Texas Children's® Health Plan

STAR Kids Member Handbook

TEXAS STAR Kids
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

800-659-5764
texaschildrenshealthplan.org

November 2025
MS-2303-222

Communication is important to us. Language assistance services, free of charge, are available to you.
Call 866-959-2555 (STAR), 866-959-6555 (CHIP), 844-780-1154 (STAR Kids) (TTY 711).
Spanish: La comunicación es importante para nosotros. Tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 866-959-2555 (STAR), al 866-959-6555 (CHIP) o al 844-780-1154 (STAR Kids)(TTY: 711).
Vietnamese: Giao tiếp là rất quan trọng đối với chúng tôi. Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn.
Hãy gọi đến số 866-959-2555 (STAR), 866-959-6555 (CHIP), 844-780-1154 (STAR Kids) (TTY 711).
Chinese (Simplified): 我们非常重视沟通。您可以获得免费的语言协助服务。
请致电 866-959-2555 (STAR)，866-959-6555 (CHIP)，844-780-1154 (STAR Kids) (TTY 711)。
Arabic: التواصل يهمنا. خدمات الدعم اللغوي متاحة لك مجانًا.
اتصل بالرقم 866-959-2555 (STAR)، 866-959-6555 (CHIP)، 844-780-1154 (STAR Kids) (TTY 711).
Urdu: مواصلت ہمارے لیے ضروری ہے۔ زبان معاون سروسز، مفت، آپ کے لیے دستیاب ہیں۔
866-959-2555(STAR) 866-959-6555,(CHIP) 844-780-1154,(STAR Kids)(TTY 711)پر کال کریں ۔
Tagalog: Mahalaga sa amin ang komunikasyon. May mga libreng serbisyo ng tulong sa wika na available para sa inyo.
Tumawag sa 866-959-2555 (STAR), 866-959-6555 (CHIP), 844-780-1154 (STAR Kids) (TTY 711).
French: La communication nous tient à cœur. Des services gratuits d’aide linguistique sont à votre disposition.
Il vous suffit de composer le 866-959-2555 (STAR), le 866-959-6555 (CHIP) ou le 844-780-1154 (STAR Kids) (TTY 711).
Hindi: हमारे लिए संचार महत्वपूर्ण है. भाषा सहायता सेवाएं आपके लिए मुफ़्त में उपलब्ध हैं.
866-959-2555 (STAR), 866-959-6555 (CHIP), 844-780-1154 (STAR Kids) (TTY 711) पर कॉल करें.
Farsi (Persian): ارتباط برای ما حائز اهمیت است. خدمات کمک زبانی به‌صورت رایگان در دسترس شما قرار دارند.
با شماره‌های 866-959- 2555 (STAR)، 866-959-6555 (CHIP)، 844-780-1154 (STAR Kids) (TTY 711) متاس بگیرید.
German: Kommunikation ist uns wichtig. Es stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung.
Rufen Sie dazu folgende Nummern an: 866-959-2555 (STAR), 866-959-6555 (CHIP), 844-780-1154 (STAR Kids) (TTY 711).
Gujarati: અમારા માટે સંચાર મહત્વપૂર્ણ છે. તમારા માટે ભાષા સંબંધી સહાયતાની સેવાઓ મફતમાં ઉપલબ્ધ છે.
866-959-2555 (STAR), 866-959-6555 (CHIP), 844-780-1154 (STAR Kids) (TTY 711) પર કૉલ કરો.
Russian: Общение важно для нас. Вы можете воспользоваться бесплатной службой языковой поддержки.
Звоните по номерам 866-959-2555 (STAR), 866-959-6555 (CHIP), 844-780-1154 (STAR Kids) (TTY 711).
Japanese: コミュニケーションは私たちにとって大切です。無料の言語サポートサービスをご利用いただけます。
866-959-2555（STAR）、866-959-6555（CHIP）、844-780-1154（STAR Kid）（TTY 711）までお電話ください。
Laotian: ການສື່ສານແມ່ນສຳຄັນສຳລັບພວກເຮົ. ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໃຫ້ຟຣີ (ບໍ ຄາໃຊ້ຈ່າຍ), ມໃຫ້ານ.
ໃຫ 866-959-2555 (STAR), 866-959-6555 (CHIP), 844-780-1154 (STAR Kids) (TTY 711).

Quick Guide – Who to Call

If you need:	Please call:
Texas Children's Health Plan	Member Services, call 800-659-5764 or TTY 800-735-2989 (Texas Relay) or 7-1-1 to find out how to get covered services for you or your child. Member Services is ready 8 a.m. to 5 p.m. Monday through Friday Central Time, excluding state-approved holidays. After hours, on weekends and holidays, our answering service is ready to help you and/or take your messages.A Member Services Advocate will return your call the next business day. In case of an emergency, go to your nearest in-network emergency room or call 9-1-1. You can talk to a Member Advocate in English or Spanish. Interpreters who speak 140 different languages are also available by phone.
A doctor's care	Your primary care provider. His or her phone number is on your ID card. Your primary care provider is ready 24 hours a day, 7 days a week.
Service Coordination Team	To ask to speak to your Service Coordinator, to ask for health information, ask about your service plan or ask for a home visit, contact us directly at 832-828-1430 or you can reach us at 844-780-1154. The Service Coordination Team is staffed with individuals who speak English and Spanish. Interpreters who speak 140 different languages are also ready by phone.
Behavioral (mental) health or substance abuse treatment	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 ready by phone. If you have an emergency and need treatment immediately, call 9-1-1 or go to the nearest emergency room.
24-Hour Help Line	800-686-3831 or TTY 800-735-2989 (Texas Relay). Registered nurses are ready 24 hours a day, 7 days a week. (Note: This is not an emergency care line.) The help line is staffed with individuals who speak English and Spanish, are knowledgeable about the STAR Kids Program, covered services, the STAR Kids population, and provider resources. Interpreters who speak 140 different languages are also ready by phone.
Emergency care	Go to an in-network hospital emergency room. If the situation is life-threatening, go to the nearest emergency facility. No primary care provider referral is needed.
Urgent care	Your primary care provider or the Texas Children's Health Plan Nurse Help Line at 800-686-3831, TTY 800-735-2989 or 7-1-1.
Hospital care	Your primary care provider or specialist, who will arrange the care you need.
Family planning	Your primary care provider, an in network OB/GYN, or a Medicaid family planning provider. No primary care provider referral is needed.
Vision care	Envolve Vision, at 844-212-7269. No primary care provider referral is needed.
Prescriptions	Member Services at 800-659-5764 Option1 for the names of participating pharmacies or for help with getting a prescription filled.
Medicaid enrollment information	STAR Kids Help Line, call 844-999-9543.
Medicaid eligibility and renewal	Your HHSC Caseworker, dial 2-1-1.

Quick Guide – Who to Call

If you need:	Please call:
Dental care* **(for children under age 21)**	Your child's Medicaid dental plan. Your child will have one of the following dental plans: • DentaQuest 800-516-0165 • MCNA Dental 800-494-6262 • UHC Dental 877-901-7321 It is also listed on your child's Your Texas Benefits Medicaid Card. If you don't know who your child's Medicaid dental plan is, call the STAR Kids Help Line free-of-charge at 877-782-6440.
Adult dental care	FCL Dental, dental care for adults aged 21 and older, call 866-548-8123.
Transportation to the doctor	Non-Emergency Medical Transportation Services (NEMT), call 888-583-0110 or TTY 800-735-2989 (Texas Relay) or 7-1-1. NEMT services are available 8 a.m. - 5 p.m. Monday – Friday CT. Where's My Ride hotline is available 5 a.m. - 7 p.m. Monday – Saturday CT. Both hotlines are staffed with individuals who speak English and Spanish. Interpreters who speak 140 different languages are also ready by phone.
Ombudsman Managed Care Assistance Team	866-566-8989, TTY 866-222-4306.
Women, Infants, and Children (WIC)*	800-942-3678.

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

Texas Children's Health Plan:

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

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TTY)

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

Contents

Welcome to Texas Children's Health Plan 7

How the Plan Works

Your primary care provider 8

Changing your primary care provider 8

Your primary care provider also can ask for changes 9

If your primary care provider leaves Texas Children's Health Plan 9

Your Texas Children's Health Plan Member ID Card 10

How to read your ID card 10

Your Texas Benefits (YTD) Medicaid Card 10

The YourTexasBenefits.com Medicaid Client Portal 11

Medicaid Temporary ID Form 1027-A 11

Specialty Care and Referrals 11

Other services that do not require a referral from your primary care provider 12

Continuity of Care 12

Second opinions 12

OB/GYN care 12

What if I am pregnant? 13

A Healthy Pregnancy with the Healthy Rewards Program 13

How to redeem your rewards 14

Newborn care 14

Healthy Texas Women 14

DSHS Primary Health Care Program 14

DSHS Expanded Primary Health Care Program . . 15

DSHS Family Planning Program 15

When you need to see a doctor 15

Routine care 15

Urgent care 15

Care after office hours 16

Emergency care 16

Post-stabilization care 17

Care when you are away from home 17

Hospital services 17

Home health services 17

What does Medically Necessary mean? 17

What is the Member Portal? 18

Benefits and Services

STAR Kids Covered Services 19

Community First Choice services for those members who qualify for these services 20

Additional services for MDCP STAR Kids 20

How to obtain covered services? 20

Services that are not covered 21

Prior Authorization Process 21

Texas Health Steps 21

Dental services 22

Migrant farm workers 23

Prescription Drug Benefits 23

Emergency Prescription Supply 25

Medicaid Lock-in Program 26

Mental health and drug abuse services 26

Mental health rehabilitation services and Mental Health Targeted Case Management 26

Vision care 27

Family planning services 27

Service Coordination for Children and Pregnant Women (CPW) 27

Disease management 28

Non-Emergency Medical Transportation (NEMT) Services 28

Ambulance services 28

Audiology services 29

Health Risk Assessment 29

Extra benefits offered to Texas Children's Health Plan members 29

How to redeem your rewards 30

What health education courses does Texas Children's Health Plan offer? 30

Other Medicaid services or programs 30

What is Early Childhood Intervention (ECI) 30

Women, Infants, and Children (WIC) program . . . 31

What is Head Start and how to get it? 31

Service Delivery Options 31

Consumer Directed Services 31

Service Responsibility Option 31

Agency Option 32

Who do I call if I have special health care needs? 32

CONTENTS

Am I allowed to see specialists for services? . . . 32
Service Coordination 32
Transition Specialist 32
Home and Community-based Services (HCS) . . . 32
Long-Term Services and Supports (LTSS) benefits 33
Prescribed Pediatric Extended Care Center (PPECC) 34
Nursing Facility 34
Acute Care benefits 35
Individual Service Plan 35
Health Home 35
Private Duty Nursing 35
What is Project Rental Assistance? 36
Durable Medical Equipment (DME) 36
Community First Choice (CFC) 36
Community First Choice (CFC) Services 37
Level of Care Determinations and Assessments for CFC eligibility 38
Person-Centered Planning 38
CFC Appeals Process 38
CFC Settings 38
Wraparound coverage 39
Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid? 39
Member copayment responsibilities 39
Members with special health care needs 39

Member Services

Member Services 40
Interpreter and translation services 40
Help for the visually impaired 40
Phone device for the deaf (TTD) services for members with hearing or speech impairments 40
You can get your materials in English and Spanish 40
What to do if you move 40
What if I get a bill from my doctor? Who do I call? 40
Changes in Texas Children's Health Plan 40
Changing health plans 41
Your health plan can also ask for changes 41
Renew your Medicaid benefits on time 41
How to renew 41

Rights and Responsibilities

New medical procedures review 42
Advance Directives 42
Information you can ask for and receive from Texas Children's Health Plan each year 42
Medicaid and private insurance 43
Doctors' incentive plans 43
Your privacy 43
When you are not satisfied or have a complaint . 43
Appeals 44
What is a State Fair Hearing? 45
External Medical Review Information 46
Members Rights and Responsibilities 46
Fraud and abuse 48
Abuse, Neglect, and Exploitation 49

Terms and Definitions 50

The Annual Newsletter is ready for you to review on our website at texaschildrenshealthplan.org/annualnotice. This annual notice gives you a wealth of information on how your Texas Children's STAR Kids plan works. Included are:

- Tips on how to find out what is covered by your plan, any restrictions and costs.
- How prescription drugs are managed under your plan
- How to get language help.
- How to find a primary care physician, doctor, specialist or hospital in your network and what happens when you get care outside your network.
- How to file a claim.
- What to do if you need care while outside the area.
- How to reach us and how to get care after hours or in an emergency.
- How to submit a complaint or appeal a decision, including getting external reviews of Utilization Management decisions.

You can access your Annual Newsletter by scanning the QR Code.

You can get a printed copy of this newsletter by calling 800-659-5764.

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 and postpartum 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 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.

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 by calling Member Services at 800-659-5764 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 is alsoimportant 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 888-583-0110.

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 visits can get them.

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.

Our Member Services representatives can tell you the:

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

Are there any reasons why a request to change a primary care provider may be denied?

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

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

How many times can I change my/my child's primary care provider?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us at 800-659-5764 or writing to:

Texas Children's Health Plan
Member Services Department
PO Box 301011 WLS 8364
Houston, TX 77230-1011

Have questions about changing your healthcare provider? Scan the QR code to learn more.

What if I choose to go to another doctor who is not my primary care provider?

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

Your 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 if:

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

If your primary care provider asks you to change to a new primary care provider, we will send you a letter. The letter will tell you that you need to pick a new primary care provider. If you do not 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, but if you'd like a different primary doctor, 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 we find you a new primary care provider on our list who can give you the same type of care, we will change your primary care provider.

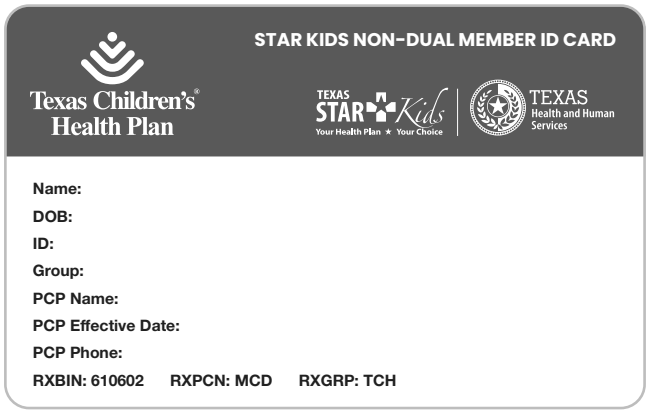
When will my primary care provider change become effective?

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.



Your Texas Children's Health Plan Member ID Card

Each person in your family covered by Texas Children's Health Plan will have a personal Member ID card. Carry this card with you at all times. It has important information needed to receive medical care. Show it to all health care providers before you receive medical services. It tells providers you are covered by Texas Children's Health Plan. If you do not show your ID card, the doctor might refuse to see you, or you might be billed for the services you receive.

You will not get a new Member ID card every month. You will get a new Member ID card only if:

- You lose your current Member ID card and ask for a new one.
- You change your primary care provider.

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

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

How to read your ID card

The front and back of your ID card shows:

- Your name and ID number.
- Your date of birth.
- Your primary care provider's name and telephone number.
- The Member Services phone number.
- The Behavioral Health/Substance Abuse free telephone number.
- The Vision Care phone number.
- The 24-Hour Help Line phone number.

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

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

Remember:

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

Your Texas Benefits (YTB) Medicaid Card

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

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

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

Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your medical and dental information through the secure online network, call at 800-252-8263 or opt out of sharing your health information at www.YourTexasBenefits.com.

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

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

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

If you forget your card, your doctor, dentist, or drugstore can call or use the link above to make sure you are getting Medicaid benefits.

The YourTexasBenefits.com Medicaid Client Portal

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

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

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

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

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

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 (HSSC) 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 2-1-1 (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)? What is a referral?

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 a referral or an 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 to always check 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 providers 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 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.

What if I get care from a doctor who is not in my network?

Always begin with your primary care provider when seeking non-emergency care. They can help you decide the care you need and refer you to a specialist.

If your doctor refers you to another provider, it is important to check if they are in your network. To confirm this, call us or the doctor you are going to see. If the provider is out of your network, make sure that your primary care provider approves your care. If they do not, you will have to pay the cost of that care out of your own pocket.

If you seek care outside of your network without a referral or authorization, you will have to pay some or all of the cost of that care.

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 in-network 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 search 'Find a Provider' on our website: texaschildrenshealthplan.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 due 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.
- Healthy Pregnancy Website with helpful pregnancy-related information at www.texaschildrenshealthplan.org/your-health/pregnancy-and-postpartum-care.

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:

- **Prenatal visit reward:** Complete at least one prenatal visit during your first trimester of pregnancy or within 42 days of enrolling with Texas Children's Health Plan and receive a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year.
- **Basic baby care and 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.
- **Portable crib/playpen:** Pregnant members who are in their third trimester and complete at least one InJoy online pregnancy class can receive a free portable crib that doubles as a playpen. Reward can be requested up to 15 days after the end of the eligible year.
- **Postpartum visit reward:** Complete at least one postpartum visit within 84 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.
- **24-Hour Help Line:** Our 24-hour 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. Call us at 800-686-3831.

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

Restrictions and limitations may apply. Age range may vary. Extra benefits valid from September 1, 2025 to August 31, 2026. Visit healthyrewardsprogram.org for more details.

How to redeem your rewards

- **Option 1:** Login to your MyChart account. Head to "Resources" and click on "Healthy Rewards" to complete the reward request form
  New to MyChart? Set up an account at texaschildrenshealthplan.org/mychart
- **Option 2:** Visit healthyrewardsprogram.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 texaschildrenshealthplan.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 texaschildrenshealthplan.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 provider 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 texaschildrenshealthplan.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 (HSSC) 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 18 to 44 (15-17 with parental permission) whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program. To learn more about services, you can get through the Healthy Texas Women Program, write, call or visit the program's website:

Healthy Texas Women's Program
P.O. Box 149021
Austin, TX 78714-9021
Phone:1-866-993-9972
Website: healthytexaswomen.org
Fax:(toll-free) 1-877-466-2409

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, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services. You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at https://findahealthcenter.hrsa.gov/.

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

Website: www.hhs.texas.gov/services/health/primary-health-care-program
Phone: 512-776-7796 or dial 2-1-1 Texas
Email: PrimaryHealthCare@hhs.texas.gov

DSHS Expanded Primary Health Care Program

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

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

Website: www.hhs.texas.gov/services/health/primary-health-care-program
Phone: 512-776-7796 or dial 2-1-1 Texas
Fax: 512-776-7203
Email: PrimaryHealthCare@hhs.texas.gov

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 https://findahealthcenter.hrsa.gov/.

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

Website: https://www.healthytexaswomen.org/healthcare-programs/family-planning-program
Phone: 512-776-7796
Fax: 512-776-7203
Email: FamPlan@hhs.texas.gov

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 you asking. Adult checkups are scheduled within 4 weeks. When you need routine care, call your primary care provider's phone number on the front of your ID card. Someone in the doctor's office or clinic will 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 sprains/strains

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

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In

some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Texas Children's Health Plan's Medicaid. For help, call us at 800-659-5764. You also can call our 24-Hour Help Line at 800-686-3831 for help with getting the care you need.

How soon can I expect to be seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Texas Children's Health Plan's Medicaid.

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

- Earache
- 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 want advice 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 24-Hour 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 anyone 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 anyone 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 hospital emergency room or call 9-1-1 for help.

After you receive care, call your primary care provider within 48 hours or as soon as possible. Your primary care provider will offer or arrange any follow-up care you may need.

Emergencies can be things like:

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

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

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

Post-stabilization care

What is post-stabilization?

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

Care when you are away from home

What if I get sick when I am out of town or traveling?

If you need medical care when traveling, call us at 800-659-5764 and we will help you find a doctor. If you need emergency services while traveling, go to a nearby hospital, then call us at 800-659-5764.

What if I am out of the country?

Medical services performed out of the country are not covered by Medicaid.

What if I am out of the state?

If you have are out of state and have a life-threatening emergency, go to the nearest emergency room, or call 9-1-1 for help. Call your primary care provider or Member Services within 48 hours 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 24-Hour 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-urgent 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 evaluate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or evaluate a defect or physical or mental illness or condition:
     – must comply with the requirements of the Alberto N., et al. v. Traylor, et al. partial settlement agreements; and
     – may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.

(2) For Members over age 20, non-behavioral health related health care services that are:
   - reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
   - provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
   - consistent with health care practice guidelines and standards that are endorsed by professionally

recognized health care organizations or governmental agencies;
- 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 investigative; 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 covered services included under the STAR Kids Program.

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

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

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 StepsComprehensive Care Program (THSteps-CCP) Member must be 20 years of age or younger. Requires approval ahead of time
- Behavioral Health Services including:
  - Inpatient mental health services.
  - 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 biologicals 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 as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - surgery and reconstruction on the other breast to produce symmetrical appearance;
    - treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - prophylactic mastectomy to prevent the development of breast cancer.
    - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) Services through the Texas Health Steps Program (EPSDT), including private duty nursing, Prescribed Pediatric Extended Care Center (PPECC) services, certified respiratory care practitioner services, and therapies (speech, occupational, physical)
- Nonemergency Medical Transportation Services, including:
  - Demand response transportation services, including

Nonmedical Transportation prearranged rides, shared rides, and public transportation services;
  - Mass transit;
  - Individual transportation participant mileage reimbursement;
  - Meals;
  - Lodging;
  - Advanced funds; and
  - Commercial airline transportation services, including out of state travel.
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age;
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals 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 (IID), 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 (MDCP) STAR Kids

The following is a list of covered services for members who qualify for (MDCP) STAR Kids services. These medically necessary services are available for members who meet the functional and financial eligibility for MDCP 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 s peak 140 different languages. Emergency Service and Behavioral Health Hotline services are available 24 hours a day, 7 days a week.

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

Behavioral Health/Substance Abuse Hotline
844-818-0125

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
844-212-7269

Dental care

Your child will have one of the following dental plans:

- DentaQuest: 800-508-6775
- MCNA Dental: 800-494-6262
- UHC Dental: 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.
- Cosmetic surgery.
- 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.
- Abortions 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 old or younger.

Health and Human Services Commission (HSSC) has settled a lawsuit that affects Private Duty Nursing, Home Health Skilled Nursing, Durable Medical Equipment and Supplies, and Personal Care Services for Medicaid beneficiaries 20 years 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 child's doctor or dentist to set up the checkup.
- Set up the checkup at a time that works best for your family.

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

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

Call Texas Children's Health Plan 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 checkups!

- Complete 6 well-child checkups by the age of 15 months and get a $100 reward card.
- Complete 2 more well-child checkups by the age of 30 months and get an additional $50 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 healthyrewardsprogram.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 the names of doctors and dentists who give Texas Health Steps services.

What if I am out of town and my child is due for a Texas Health Steps checkup?

Office visits for Texas Health Steps services when your child is out of town but within the Texas Health and Human Services will be covered 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 888-583-0110.

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

What if I need to cancel an appointment?

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

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

Dental services

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

Texas Children's Health Plan covers emergency dental services in a hospital or ambulatory surgical center,

including, but not limited to, payment for the following:

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

Texas Children's Health Plan covers hospital, physician, and related medical services for the above conditions. This includes services the doctor provides and other services your child might need, like anesthesia or other drugs.

Texas Children's Health Plan is also responsible for paying for treatment and devices for craniofacial anomalies.

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

Are emergency dental services for children covered by the health plan?

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

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

What do I do if my child needs emergency dental care?

During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call us at 800-659-5764 or call 911.

Migrant farm workers

What is a migrant farm worker?

A migrant farm worker is a person who works on farms as a field worker or as a food packer during certain times of the year. Migrant farm workers move from place to place to follow the crops. We have extra services for migrant farm workers and their children. Call Member Services at 800-659-5764 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 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 to the drug store 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.

How much will my medicine cost?

You do not have a copayment for prescription medications covered under the Medicaid Benefit.

How do I find a network drug store?

You can call Member Services at 800-659-5764 to find a drug store in our network. We can help you find pharmacies that deliver medications for free, open 24 hours a day 7 days a week, are handicap accessible, or speak different languages. You can request a printed copy of the pharmacies in our network or visit our website at texaschildrenshealthplan.org to use our online search tool.

What if I or my child go to a drug store not in the network?

If you go to a drug store that is not in the network, you may not be able to fill your medications, or may have to pay out of pocket yourself. You can contact Member Services at 800-659-5764 to find an in-network drug store, or request 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/CHIP formulary. The formulary is a list of brand and generic medicines based on quality and value. The formulary also identifies which medications require prior authorization, and which medications are on a preferred drug list (PDL). The Texas Health and Human Services (HHSC) Vendor Drug Program (VDP) 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. The formulary list and prior authorization criteria are 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 pre-approval?

You can review the list of medications by visiting https://www.txvendordrug.com/searches/formulary-drug-search/ or https://txstarchip.navitus.com/formulary. There is a tool to search medications by Drug Name, or National Drug Code (NDC).The tool also identifies if a medication needs 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 Medicare-Medicaid 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 processed.
- Reviewing prior approval requests from doctors for drugs that require pre-approval.
- Reviewing exceptions for quantity limits or high doses.

How much medicine can I pick up for myself or my child?

Texas Children's Health Plan allows up to 34-days' supply of medicines per fill. You may request an exception for a refill by contacting Member Services at 800-659-5764.

What if my or my child's medications require prior authorization?

Some medications need a pre-approval before you can fill them at a drug store. Your doctor must submit an approval request. We work with a Pharmacy Benefit 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 your online member portal. You can also find it under "Prior Authorization Forms" or Navitus pharmacy benefit manager (PBM) website: https://txstarchip.navitus.com/priorauthorizationforms

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

- If the prescribing doctor cannot be reached or unable to request a prior authorization.
- If a prior authorization decision was not made within 72 hours submitting the request.
- This does not apply to 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://txstarchip.navitus.com under "Prior Authorizations Forms."

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 https://www.txvendordrug.com/formulary/preferred-drugs.The PDL is controlled by HHSC. Texas Children's Health Plan is required to follow PDL requirements. The PDL is updated approximately every 6 months in January and July. Texas Children's will notify you directly if there are 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 is denied, your doctor may request an

exception by appealing the pre-approval denial. Your doctor may also submit a separate "Exception to Request" form for high dose drugs, or for requests beyond standard quantity limits. The Exception to Coverage form can be found at txstarchip.navitus.com under "Prior Authorization Forms."

What are exceptions to the PDL?

If your medicine is being rejected because it is not on the preferred drug list, your doctor can request an exception if one or more conditions below are met:

- The preferred drug is contraindicated.
- The preferred drug is expected to be ineffective.
- The preferred drug will cause an adverse reaction, or physical or mental harm.
- The member tried and discontinued the preferred drug at any point due to ineffectiveness, diminished effect, or adverse events.
- The preferred drug is in short supply, on backorder, allocation, or there is a drug shortage.
- For antipsychotics and antidepressants: If you were taking the non-preferred drug before discharge from an inpatient facility.
- For antipsychotics and antidepressants: If you are stable on the non-preferred drug.
- For antipsychotics and antidepressants: If you are at risk of experiencing complications due to switching from non-preferred drug.

How do I file a complaint or an appeal for medications ordered by my or my child's doctor?

If you or your doctor does not agree with a pre-approval request decision, you have the right to submit an appeal. Texas Children's Health Plan reviews all appeal requests. Instructions on how to appeal are included in the prior authorization denial letter. If you have a concern about a drug store benefit, claim, or other service, please call Member Services at 800-659-5764.

What if I can't get the medication my or my child's doctor ordered approved?

If your or your child's doctor cannot be reached to approve a prescription, you or your child may be able to get a three-day (72-hour) emergency supply of your or your child's medication. Ask your drug store about providing you or your child an emergency supply. You can also call Texas Children's Health Plan at 800-659-5764 for help. The pharmacist will use his or her clinical judgement if they will provide you with a 72-hour supply. Texas Children's Health Plan does not make that decision and will not prevent members from obtaining the 72-hour supply.

What if I need my or my child's medications delivered to me?

If you need your medication(s) delivered, you can use a pharmacy in our network that provides delivery services. You can search for a pharmacy that provides delivery services using our online website, or you can call Member Services at 800-659-5764.

How do I get my or my child's medications if I am in a nursing facility?

If you are in a nursing facility, they will provide you with medications.

What if I lose my or my child's medication(s)?

If you lose your medications, you should call your doctor or clinic for help. If your doctor or clinic is closed, the drug store may be able to provide an emergency 72-hour supply. Sometimes, you may need special permission from the Texas Children's Health Plan for an early refill. You can call Member Services at 800-659-5764 for help.

What if I need/my child needs an over-the-counter (OTC) medication?

The formulary may cover some over-the-counter medications. If a requested OTC is not on the formulary, you will have to pay for it out of pocket.

What if I need or my child needs more than 34 days of a prescribed medication?

The drug store can only give you an amount of a medication that you need/your child needs for the next 34 days. For exception requests, please call Texas Children's Health Plan at 800-659-5764.

How are generic substitutes or therapeutic interchanges handled?

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

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

Emergency Prescription Supply

You may receive a 72-hour emergency supply of a prescribed drug if a medication is needed without delay and if a medication requires prior authorization but the prescribing

physician cannot be contacted. This applies to all drugs requiring a prior authorization, either because they are non-preferred drugs on the preferred drug list or because they are subject to analysis for getting your money back. The pharmacist at your pharmacy will decide in the end if they want to give out the 3-day supply or not.

For more information, please call Member Services at 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. The Lock-In Program checks how you use Medicaid drug store services if you do not follow Medicaid rules.

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

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

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

If you are locked into a drug store but have an urgent/immediate medication need that the locked-in drug store cannot meet, please contact Member Services immediately at 866-959-2555. 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.

In certain situations, members may be allowed to obtain medications from a pharmacy other than their designated lock-in pharmacy. Exceptions will be reviewed and approved on a case-by-case basis. Situations in which an exception may be granted include, but are not limited to:

- Member moved out of the geographical area (greater than 30 miles from lock-in pharmacy).
- The limited pharmacy does not have the prescribed medication and will remain unavailable for more than 3 days.
- The limited pharmacy is closed for the day and the member needs the medication urgently.
- The limited pharmacy does not carry the medication, and is either unable to order or stock it.
- The pharmacy refused to continue as a limited pharmacy.
- The limited pharmacy is disenrolled from the Medicaid Program.
- The member has valid complaints against the limited pharmacy or its staff; or
- Any other exception as deemed appropriate by TCHP and regulations.

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.

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 Envolve 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 Envolve 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 once 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 fittings. 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 https://www.healthytexaswomen.org/healthcare-programs/family-planning-program/ 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 Case Management for Children and Pregnant Women (CPW)?

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

Need help finding and getting services?

You might be able to get a Case Manager to help you.

Who can get a Case Manager?

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

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

What do Case Managers do?

A Case Manager will visit with you and then:

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

What kind of help can you get?

Case Managers can help you:

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

How can you get a Case Manager?

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

- Texas Children's Health Plan 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.
- Strives 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 sickle 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 trips do NOT include ambulance trips.

What services are part of NEMT Services?

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

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

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

How to get a ride?

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 severe 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 our Health Risk Assessment (HRA). Your answers helps us to better understand your health and create a personalized care plan for you. Visit texaschildrenshealthplan.org/hra for more information.

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

- **Prenatal visit reward:** Complete at least one prenatal visit during your first trimester of pregnancy or within 42 days of enrolling with Texas Children's Health Plan, and receive a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year.
- **Basic baby care and 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.
- **Portable crib/playpen:** Pregnant members who are in their third trimester and complete at least one InJoy online pregnancy class can receive a free portable crib that doubles as a playpen. Reward can be requested up to 15 days after the end of the eligible year.
- **Postpartum visit reward:** Complete at least one postpartum visit within 84 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.

Health and Wellness

- **Diabetes screening reward (Type 1 or 2):**
  - Complete a diabetic (retinal or dilated) eye exam once a year and get a $25 reward card.
  - Complete an HbA1c blood test and get a $25 reward card.
  - Complete a Kidney Health Evaluation and get a $25 reward card.

  Rewards can be requested up to 30 days after the end of the eligible year. Ages 18 and older for the diabetic eye exam and kidney health evaluation. Ages 10 and older for the HbA1c blood test.
- **Health education special events:** Learn about healthy habits while having family fun with your family at our special events, such as seasonal activities and community events.
- **Mental health follow-up 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.
- **Eyewear support:** 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 6 well-child checkups by the age of 15 months and get a $100 reward card.
  - Complete 2 more well-child checkups by the age of 30 months and get an additional $50 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 16-21.
- **Asthma education reward:** If you are diagnosed with high risk asthma, enroll and complete the full 90-day asthma case management program and receive a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year.
- **ADHD management reward:** If you are newly diagnosed with ADHD, are prescribed, and pick up your ADHD medication, and complete a 30-day follow up visit after initial diagnosis, you can receive a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year. Ages 6-12.
- **(New) Childhood Flu Immunization reward:** Members age 0-2 who receive a flu vaccine can receive a $25 reward card. Reward can be requested up to 30 days after the end of the eligible year.
- **(New) Chlamydia screening reward:** Complete a chlamydia screening and receive a $25 reward card. For members age 16-24. Reward can be requested up to 30 days after the end of the eligible year.

Healthy Play and Exercise:

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

Extra Help for Families:

- **24-Hour 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 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, 2025 to August 31, 2026. Visit healthyrewardsprogram.org for more details.

How to redeem your rewards

- **Option 1:** Login to your MyChart account. Head to "Resources" and click on "Healthy Rewards" to complete the request form.
  New to MyChart? Set up an account at texaschildrenshealthplan.org/mychart
- **Option 2:** Visit healthyrewardsprogram.org or call Member Services at 1-800-659-5764.

What health education classes does Texas Children's Health Plan offer?

Much care and preparation are needed during a pregnancy for a healthy baby to be born! Join a variety of online classes through INJOY to learn more about:

- Understanding Pregnancy
- Understanding Birth
- Understanding Breastfeeding
- Understanding Postpartum Health and Baby Care
- Understanding Your Newborn

Printed materials upon request.
Questions? Call 800-990-8247 or visit healthyrewardsprogram.org.

Other Medicaid services or programs

What other services can Texas Children's Health Plan help me get?

Medicaid covers some services that Texas Children's Health Plan does not. You may be able to get these services and programs.

You do not need a referral from your primary care provider. Call Member Services at 800-659-5764 for help with using these services and programs.

- Early Childhood Intervention (ECI) program.
- Mental Health or Mental Retardation (MHMR) case management.
- Mental Retardation Diagnostic Assessment (MRDA) program.
- Mental Health Rehabilitation (MHR) program.

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

What is Early Childhood Intervention (ECI)?

ECI provides information on services to help children, from birth to 3 years old, who may have a disability or developmental delay. ECI supports families to help their children reach their potential through developmental services. Services are provided by a variety of local agencies and organizations across Texas.

Do I need a referral?

No, ECI services do not require a referral from your provider.

Where do I find an ECI provider?

To learn more about ECI or to refer your child, call your Service Coordinator or find the nearest ECI program at https://citysearch.hhsc.state.tx.us/

Women, Infants, and Children (WIC) program

WIC has been offering support for families in Texas for more than 20 years. WIC helps mothers make good feeding choices for their babies and teaches them how to cook healthy meals for the whole family. WIC provides dairy foods like milk, cheese, eggs, cereal, and juice.

It's easy to find out if you are able to get WIC. If you are pregnant, breastfeeding, or have children under the age of 5, call 800-942-3678 and speak to someone in the WIC office.

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 5 years old from low-income families by enhancing their cognitive, social, and emotional development. Head Start programs provide a learning environment that supports children's growth in many areas such as language, literacy, and social and emotional development. Head Start emphasizes the role of parents as their child's first and most important teacher.

How do I 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 payroll 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 5.

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 your child's immunization records from your doctor's office. Your child will need proof that he has received the needed immunizations. If you do not have these, your Service Coordinator will help you make an appointment.

You can make a list of any special needs your child has such as speech or physical impairments. There are programs ready to help in these areas. Most community Head Start programs offer prenatal and home-based visits. For more information, visit https://www.acf.hhs.gov/.

Service Delivery Options

The person or Legally Authorized Representative (LAR) by Texas law must be allowed to self-direct their home-based services, which entails employing service providers and directing the delivery of program services.

There are three self-directed services models for individuals to manage their home services and supports:

- Consumer-directed Services Option (CDS)
- Service Responsibility Option (SRO)
- Agency Option (AO)

Consumer Directed Services (CDS)

CDS is not a service program. It is an option available in certain programs, and for specific services, which allows you more personal control over how your services are delivered, if you are able and willing to take more responsibility for coordinating those services.

If you choose CDS, you or your designated representative will:

- Recruit, hire and train your own employees and backup employees (including family, friends or neighbors).
- Set wages and benefits for your employees based on a service budget created with the help of your service planning team.

- Set schedules and submit timesheets for your employees.
- Pick a Consumer Directed Services Agency (CDSA) to:
  - Train you to hire and manage employees.
  - Work on your timesheets and payroll.
  - Work on receipts and invoices.
  - Act as your agent to pay federal and state employment taxes.

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 (TxHmL)
- STAR Kids Community First Choice or Personal Care Services benefits
- Youth Empowerment Services (YES)

Service Responsibility Option

A service delivery option that empowers the member to manage day-to-day activities. This includes supervision of the person providing 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 try to talk with you within 2 working days to assess your needs.

Am 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 Service Coordination?

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 you/your child's 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 psychosocial 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 contact us directly at 832-828-1430 or you can reach us at 844-780-1154.

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 or 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.

How old do you have to be to start receiving services in Texas?

You can of be any age and get waiver services. Your age will determine which waiver you qualify for.

What services does the Home and Community-based Services (HCS) offer in Texas?

- Adaptive aids
- Day habilitation
- Dental treatment
- Minor home modifications
- Nursing
- Residential assistance
- Respite
- Specialized therapies
- Supported employment

The HCS program provides individualized services and support to people with intellectual disabilities who are living with their families, in their own homes, or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

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

Long-Term Services and Supports (LTSS) benefits

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 Activity and Health Services, the Medically Dependent Children Program (MDCP) and the 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 members to live in the community in lieu of a nursing facility.

Care planning and care coordination services help beneficiaries and families navigate the health system and make sure 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 living in facility-based care settings (such as a nursing home or intermediate care facility). These 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), as well as all MDCP services will be delivered through Texas Children's Health Plan. 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 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 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.

I am in the Community Living Assistance and Support Services (CLASS) waiver. How will I receive my LTSS?

State plan LTSS, like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through Texas Children's Health Plan. Your CLASS 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. You can also contact your CLASS case manager for questions specific to CLASS waiver services.

I am in the Deaf Blind with Multiple Disabilities (DBMD) waiver. How will I receive my LTSS?

State plan LTSS, like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through Texas Children's Health Plan. Your DBMD 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. You can also contact your DBMD case manager for questions specific to DBMD waiver services.

I am in the Home and Community-based Services (HCS) waiver. How will I receive my LTSS?

State plan LTSS, like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through Texas Children's Health Plan. Your HCS 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. You can also contact your HCS Service Coordinator at your Local Intellectual and Developmental Disability Authority (LIDDA) for questions specific to HCS waiver services.

I am in the Texas Home Living (TxHmL) waiver. How will I receive my LTSS?

State plan LTSS, like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through Texas Children's Health Plan. Your TxHmL 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. You can also contact your TxHmL Service Coordinator at your Local Intellectual and Developmental Disability Authority (LIDDA) for questions specific to TxHmL 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 (PPECC)

What is a PPECC?

PPECCs 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 PPECC 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 Legally Authorized Representative (LAR) to identify Community-Based Services and Long-Term Services and Supports (LTSS) programs to help the member return 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 approval, referral, or 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 Legally 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 caretakers, 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 the extent possible and applicable, the ISP must also account for school-based service plans and service plans provided outside of Texas Children's Health Plan. Texas Children's Health Plan requests but does not require the member to provide a copy of the member's Individualized Education Plan (IEP).

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

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 care 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:

1. Patient self-management education;
2. Provider education;
3. Patient-centered and family-centered care;
4. Evidence-based models and minimum standards of care; and
5. 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 must be available to members who require assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or Health Maintenance Activities (HMAs) 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 (HHA) 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. PDN is ordered from the Primary Care Provider.

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 (DME)

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 of 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.
- **Habilitation (HAB):** 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 advisor and provides a level of assistance and training beyond that provided by the Financial Management Services Agency (FMSA) through Financial Management Services (FMS). Support consultation helps an employer meet the required employer responsibilities of the CDS option and successfully deliver program services.
- PAS and HAB are available through the CDS option.

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 Choice 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 PCS as 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.
- 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 (CFS 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 locations 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 denials?

Yes, individuals will have the right to appeal any adverse action related to CFC (reductions 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 the community qualify for CFC?

If a person is transitioning from a nursing facility and keeps meeting the eligibility criteria for CFC, they would be able to receive CFC services if they have an identified need.

Wraparound Coverage

Texas Children's Health Plan provides Medicaid wraparound services for outpatient medicines, biological products, certain Limited Home Health Supplies (LHHS), and vitamins and minerals as identified on the Texas Health and Human Services Commission (HHSC) drug exception file to STAR Kids members.

If you have Medicare and other health insurance coverage, each type of coverage is called a "payer." When there's more than one payer, "coordination of benefits" rules decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. In some cases, there may also be a third payer.

In the case of STAR Kids, the insurance that pays first (primary payer) pays up to the limits of its coverage, then benefits of STAR Kids are used. Be sure to tell your doctor or Service Coordinator if you have other insurance coverage.

Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid?

You cannot be billed for Medicare "cost-sharing," which includes deductibles, coinsurance, and copayments that are covered by Medicaid.

Member copayment responsibilities

You do not have any copay or copayments.

Members with special health care needs

Who do I call if I have special health care needs and need someone to help me?

If you have or your child has special health care needs, such as developmental delays, diabetes, or sickle cell disease, call Member Services at 800-659-5764 to get more information on how to get help. Texas Children's Health Plan has a Service Coordination program that offers families help with you or your child's special needs. The services range from simple outreach and information to intensive care management. They also include coordination with and referral to community resources to help families with transportation and basic living needs. Your information will be given to a service coordinator. The service coordinator will call you within 15 business days to assess your needs. The service coordinator will work with you to develop a service plan within 30 business days. You can decline or opt out of Service Coordination at any time.

A service coordinator is a nurse who can help you:

- Find services in your community.
- 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 or your child's doctors to get medically necessary care for you or your child.

Be sure to tell the service coordinator about any special providers you have or your child has been seeing. It is also important to tell your or your child's primary care provider that you have or your child has special health care needs. The best way to tell your or your child's doctor is to schedule a visit to see them.

Member Services

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.
- Get a bill from a provider.
- Have a complaint.
- Move or change your phone number.
- Need an interpreter for a medical visit.
- Need to replace an ID card.
- Don't understand something you get in the mail.
- Need to get a ride to the doctor.
- Have 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 your 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.

Who do I call if I get a bill from my doctor? Do I file a claim?

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 800-964-2777. You can change health plans as often as you want.

When will my health plan change become effective?

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place 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 form 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, and, when applicable, professional qualifications, specialty, medical school attended, residency completion and board certification status.
- Any limits on your freedom of choice among Network Providers.
- Your rights and responsibilities.
- Information on Complaint, appeal, External Medical Review and State Fair Hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- Information about In-Lieu-Of Services and Settings, if offered by your MCO, including amount, duration and scope of benefits and the policy on referrals.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from Out-of-Network providers and limits to those benefits.
- How you get after hours and emergency coverage and limits to those kinds of benefits, including::
  - What makes up Emergency Medical Conditions, Emergency Services, and Post-Stabilization Services.
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - How to get Emergency Services, including instructions on how to use the 911 telephone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish Emergency Services covered by Medicaid.

– A statement saying you have a right to use any hospital or other settings for emergency care.

– Post-stabilization rules.

- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- Texas Children's 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 if:

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

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

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

Appeals

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

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

How will I find out if services are denied?

We will send you a letter if a covered service requested by your doctor is denied, delayed, limited, or stopped.

What can I do if my doctor asks for a service or medicine for me that'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 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 we received your appeal request. The letter will list all the information we will need to receive to review the appeal. If you make a written request for an appeal, you can send the appeal letter to the Utilization Management Appeals Department address:

Texas Children's Health Plan
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 day 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.

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

What is an expedited appeal?

An expedited 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.

What happens if the health plan denies the request for an expedited appeal? What are the timeframes for an expedited appeal?

Requests for expedited appeals can be oral or written. When we get your request for an expedited 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 if we need to get additional information. An extension is not applicable to cases of an ongoing emergency or denials of continued hospitalization. We will call you promptly with the decision. We will also send you a letter within 2 business days of the decision.

How do I ask for an expedited appeal? Does my request have to be in writing? Who can help me in filing an expedited 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 request an External Medical Review and State Fair Hearing?

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

Can I request a State Fair Hearing only?

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

What is a State Fair Hearing?

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

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

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

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

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

Can I ask for an emergency State Fair Hearing?

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

If you need help filing a request for a State Fair Hearing you can call Member Services at 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 on audiotapes. Call Member Services to discuss your needs. Texas Children's Health Plan uses Relay Texas TTY services for members and their parents or guardians who have hearing or speech impairments. For TTY, call 800-735-2989 or 7-1-1.

External Medical Review Information

Can a Member ask for an External Medical Review?

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

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

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

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

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

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

Can I ask for an emergency External Medical Review?

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

Members Rights and Responsibilities

Member rights:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   - Be treated fairly and with respect.
   - Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider. This is the doctor or health care Provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or Provider in a reasonably easy manner. That includes the right to:
   - Be told how to choose and change your health plan and your Primary Care Provider.
   - Choose any health plan you want that is available

in your area and choose your Primary Care Provider from that plan.
- Change your Primary Care Provider.
- Change your health plan without penalty.
- Be told how to change your health plan or your Primary Care Provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   - Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   - Be told why care or services were denied and not given.
   - Be given information about your health, plan, services providers
   - Be told about your rights and responsibilities.
4. You have the right to 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.
   - Have a candid discussion of treatment options regardless of cost or benefit coverage.
5. If your MCO offers In-Lieu-Of Services and Settings, you have the right to:
   - Be given information about the In-Lieu-Of Services and Settings you can get and how to request them.
   - Be told why any In-Lieu-Of Services and Settings were reduced or denied.
   - Choose to refuse to receive In-Lieu-Of Services and Settings instead of other Covered Services.
6. You have the right to use each Complaint and appeal process available through the Managed Care Organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   - 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.
7. 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.
   - Be given information you can understand about your health plan rules, including the Health Care Services you can get and how to get them.
8. 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.
9. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a Covered Service.
10. 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.
11. You have a right to make recommendations to your health plan's member rights and responsibilities.

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:
   - 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 healt.
   - 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.
5. You must follow plans and instructions for care that you have agreed to with your provider.

Additional Member responsibilities while using NEMT Services

1. When 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) toll-free at 1-800-368-1019. 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 includes items listed as non-covered services in the Texas Medicaid Provider Procedures Manual (TMPPM) or any item of DME and supplies that is not considered a benefit of Medicaid. Home Health DME and Supplies Exceptional Circumstances requests must be pre-authorized. Requests for medically necessary DME and supplies not covered as a benefit under Texas Medicaid should be submitted through the Home Health DME and Supplies Exceptional Circumstances process.

Fraud and abuse

Do you want to report Fraud, Waste, And Abuse?

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

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

To report fraud, waste, and abuse:

- You can report directly to your health plan:
  Texas Children's Health Plan
  Fraud and Abuse Investigations
  PO Box 301011, WLS 8302
  Houston, TX 77230-1011
  832-828-1320 or Member Services Hotline 800-659-5764
  Email: TCHPSIU@texaschildrens.org
- or call the Office of Inspector General (OIG) Hotline at 800-436-6184 or visit https://oig.hhs.texas.gov/ and click on "Report Fraud".

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

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and the phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

When reporting about someone who gets benefits, include:

- The person's name.
- The person's date of birth, Social Security Number, or case number, if you have it.
- The city where the person lives.
- Details about the fraud, waste, and abuse.

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 SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Reporting abuse, neglect, and exploitation

The law requires that you report suspected abuse, neglect, or exploitation, including unapproved use of restraints or isolation that is committed by a provider.

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

Report by phone (non-emergency); 24 hours a day, 7 days a week, toll-free.

Report to the Department of Aging and Disability Services (DADS) by calling 800-647-7418 if the person being abused, neglected, or exploited lives in or receives services from a:

- Nursing facility
- Assisted living facility
- Adult day care center
- Licensed adult foster care provider
- 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://txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

Helpful information for filing a report

When reporting abuse, neglect, or exploitation, it is helpful to have the names, ages, addresses, and phone numbers of everyone involved.

Terms and Definitions

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

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

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

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

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

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

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

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

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

Grievance - A complaint to your health insurer or plan.

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

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

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

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

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

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

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

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

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

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

Physician Services - Healthcare 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 healthcare services.

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

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

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

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

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

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

Rehabilitation Services and Devices - Healthcare 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 Help Line
We have answers around the clock.

Whenever you need answers, the Texas Children's® Health Plan 24-Hour 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.

Texas Children's® Health Plan

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

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

800-686-3831

texaschildrenshealthplan.org

Good health starts here!

HEALTHY REWARDS PROGRAM

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

- **Healthy Pregnancy:** Services and rewards to help our members give their baby a healthy start!
- **Health and Wellness:** Members can get rewards just for taking care of their well-being!
- **Healthy Play and Exercise:** Benefits and rewards to help members get stronger and take control of their health.
- **Extra Help for Families:** With services like transportation help and a 24-Hour 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**

Texas Children's® Health Plan

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

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