pregnancy, childbirth, breastfeeding, postpartum health and baby care, newborn care, and more. Printed materials provided upon request.

3. 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.

4. 24-Hour Nurse Help Line: Our 24-hour nurse help line is here when you need it, day or night. You can get advice from a nurse about health issues you may be having. You can also get tips on understanding doctor’s instructions, and more.

5. Transportation services: Need a ride to a Texas Children’s Health Plan clinic or event? We provide transportation services for you at no cost! Transportation to medical appointments and the pharmacy are already covered services for STAR Kids members.

Restrictions and limitations may apply. Age range may vary. Extra benefits valid from September 1, 2023 to August 31, 2024. Visit healthylifeprogram.org for more details.

HOW TO DETERMINE MEDICAID ELIGIBILITY

To learn more about services, you can get through the Family Planning program, email, call, or visit the program’s website:
Website: texaschildrenshealthplan.org/healthywomen/familyplanning
Phone: 512-776-7796
Email: PPCU@texaschildrens.org

DSHS Expanded Primary Health Care Program

The Expanded Primary Health Care Program provides preventive, screening and 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 and contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breastfeeding.

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

Healthy Texas Women

Healthy Texas Women’s Program provides family planning exams, related health screenings and birth control to women ages 10 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 Program
P.O. Box 14000
Midland, TX 79711-9902
Phone: 800-335-8957
Website: healthytexaswomen.org
Fax: 866-993-9971

How can I receive health care after my baby is born (and I am no longer covered by Medicaid)?

After your baby is born you may lose Medicaid coverage. You may be able to get some health care services through the Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

Healthy Pregnancy Website with helpful pregnancy-related information at healthypregnancies.org

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 texascare.onhealthplan.org/primary.html.

• Option 2: Call Healthy Connections at 866-475-1619 (TTY 711)

For all other benefits and more information:
Visit healthylifeprogram.org or call Member Services at 1-800-659-5764.

WHERE CAN I FIND A LIST OF BIRTHING CENTERS?

A list of birthing centers may be found on our website at texascare.onhealthplan.org/find-a-provider or by calling Member Services at 800-659-5764.

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 Provider tool. Just visit texascare.onhealthplan.org/find-a-provider.

You can also call Member Services at 800-659-5764. We will be glad to help you pick a new primary care provider or send you a copy of our directory.

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 Provider tool. Just visit texascare.onhealthplan.org/find-a-provider.

Once you pick out a primary care provider, you should call Member Services at 800-659-5764. Be sure to have your baby’s member ID number ready.

How do I sign up my newborn baby?

As soon as your baby is born, call the Health and Human Services Commission (HHSC) benefits office at 2-1-1 to enroll your baby in Medicaid. Also, be sure to call your caseworker. He or she can answer any questions about your baby’s Medicaid 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 health care after my baby is born (and I am no longer covered by Medicaid)?

After your baby is born you may lose Medicaid coverage. You may be able to get some health care services through the Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

Healthy Texas Women

Healthy Texas Women’s Program provides family planning exams, related health screenings and birth control to women ages 10 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 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 copayment, 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, medications 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://tedixx.com/.

To learn more about services, you can get through the Primary Health Care program, email, call, or visit the program’s website:
Website: texaschildrenshealthservices/primary-health-care-services-program
Phone: 512-776-7796
Email: PPCU@texaschildrens.org

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://tedixx.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@texaschildrens.org

When you need to see a doctor

When you need to see a doctor, we recommend that you call your primary care provider. The phone number is listed on your Member ID card. If your primary care provider’s office is closed, a phone message will tell you how to get help. If you set up a visit with your doctor but find you can’t keep it, call to cancel and set up a new date and time. You should not have to wait more than 14 days to see your primary care provider.

If your primary care provider can’t see you within 14 days or if you have problems with your primary care provider, call Member Services at 800-659-5764.

Routine and regular 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 known as routine care. Most routine visits, including well-child checkups, are scheduled within 14 days of your asking. Adult checkups are scheduled within 4 weeks. When you need routine care, call your primary care provider’s number or your front-of-the-ID card. Someone in the doctor’s office or clinic will make an appointment for you. It is very important that you keep your appointments. If you cannot keep your appointment, call the doctor’s office to let them know.

Urgent care

What is urgent medical care?

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

• Minor burns or cuts
• Earaches
• Sore throat
• Muscle strains/sprains

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

For urgent care, you should call your doctor’s office or go to your emergency room if you have problems with your primary care provider, call Member Services at 800-659-5764.

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need to call the clinic before going. You need to go to a clinic that takes Texas Children’s Health Plan’s Medicaid. For help, call us at 800-659-5764. You also can call our 24-hour Nurse Help Line at 800-686-3831 for help with getting you 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’s Medicaid.

Call your primary care provider first if you have any of these problems:

- Ear ache
- Toothache
- Colds, cough, sore throat, flu, or sinus problems
- Minor cooking burns
- Teething
- Rash
- Minor headache

Care after office hours

How do I get medical care after my primary care provider’s office is closed?

There may be times when you need to speak to your primary care provider but his or her office is closed. For example, you may wonder about how to care for a sick child. Your child’s primary care provider or another doctor working with him or her is ready 24 hours a day, 7 days a week. Call the primary care provider’s office using the phone number located 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 after hours. The recording will tell you to call another number 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. The free phone number is 800-686-3831. Nurses are available 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 care

What is emergency medical care?

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

Emergency medical condition means:

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

- Placing the patient’s health in serious jeopardy.
- Serious damage to bodily functions.
- Serious breakdown of any bodily organ or part.
- Serious harm to your appearance.
- In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency behavioral health condition means:

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

- Requires immediate medical attention without which the member would present an immediate danger to themselves, or others.
- Makes the Member unable to control, know, or understand the consequences of their actions.

Emergency services and emergency care means:

Covered inpatient and outpatient services furnished by a provider that can furnish such services and that are needed to evaluate or stabilize an emergency medical condition or an emergency behavioral health condition, including post-stabilization care services.

How soon can I expect to be seen?

You should be seen the same day if you need emergency care. If you are sure your situation is not life-threatening but are not sure if you need emergency care, call your primary care provider if you feel that taking the time to call the primary care provider will endanger your health, get care immediately.

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

If it’s not an emergency, but you get sick or need medical care while you are out of state, call your primary care provider and they can tell you 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.

Routine care, or regular care, like adult regular checkups, follow-up visits, and other non-emergency care, is not covered when you are out of state. If you go to someone other than your primary care provider to get these services, you might have to pay. Remember to keep your Member ID card and Your Texas Benefits Medicaid Card with you at all times.

Hospital services

Your primary care provider or a specialist may decide 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.

What does Medically Necessary mean?

Medically necessary means:

(1) For Members birth through age 20, the following Texas Health Steps services:
- screening, vision, and hearing services; and
- 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. Taylor, et al. partial settlement agreements; and
- may include consideration of other relevant factors, such as the criteria described in parts (2)(b)-(3)(d) of this definition.

(2) For Members over age 20, non-behavioral health related health care services that are:
- 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 incapacity of a Member, or endanger life;
- provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member’s health conditions; and
- consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies; and
- consistent with the diagnoses of the conditions;
- no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- not experimental or investigatory; and
- not primarily for the convenience of the Member or provider; and

(3) For Members over age 20, behavioral health services that:
- 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;
- are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
- are the most appropriate level or supply of service that can safely be provided;
- could not be omitted without adversely affecting the Member’s mental and/or physical health or the quality of care rendered;
- are not experimental or investigative; and
- are not primarily for the convenience of the Member or provider.

What is the Member Portal?

The member portal is an online tool that allows you to play an active role in your health care needs. You can now change your main doctor, keep track of your appointments, see your shot records and so much more. It is easy just go to our website texaschildrenshealthplan.org and click the Member Login link at the top of the page to get started.
Benefits and Services

STAR Kids Covered Services

What are my health care benefits?

The following is a list of many of the medically necessary health care services included under the STAR Kids Program.

What services are not covered?

Services that are not covered include:

• Health care performed by a physician who does not take
  Medicaid.
• Health care performed in a state or federal hospital.
• Acupuncture (healing using needles and pins).
• Health care performed in a state or federal hospital.
• Health care performed by a doctor who does not take
  Medicaid.
• Cosmetic surgery.

For more information or if you have questions, call Member Services at 1-800-659-5764.

Medically necessary services included under the STAR Kids program:

• 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
  Steps Comprehensive 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.
  – Mental Health Rehabilitative Services and Mental Health
    Targeted Case Management for individuals who are not
    dually eligible in Medicare and Medicaid
  – Outpatient mental health services
  – Psychiatry services
  – Collaborative Care Model services
• Substance Use Disorder treatment services, including
  Outpatient services, such as:
  - Assessment
  - Detoxification services
  - Counseling treatment
  – Medication-assisted therapy
• Residential services, which may be provided in a
  chemical dependency treatment facility in lieu of an
  acute care inpatient hospital setting, including:
  – Detoxification services
  – Substance Use Disorder treatment (including room
    and board)
• 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
• Birthing services provided by a physician and CNM in
  a licensed birthing center
• Birthing services provided by a licensed birthing center
• Cancer screening, diagnostic, and treatment service
• Chiropractic services
• Day Activity and Health Services (DAHS)
• Dialysis
• Drugs and biologics provided in an inpatient setting
• Durable medical equipment and supplies
• Early Childhood Intervention (ECI) services
• Emergency Services
• Family planning services
• Financial Management Services
• Home health care services provided in accordance with 42
  C.F.R. § 440.70, and as directed by HHSC
• Hospital services, 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
  – Clinical appropriateness, 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 lymphedema and
      prophylactic mastectomy to prevent the development
      of breast cancer.
  – external breast prostheses for the breast(s) on which
    medically necessary mastectomy procedure(s) have
    been performed.
• Medical checkups and Comprehensive Care Program
  (CCP) Services through the Texas Health Steps Program
  (EPSTP), including direct primary care, Prescribed
  Pediatric Extended Care Center (PPECC) services,
  certified respiratory care practitioner services, and
  therapies (speech, occupational, physical)
• Non-emergency 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;
• Optometry, glasses, and contact lenses, if medically
  necessary
• Outpatient drugs and biologicals
• Personal Care Services (PCS)
• Podiatry
• Prescribed pediatric extended care center (PPECC)
  services
• Primary care services
• Private Duty Nursing (PDN) services
• Radiology, imaging, and X-rays
• Specialty physician services
• Telemonitoring
• Telehealth
• Therapies – physical, occupational, and speech
• Transplantation of organs and tissues
• Vision services

Community First Choice (CFC) services for those

Members who qualify for these services

Additional services are available for Members who would
otherwise qualify for care in a Nursing Facility, an Intermediate
Care Facility (ICF) for Individuals with Intellectual Disabilities
(ID), or an Institution for Mental Diseases (IMD). These include:

• Personal Care Services - CFC
• Habilitation, acquisition, maintenance and enhancement
  of skills
• Financial Management Services
• Emergency Response Services
• Emergency Response Services under CFC
• Support Management

Additional Services for Medically Dependent

Children Program (MDSCP) STAR Kids

The following is a list of covered services for members who
qualify for (MDSCP) STAR Kids services. These medically
necessary services are available for members who meet the
functional and financial eligibility for MDSCP STAR Kids:

• Respite Care;
• Supported Employment;
• Financial Management Services;
• Adaptive Aids;
• Employment Assistance;
• Flexible Family Support Services;
• Minor home modifications and
• Transition Assistance Services.

How to obtain covered services?

Texas Children’s Health Plan wants to keep your family happy
and healthy. Our Member Services team is ready to take your
call from 8 a.m. to 5 p.m., Monday through Friday. After hours,
on weekends, and holidays, our answering service is ready to
provide assistance by taking your messages. A Member Services
Representative will return your call the next business day.

We speak English and Spanish. We also have interpreters available
by phone who speak 140 different languages. Emergency Service
and Behavioral Health Hotline services are available 24 hours a
day, 7 days a week.

24-Hour Nurse Help Line
800-686-3831 or
TTY 800-735-2989 (Texas Relay)

Behavioral Health/Substance Abuse Hotline
800-731-8529

By mail:
Texas Children’s Health Plan
PO Box 301011
Houston, TX 77230-1011

By phone:
STAR Kids Member Services
800-659-5764

Vision care
(844)312-7269

Dental care
Your child will have one of the following dental plans:
• DeltaQuest: 800-506-6775
• MCNA Dental: 800-494-6262
• UHCDental: 800-516-0165

If you don’t know who your child’s STAR Kids dental plan is, call
Member Services at 800-659-5764.

Service Coordination:
800-659-5764, option 2 for the Coordination Support Center

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? Ask your
doctor or call Texas Children’s Health Plan at 800-659-5764. We will tell you if a service has a limit.

Services that are not covered

What services are not covered?

Some services that are not covered include:

• Faith healing (healing with prayer).
• Acupuncture (healing using needles and pins).
• Health care performed in a state or federal hospital.
• Health care performed by a doctor who does not take
  Medicaid.
• Behavioral Health Services including:

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Any service that is not medically necessary.
Any service received out of the country.
Infertility services, including reversal of voluntary sterilization procedures.
Voluntary sterilization if 20 years and younger or legally incapable of consenting to the procedure.
Vaccines for travel outside the United States.
Experimental services, including drugs and equipment, not covered by Medicaid.
Aborts except in the case of a reported rape, incest, or when medically necessary to save the life of the mother.
Paternity tests.
Immunizations for travel outside the United States.
Sex reassignment surgery or gender reassignment surgery and related services.
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 Kids members 20 years of age or younger. You can get a copy of the Settlement Agreement by visiting www.hhs.texas.gov and www.disabilityrightstx.org. If you have any questions, call Disability Rights Texas at 713-974-7691.
How do I get these services?
See your primary care provider to ask about medical services. He or she will give or arrange needed medical services. You can also call Member Services free-of-charge at 800-659-5764 to learn how to get these services.
Prior Authorization Process
Certain services require authorizations 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 for authorization of medically necessary services that are not available 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 days if the member or provider requests 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.
Texas Health Steps
What is Texas Health Steps? What services are offered by Texas Health Steps?
Texas Health Steps is the Medicaid health care program for STAR and STAR Kids children, teens, and young adults, birth through age 20.
Texas Health Steps gives your child:
- Free regular medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.
- A case manager who can find out what services your child needs and where to get these services.

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

When to set up a checkup:
- You will get a letter from Texas Health Steps telling you when it’s time for a checkup. Call your doctor’s child 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 at 800-659-5764 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 checkup!
- 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.

If you can’t get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital, or drug store. Contact Texas Children’s Health Plan for more information. Visit healthytexasprogram.org or call Member Services at 1-800-659-5764 for more information.

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 800-659-5764 or Texas Health Steps at 877-847-8377 for a list 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 will be covered as long as 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 346-223-9229 to be added to the transportation list.

If you are a migrant farm worker family, we will:
- Help you pick 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.

Prescription Drug Benefits
What are my prescription drug benefits?
Your prescription medicines are a benefit through your Texas STAR Kids 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 network.

BENEFITS AND SERVICES
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 or my child’s 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 800-659-5764.

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 your or your child's prescription benefit are part of the Texas Medicaid/CCHIP 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 Children’s Health Plan (TCHP) 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 look at 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 and Human Services (HHSC). Where can I go to find out what drugs are covered and/or require prior-approval? You can review the list of medications by visiting https://www.texasmedicaredrug.com/. There is a tool to search medications by brand or generic name. The tool also identifies if a medication has 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 800-659-5764 if you need help.

What if I also have Medicare? Some Medicare plans may not have pharmacy benefit coverage. If you or your child have Medicare and Medicaid pharmacy coverage, please bring both insurance cards to the Pharmacy. Medicare will pay first up to the limits of its coverage. Medicaid will cover the remaining costs if within the limits of its coverage. Medicines covered under Medicaid-Medicare dual coverage may not be the same as typical Medicaid only benefits.

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 paid.
- 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 800-659-5764. 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. Prior authorizations help Texas Children’s Health Plan to ensure the medications are safe and effective. Your doctor must submit an approval request. We work with a pharmacy benefits manager to review requests. Decisions are made typically within 24 to 72 hours of submitting a prior authorization request. You can find a list of prior authorization forms on our online member portal. You can also find it under “Prior Authorization Forms.”

There are times when a drug store may give you an emergency fill for 3 days supply. These are:

- The drug store cannot reach your doctor.
- It will take longer than 72 hours to resolve.
- This does not apply to:
  - Unbreakable packages like inhalers.
  - Controlled substances like opioids.

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://www.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 texascovendrug.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 appeal by the pre-approval denial. Your doctor may also submit a separate “exception” to receive an emergency supply of a drug for standard quantity limits. The Exception to Coverage form can be found at twistphrc.navitus.com under “Prior Authorization Forms.”

What if I lose my or my child’s medication(s)? If you or your doctor believe you need the medication.

What if I need or my child needs an over-the-counter (OTC) medication? The pharmacy cannot give you an over-the-counter medication as part of your or your child’s Medicaid drug benefits 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 Medicaid plan may 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 800-659-5764.

How are generic substitutes or therapeutic interchange 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 out 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 deny any coverage of any product covered under Medicaid/CCHIP 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 get a 72-hour emergency supply of a prescribed drug. This is only if a medication is needed without delay and prior authorization is not available. This is for all drugs requiring a prior authorization. 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 prior authorization 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 prior authorization, 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 allulose inhaler, as a 72-hour emergency supply. For more information, please call Member Services with a free call to 800-659-5764.

Medicaid Office of Inspector General (OIG) Lock-In Program What is Medicaid Lock-In Program? The Office of Inspector General (OIG) Lock-In Program 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,
BENEFITS AND SERVICES

How do I get help if I have behavioral (mental), health, alcohol, or drug problems? Do I need a referral for this?

You can get mental health or drug abuse services when needed. You do not need a referral from your primary care provider. These services include:

- Counseling services.
- In and out of hospital care.
- Detoxification and treatment for drug addiction and alcoholism.

You can get mental health or drug abuse services by:

- Calling Texas Children’s Health Plan’s Mental Health/Drug Abuse Hotline at 800-731-8529. The hotline is available 24 hours a day, 7 days a week.
- Choosing a mental health or drug abuse provider from the Texas Children’s Health Plan provider network.

If you have an emergency and need mental or drug abuse treatment immediately, go to the nearest emergency room or call the free 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.

Mental health rehabilitation services and Mental Health Targeted Case Management

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 Member Services at 800-659-5764. Texas Children’s Health Plan offers these services:

- Education, planning and coordination of behavioral health services.
- Mental health and substance use services outside of the hospital.
- Psychiatric partial and inpatient hospital services (for members 21 and under).
- Non-hospital and inpatient residential detoxification, rehabilitation and halfway house.
- Crisis services 24 hours a day, 7 days a week.
- Residential care (for Members 21 and under).
- Medications for mental health and substance use care.
- Lab services.
- Referrals to other community resources.
- Transitional health care services.
- Targeted Case Management (designed to help members with gaining access to needed medical, social, educational, and other services and support).
- Mental health rehabilitation (supports members to their best possible functioning level in the community).
- 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 care

How do I get eye care services?

To get eye checkups or eyewear, call Enroll Vision at 844-212-7269. Customer Service Representatives are ready to help you pick a provider near you. They will also provide instructions on how to get your eyeglasses. You do not need a referral from your primary care provider to get regular eye checkups from eye doctors in the Enroll Vision’s provider network.

Covered eye care services are different for adults and children.

If you are age 20 years or younger:

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

If you are age 21 years or older:

- You can get an eye checkup every 24 months.
- Eyewear may be replaced every 24 months.

As part of our Healthy Rewards Program, members up to age 18 are eligible for an allowance on upgrades of $110 for framed glasses or $90 for contact lenses and fits. Visit healthyrewardsprogram.org for more details.

Family planning services

How do I get family planning services? Do I need a referral for this?

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 parent 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.
- 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 www.dshs.state.tx.us/familyplanning or you can call Texas Children’s Health Plan at 800-659-5764 for help in finding a family planning provider.

Case Management for Children and Pregnant Women (CPW)

What is a 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 be 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 Service Coordination Phone: 832-828-1430
- Website: texaschildrenshealthplan.org

Disease management

Disease management is a proactive, multidisciplinary, systematic approach to health care delivery that:

- Includes members with a chronic disease.
- Supports the provider-patient relationship and plan of care.
- Optimizes patient care through prevention and proactive interventions based on evidence-based guidelines.
- Incorporates patient self-management.
- Continuously evaluates health status.
- Measures outcomes.
- Serves to improve overall health and quality of life and lower cost of care.

If you have special health care needs like diabetes, ADHD, asthma, or skin cell disease, make a free call to Member Services at 800-659-5764. We will ask about your current health status. Your information will be given to a Service Coordinator. The Service Coordinator will make outreach to you within 7 days to assess your needs.

A Service Coordinator can help you:

- Find services in your community.
- Find providers in your area.
- Make appointments with special doctors.
- Learn about your medical condition.
- Explain your covered benefits and services.
- Create a plan of care just for you.
- Work with your main doctor to help you get medically necessary care.

Be sure to tell the Service Coordinator about any special doctors you have been seeing.

For more information, call the Member Services at 800-659-5764.

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

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 800-659-5764 and ask to speak to a pharmacist about the Medicaid Lock-In Program.

Mental health and drug abuse services

How do I get help if I have behavioral (mental), health, alcohol, or drug problems? Do I need a referral for this?

You can get mental health or drug abuse services when needed. You do not need a referral from your primary care provider. These services include:

- Counseling services.
- In and out of hospital care.
- Detoxification and treatment for drug addiction and alcoholism.

You can get mental health or drug abuse services by:

- Calling Texas Children’s Health Plan’s Mental Health/Drug Abuse Hotline at 800-731-8529. The hotline is available 24 hours a day, 7 days a week.
- Choosing a mental health or drug abuse provider from the Texas Children’s Health Plan provider network.

If you have an emergency and need mental or drug abuse treatment immediately, go to the nearest emergency room or call the free 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.
trips do NOT include ambulance trips.

What services are part of NEMT Services?
• Pases 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 caregiver.

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 adult on file to travel alone. Parental consent is not needed if the health care service is confidential in nature.

How to get a ride? Texas Children’s Health Plan will provide you with information on how to ask for NEMT services. You should ask for the ride as early as possible, and at least two business days before you need the NEMT 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 serious or painful enough to require treatment within 24 hours.

You must tell Texas Children’s Health Plan before the approved and scheduled trip if your medical visit is cancelled.

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

Audiology services
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.

Health Risk Assessment
Texas Children’s Health Plan encourages members to complete their Health Risk Assessment (HRA). Your answers help us to better understand your health and create a personalized care plan for you. Fill out the form at texaschildrenshealthplan.org/hra.

As part of our Healthy Rewards Program, new members can receive a $10 reward card when they complete the Health Risk Assessment within 90 days of enrollment. Learn more at healthyrewardsprogram.org.

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
- Healthy Wellness
- Healthy Play and Exercise
- Healthy Food and Exercise

• 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.

• Health Risk Assessment Reward: Fill out this form within 90 days of becoming a member so we can better understand your health care needs and receive a $10 reward card. Reward can be requested up to 30 days after the end of the eligible year.

• 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.

• Health Risk Assessment Reward:
  - Complete 1 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 30 days after the end of the eligible year.

• Sports and school physicals:
  - Get one yearly sports or school physical at $25.

• Sports Clinics:
  - Get active and attend a variety of sports clinics.

• Extra Help for Families:
  - 24-Hour Nurse Help Line: Don’t feel good? Call us at 1-800-686-3831. 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.

• Transportation services: Get a ride at no cost to Texas Children’s Health Plan classes or events. Transportation 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, breastfeeding, formulas, nutrition, and healthy eating.
What is Head Start and how to get it?

What is Head Start?
Head Start is a Federal program that promotes the school readiness of children from birth to age 3 while involving their families and communities. This includes providing services to low-income families by enhancing their cognitive, social, and emotional development. Head Start emphasizes the role of parents as their child’s first teacher, and the importance of creating a supportive environment that supports children’s growth in many areas such as language, literacy, and social and emotional development.

How to sign up my child?

Step 1. To sign up for Head Start, families must meet the income requirements as identified by the Federal Government. You will need to provide proof of income. You can bring copies of your tax return, W-2 forms or current pay stubs if applicable.

Step 2. You will need your child’s birth certificate or other identification. Head Start services are for children ages birth to 3.

Step 3. You can contact your Service Coordinator to help you find the nearest Head Start center.

When you are approved for services, be sure to visit or call the Head Start program about their availability. Please ask for a copy of the member’s choosing.

In which programs can I use CDS?
The CDS option is available in the following programs:

- Community Living Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services (HCS)
- Medically Dependent Children Program (MDCP)
- Texas Home Living (TXHL)
- STAR Kids Community First Choice or Personal Care Services
- Youth Empowerment Services (YES)

Service Responsibility Option
A service delivery option that empowers the manager to manage day-to-day activities. This includes supervision of the person providing their personal attendant services. The member decides how services are provided. It leaves the business details to a provider of the member’s choosing.

Agency Option
Choosing the agency option allows you to entrust responsibility to an agency for your program services. Your provider agency handles all aspects of attendant care.

If you choose the agency option, your provider agency will:
- Pick, schedule and manage your attendants and substitutes, with input from you about your needs.
- Set wages and benefits for your attendants.
- Manage time sheets, payroll and employment records.

Who do I call if I have special health care needs and need someone to help me?
If you have special health care needs and require help, call Member Services at 800-659-5764. We will connect you to a member of your Service Coordination Team or your named Service Coordinator. The Service Coordinator will talk with you within 2 working days to assess your needs.

And I allowed to see specialists for services?
Texas Children’s Health Plan allows members with special health care needs to have direct access to specialists, as appropriate for their condition and identified needs.

Direct access means that no referral or authorization is needed to receive services from specialists in the Texas Children’s Health Plan network.

Service Coordination

What is a Service Coordinator?

Service Coordination provides initial and ongoing assistance identifying, picking, obtaining, coordinating and using covered services and other supports to enhance a member’s well-being, independence, integration in the community and potential for productivity. As a benefit upon enrollment, each STAR Kids member is assigned a Service Coordinator. Your assigned Service Coordinator sees to it that you receive timely, high-quality, cost-effective care and support during both acute and chronic phases of your health. Service Coordinators safeguard your health through the creation of an individualized service plan, which includes a holistic evaluation of your physical, behavioral and social needs.

What will a Service Coordinator do for me?
- Provide a holistic evaluation of individual dynamics, needs and preferences that includes conducting a once-a-year STAR Kids Screening and Assessment in order to ensure appropriate coordination of care.
- Educate and help provide health-related information.
- Help identify any physical, behavioral, functional, and psychological needs.
- Work with the member and the member’s Legally Authorized Representative (LAR) and other caretakers in the design of an Individual Service Plan (ISP).
- Connect and coordinate covered and non-covered services to meet members identified needs.
- Monitor to make sure the covered services are timely and appropriate.
- Coordinate covered and non-covered services.
- Intervene on behalf of the member if approved by the member’s Legally Authorized Representative (LAR).

How can I talk with a Service Coordinator?

Upon enrollment to Texas Children’s Health Plan, your assigned Service Coordinator will contact you in order to introduce themselves and schedule the needed STAR Kids Screening and Assessment Instrument (SK-SAI). You can also reach your assigned Service Coordinator by calling 800-659-5764 Option 2.

Transition Specialist

What is a Transition Specialist?
Transition Specialists help to assist members with transition planning for adulthood, specifically engaging members ages 15 and older.

What will a Transition Specialist do for me?
Transition Specialists help make sure that teens and young adult members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will happen following their 21st birthday. The Transition Specialist delivers ongoing transition planning through a team approach starting when the member turns 15 years old. Transition Specialists are trained on the STAR Kids system and maintain current information on local and state resources to help members going through the transition process.

How can I talk to a Transition Specialist?
You can contact your Transition Specialist through your assigned Service Coordinator by calling Member Services at 800-659-5764.

Home and Community-based Services (HCS)
The Home and Community-based Services (HCS) is a waiver program that assists people who have developmental disabilities in Texas.

What is considered a developmental disability in Texas?
A developmental disability is a severe, life-long disability that begins before the person reaches the age of 22 and is likely to keep going throughout his or her life.

Who can get services in Texas?

- You can be of any age.
- You must qualify for care in an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID).
- You must have a determination of an intellectual disability in accordance with state law or have a diagnosis of a related condition with an IQ of 75 or below.
- You cannot be enrolled in another waiver program.
- Your income and resources may not exceed specified limits.
MDCP members can get additional LTSS services. Medical necessity requirements for nursing facility level of care. Medically Dependent Children Program (MDCP) waiver services include:
- LTSS beneficiaries who often have substantial acute care needs.
- Right providers and services are in place to meet the members’ and families’ needs.
- Services include Primary Home Care, Day Habilitation, and Home Community Based Services (HCBS). These services are delivered under the authority of the Texas Health and Human Services (HHS). Please contact your Texas Children’s Health Plan Service Coordinator at your Local Intellectual and Developmental Disability Authority (LIDDA) for questions specific to TCHS waiver services.

**What are LTSS?**
LTSS provides assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping). Services include Primary Home Care, Day Habilitation, and Home Community Based Services (HCBS). These services are delivered under the authority granted to the state of Texas to allow delivery of LTSS that help individuals with intellectual disabilities to live in the community in a manner of their choosing.

**Care planning and care coordination services** help beneficiaries and families navigate the health system and ensure that the right providers and services are in place to meet the members’ needs and preferences. These services can also be essential for LTSS beneficiaries who often have substantial acute care needs.

**LTSS available under the State plan for STAR Kids members include:**
- Private Duty Nursing (PDN)
- Personal Care Services (PCS)
- Community First Choice (CFC)

**Medically Dependent Children Program (MDCP) waiver services:** are available to members who meet income, resource, and medical necessity requirements for nursing facility level of care. MDCP members can get additional LTSS services.

**Services available in all medically dependent children program (MDCP) waivers:**
- Adaptive aids (AA)
- Employment Assistance (EA)
- Financial Management Services (FMS)
- Flexible Family Support
- Minor Home Modifications (MHM)
- Respite
- Supported Employment (SE)
- Transition assistance services

For more information, please contact your Service Coordinator at 800-659-5764.

**What are my Long-Term Services and Supports (LTSS) benefits?**
Home and community-based services programs provide choices to live in a community setting. Services can be part of the normal Medicaid coverage (such as private duty nursing or personal care services) or may be delivered through programs called “waivers” that allow for consumers to have an active role in their health care and to remain in the community.

**How do I get these services?**
LTSS benefits and waivers serve people who have behavioral, developmental, or physical disabilities, based upon a needs assessment. Talk to your doctor to discuss your health needs requiring long term care services and supports.

**What number do I call to find out about these services?**
Call Member Services at 800-659-5764.

I am in the Medically Dependent Children Program (MDCP). How will I receive my LTSS?
State plan LTSS, like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC), will be delivered through Texas Children’s Health Plan. Your MDCP waiver services will be delivered through Texas Health and Human Services (HHS). Please contact your Texas Children’s Health Plan Service Coordinator if you need assistance with accessing these services.

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

Am I allowed to see specialists for services? Texas Children’s Health Plan allows members who need LTSS services to have direct access to specialists, as appropriate for their condition and identified needs.

Direct access means that no referral or authorization is needed to receive services from specialists in the Texas Children’s Health Plan network.

**Prescribed Pediatric Extended Care Center (PPEC) What is PPEC?**
PPECs allow minors from birth through age 20 with medically complex conditions to receive daily medical care in a non-residential setting.
When prescribed by a doctor, minors can attend a PPEC up to a maximum of 12 hours per day to receive medical, nursing, psychosocial, therapeutic and developmental services appropriate to their medical condition and developmental status. This benefit does require authorization by a physician.

**Nursing Facility**
Will my STAR Kids benefits change if I am in a Nursing Facility? No. Benefits remain the same, and a Service Coordinator continues to be in place to support the needs, goals and preferences of the member.

**Will I continue STAR Kids benefits if I go into a Nursing Facility?**
A STAR Kids Member who enters a Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) will remain a STAR Kids Member. Texas Children’s Health Plan must provide Service Coordination and any covered services that happen outside of the Nursing Facility or ICF/IID when a STAR Kids Member is a Nursing Facility or ICF/IID resident. Throughout the duration of the Nursing Facility or ICF/IID stay, Texas Children’s Health Plan must work with the member and the member’s Legal Authorized Representative (LAR) to identify Community-Based Services and Long-Term Services and Supports (LTSS) programs to help the member transition to the community.

**Acute care benefits**

**What are my Acute Care benefits?**

Acute care services includes such settings as doctor offices, clinics, laboratories, therapy visits, pharmacies, hospitals or diagnostic centers. Texas Children’s Health Plan contracts with all types of care providers to offer Member’s access to a full spectrum of acute care services.

**How do I get these services?**
You may access acute care services at any time. Calling your primary care provider is the best place to start. Texas Children’s Health Plan supports members visiting their primary care provider for an evaluation and planning of care needs including preventive care.
Texas Children’s Health Plan does not require referral, authorization to in-network specialists, including behavioral health care, women’s health care, or urgent care.

**What number do I call to find out about these services?**
For more information, call Member Services at 800-659-5764.

**Individual Service Plan (ISP)**

**What is the ISP?**
The ISP is used to talk and align expectations between the Member, their Legal Authorized Representative (LAR), Texas Children’s Health Plan and key service providers regarding:
- Assessment findings
- Short and long-term goals
- Service needs
- Member preferences

An ISP can be created at the time of onboard, yearly, upon request and whenever a life or health event dictates a change that might influence the plan or level of care delivered to a STAR Kids member. The ISP is informed by the findings from the STAR Kids Screening and Assessment process, in addition to input from the member, their family and caregivers, providers, and any other person with knowledge and understanding of the member’s strengths and service needs who is identified by the member, the member’s LAR, or Texas Children’s Health Plan. To
To get PDN, members must:

1. Evidence-based models and minimum standards of care; and
2. Patient-centered and family-centered care;

A Health Home must be part of a person-based approach and holistically address the needs of people with multiple chronic conditions or a single serious and persistent mental or health condition.

Health Home services must include:

- Patient self-management education;
- Provider education;
- Patient-centered and family-centered care;
- Evidence-based models and minimum standards of care; and
- Patient and family support (including authorized representatives).

**Private Duty Nursing**

**Private Duty Nursing (PDN)**

- PDN services are a Medicaid benefit, which include direct skilled nursing care, caregiver training and education.
- PDN services must be provided by a Registered Nurse (RN) or Licensed Vocational Nurse (LVN).
- PDN services must be available to members who require assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or Health Maintenance Activities (HMA) because of a physical, cognitive, or behavioral limitation related to the members disability or chronic health condition.
- Texas Children’s Health Plan must make sure members who receive PDN, PCS, or both, have access to appropriate providers.

To get PDN, members must:

- Be age 20 or younger and have Medicaid.
- Meet medical necessity criteria.
- Require individualized, continuous, skilled care beyond the level of skilled nursing visits normally authorized under Texas Medicaid Home Health Skilled Nursing and Home Health Aide (HHHA) Services.

**Assessments and reassessments**

An assessment is a review of your child’s condition to decide if your child may need PDN. Reassessments are other reviews that are done after the first one. You and your child’s Service Coordinator will complete an assessment of PDN needs. There are steps to take after your child begins getting PDN.

**Health Home**

**What is a Health Home?**

A Health Home must provide an array of services and supports, outlined below that extend beyond what is needed of a primary care provider. STAR Kids Health Homes must operate through either a primary care practice or if appropriate, a specialty primary practice and must provide a team-based approach to care that is designed to enhance ease of access, coordination between providers, and quality of care.

Health Home services must be part of a person-based approach and holistically address the needs of people with multiple chronic conditions or a single serious and persistent mental or health condition.

Health Home services must include:

- Patient self-management education;
- Provider education;
- Patient-centered and family-centered care;
- Evidence-based models and minimum standards of care; and
- Patient and family support (including authorized representatives).

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- Be age 20 or younger and have Medicaid.
- Meet medical necessity criteria.
- Require individualized, continuous, skilled care beyond the level of skilled nursing visits normally authorized under Texas Medicaid Home Health Skilled Nursing and Home Health Aide (HHHA) Services.

**Assessments and reassessments**

An assessment is a review of your child’s condition to decide if your child may need PDN. Reassessments are other reviews that are done after the first one. You and your child’s Service Coordinator will complete an assessment of PDN needs. There are steps to take after your child begins getting PDN.

**Your child must have a reassessment:**

1. Every 12 months.
2. When there is a change in medical condition or in your living situation at home.

For more information, call the Coordination Support Center at 800-659-5764.

**What is Project Rental Assistance?**

Section 811 Project Rental Assistance Program (PRA)

The Section 811 PRA program provides project-based rental assistance for extremely low-income persons with disabilities linked with long term services. The program is made possible through a partnership between the Texas Department of Housing and Community Affairs (TDHCA), the Texas Health and Human Services Commission (HHSC) and eligible multifamily properties.

The Section 811 PRA program creates the opportunity for persons with disabilities to live as independently as possible through the coordination of voluntary services and providing a choice of subsidized, integrated rental housing options.

**Target Populations**

- People with disabilities living in institutions. People with intellectual and developmental disabilities that wish to transition from nursing and intermediate care facilities to the community who may not have access to affordable housing.
- People with serious mental illness. Individuals engaged in services but facing challenges because of housing instability. Stable, integrated, affordable housing would enable these individuals to have the chance to fully engage in rehabilitation and treatment, greatly improving their prospects for realizing their full potential in the community.
- Youth with disabilities exiting foster care. Youth exiting foster care often become homeless, particularly without the stability of long-term housing.

For more information, please contact your Service Coordinator at 800-659-5764.

**Durable Medical Equipment**

Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a doctor for use in the home, and needed to correct or ameliorate a client’s disability, condition, or illness.

**DME must:**

- Be medically necessary because of illness or injury or to improve the functioning of a body part.
- Be considered safe for use in the home.

- Be provided through an enrolled DME provider/supplier.
- Meet the client’s existing medical and treatment needs.
- To get DME, members must:
  - Be age 20 or younger and have Medicaid.
  - Meet medical necessity criteria.

For more information, call Member Services at 800-659-5764.

**Community First Choice (CFC)**

**How does CFC work in Texas?**

CFC services are ready across all service models for children and adults who qualify for this benefit.

**What is CFC?**

CFC is a state plan option that allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees.

Who can get Community First Choice (CFC)?

To get CFC, a person must:

- Be a child or an adult who is able to get Medicaid.
- Meet an institutional level of care, including:
  - A hospital.
  - A nursing facility.
  - An intermediate care facility for individuals with an intellectual or developmental disability.
  - An institution providing psychiatric services for individuals under age 21.
  - An institution for mental diseases for individuals aged 65 or over.
- Need help with Activities and Instrumental Activities of Daily Living (ADLs and IADLs), such as dressing, bathing and eating.

Do people with Intellectual or Developmental Disabilities (IDD) who meet the eligibility criteria for CFC have access to CFC services, regardless if services they are receiving from other IDD waivers?

Yes. Individuals with IDD that meet the coverage criteria and are being served in a home or community setting have access to CFC. CFC is available to individuals that reside in their own home, or the home of a family member (own home, family home setting).

Is habilitation accessible to all people regardless of their level of functioning?

All people who meet the eligibility criteria for CFC are able to receive habilitation if the person has an identified unmet need for the service as determined by the person and the service planning team using a person-centered planning process.

**Community First Choice (CFC) Services**

What services are included in the CFC benefit?

- Personal Assistance Services (PAS): Assistance with ADLs and IADLs through hands-on assistance, supervision, and/or cueing.
- Durable Medical Equipment (DME): Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.
- Emergency Response Services (ERS): Backup systems and supports are used to ensure continuity of services and supports. Backup systems and supports include electronic devices to ensure continuity of services and supports and are available for individuals who live alone, who are alone for significant parts of the day, or have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.
- Support Management: This is a voluntary service that offers practical skills training and assistance related to recruiting, screening, hiring, managing, and dismissing attendants.
- Support Consultation: An optional service for those who use the Consumer Directed Services (CDS) option that is provided by a support provider and assists in the planning and monitoring of the service plan.

For children receiving Personal Care Services (PCS), must the client choose either PCS or CFC or can they receive both at the same time? Clients are assessed for CFC services at the time of their PCS assessment. In cases where children qualify for CFC services, CFC replaces the PCS benefit for children who meet the CFC eligibility criteria. Individuals who do not meet the CFC eligibility criteria, but meet the criteria for PCS, are able to get PCS consistent with current PCS policy requirements.

**Can Community First Personal Attendant Services/ Habilitation (CFS PAS/HAB)** be provided long term, since it includes habilitation and a child may need ongoing support to complete tasks such as eating, bathing, and dressing? If the child continues to need CFC year after year, would they have to consider using CFC services because they have not gained sufficient skills to complete tasks by themselves?

CFC services are not time or age limited. Eligible individuals are able to use CFC services as long as needs are present.

Is there a limit on the amount of CFC services an individual may receive?

There is not a defined once a year cost limit for CFC. However, the amount of CFC services a person receives is based on an assessment of an individual’s need for the service as developed by the service planning team, using a person-centered planning process.

What are Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)?

- ADLs means basic personal everyday activities including, but not limited to, eating, toileting, grooming, dressing, bathing, and transferring.

For more information, call Member Services at 800-659-5764.
• IADLs means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

What is support management, how will it be provided, and will the provider be compensated?

Support management is voluntary training on how to pick, manage, and dismiss attendants. If a person requests this service, the CFC provider will be expected to provide the person with information about support management. There is not a separate rate for support management.

In general, what is the difference between Personal Care Services (PCS), Personal Assistance Services (PAS) and Community First Choice (CFC)?

PAS and PCS provide personal assistance services in completing tasks related to Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). CFC provides personal assistance services and habilitation. Habilitation includes acquisition, maintenance, and enhancement of skills necessary for the person to accomplish ADLs, IADLs, and health-related tasks. In addition, individuals receiving CFC must meet institutional level of care requirements.

Does CFC replace respite?

No. CFC does not replace respite. Respite remains a service in the waiver programs. Respite cannot be provided at the same time as Community First Choice or Personal Attendant Services/Habilitation (CFC PAS/HAB).

Does the State plan include respite?

No, respite is not a State plan benefit.

Does CFC have an impact on day habilitation?

Day habilitation is not a CFC service, and it remains a service in the Intellectual or Developmental Disabilities (IDD) waiver programs. Day habilitation may not be provided at the same time as CFC PAS/HAB.

Is Community First Choice Emergency Response Services (CFC ERS) available for individuals who do not live in their own home or a family home setting (e.g., an assisted living facility)?

No. CFC ERS is available only to individuals who reside in their own home or family home setting.

Level of Care Determinations and Assessments for CFC eligibility

Who is responsible for determining level of care for CFC eligibility?

There are three levels of care determinations which include: nursing facility; hospital; Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID), and Institutions for Mental Diseases (IMD) (for individuals under 21 and over 64 years old). Different entities are responsible for completion and approval, depending on the program through which CFC is being delivered. Texas Children’s Health Plan is responsible for assessing and authorizing CFC services which may include collaboration with the Local Mental Health Authority or the Local Intellectual and Developmental Disability Authorities (LIDDA).

Who is responsible for completing the functional assessment?

Different entities are responsible for completion of the functional assessment depending on the program through which CFC is being delivered.

Is the Level of Care (LOC) reassessment still needed yearly?

Yes, LOC determinations are needed yearly or if there is a significant change in condition.

Person-Centered Planning

What is person-centered planning?

Person-centered planning is an individualized process that includes people chosen by the person receiving services and is directed by the person to the maximum extent possible. The planning enables the person to make informed choices and decisions, is timely and occurs at times and places convenient to the individual. The process reflects cultural considerations of the individual, includes strategies for solving conflict or disagreement within the process, and offers choices to the person regarding the services and supports they receive and from whom. The person-centered process includes a method for the person to require updates to the plan, and records choice settings that were considered by the individual.

Who must receive person-centered planning training?

All staff who assist members in person-centered planning must receive person-centered training.

Community First Choice (CFC) Appeals Process

Do individuals have appeal rights for CFC eligibility denial?

Yes, individuals will have the right to appeal any adverse action related to CFC (denials and denials of services, suspensions, denial of eligibility, terminations). To start a CFC appeal, call Member Services at 800-659-5764.

CFC Settings

Where can CFC be provided?

All CFC services are provided in a home or community-based setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental disease and intermediate care facility for individuals with an intellectual disability or related condition or setting with the characteristics of an institution.

Can people in group homes receive CFC?

A person must live in their own home or family home to receive CFC services.

Do people leaving a Nursing Facility (NF) and going into a group home lose their State plan benefits?

No, respite is not a State plan benefit.

What is support management, how will it be provided, and will the provider be compensated?

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Member Services

If you have questions about your coverage or need help, please call Member Services at 800-659-5764. The phone number is on the front bottom of your Texas Children’s Health Plan Member ID Card. You will need your member ID number when you call.

With the help of online interpreters, Member Services Representatives can speak to you in 140 languages. Member Services Representatives are available 24 hours a day, 7 days a week. We also welcome your calls to tell us how we are doing. We appreciate feedback and advice on how we can better serve you.

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.
- Need to pick a primary care 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 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.

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 800-659-5764 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 before your visit. Call Member Services at 800-659-5764, 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 800-659-5764.

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 (TTY) 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.

You can get your materials in English and Spanish
This member handbook and all other materials included in your member packet are provided in English and Spanish. You can also get many of the other health educational materials we give to members through our health education library also are available in Spanish.

What to do if you move
What do I have to do if I move?
As soon as you have your new address, give it to the local Texas Health and Human Services Commission (HHSC) benefits office and Texas Children’s Health Plan Member Services Department calling at 800-659-5764. 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 800-659-5764.

What information will they need?
Have the bill ready 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, its covered services, or its network of doctors and hospitals. We will mail you a letter when we make changes in the services.

Changing health plans
What if I want to change health plans?
You can change your health plan by calling the Texas STAR Kids Program Help Line at 800-764-2777. 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 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. You will need to renew your benefits every 6 months. 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. If you need assistance with completing your renewal packet please contact Member Services at 800-659-5764.

How to renew
What do I have to do if I need help with completing my renewal application?
Texas Children’s Health Plan can help you fill out your renewal application. Just call us at 800-659-5764.

Families must renew their children’s Medicaid coverage every year. In the months before a child’s coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family’s income and cost deductions. The family needs to:
- Look over the information on the renewal application.
- Fix any information that is not correct.
- Sign and date the application.
- Look at the health plan options, if Medicaid health plans are available.
- Return the renewal application and documents of proof by the due date.

Once HHSC receives the renewal application and documents of proof, the staff will check 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 will send the family a letter telling them about the referral and will check if the child can get benefits in the other program.

If the child qualifies, the coverage in the new program (Medicaid) will begin 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 877-782-6440.

Completing the renewal process
If 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.
New medical procedures review
You have benefits as a member. One of them is that we look at new medical advances. Some of these are like 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. For more information, call Member Services at 800-659-5764.

Advance Directives
For adults 18 years and older.

What if I am too sick to decide about my medical care?
You can decide the care you will get. You can also talk these decisions to your doctors. If you are too sick to 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 lets you 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 lets you make medical decisions ahead of time so your doctor can know your wishes for treatment. This is if you are in a terminal condition and become unable to talk or make decisions.

• Out-of-Hospital Do-Not-Resuscitate (DNR) Order – This is a form you complete with your doctor. 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 800-659-5764.

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 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 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 9-1-1 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 setting 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 are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file:

• Your other health insurance is canceled.

• You get new insurance coverage.

• You have general questions about third party insurance.

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

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

IMPORTANT: Medicaid providers cannot turn you down for services because you have 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 cannot make payments under a doctor 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 doctor incentive plan. You also have a right to know how the plan works. You can call 800-659-5764 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 complying 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 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 by calling Member Services at 800-659-5764. 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, his or her office staff, or the Texas Children’s Health Plan staff.

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us at 800-659-5764 to tell us about your problem. Member Services can help you file a complaint. 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 Houston, Texas 77230-1011

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

What are the requirements and timeframes for filing a complaint?
You can file a complaint at any time. You will get a letter within 5 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 take action within 30 days of receiving your complaint. A 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 file a complaint to the Health and Human Services Commission (HHSC) by calling 866-566-8999. 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.
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 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 and couldn’t 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 Texas Children’s Health Plan making 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 send a letter to the health plan or call Texas Children’s Health Plan Member Services at 800-659-5764.

What is an emergency appeal?  
An emergency appeal is when Texas Children’s Health Plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

How does an appeal work?  
An appeal is the process you or someone acting on your behalf can use to challenge a decision 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 the decision notice letter.

What is an appeal?  
An appeal is the process you or someone acting on your behalf asks for when you are dissatisfied with Texas Children’s Health Plan’s action and you want a review. An action means the denial or limited authorization for 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’s 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 800-659-5764. 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 agreement in writing to have them act on your behalf. You may file an appeal within 60 calendar days from the receipt of the notice of the action.

To keep receiving currently authorized services, you must file the appeal within 10 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. 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 agreement 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 you 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
Attention: Member Services Complaints
PO Box 301011 WLS 8360
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 the Texas Children’s Health Plan needs to extend, the Member must receive written notice of the reason for delay.

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

What happens if the health plan denies the request for an emergency appeal?  
What are the timeframes for an emergency appeal?  
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. If we decide that your appeal does need an expedited review, a decision will be made within 72 hours 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. Texas Children’s Health Plan can also ask you for an extension of time 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?  
Does my request have to be in writing?  
Who can help me in filing an emergency appeal?  
You can make a free call to Member Services at 800-659-5764 and ask for help in making an appeal. A Member Advocate is ready to help you. Appeals must be accepted orally or in writing. Your child’s doctor can ask for this type of appeal on your behalf.

Can I ask for a State Fair Hearing?  
If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, you have the right to 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 filling a request for a State Fair Hearing you can call Member Services at 800-659-5764 and ask a Member Advocate to help you.

If you need oral interpretation or written translation of materials, please call STAR Kids Member Services at 800-659-5764, 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 audiotape. 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 them or have the health plan select 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 800-659-5764;
• Email Texas Children’s Health Plan at healthplan@texaschildrens.org; or;
• If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision notice from the health plan, the Member has the right to keep getting services 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 notice 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
1. 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 denied and not given.
2. You have the right to the agree to or refuse treatment and actively participate 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.
   • You can talk about treatment options regardless of cost or benefit coverage.
3. 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:
   • Make a Complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   • Get a timely answer to your complaint.
   • Use the plan's appeal process and be told how to use it.
   • Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   • Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
4. 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 telephone 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 that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a Covered Service.
9. You have a right to know that you are not responsible for paying for Covered Services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for Covered Services.
10. You have the right to receive information on Texas Children's Health Plan, its services, the doctors, hospitals, and others who care for you can advise you about your health status, medical care and treatment, and your rights and responsibilities.
11. You have the right to make recommendations to the rights and responsibility policy.
Member responsibilities:
1. You must learn and understand 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 abide by 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 your 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 all of your medications.
Additional Member responsibilities while using NEMT Services
1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced 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 Durable Medical Equipment (DME) and products normally found in a drugstore 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 about these benefits? Call 800-659-5764.
For members 21 years of age and older, Medicaid is obligated to consider coverage of medically necessary DME and supplies under the provision called the Home Health Durable Medical Equipment (DME) and Supplies Exceptional Circumstances. This
Abuse, Neglect, and Exploitation
You have the right to respect and dignity, including freedom from abuse, neglect, and exploitation.

What are abuse, neglect, and exploitation?
Abuse is mental, emotional, physical, or sexual injury, or failure to prevent such injury. Neglect results in starvation, dehydration, overmedicating or under medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care, and personal hygiene.

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

Reporting abuse, neglect, and exploitation
The law requires that you report suspected abuse, neglect, or exploitation, including unapproved use of restraints or isolation that is committed by a provider. Call 9-1-1 for life-threatening or emergency situations.

Report by phone (non-emergency); 24 hours a day, 7 days a week, toll-free.
Report to the Department of Aging and Disability Services (DADS) by calling 800-647-7418 if the person being abused, neglected, or exploited lives in or receives services from:
- Nursing facility
- Assisted living facility
- Adult day care center
- Licensed assisted foster care provider
- Home and Community Support Services Agency (HCSSA) or Home Health Agency

Suspected abuse, neglect or exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS). Report all other suspected abuse, neglect, or exploitation to DFPS by calling 800-252-5400.

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

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

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.
Health Home Care - Health care services a person receives in a home.
Hospital 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.
Medical Excess City - 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 plan will cover the cost.
Premium - The amount that must be paid for your health insurance plan 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 laws.
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 at 800-686-3831. 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.

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

800-686-3831
texaschildrenshealthplan.org

Good health starts here!

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

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.