INTRODUCTION

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, we are a proven leader in health care.

- 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.

Keep this handbook close by. It has information on how this Medicaid 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:

- Have a hard time reading.
- Are hearing impaired.
- Speak a language other than English or Spanish.

You can also ask for the member handbook in audio, other languages, Braille or larger print. To get help call Member Services at 1-800-964-2247. If you are hearing impaired and need to contact Cook Children’s Health Plan, please call 682-885-2138 or toll-free at 1-844-644-4137.

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

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

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

- Check your eligibility.
- Update your PCP, 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.

Emergency care

Conditions that need immediate attention and without it you think will cause serious harm or jeopardy to your health are considered emergency care. If you have a life-threatening condition or behavioral health crisis, go to the nearest emergency room or call 9-1-1. You do not need a referral for emergency care. For a behavioral health crisis call Beacon Health Strategies at 1-855-481-7045.

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

Thank you for choosing Cook Children’s Health Plan.
Please write the following names and numbers and keep with you.

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<thead>
<tr>
<th>Name/Number</th>
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<tr>
<td>Your STAR (Medicaid) ID Number</td>
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<td>Your Primary Care Provider Name</td>
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<td>Your Primary Care Provider Phone Number</td>
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### Cook Children’s Health Plan

Member Services (8 a.m. to 5 p.m. Monday thru Friday except for state holidays).

Member Services representatives speak English and Spanish. We have an interpreter service that can help with other languages.

**If you have an emergency after hours/weekend, please call 9-1-1 or go to the nearest emergency room.**

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

Cook Children’s Health Plan has a nurse advice line that is available 24 hours if you need to speak to a live nurse.

- Pharmacy questions – call Member Services.
- Care Management.
- TDD/TTY (hearing impaired).

**Behavioral Health/Substance Abuse Services:** Beacon Health Strategies

24/7 English and Spanish – with other language translations available. Interpreter services available.

**Vision:** National Vision Administrators (NVA)

**STAR Dental Managed Care Plans:**

(For Medicaid (STAR) members under the age of 21)

- DentaQuest
- MCNA

**Texas Medicaid Managed Care Helpline**

**TDD/TTY**

**Dental Value Add for Pregnant Women:** Delta Dental

**Medical Transportation Services:** LogistiCare

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<td>Behavioral Health/Substance Abuse Services</td>
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<td>Vision</td>
<td>1-877-236-0661</td>
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<td>STAR Dental Managed Care Plans:</td>
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<td>Texas Medicaid Managed Care Helpline</td>
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<td><strong>TDD/TTY</strong></td>
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When and where do I use my Cook Children’s Health Plan ID card?

Every one that 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 or if it has wrong information listed, call Member Services. They will help you get a new ID card.

How to use your ID card

Take 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 this information on it:

• Member’s name.
• Member’s ID number.
• Primary care provider’s name and phone number.
• Member Services (1-800-964-2247).
• Beacon Health Strategies Behavioral Health Services 24/7.
• NVA Vision services.
• Nurse Advice Line 24/7 (1-866-971-2665).

How to replace a lost or stolen ID card?

If you lose your ID card or it is stolen, call Member Services. They will send you a new ID card.

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

Your Texas Benefits Medicaid Card

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

You will only be issued one card, and will only receive a new card in the event of the card being lost or stolen. If your Medicaid ID card is lost or stolen, you can get a new one by calling toll-free at 1-855-827-3748. 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 history 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 health history through the secure online network, call toll-free at 1-800-252-8263.

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

• Your name and Medicaid ID number.
• The date the card was sent to you.
• The name of the Medicaid program you’re in if you get:
  » Medicare (QMB, MQMB)
  » Texas Women’s Health Program (TWHP)
  » Hospice
  » STAR Health
  » Emergency Medicaid, or
  » Presumptive Eligibility for Pregnant Women (PE)
• Facts your 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 Your Texas Benefits Medicaid card has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call toll-free (1-800-252-8263) if you have questions about the new card.

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

Your Temporary Verification Form (Form 1027A)

You can request a temporary Verification Form if you lose your Texas Medicaid Benefits ID Card. Contact your local HHSC eligibility office or call 211 for information on getting a Temporary Verification Form.
What do I need to bring with me to my doctor’s appointment?

• Cook Children’s Health Plan 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.

What is a primary care provider (PCP)?
A PCP is someone who knows you well and takes care of your medical needs. You must pick a PCP from the Cook Children’s Health Plan list of providers. Your PCP will treat most of your health care needs. If the PCP cannot help a need, you will be referred to a provider who can.

How can I change my PCP?
Call Member Services if you want to change your PCP.

How many times can I change my/my child’s PCP?
There is no limit on how many times you can change your or your child’s primary care provider. You can change PCPs by calling us toll-free at 1-800-964-2247 or 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 (PCP) change become effective?
A PCP change will become effective the same day that you call us to change it.

Are there any reasons why a request to change a PCP may be denied?
• The PCP you picked is not accepting new patients.
• The PCP you picked is no longer a part of our Health Plan.

Can a clinic be my PCP?
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 PCP?
If you have special health care needs, you have the right to request a specialist as a PCP. 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’s Medical Director must also approve the request.
The Cook Children’s Health Plan Care Management Department can help you start this process.

What if I choose to go to another doctor who is not my PCP?
Except in emergencies, always call your PCP before you go to another doctor or the hospital. You can reach your PCP or back-up doctor 24 hours a day, seven days a week.

How do I get medical care after my PCP office is closed?
If you get sick at night or on a weekend and cannot wait to get medical care, call your PCP for advice. Your PCP or another doctor is ready to help by phone 24 hours a day, 7 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 PCP move me or my child to another PCP for non-compliance?
Yes. A Primary Care Provider can ask that you or your child pick a new PCP if:
- You or your child often misses appointments, and you have not called to let them know.
- You do not follow advice from your / your child’s PCP.

Physician incentive plan information
A physician incentive plan rewards doctors for treatments that reduce or limit services for people covered by Medicaid. 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. If you are 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.

What if I need to see a special doctor (specialist)?
Your primary care provider (PCP) is the only doctor you need for most health care services. If you have a special health problem, they might ask you to see another doctor or have special tests done. This is called a referral.

What is a referral?
Your PCP will arrange for you to see a specialist. This is called a “referral”.

How soon can I expect to be seen by a specialist?
After getting a referral from your PCP, you should be able to see the specialist within three weeks for a routine appointment; within 24 hours for urgent care appointments.
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 (PCP) or not.
You have the right to pick an OB/GYN without a referral from your PCP. 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 cookchp.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 two weeks of contacting your doctor to request a prenatal visit. If you are not pregnant, you should be seen within three 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 Care 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 1-800-862-2247.

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 PCP for my baby before the baby is born?
Yes, we would like you to pick a PCP 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 PCP 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.

Is a referral needed for family planning?
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 http://www.dshs.state.tx.us/famplan/locator.shtml, or you can call Cook Children’s Health Plan at 1-800-964-2247 for help in finding a family planning provider.
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 can I switch my baby’s PCP?
You can change your baby’s PCP 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 PCP.

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.

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.

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/my child is out of the country?
Medical services performed out of the country are not covered by Medicaid.

What if I am/my child is 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 PCP for advice.

What do I have to do if I move?
As soon as you have your new address, give it to the local Health and Human Services Commission benefits office and 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.
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 or STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want, but not more than once a month.

If you are in the hospital, a residential Substance Use Disorder (SUD) treatment facility, or residential detoxification facility for SUD, you will not be able to change health plans until you have been discharged.

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.

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

If the provider does not have someone to interpret for you, call Member Services. We will help find an interpreter.

How far in advance do I need to call?

Call as soon as you make a doctor’s appointment. We need at least a two-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?
If you need a physical checkup, 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 Helpline at 1-866-971-2665 for help with getting the care you need.

How soon can I expect to be seen at an urgent care facility?
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.

What is an emergency medical condition?
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.

What is an emergency behavioral health condition?
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.

What qualifies as emergency services and/or emergency care?
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 in an emergency situation?
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.
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 (PCP). Your PCP 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 six 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.
- Therapy: 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 1 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.

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, 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. Janek, 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 are:

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.
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 drugstore, 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
• Refer to your CHIP provider directory

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. Member Services can be reached 8 a.m. – 5 p.m., Monday – Friday at 1-800-964-2247 or 682-885-2247.

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 pharmacy?
Some durable medical equipment (DME) and products normally found in a pharmacy 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.
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 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.
- All other areas: 1-877-633-8747 (1-877-MED-TRIP).

How and when do I get Texas Health Steps medical and dental checkups for my child?
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 Texas Health Steps 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 1-800-964-2247 and ask for Outreach.

What if I need to cancel a Texas Health Steps appointment?
Call your PCP’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

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 having health problems.

What do case managers do?
• 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?
• Get medical and dental services.
• Get medical supplies or equipment.
• Work on school or education issues.
• Work on other problems.

How can you get a case manager?
Call the Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8 a.m. to 8 p.m.
To learn more, go to: www.dshs.state.tx.us/caseman.
MEDICAL TRANSPORTATION PROGRAM (MTP)

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

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

Who do I call for a ride to a medical appointment?
Call Logisticare if you live in the counties of Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Navarro, Parker, Rockwall, Tarrant and Wise:
• Phone Reservations: 1-855-687-3255
• Phone Ride Help Line: 1-877-564-9834
Hours: LogistiCare takes requests for routine transportation by phone Monday through Friday from 8:00 a.m. to 5:00 p.m. Routine transportation should be scheduled 48 hours (2 business days) before your appointment.

Call MTM if you live in the counties of Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller and Wharton.
• Phone Reservations: 1-855-687-4786
• Where’s My Ride: 1-888-513-0706
Hours: 7:00 a.m. to 6:00 p.m., Monday-Friday/Call (855) MTP-HSTN or (855) 687-4786 at least 48 hours before your visit. If it’s less than 48 hours until your appointment and it’s not urgent, MTM might ask you to set up a different date and time.

Call MTP if you live in another country.
• Phone Reservations: 1-877-633-8742
All requests for transportation services should be made within 2-5 days of your appointment. Exceptions may be authorized in the event of an emergency.

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

You can write a letter that is called an advance directive that tells people what you want to happen if you get very sick. For more information on how to write an advance directive, call Member Services. We can send you forms to fill out that tell others the kind of health care you want if you are too sick to tell them.

What are advance directives?

An advance directive lets you make decisions about your health care before you get too sick. What you decide is put in writing. Then, if you become too sick to make decisions about your health care, your doctor will know what kind of care you do or do not want. The advanced directive can also say who can make decisions for you if you are not able to.

How do I get an advance directive?

You can get forms to write advance directives by calling Member Services. They will help you get the information you need to complete these forms.

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.

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.
How do I get help if I have/my child has behavioral (mental) health or 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 Strategies at 1-855-481-7045. They are there to help you 24-hours a day, seven 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, seven days a week.

How do I get eye care services?

You can get routine eye care by going to a National Vision Administrators (NVA) vision care provider. You will not need a referral from your primary care provider for routine vision care.

How do I get dental services for my child?

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.

Are emergency dental services covered?

Cook Children’s Health Plan covers limited emergency dental services for the following:

- Dislocated jaw.
- Traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment and devices for craniofacial anomalies.
- Drugs for any of the above conditions.

Cook Children’s Health Plan also covers dental services your child gets in a hospital or ambulatory surgical center, including other services your child might need, like anesthesia.

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

During normal business hours, call your child’s dentist to find out how to get emergency services. If your child needs emergency dental services after the dentist’s office has closed, call us toll-free at 1-800-964-2247 or call 911.
What extra benefits does a Cook Children’s Health Plan member get? How can I get these benefits?

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<tr>
<th>Extra benefit</th>
<th>How does it work?</th>
<th>How to get it</th>
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<tbody>
<tr>
<td>Nurse advice line</td>
<td>You can talk to a nurse 24 hours a day, seven days a week. They can answer questions or help you decide what to do about your health needs.</td>
<td>Call 1-866-971-2665</td>
</tr>
<tr>
<td>Obesity reduction</td>
<td>For members ages 10 through age 17 and adults 18 and over. A structured program that includes registration and payment for Weight Watchers classes.</td>
<td>Call Care Management</td>
</tr>
<tr>
<td>Prepared childbirth classes</td>
<td>Up to $100 per program for prepared-childbirth, Lamaze and breastfeeding classes. Classes are limited to one enrollment per program per pregnancy.</td>
<td>Call Care Management</td>
</tr>
<tr>
<td>Diapers</td>
<td>Maximum of $50 reimbursement for diapers for pregnant members who complete 10 prenatal and 1 post-partum visit. Benefit is limited to one reimbursement per pregnancy.</td>
<td>Cook Children’s Health Plan</td>
</tr>
<tr>
<td>Asthma education</td>
<td>Coverage for asthma education classes provided by Cook Children’s Medical Center. Benefit limited to one class per member per year.</td>
<td>Cook Children’s Medical Center</td>
</tr>
<tr>
<td>Over-the-counter drug benefit</td>
<td>Maximum of $25 in reimbursement for FDA-approved over-the-counter medications and first aid supplies such as thermometers, band aids and bandages. Up to $25 in per year for over the counter medications. Send the receipts to us once the total reaches $25 for payment.</td>
<td>Call Member Services</td>
</tr>
<tr>
<td>Prenatal dental benefit</td>
<td>Up to $250 for basic and major dental for members. Does cover under PREG Medicaid (TP40), age 21 and over. Does not include orthodontia or cosmetic services.</td>
<td>Delta Dental providers</td>
</tr>
<tr>
<td>Boys and Girls Club membership</td>
<td>Boys and Girls Club basic membership per family where available for Members ages 6-18. Benefit is limited to one basic membership per family. Benefit is available to children ages 6-18 years of age.</td>
<td>Contact Boys and Girls Clubs</td>
</tr>
<tr>
<td>Increased frame allowance</td>
<td>Members are eligible for either: A $125 allowance on prescription eyeglasses (frame and lenses); or A $75 allowance towards contact lenses, including disposables, and contact lens fitting fees. Replacements are not covered Members are responsible for any charges exceeding the allowance.</td>
<td>Ask your NVA Vision Provider</td>
</tr>
<tr>
<td>School/sports physical</td>
<td>One sports/school physical per calendar year under the age of 19 years.</td>
<td>Call Member Services</td>
</tr>
<tr>
<td>Temporary phone help</td>
<td>Assistance to women enrolled in PREG Medicaid in applying for the Federal Lifeline Program (Assurance Wireless) and provide 500 extra minutes upon registration with Cook Children’s Health Plan Case Management Benefit limited to 500 extra minutes upon registration.</td>
<td>Call Care Management</td>
</tr>
</tbody>
</table>
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 does Cook Children’s Health Plan offer?
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.
- Department of Aging and Disability Services (DADS).
- DARS Division of Blind Services.
- Early Childhood Intervention (ECI).
- Medical transportation service.
- Hospice.
- Dental services for children.
To learn more about these services, call Member Services.

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 & 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 at 1-800-964-2247 to tell us about your problem.

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 can I do if my doctor asks for a service or medicine for me that’s covered but Cook Children’s Health Plan (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 30 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 days after Cook Children’s Health Plan:
• mailed of the notice of the action; or
• the intended effective date of the proposed action.

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 during or after the health plan’s appeals process.

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 for an expedited appeal 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 Care Management.

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 90 days of the date on the health plan’s letter with the decision. If you do not ask for the fair hearing within 90 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 calendar days following the MCO’s mailing of the notice of the action, or (2) the day the health plan’s letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

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. The Health and Human Services Commission will give you a final decision within 90 days from the date you asked for the hearing.
What are my 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.

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.
MEMBER RIGHTS & RESPONSIBILITIES

d. Keep your scheduled appointments.

e. Cancel appointments in advance when you cannot keep them.

f. Always contact your primary care provider first for your non-emergency medical needs.

g. Be sure you have approval from your primary care provider before going to a specialist.

h. Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:

   a. Tell your primary care provider about your health.

   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.

   c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:

   a. Work as a team with your provider in deciding what health care is best for you.

   b. Understand how the things you do can affect your health.

   c. Do the best you can to stay healthy.

   d. Treat providers and staff with respect.

   e. Talk to your provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.
Do you want to report Waste, Abuse or Fraud?
Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

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

To report waste, abuse, or fraud, choose one of the following:
- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
- You can report directly to your health plan:
  Cook Children’s Health Plan
  Attn: 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.

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 reserve the right to get back the cost of medical benefits paid when another party is (or might be) responsible for causing the illness or injury to you. We can ask to get back the cost of medical expenses from you if you get expenses from the other party.
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.

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 2 for more information on these rights and how to exercise them

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 3 for more information on these choices and how to exercise them

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 pages 3 and 4 for more information on these uses and disclosures
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

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.

Run our organization

• 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.

continued on next page
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

Privacy Official: Kathleen Roman; 682-885-2866; kathy.roman@cookchildrens.org
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