STAR Member handbook

Important information for you

We're here to help!

Call 1-800-964-2247 | cookchp.org

June 2021
STARMbrHnbkTA060121

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Important phone numbers

<table>
<tr><td colspan="3">Cook Children's Health Plan
8 a.m. to 5 p.m., Monday – Friday, except for state holidays.
Our representatives speak English and Spanish to help you. We also have an interpreter service that can help with other languages, free of charge. Also, you can call us or use the TTY/TDD option if you have any questions or concerns about any type of Utilization management (UM) issues. The interpreter service is also available free of charge for UM questions or concerns. We are ready to help!

For Emergencies and/or behavioral health crisis after hours/weekends, please call 9-1-1 or go to the nearest emergency department.

If your call is not an emergency, you can leave a message and your call will be returned the next business day.

Care Management/Baby Steps program/Utilization Management
8 a.m. to 5 p.m., Monday – Friday, except for state holidays
We have Case Managers and utilization managers ready to help you with your healthcare needs. If you have questions about requests for medical services call Cook Children's Health Plan.

Pharmacy assistance
8 a.m. to 5 p.m., Monday – Friday, except for state holidays
If you have questions about your pharmacy benefits call Cook Children's Health Plan</td><td>Toll-free:
1-800-964-2247
(local) 682-885-2247

TTY/TDD
for the deaf and
hard of hearing:
7-1-1
1-800-735-2988</td></tr>
<tr><td colspan="2">24-hour nurse advice line
Cook Children's Health Plan has a nurse advice line that is available 24 hours a day, 7 days a week if you need to speak to a nurse.</td><td>1-866-971-2665</td><td>TDD/TTY:
(toll-free) 1-844-514-3774</td></tr>
<tr><td colspan="3">Behavioral health – Substance abuse services
Beacon Health Options is available 24 hours a day, seven days a week. They have bilingual staff in English and Spanish and also interpreter services for other languages free of charge. Also, you can call Beacon or use the TTY/TDD option if you have any questions or concerns about any type of Utilization management (UM) issues related to behavioral health and substance abuse services. The interpreter service is also available free of charge for UM questions or concerns relating to behavioral health and substances abuse services.

If you have a life-threatening condition or behavioral health crisis, go to the nearest emergency room or call 9-1-1.</td><td>1-855-481-7045

TTY/TDD:
1-855-539-5876</td></tr>
<tr><td colspan="2">Vision services are provided by National Vision Administrators (NVA)</td><td>1-877-236-0661</td><td>TTY/TDD:
1-888-820-2990</td></tr>
<tr><td>STAR Dental Managed Care Plans
(For Medicaid Members under 21 years of age)</td><td>DentaQuest:
1-800-516-0165</td><td>MCNA Dental:
1-800-494-6262</td><td>United Healthcare Dental:
1-877-901-7321</td></tr>
<tr><td colspan="3">Value-Added dental benefit for pregnant women (for pregnant Members over 21 years of age)</td><td>Liberty Dental:
1-888-902-0349</td></tr>
<tr><td colspan="3">Medical transportation services-reservations (Access2Care)
If you need non-emergency transportation to your health care appointments, Access2Care can help arrange those services for you. They have bilingual staff that speak English and Spanish and interpreter services for other languages free of charge. Access2Care is available 24 hours a day, seven days a week. Members need to call at least 2 business days before their appointment.</td><td>1-844-572-8195
TTY:
711
Where's My Ride:
1-844-572-8195</td></tr>
<tr><td colspan="3">Texas Medicaid Managed Care Helpline</td><td>1-800-252-8263</td></tr>
<tr><td colspan="3">Ombudsman Managed Care Help
The Health and Human Services Commission's (HHSC) Office of the Ombudsman is designed to help people who are already on Medicaid and need help getting health care services. A priority is placed on people with urgent or complex health care needs. The office provides:
• Information about the member's coverage.
• Guidance on how to get services.
• Referrals to the right place to get help.
• Direct help from their staff to help resolve a problem</td><td>Toll-free:
1-866-566-8989

TDD/TTY:
1-866-222-4306</td></tr>
</table>

Thank you for choosing Cook Children's Health Plan

Cook Children's Health Plan offers health care for Texans covered by Medicaid STAR. Our service area is Denton, Hood, Johnson, Parker, Tarrant, and Wise counties in Texas.

We have a long history of caring for North Texans. As a part of **Cook Children's Health Care** System, we are a proven leader in health care. Working closely with a wide range of providers, we want to be sure that you get the best care when you need it.

- Our staff cares for our members and our community.
- We listen to and help those we serve.
- We understand the needs of our members.
- We work with local health care providers to meet your needs.

To make sure that you get the most out of your STAR benefits, you need to know how your health plan works. Keep this handbook close by. It has information on how this medical plan works and what services are covered. This will help you get the best care possible. If you need help understanding or reading this handbook we have staff that speak English and Spanish that can help you if you: Are deaf, are hard of hearing or speak a language other than English or Spanish. You can also ask for the member handbook in audio, other languages, Braille or larger print.

Cook Children's Health Plan has a Member Services department that can answer your questions and help you with:

- Changing your primary care provider.
- Mail a new ID card.
- Change your address or phone number.
- Letting you know what services are covered.
- Listening to your complaints and concerns.
- Schedule an interpreter.

You can also access your member account online at www.cookchp.org 24 hours a day, 7 days a week to:

- Check your eligibility
- Update your Primary Care Provider, address, or phone number.
  (to report your new address to HHSC, call 2-1-1 or go to yourtexasbenefits.com).
- Request a new ID card.
- Contact us.

Our commitment is to you and your family. We look forward to serving you.

To get help, call Member Services | 1-800-964-2247

Your Cook Children's Health Plan ID card

When and where do I use my Cook Children's Health Plan ID card?

Everyone who becomes a member of our health plan gets an ID card. This ID card has important phone numbers that you may need. The ID card gives the doctor and office staff important information.

If you get an ID card that does not have the correct Primary Care Provider (PCP) or if it has wrong information listed, call Member Services at **1-800-964-2247**. They will help you get a new ID card.

How to use your ID card

Keep your Cook Children's Health Plan ID card with you at all times and show it to the provider, clinic or hospital to get the care you need. They will need the details on the card to know that you are a Cook Children's Health Plan Member. Do not let anyone else use your ID card.

You will not get a new ID card every month. If you call us to change your Primary Care Provider, we will send a new ID card.

How to read your Cook Children's Health Plan ID card

Your ID card will say STAR and will have Cook Children's Health Plan on it.

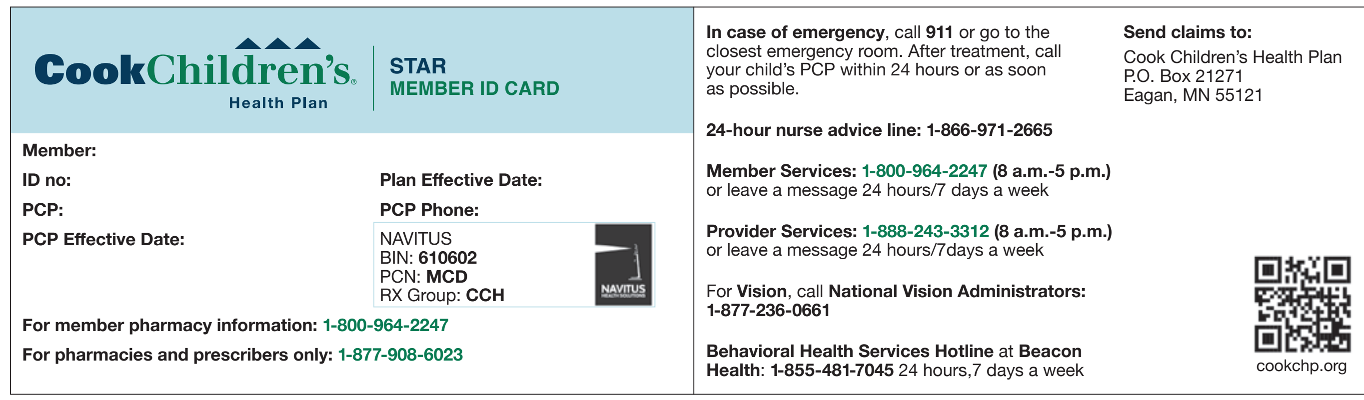
Your Cook Children's Health Plan ID card is in English and Spanish, and has the following information on it:

- Member's name
- Member's ID number
- Primary care provider's name and number
- Member Services phone number
- Beacon Health Strategies 24/7 phone number.
- Vision services phone number.
- Nurse Advice Line 24/7 phone number.

How to replace a lost or stolen ID card?

If you lose your ID card or it is stolen, call Member Services at **1-800-964-2247**. They will send you a new ID card.

Here is what a Cook Children's Health Plan ID card looks like:



CookChildren's Health Plan | STAR MEMBER ID CARD

Member:
ID no: **Plan Effective Date:**
PCP: **PCP Phone:**
PCP Effective Date:

NAVITUS
BIN: **610602**
PCN: **MCD**
RX Group: **CCH**

For member pharmacy information: 1-800-964-2247
For pharmacies and prescribers only: 1-877-908-6023

In case of emergency, call **911** or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

24-hour nurse advice line: 1-866-971-2665

Member Services: 1-800-964-2247 (8 a.m.-5 p.m.) or leave a message 24 hours/7 days a week

Provider Services: 1-888-243-3312 (8 a.m.-5 p.m.) or leave a message 24 hours/7days a week

For **Vision**, call **National Vision Administrators: 1-877-236-0661**

Behavioral Health Services Hotline at **Beacon Health**: **1-855-481-7045** 24 hours,7 days a week

Send claims to:
Cook Children's Health Plan
P.O. Box 21271
Eagan, MN 55121

cookchp.org

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 be issued only 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 toll-free **1-800-252-8263**, or by going online to order or print a temporary card at **www.YourTexas Benefits.com**.

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

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 toll-free at **1-800-252-8263** or opt out of sharing your health information at **www.YourTexasBenefits.com**.

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

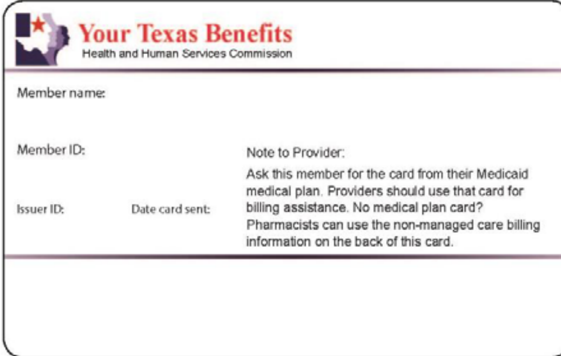
- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - Medicare (QMB, MQMB)
  - Healthy Texas Women Program (HTW)
  - Hospice
  - STAR Health
  - Emergency Medicaid, or
  - Presumptive Eligibility for Pregnant Women (PE).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

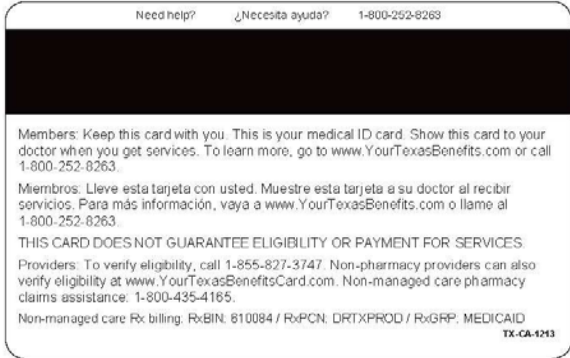
The back of the YTB Medicaid card has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call toll-free (1-800-252-8263) if you have questions about the new card. If you forget your card, your doctor, dentist, or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

Your Temporary Verification Form (Form 1027A)

If you lose the Your Texas Medicaid Benefits ID Card, and you need proof of your eligibility quickly, you can request a temporary Verification Form. You must apply for the temporary form in person at an HHSC eligibility office. To find the nearest office, call 2-1-1 (pick a language and then pick option 2).

Sample Your Texas Benefits ID card





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 access:

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

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

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

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

If you have questions, call **1-855-827-3748** or email **ytb-card-support@hpe.com**

Appointments

What do I need to bring with me to my doctor's appointment?

You should take this with you when you go to your doctor's appointment:

- Cook Children's Health Plan Member ID card.
- Your Texas Benefits ID card.
- Immunization (shot) records.
- List of all medications you are taking.
- Paper to take notes on information you get from the doctor.

Primary Care Providers

What is a Primary Care Provider?

A Primary Care Provider is someone who knows you well and takes care of your medical needs. You must pick a Primary Care Provider from the Cook Children's Health Plan list of providers. Your Primary Care Provider will treat most of your health care needs. If the Primary Care Provider cannot treat a need, you will be referred to a provider who can.

How can I change my Primary Care Provider?

Call our Member Services department at 800-964-2247 if you decide you want to change your Primary Care Provider (PCP). You may also change your PCP online using the MyCookChildren's member portal. You can access this portal on our website at cookchp.org.

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 child's Primary Care Provider. You can change your Primary Care Provider by calling us toll-free at **1-800-964-2247** or in writing to:

> **Cook Children's Health Plan**
> Attn: Member Services
> P.O. Box 2488
> Fort Worth, TX 76113-2488

When will a Primary Care Provider change become effective?

A Primary Care Provider change will become effective the same day that you call us to change your Primary Care Provider.

Are there any reasons why a request to change a Primary Care Provider may be denied?

In some cases, your request to change Primary Care Provider can be denied if:

- The Primary Care Provider you picked is not accepting new patients.
- The Primary Care Provider you picked is no longer a part of our Health Plan.

Can a clinic be my Primary Care Provider? (Rural Health Clinic/Federally Qualified Health Center)

Yes, a primary care provider can also be a clinic, like a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

Can a specialist ever be considered a Primary Care Provider?

If you have special health care needs, you have the right to request a specialist as a primary care provider. Your Specialist may also make this request. In order to accept this request:

- The specialist must agree to provide all of the primary care services such as;
  - Immunizations
  - Well child care
  - Coordination of all health care services
- Cook Children's Health Plan Medical Director must also approve the request

Your care management team can help you start this process.

What if I choose to go to another doctor who is not my Primary Care Provider?

Except in emergencies, always call your Primary Care Provider before you go to another doctor or the hospital. You can reach your Primary Care Provider or back-up doctor 24 hours a day, seven days a week.

How do I get medical care after my Primary Care Provider's office is closed?

If you get sick at night or on a weekend and cannot wait to get medical care, call your Primary Care Provider for advice. Your Primary Care Provider or another doctor is ready to help by phone 24 hours a day, seven days a week

You can also call our 24-hour Nurse Advice Line at **1-866-971-2665** to speak with a nurse to help you decide what to do.

Can a Primary Care Provider move me or my child to another Primary Care Provider for non-compliance?

Yes. A Primary Care Provider can ask that you or your child pick a new primary care provider if:

- You often missed appointments, and you have not called to let them know.
- You do not follow their advice.

If you would like to learn more about your PCP or a specialist, such as the doctor's specialty, medical school, residency training or board certification, visit these websites:

American Medical Association
www.ama-assn.org

The Texas Medical Board
www.tmb.state.tx.us

Provider directories are also available on our website at cookchp.org or you can call Member Services at 800-964-2247 to request a free copy.

Physician incentive plan information

The MCO cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. Right now, Cook Children's Health Plan does not have a physician incentive plan.

What is the Medicaid Lock-in Program?

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

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

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

To learn more, call Cook Children's Health Plan at **1-800-964-2247**.

Specialty care

What if I need to see a special doctor (specialist)?

Your primary care provider or attending specialist may request that a specialist see you or perform special tests. If you think you may need to see a specialist doctor, we advise you to talk to your primary care provider, attending specialist or care manager.

What is a referral?

Your primary care provider or attending specialist may request or arrange for you to see a new specialist. This is called a “referral”. If you have a specialist who already takes care of you then a referral is not needed. If your specialist is contracted with Cook Children’s Health Plan, then no approval is needed for specialist visits. An approval is needed for out of network specialists to help with claims payment. Your care manager can also help you with access to specialists.

How soon can I expect to be seen by a specialist?

After getting a referral from your primary care provider, you should be able to see the specialist within 3 weeks for a routine appointment or within 24 hours for urgent care appointments. If you need help with this, please contact your primary care provider, your attending specialist, or your care manager.

What services do not need a referral?

There are certain services you can get without a referral from your primary care provider or Cook Children’s Health Plan. These services include:

- Emergency care
- OB/GYN care
- Behavioral health or drug and alcohol treatment
- Routine vision
- Family planning
- Specialists, in network, who currently provide care.

How can I ask for a second opinion?

You have the right to get checked by another doctor to get a second opinion if your doctor tells you, you have a disease or need an operation. If you think you want another doctor to see you and get a second opinion, you can tell your primary care doctor, we will pay for that visit.

To determine how and when to obtain referrals and authorizations for specific services, you can call our Member services department. You may also view this information online using the MyCookChildren’s member portal. You can access this portal on our website at **cookchp.org**.

Women’s health

What if I need OB/GYN care?

Cook Children’s Health Plan allows you to pick any OB/GYN, whether that doctor is in the same network as your Primary Care Provider or not.

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

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

Do I have the right to choose an OB/GYN?
Yes.

How do I choose an OB/GYN?
Check our STAR Provider Directory to find an OB/GYN. You can get a copy of the provider directory online at www.cookchildrens.org or call Member Services.

Will I need a referral?
No, you do not need a referral.

If I don't choose an OB/GYN, do I have direct access?
Yes. You have the right to pick an OB/GYN from our network without a referral.

How soon can I be seen after contacting my OB/GYN for an appointment?
If you are pregnant you can be seen within 2 weeks of contacting your doctor to request a prenatal visit. If you are not pregnant, you should be seen within 3 weeks of asking for an appointment.

Can I stay with an OB/GYN who is not with Cook Children's Health Plan?
If you are past the 24th week of pregnancy when you join Cook Children's Health Plan you will be able to stay under the care of your current OB/GYN. If you choose you can pick an OB/GYN who is in our network as long as the doctor agrees to treat you. We can help you change doctors. Please call our Baby Steps Program at **1-800-862-2247**.

What if I am pregnant? Who do I need to call?
Call Case Management as soon as you know you or your daughter is pregnant. They will help you get the medical care that is needed during pregnancy.

Where can I find a list of birthing centers?
To find a birthing center, call our Baby Steps Program at **1-800-962-2247**.

What other services/activities/education does Cook Children's Health Plan offer pregnant women?
We offer pregnant women our "Baby Steps" program. Our case managers help pregnant members get the services that they need. We mail a prenatal packet to all pregnant members. It has information about how to stay healthy, a list of childbirth classes, and much more.

To speak to a case manager or to get more information about the Baby Steps program, please call **1-800-862-2247**.

Can I pick a Primary Care Provider for my baby before the baby is born?
Yes, we would like you to pick a primary care provider before your baby is born. Member Services can help you pick a primary care provider for your baby.

How do I get family planning services?
You can go to your Primary Care Provider or any doctor or family planning clinic that takes Medicaid to help you with family planning. You do not need a referral. Family Planning Services are very private. You do not have to worry about anyone else knowing that you are going there.

Do I need a referral for this?

No referral is needed for Family Planning Services.

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/family-planning-program**, or you can call Cook Children's Health Plan at **1-800-964-2247** for help in finding a family planning provider.

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

After your baby is born you may lose Medicaid coverage. You may be able to get some health care services through the Healthy Texas Women's 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's Program

The Healthy Texas Women's Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (200 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.

To learn more about services available through the Healthy Texas Women's 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: **https://www.healthytexaswomen.org/**
Fax: (toll-free) **1-866-993-9971**

Primary Health Care Services Program

The Primary Health Care Services Program serves women, children, and men who are unable to access the same care through insurance or other programs. This program is available to anyone who is a Texas resident, has an income level at or below 200 percent of federal poverty guidelines and is not receiving other non-HHSC programs or benefits that provide the same services.

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

- Health education
- Emergency services
- Family planning services
- Diagnosis and treatment
- Diagnostic testing, such as X-rays and lab services
- Preventive health services, including immunizations

You will be able to apply for Primary Health Care services at certain clinics in your area. Applications and eligibility forms can be found at contracted clinic sites. To find a clinic where you can apply, visit the Office of Primary and Specialty Health Service Locator at **http://txclinics.dshs.texas.gov/chcl/**

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

> Website: **https://hhs.texas.gov/services/health/primary-health-care-services-program**
> Phone: **1-800-222-3986**
> Email: **PrimaryHealthCare@hhsc.state.tx.us**

Family Planning Program

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

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at **http://txclinics.dshs.texas.gov/chcl/**

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/family-planning-program**
> Phone: **(512) 776-7796**
> Fax: **(512)-776-7203**
> Email: **famplan@hhsc.state.tx.us**

Newborns

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

In order for your baby to be issued a "Your Texas Benefits Medicaid" card, you will need to call 2-1-1 and your caseworker and report the birth to Health and Human services. You can also do this in person at your local SNAP/Medicaid office. If you need help with food for you and your baby call Texas Health and Human Services Commission at **1-800-252-8263** to apply for Temporary Assistance for Needy Families (TANF).

How and when do I tell my Health Plan?

Call Member Services as soon as possible when you have your baby. We will give you information on the steps you need to take to keep your baby covered.

How and when can I switch my baby's Primary Care Provider?

You can change your baby's Primary Care Provider any time before or after your baby's birth. Call Member Services. There is no limit on how many times you can change your or your child's primary care provider.

Can I switch my baby's health plan?

For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at **1-800-964-2777**.

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

Out of the area

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

If you need medical care when traveling, call us toll-free at **1-800-964-2247** and we will help you find a doctor. If you need emergency services while travelling, go to a nearby hospital, then call us toll-free at **1-800-964-2247**.

What if I am out of the state?

When you are not in the State of Texas, there is only coverage for emergency care. If you get sick or injured and not in serious danger, call your Primary Care Provider for advice.

What if I am out of the country?

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

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and Cook Children's Health Plan Cook Children's Health Plan Member Services Department at **1-800-964-2247**. Before you get Medicaid services in your new area, you must call Cook Children's Health Plan, unless you need emergency services. You will continue to get care through Cook Children's Health Plan until HHSC changes your address.

Changing health plans

What if I want to change health plans? Who do I call? When will my health plan change become effective?

You can change your health plan by calling the Texas STAR, STAR Kids, or STAR+PLUS Program Helpline at **1-800-964-2777**. You can change health plans as often as you want.

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

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

How many times can I change health plans?

You can change health plans as many times as you want, but not more than once a month.

Can Cook Children's Health Plan ask that I get dropped from their health plan?

Yes. Cook Children's Health Plan might ask that a member be taken out of the plan for "good cause". "Good Cause" could be, but is not limited to:

- Threats or physical acts leading to harming of Cook Children's Health Plan staff or providers
- You lend your Cook Children's Health Plan STAR ID card to another person so that they can obtain services
- You make false statements
- You are dishonest in the use of services or facilities
- You continue to disregard your Primary Care Provider's advice
- You keep going to the emergency room when you do not have an emergency
- Refusal to go by Cook Children's Health Plan's policies and procedures, such as:
- Let someone use your ID card
- Miss visits over and over again
- Rude or act out against a provider or a staff person
- Keep using a doctor that is not a Cook Children's Health Plan provider

Cook Children's Health Plan will not ask you to leave the program without trying to work with you. If you have any questions about this process call Member Services. The Texas Health and Human Services Commission will decide if a Member can be told to leave the program.

Interpreter services

Can someone interpret for me when I talk with my doctor? Who do I call for an interpreter?

Cook Children's offers interpreter services at no cost to you if the provider does not have someone to interpret for you. Call our Member Services Department at **1-800-964-2247** (TTY/TDD for deaf or hard of hearing: **7-1-1** or **1-800-735-2988**) to schedule an interpreter and we will let your provider know who that person will be.

How far in advance do I need to call?

Call as soon as you make a doctor's appointment. We need at least a 2 day notice.

How can I get a face-to-face interpreter in the provider's office?

When you call to set up your visit, tell the person you are talking to you need an interpreter with you during the visit. If they cannot help, call Member Services.

Care defined

What is routine medical care? How soon can I expect to be seen?

If you need a physical checkup, then the visit is routine. Your doctor should see you within 14 days.

Remember: It is best to see your doctor before you get sick so that you can build your relationship with him/her. It is much easier to call your doctor with your medical problems if he/she knows who you are.

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 sprain/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 Cook Children's Health Plan Medicaid. For help, call us toll-free at **1-800-964-2247**. You can also call our 24-hour Nurse Advice Line at **1-866-971-2665** 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 Cook Children's Health Plan Medicaid.

What is emergency medical care?

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

Emergency medical condition means:

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

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

Emergency behavioral health condition means:

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

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

Emergency services and emergency care means:

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

How soon can I expect to be seen?

Emergency wait time will be based on your medical needs and determined by the emergency facility that is treating you.

What is post-stabilization?

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

Benefits and services

Benefits and services

What are my health care benefits? How do I get these services?

Here is a summary of services that are covered for Medicaid members. You can get most services by calling your Primary Care Provider. Your Primary Care Provider will need to coordinate any services that you may need.

Your health care benefits in the STAR Medicaid program include:

- Preventive services. This includes an annual adult well check for patients 21 years of age and older
- Ambulance services
- Audiology services. This includes hearing aids for adults (audiology services and hearing aids for children 20 years old and younger are a non-capitated service and provided through the Hearing Services for Children Program.)
- Behavioral Health Services, including:
  - Inpatient mental health services for Children (under age 21)
  - Outpatient mental health services
  - Psychiatry services
- Counseling services for adults (21 years of age and older) Outpatient substance abuse use disorder treatment services including:
  - Assessment
  - Detoxification services
  - Counseling Treatment
  - Medication assisted therapy
- Residential substance use disorder treatment services including:
  - Detoxification services
  - Substance use disorder treatment (including room and board)
- Birthing services provided by a physician or Advanced Practice Nurse in a licensed birthing center
- Birthing services provided by a certified nurse midwife in a birthing center
- Cancer screening, diagnostic and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - Surgery and reconstruction on the other breast to produce symmetrical appearance;
    - Treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - Prophylactic mastectomy to prevent the development of breast cancer.
    - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.

- Medical checkups and Comprehensive Care Program (CCP) services for children 20 years old and younger through the Texas Health Steps Program
- 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.
- Podiatry
- Prenatal care
- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies-physical, occupational, and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction, which cannot be accomplished by glasses.)

Are there any limits to any covered services?

- Chiropractic services are limited to an acute condition and 12 treatments for each member per 12-month benefit period. Benefits cannot exceed one treatment per day.
- Maintenance therapy is not a covered benefit.
- Cochlear implants and bone anchored hearing aids for children age 20 and younger are a covered Medicaid service. These hearing aids are not provided by the Hearing Services for Children Program.
- Texas Health Steps checkups do not include sports physicals unless a Texas Health Steps checkup is due at the same time.
- Vision care services are limited to one exam every 24 months for adults age 21 and older.
- Members 20 years of age and younger are eligible for one examination with refraction for the purpose of getting eyewear per state fiscal year of September 1st to August 31.

What services are not covered?

There are some services that are not covered by STAR Medicaid. These services include but are not limited to:

- Autopsies Services
- Supplies in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member, or when prior authorized for specific purposes by TMHP (including the removal of keloid scars).
- Biofeedback therapy
- Custodial Care
- Infertility
- Intragastric balloon for obesity
- Mammoplasty for gynecomastia
- Procedures and services considered experimental or investigational
- Treatment of flat foot conditions for solely cosmetic purposes and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot.
- Sex change operations
- Silicone injections
- Sterilization reversal
- Services not approved by your Primary Care Provider
- Services or supplies that are not medically necessary

What does medically necessary mean?

Medically necessary means:

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

Prescriptions

What are my prescription drug benefits?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drugstore, or may be able to send the prescription for you. Adults as well as children can get as many prescriptions as are medically necessary.

How do I get my medications?

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

How do I find a network drug store?

If you need to find a drug store, you can:

- Call Member Services.
- Go to the Cook Children's Health Plan web site at www.cookchp.org.
- Refer to your STAR Provider Directory.

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

If you go to a pharmacy that is not in our network, that pharmacy can call the Pharmacist Help Line number on the back of your Cook Children's Health Plan ID card. They can help you get your prescription.

What do I bring with me to the drug store?

You must take your Cook Children's Health Plan ID card with you when you go to the drug store to get a prescription.

What if I need my medications delivered to me?

For a list of pharmacies that deliver, you can:

- Call Member Services

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

If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication.

Call Cook Children's Health Plan at **1-800-964-2247** for help with your medications and refills.

Who do I call if I have problems getting my medications?

Call Member Services.

What if I lose my medication(s)?

Medications that are lost or stolen are not a covered benefit. You can call your pharmacy for an early refill and pay the cost of the medication.

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 drug store are covered by Medicaid. For all Members, Cook 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), Cook Children's Health Plan also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call **1-800-964-2247** for more information about these benefits.

You can find important pharmacy information such as drug recalls or locations of in-network pharmacies near you online on our website at **cookchp.org**.

Texas Health Steps

What is Texas Health Steps?

There is a special health care program for children. It is called Texas Health Steps. This program is for children and teens age 0 to 20 years who receive Medicaid and is designed to keep children healthy. If you get your child's checkups, the doctor can find and treat problems before they become serious.

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 he or she needs, such as:

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

Call Cook Children's Health Plan at 1-800-964-2247 or
Texas Health Steps 1-877-847-8377 (1-877-THSTEPS) (toll-free) if you:

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

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

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

Every parent wants their child to be happy and healthy. Keeping them up-to-date with all checkups is one of the ways to promote your child's well-being. Your children should visit the doctor at these times for their Texas Health Steps checkups:

Infancy:
- At birth while still in the hospital
- 3 – 5 days of life
- 2 weeks
- At 2, 4, 6 and 9 months

Early Childhood:
- At 12, 15 and 18 months
- 2, 3 and 4 years

Late Childhood:
- At 5, 6, 7, 8, 9, 10, 11 and 12 years

Adolescence:
- At 14, 15, 16, 17, 18 and 20 years

Does my doctor have to be part of the Cook Children's Health Plan Network?

No. Your child can go to any Texas Health Steps Medicaid provider for Texas Health Steps services.

Do I have to have a referral?

No.

Can I get help making a Texas Health Steps appointment?

Yes, our Outreach team can help you make an appointment. Call **1-800-974-2247** and ask for Outreach.

What if I need to cancel an appointment?

Call your Primary Care Provider's or dentist's office if you need to cancel a Texas Health Steps appointment. Reschedule the checkup as soon as you can so your child will stay healthy.

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

If you are out of town and your child is due for a Texas Health Steps checkup, call the Outreach team at Cook Children's Health Plan. We will help you set up a visit with your doctor as soon as you get home.

What if I am a Migrant Farmworker?

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

Case Management Services for Children and Pregnant Women

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

Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?

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

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

What do case managers do?

A case manager will visit with you and then:

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

What kind of help can you get?

Case managers can help you:

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

How can you get a case manager?

Call the Texas Health Steps at **1-877-847-8377** (toll-free), Monday to Friday, 8 a.m. to 8 p.m. To learn more, go to: **https://hhs.texas.gov/services/health/medicaid-chip/texas-health-steps**

Care Management Programs

We are here to help. As a Cook Children's Health Plan member, you may be eligible for one of our Care Management programs at no cost to you.

Health and Wellness Program

This program promotes recommended health screenings and wellness programs for improved health. We offer self-management tools that give you the information you need for your health and wellness, including:

- Healthy weight maintenance
- Quitting smoking.
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depression symptoms
- Diabetes Education

Disease Management (DM) Programs

If you have asthma or diabetes, our program can help you. We will mail you information that will help you understand and manage your condition. You may also receive a call from one of our DM Program Nurse Case Managers. They will:

- Help you create health goals and make a plan to help you reach them.
- Support you through one-on-one phone calls.
- Provide you information about local support resources.
- Answer any questions you might have about your condition and your treatment plan.
- Coordinate your care with your health care providers.

Baby Steps Program

Pregnancy is an amazing time for a woman. It can also be a time full of questions. The Baby Steps team of nurses and community health workers is here to answer your questions. They will send you pregnancy, postpartum and newborn educational materials. If you have a "high-risk" pregnancy, you will have a personal Nurse Case Manager. They will answer your questions and help you find any services you may need. A "high-risk" pregnancy means you have something that raises your or your baby's chance for health problems or early (preterm) delivery.

Case Management/ Complex Case Management and Service Management/Service Coordination Programs

Our Members with Special Health Care Needs (MSHCN) are eligible for these programs. A MSHCN is someone who:

- Has a serious ongoing illness, a chronic or complex condition or a disability that will likely last for a long period of time, and
- Requires regular, ongoing treatment and evaluation for the condition by appropriate health care personnel

You will have your own Case Manager or Service Manager/Coordinator. They will help you get the services you need by:

- Completing an assessment to identify your needs
- Creating a service plan or care plan to meet your needs
- Discuss the plan with you to make sure you understand and agree with the plan
- Working with you and your doctors to help you get needed services

Cook Children's Health Plan has multiple avenues for members to be considered for complex case management services, including, but not limited to:

1. Medical management program referral
2. Discharge planner referral
3. Member or caregiver referral
4. Practitioner referral

Referral Process:
Each referral is reviewed to enroll members in to Complex Case Management based on available information and telephonic member assessment. Participation in this program is voluntary and at no cost for all eligible Cook Children's Health Plan members. If you would like to refer a member or if you would like more information about eligibility for this program, please call **1-800-964-2247** (Monday through Friday from 8:00 am to 5:00 p.m. local time).

How to Join One of Our Care Management Programs

You do not need to have a referral from your doctor to join one of our programs. If you qualify for any of these programs, you can call us at **1-800-964-2247** (Monday through Friday from 8:00 am to 5:00 p.m. local time). Members that are eligible for any of these programs that require contact between them and Cook Children's Health Plan staff will receive the following information:

- How they became eligible for the program
- How to use program services
- How to opt in or out of the program

Care Management Program outreach and ongoing management for our members will be made by phone. All calls are live between Care Managers and the member. If you do not want to participate in these programs, you can opt out of the program at any time by calling the same number. This means that we will take you out of the program but it will not affect your benefits.

Early Childhood Intervention

What is Early Childhood Intervention (ECI)?

If you have a child (birth to 36 months) with a developmental delay or disability, Early Childhood Intervention (ECI) services may be able to help you and your child. Services are provided in the home and other places your child goes regularly, for example, a child care center, park, library or other community setting.

ECI services feature:
- Individualized planning process.
- Family-Centered services.
- Case management.
- Familiar settings.
- Professional providers.
- Plans for continuing services.

The following services are provided at no cost to the family regardless of income:
- Evaluation/assessment.
- Translation and interpreter services.
- ECI programs provide services in every Texas County.

Do I need a referral for this?

A referral to ECI happens when a parent or someone else, such as a child's doctor, contacts ECI to recommend that a child be evaluated. The evaluation determines if a child is eligible for ECI services.

Within a few days of receiving a referral, someone from the local ECI program nearest to your home will contact you to set up the visit. The visit must occur within 45 days of the time ECI received the referral. This is a time for ECI to learn about your child and family, as well as to give you the information about ECI,

Where do I find an ECI provider?

ECI is here to help and can become an important resource for all families. For more information about ECI, call Health and Human Services (HHS) inquiries line **1-800-628-5115**. You can also go to their website **hhs.texas.gov/services/disability/early-childhood-intervention-services**.

What is Service Management for Members with Special Health Care Needs?

Service Management for members with special health care needs is a service Cook Children's Health Plan provides for you. You and your Cook Children's Health Plan service manager will work together to find what your health needs are.

With their help, you will also create a care plan, arrange all your services and keep track of your progress towards your health care goals. When you enroll with Cook Children's Health Plan, you will be assigned to a service management team that will help you with all your needs.

What will a Service Manager do for me?

Get answers to any questions or concerns you have:
- Identify what kinds of services your child may need
- Develop a care plan with your child's doctor(s)
- Get referrals, make appointments and make sure you have access to the care your child needs
- Help you request a Pre-Appeal

How can I talk with a Service manager?

You can talk to a service manager by calling the Cook Children's Health Plan: **1-800-964-2247**.

Special services
Special health care needs

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

You can call Case Management to get help with special health care needs. We can tell you about services that we have in your area or community resources in your area.

DFPS adoption assistance

Thinking about adoption but not sure if you can afford all of the related expenses? The Texas Department of Family and Protective Services (DFPS) has an adoption assistance program to help defray some of the costs associated with adoption of a child with special needs.

Program benefits

- Medicaid health care coverage for the adopted child. This benefit assists with the child's medical and dental care, eye care, durable medical equipment and supplies, psychiatric/behavioral health care, and medical transportation.
- Reimbursement for certain one-time expenses relating to completing the adoption process (non-recurring adoption expenses). This benefit provides reimbursement up to $1,200 per adoption for reasonable and necessary adoption expenses directly related to completing the adoption process. These expenses may include fees paid directly to child placing agencies as well as court costs, attorney fees, and other fees directly related to the legal completion of the adoption.
- Monthly payments to assist with the child's needs. The monthly adoption assistance payments are determined based upon the child's needs and the adoptive family's circumstances. Assistance is considered for the following types of special needs:
  (a) Exceptional initial placement expenses, (b) special maintenance, (c) child care, (d) supportive educational needs, (e) maintaining sibling/other family contact, and (f) routine maintenance when needed.

Sources of adoption assistance

DFPS provides adoption assistance from two sources. The first source is the:

- Federal Title IV-E of the Social Security Act and
- Texas' own state adoption assistance

Title IV-eligibility requirements

5. The following five requirements must be met for a child to be eligible for Title IV-E funded adoption assistance:
6. The child must qualify as "special needs," as described below, at the time the adoptive placement agreement is signed.
7. Reasonable efforts must be made to place the child without adoption assistance, except when to do so is contrary to the child's best interest.
8. The child must be placed for adoption by DFPS, or a private, licensed, non-profit child placing agency. For both relative and non-relative placements, the adoptive home must meet all of the requirements for approval under licensing minimum standards, including the criminal-records check

   The child must be in an adoptive placement and meet one of the following four conditions:
   a. The child is eligible for Supplemental Security Income (SSI) benefits, as determined by the Social Security Administration (SSA) during the adoptive placement,
   b. The child is AFDC eligible both in the month that court proceedings began that resulted in the order removing the child from the home and in the month the adoption petition is filed,

    c. The child was determined eligible for Title IV-E foster care assistance both at the time the child entered care and in the month the adoption petition is filed, or
    d. The child lives with a minor parent in foster care, and the child's costs are included in the Title IV-E foster care payments being made on behalf of the minor parent.
9. The adoption assistance agreement must be signed before the adoption is consumed.

State adoption assistance requirements

The following six requirements must be met for a child to be eligible for state adoption assistance:

1. The child must not be eligible for Title IV-E adoption assistance.
2. The child must qualify as "special needs," as described below at the time the adoptive placement agreement is signed.
3. Reasonable efforts must have been made to place the child without adoption assistance, except when to do so was contrary to the child's best interest.
4. The child must be placed in an approved adoptive placement with DFPS as the child's managing conservator. For both relative and non-relative placements, the adoptive home must meet all of the requirements for approval under licensing minimum standards, including criminal records checks.
5. The child's resources must be less than $10,000.
6. The adoption assistance agreement must be signed before the adoption is consummated.

Requirements for non-recurring adoption expenses

These expenses may include fees paid directly to child placing agencies as well as court costs, attorney fees, and other fees directly to the legal completion of the adoption.

Children who meet Title IV-E or state adoption assistance eligibility requirements automatically qualify for reimbursement of non-recurring adoption expenses.

However, reimbursement will not be made until the adoption is consummated. A separate request for adoption assistance is not necessary.

For adoptions that do not qualify for Title-IV-E or state adoption assistance, the following four requirements must be met to gain reimbursement for non-recurring adoption expenses.

1. The child must qualify as having "special needs" at the time an adoptive placement agreement is signed.
2. The adoptive placement must occur in accordance with relevant state and federal laws relating to child placement.
3. The adoptive parents must be residents of Texas.
4. The adoptive parents must sign an agreement to receive reimbursement for non-recurring adoption expenses prior to consummation of the adoption.

Step parent adoptions

By federal policy, stepparent adoptions do not qualify for nonrecurring adoption expense reimbursement.

International adoption

An international adoption may qualify for this benefit if the child is a "special needs" child at the time of adoptive placement and the adoption assistance agreement is signed prior to consummation of the adoption.

Definition of special needs

The child must be younger than 18 years old and meet one of the following criteria when the adoptive placement agreement is signed:

1. The child is at least six years old;
2. The child is at least two years old and a member of a minority group that traditionally has barriers to adoption;
3. The child is being adopted with a sibling or to join a sibling; or
4. The child has a verifiable physical, mental, or emotional handicapping condition, as established by an appropriately qualified professional through a diagnosis that addresses; (a) what the condition is; and (b) that the condition is indeed handicapping.

The state must determine that the child cannot or should not be returned to the home of his parents. A reasonable effort must be made to find an adoptive placement without providing adoption assistance, unless doing so is against the child's best interests.

Children under DFPS jurisdiction

DFPS is responsible for determining eligibility and negotiating the adoption assistance agreements for children who are placed for adoption under varying circumstances. Foremost among these responsibilities are determinations for children who are in the managing conservatorship of DFPS, regardless of the location of the placement. These responsibilities also extend to children who are in the legal care of and placed for adoption by a licensed, nonprofit child-placing agency when the child is placed with a family that resides in Texas. The child-placing agency need not be licensed in Texas but at least must be licensed/certified by another state to provide adoption placement services.

DFPS also determines eligibility and negotiates agreements for children who are previously received Title IV-E adoption assistance or state adoption assistance and whose adoption terminated because of the death of the adoptive parents or termination of their parental rights and at the same time are not in the care of another state's public child welfare agency. DFPS will also assume responsibility for children who have subsequent adoptive parents who resided in Texas at the time of the adoptive placement. If the child received prior state adoption assistance, DFPS will assume responsibility regardless of the adoptive parents' state of residence.

Payment ceilings for adoption assistance

The payment ceilings are established by the DFPS Board and are based upon two separate amounts. For children whose service level is Basic at the time of adoptive placement the ceiling is $400 per month. For children whose service level is Moderate or higher, the payment ceiling is $545 per month. The payment ceilings cannot be exceeded and are not automatically provided to any child.

What if I need to change my address?

- The adoptive parent of the Permanency Care Assistance caregiver should contact (or be referred to) the Texas Department of Family and Protective Services' Regional Adoption Assistance Eligibility Specialist (AAES) assigned to their case.
- If they do not know who their AAES is, they can contact the DFPS hotline, **1-800-233-3405**, to find out who their assigned eligibility specialist is.
- The AAES will then be able to assist them with the address change

Non-Emergency Medical Transportation (NEMT) Services - Access2Care

What are Non-Emergency Medical Transportation (NEMT) services?

NEMT services provide transportation to nonemergency 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. Cook Children's Health Plan works with Access2Care to help provide you with these services.

What services are part of Access2Care?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare 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 required if the health care service is confidential in nature.

How to get a ride?

You should request NEMT Services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances, you may request the NEMT service with less notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy 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.

Call Access2Care: 1-844-572-8195
TTY: 7-1-1
Where's My Ride: 1-877-564-9834

Hours: Access2Care is available 24 hours a day, seven days a week. Members need to call at least 2 business days before their appointment.

You must notify CCHP prior to the approved and scheduled trip if your medical appointment is cancelled.

Other important information
Advance directives

What if I am too sick to make a decision about my medical care?

If you are sick and cannot make decisions for yourself, you can have someone make decisions for you by filling out a form called an Advance Directive. For more information on Advance Directives, call Cook Children's Health Plan's Member Services Department at **1-800-964-2247.**

What are advance directives?

An advance directive lets you make decisions about your health care before you get too sick. This form allows you to tell your family and your doctors what kind of care you want if you are not able to and if you want anyone to make decisions about your treatment. These are the two most common types of advance directives:

- A *living will* explains your health care wishes in the case that you are terminally ill or injured and cannot make decisions.
- A *durable power of attorney for health care* allows you to name someone to make your healthcare decisions for you in you cannot make them.

An Advance Directive can be cancelled at any time.

How do I get an advance directive?

You can get forms to write advance directives by calling your case manager or our Member Services department at **1-844-843-0004**. They can help you get the forms. You can also go to **https://hhs.texas.gov/laws-regulations/forms/miscellaneous/form-livingwill-directive-physicians-family-or-surrogates**

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

Medicaid and Private Insurance

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

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

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

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

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

What happens if I lose my Medicaid coverage?

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

Information available on an annual basis

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

- Information about network providers – at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal, and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and 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.
- Cook Children's Health Plan's practice guidelines.

What do I have to do if I need help with completing my renewal application?

How to renew

Families must renew their Children's Medicaid coverage every year. In the months before a child's coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family's income and cost deductions.

The family needs to:

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

Once HHSC receives the renewal application and documents of proof, staff checks to see if the children in the family still qualify for their current program or if they qualify for a different program. If a child is referred to another program, HHSC sends the family a letter telling them about the referral and then looks to see if the child can get benefits in the other program.

If the child qualifies, the coverage in the new program begins the month following the last month of the other program's coverage.

During renewal, the family can pick new medical and dental plans by calling the Children's Medicaid call center at **1-800-964-2777**.

Completing the renewal process

If the child still qualifies for coverage in the current program (Medicaid), HHSC will send the family a letter showing the start date for the new coverage period.

Medicaid renewal is complete when the family signs and sends to HHSC the appropriate Enrollment / Transfer Form if the family picks a new medical or dental plan.

To learn more about renewing your health coverage call our Member Services department toll-free at **1-800-964-2247**.

Evaluation of new technologies

Cook Children's Health Plan follows changes and advances in health care by reviewing new treatments, medicines, procedures and devices. This is also called "new technology." The state (Medicaid and Texas Health and Human Services) also follows advancements and is always making changes to Medicaid covered services and communicates this with all Health Plans.

Cook Children's Health Plan assesses new technology to be sure that members have access to safe and effective care but, also, that medical necessity has been shown for the new technology and that alternative, existing technology is not meeting or cannot meet the current medical needs of the member. Requests to review a new technology may come from a member, requesting practitioner or other staff.

Sources for reviews for medical necessity of the new technologies can include literature searches, governmental (including FDA) recommendations, Cook Children's Health Plan's internal specialty consultants and/or outside medical experts, national professional organizations' guidelines, our accepted medical screening criteria sources, among others.

Mental health and substance abuse

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

Cook Children's Health Plan has arranged for confidential mental health and drug or alcohol abuse services to be provided by Beacon. You do not need a referral to access these services.

Call Beacon Health Options at **1-855-481-7045**. They are there to help you 24-hours a day / 7 days a week.

What are mental health rehabilitative services and mental health targeted case management? How do I get these services?

Mental Health rehabilitative services include training and services that help the Member maintain independence in the home and community, such as the following:

- Medication training and support- curriculum-based training and guidance that serves as an initial orientation for the Member in understanding the nature of his or her mental illness or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community.
- Psychosocial rehabilitative services- social, educational, vocational, behavioral, or cognitive interventions to improve the Member's potential for social relationships, occupational or educational achievement, and living skills development.
- Skills training and development- skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers.
- Crisis Intervention- intensive community-based one-to-one service provided to Members who require services in order to control acute symptoms that place the Member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.
- Day program for acute needs- Short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms of prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting.
- Call Beacon Health Strategies at **1-855-481-7045**. They are there to help you 24-hours a day, 7 days a week.

Vision/Eye care services

How do I get eye care services?

You can get routine eye care by going to an NVA vision care provider. You will not need a referral from your primary care provider for routine vision care.

Dental

Your child's Medicaid dental plan provides 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.

Cook Children's Health Plan covers emergency dental services your child gets in a hospital or ambulatory surgical center. This includes services the doctor provides and other services your child might need like anesthesia.

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

Cook 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.

Cook 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.

Cook Children's 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.

What do I do if my child needs Emergency Dental Care?

During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, call us toll-free at **1-800-964-2247** or call 911.

Are Emergency Dental Services Covered by the health plan?

Cook 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.

Extra benefits

What extra benefits does a Cook Children's Health Plan member get? How can I get these benefits?

Cook Children's Health Plan members get the following value-added services and extra benefits.

Extra benefit	How does it work	How to get it
Nurse Advice Line	You can talk to a nurse 24 hours a day, 7 days a week. They can answer questions or help you decide what to do about your health needs.	Call: **1-866-971-2665**
Prepared Childbirth Classes	Coverage up to $100 per program for prepared childbirth and breast-feeding classes per pregnancy with contracted health/childbirth educators, community agencies, and OB provider offices. Classes may be online or in person.	Call Member Services: **1-800-964-2247**
Healthy Me Rewards Program	• $50 incentive per pregnancy for Members who complete a prenatal visit with an approved provider during the first trimester of pregnancy, on or before enrollment start date, or within 42 days of enrollment in Cook Children's Health Plan. • $50 incentive per pregnancy for postnatal members who complete a post-partum visit with an approved provider between 7-84 days after delivery. (Incentives are loaded on a reloadable prepaid card. The reloadable card will expire 6 months after the member's coverage ends with Cook Children's Health Plan.) • $25 incentive for members ages 2-21 who complete an annual Texas Health Steps well-visit. • $15 incentive for members who complete a Texas Health Steps well visit at 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months of age (up to 8 visits, maximum $120). • Cook Children's Health Plan will offer members ages 18 and over with a diagnosis of diabetes a $25 incentive for each of the following that is completed per year (up to $150). This benefit does not apply to CHIP members or members diagnosed with gestational diabetes: ▪ Diabetes Health Risk Assessment, ▪ Having Hemoglobin A1c tested, ▪ Hemoglobin A1c<8%, ▪ Urine Protein test, ▪ Maintaining blood pressure of <140/90 (readings taken in a doctor's office or inpatient hospital are exluded), ▪ Retinal eye exam (Incentives are loaded on a reloadable prepaid card. The reloadable card will expire 2 months after the member's coverage ends with Cook Children's Health Plan.)	Call Member Services: **1-800-964-2247**
Prenatal Dental Benefit	Up to $350 for basic and major dental services for women enrolled in PREG Medicaid (TP40) and Cook Children's Health Plan Baby Steps Program. Does not cover orthodontia or cosmetic services	Call Liberty Dental: **1-888-902-0349**
Extra Vision Services	$125 for prescription eyeglasses (frames and lenses) or $75 for contact lenses and contact lenses fitting fees. Replacements are not covered.	Call NVA Vision: **1-877-236-0661**
School/Sports Physical	One additional school/sports physical per calendar year for children ages 3-18 with any participating Cook Children's Health Plan Provider.	Call Member Services: **1-800-964-2247**
Baby Basics Book	One (1) Baby Basics Book for pregnant members enrolled in the Cook Children's Health Plan Baby Steps Program.	Call Case Management: **1-800-862-2247**
Bathtub kneeler	A (one time) bathtub kneeling pad per household for Cook Children's Health Plan members ages 3 months to 3 years to prevent drowning during bath time.	Call Member Services: **1-800-964-2247**

Health education

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

We have the Baby Steps program just for pregnant moms. This program gives you information on having a healthy pregnancy and important things to do for your baby. You will also work with someone that will help you during the time you are pregnant. This person will also help you with what to do after your baby is born.

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

We care about your health and well-being. We have many services and agencies that we work with to help get you the care you need. Some of these services/agencies include:

- Prescription Medications
- Public Health Departments
- Health and Human Services (HHS)
- Early Childhood Intervention (ECI)
- Medical Transportation Service
- Hospice
- Dental services for children

To learn more about these services, call Member Services.

Costs/Money

What if I get a bill from my doctor? Who do I call? What information will they need?

Your doctor should not bill you for a covered service. If you do get a bill from a doctor, call the doctor's office and make sure they have your Medicaid (STAR) information. All of the information your doctor needs to bill Cook Children's Health Plan for the service is on your/child's ID card. If you feel that you should not have gotten a bill or you need help to understand the bill, call Member Services. We can talk to the doctor's office for you to explain your child's benefits. When you call us, please have your ID card and the doctor's bill with you so we can help you.

Complaints and appeals

Complaints

What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call Member Services toll-free at **1-800-964-2247** to tell us about your problem. A Cook Children's Health Plan Member Services Advocate can help you file a complaint. Just call 1-800-964-2247. Most of the time, we can help you right away or at the most within a few days

Once you have gone through the Cook Children's Health Plan complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free **1-866-566-8989**. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
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**

What are the requirements and timeframes for filing a complaint?

There is no time limit on filing a complaint with Cook Children's Health Plan. We will send you a response letter telling you what we did about your complaint.

How long will it take to process my complaint?

Most of the time we can help you right away or within a few days. You will get a response letter within 30 days from when your complaint was received by Cook Children's Health Plan.

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

Yes, a Member Services representative can help you file a complaint. Just call **1-800-964-2247**. Most of the time, we can help you right away or within a few days.

How do I file a complaint with HHSC, once I have gone through Cook Children's Health Plan's complaint process?

Once you have gone through the Cook Children's Health Plan complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling Toll Free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations - H-320
ATTN: Resolution Services
P.O. Box 85200
Austin, TX 78708-5200

You can also e-mail your complaint to: **HPM_Complaints@hhsc.state.tx.us**

Appeals

What is an appeal?

An appeal is the process you or someone acting on your behalf can ask for when you do not agree with Cook 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.

What can I do if my doctor asks for a service or medicine for me that's covered but Cook Children's Health Plan denies or limits it?

You may ask Cook Children's Health Plan for another review of this decision. This is called an "appeal". You can call Member Services and ask for an appeal.

When do I have a right to ask for an appeal? Does my request have to be in writing?

You have the right to ask for an appeal within 60 days after you receive the letter telling you that the service was denied. You can ask for an appeal orally or in writing.

Any oral request for appeal must be confirmed by a written signed appeal by you or your representative unless an expedited appeal is requested. You can appeal the denial of payment as a whole or in part.

If you are currently receiving authorized services and would like to keep getting them while the appeal is pending you must ask for an appeal no later than 10 business days after Cook Children's Health Plan:

- mailed of the notice of the action; or
- the intended effective date of the proposed adverse benefit determination.

You can also get an extension if Cook Children's Health Plan shows that there is need for more information and if the delay is in the member's interest. If Cook Children's Health Plan needs to extend benefits, you will get a written notice of the reason for the delay.

How will I find out if services are denied?

If your services are denied, you and your doctor will get a letter that tells you the reason for denial. The letter will tell you how to file an appeal and how to ask for a State Fair Hearing.

What are the timeframes for the appeal process?

Cook Children's Health Plan has up to 30 calendar days to decide if your request for care is medically needed and covered. We will send you a letter of our decision within 30 days. In some cases you have the right to a decision within one business day.

You can get a quick decision if your health or ability to function could be seriously hurt by waiting. The resolution of your appeal can be extended up to fourteen (14) calendar days of the appeal if you ask for more time, or if Cook Children's Health Plan can show that we need more information. We can only do this if more time will help you. We will send you a letter telling you why we asked for more time.

Can someone from Cook Children's Health Plan help me file an appeal?

Yes. Cook Children's Health Plan Case Managers can help you file an appeal. They will help you file it and then send you a letter and ask you or someone acting on your behalf to sign a form and send it back to Cook Children's Health Plan. If you disagree with Cook Children's Health Plan's decision on the appeal, you have the right to ask for a State Fair Hearing. You can ask for a State Fair Hearing at any time after the health plan's Appeals process has been completed.

What is an expedited appeal?

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

How do I ask for an expedited appeal?

You may ask for this type of appeal in writing or by phone. Make sure you write "I want a quick decision or an expedited appeal," or "I feel my / my child's health could be hurt by waiting for a standard decision." To request a quick decision by phone, call Member Services.

Does my request have to be in writing?

We can accept your request orally or in writing. Mail written requests to:

Cook Children's Health Plan
Attn: Appeals
P.O. Box 2488
Fort Worth, TX 76113-2488

Who can help me file an expedited appeal?

You can ask for an expedited appeal if you feel that serious medical problems will occur. Our Medical Director will review your request within one business day. You will be told, by phone and in a letter, of the decision. If you need help filing an appeal, please call Cook Children's Health Plan's Case Management Department.

What happens if Cook Children's Health Plan denies the request for an expedited appeal?

If Cook Children's Health Plan denies an expedited appeal, the appeal is processed through the normal appeal process, which will be resolved within 30 days. You will receive a letter explaining why and what other choices you may have.

What are the timeframes for an expedited appeal?

Cook Children's Health Plan must decide this type of appeal in one working day from the time we get the information and request.

Can I ask for a State Fair Hearing?

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

Cook Children's Health Plan
Attn: Member Services
P. O. Box 2488
Fort Worth, TX 76113-2488 or call **1-800-964-2247**

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of: (1) 10 business days following the MCO's mailing of the notice of the adverse benefit determination.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied. HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Member rights and responsibilities

Member rights and responsibilities

Member rights:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
11. You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
12. You have a right to make recommendations regarding the organization's member rights and responsibilities policy.

Member responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a primary care provider quickly.
   c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.
5. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
6. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

Additional Member Responsibilities while using Access2Care for Non-Emergency Medical Transportation (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 **800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at **hhs.gov/ocr**.

Fraud and abuse

Do you want to report waste, abuse or fraud?

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

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

Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse or fraud, choose one of the following:
- Call the OIG Hotline at **1-800-436-6184**;
- Visit **oig.hhsc.texas.gov** and click the red box labeled "Report Fraud". On the Report Fraud, Waste or Abuse page, click the blue box labeled "Continue to IG's Fraud Reporting Form" and follow the steps to fill out the online complaint form; or
- You can report directly to your health plan:

Cook Children's Health Plan
Attention: Compliance
P.O. Box 2488
Fort Worth, TX 76113-2488
1-800-964-2247

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

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

When reporting about someone who gets benefits, include:
- The person's name.
- The person's date of birth, Social Security number, or case number if you have it.
- The city where the person lives.
- Specific details about the waste, abuse or fraud.

Subrogation

What is subrogation?

We might ask for payment for medical expenses to treat an injury or illness that was caused by someone else. This is a "right of subrogation" provision. Under our right of subrogation, we have the right to get back the cost of medical benefits paid when another party is (or might be) liable for your illness or injury. We can ask for you to pay back medical costs if you get expenses from the other party.

Cook Children's Health Plan
P.O. Box 2488, Fort Worth,
Texas 76113-2488

Privacy Official: Kathleen Roman
Phone: 682-885-2866

Email: kathy.roman@cookchildrens.org
website: www.cookchp.org

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

See page 48 *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

See page 49 *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

See page 49-50 *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
In these cases we never share your information unless you give us written permission:	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues	• We can share health information about you for certain situations such as: - Preventing disease - Helping with product recalls - Reporting adverse reactions to medications - Reporting suspected abuse, neglect, or domestic violence - Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Cook Children's Health Plan never markets or sells personal information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective 09/07/2013

This Notice of Privacy Practices applies to the following organizations.

Cook Children's Health Plan

Cook Children's
Health Plan