STAR+PLUS Nursing Facility

Member Handbook

superior healthplan™

We are ready to help! Call 1-877-277-9772

SuperiorHealthPlan.com

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TEXAS STAR PLUS Your Health Plan ★ Your Choice

TEXAS Health and Human Services

Numbers to Remember

If you have any questions, call us at 1-877-277-9772. Superior's Member Services team will help you. Our staff is available from 8 a.m. to 5 p.m., Monday through Friday, except for state-approved holidays. You can also reach a nurse 24 hours a day, 7 days a week. They can answer your health questions after hours and on weekends. You can call 1-877-277-9772. Our staff is bilingual in English and Spanish. If you speak another language or are deaf/hard of hearing, call Member Services for help.

Superior Member Services	1-877-277-9772
Superior Service Coordination	1-877-277-9772
Texas STAR+PLUS Nursing Facility Program Helpline	1-800-964-2777
Ombudsman Managed Care Assistance Team	1-866-566-8989
24-Hour Nurse Advice Line	1-877-277-9772
Relay Texas/TTY Line (Deaf/Hard of Hearing)	1-800-735-2989
Pharmacy Helpline (Prescription Drugs)	1-877-277-9772
Non-Emergency Ambulance Transportation	1-877-277-9772
Eye Care	1-888-756-8768
Teladoc (Telehealth Services)	1-800-835-2362
Dental Care	1-888-308-4766
Behavioral Health	1-877-277-9772
Alcohol/Drug Crisis Line	1-877-277-9772
Member Connections (Additional Community Services)	1-877-277-9772
Member Advocate	1-877-277-9772

Behavioral Health Services

You can get behavioral health and/or substance use disorder help right away by calling 1-877-277-9772. You can call 24 hours a day, 7 days a week. We will help you find the best provider for you. You should call 911 if you are having a life-threatening behavioral health emergency. You can also go to a crisis center or the nearest emergency room. You do not have to wait for an emergency to get help. Our staff is bilingual in English and Spanish. If you speak another language or are deaf/hard of hearing, call 1-877-277-9772 for help. You can also call 988. The 988 Suicide and Crisis Lifeline provides 24/7, confidential support to people in suicidal crisis or mental health-related distress.

Emergency Care

Call 911 or go to the nearest hospital/emergency facility if you think you need emergency care. You can call 911 for help getting to the hospital emergency room. If you receive emergency services, call your doctor to schedule a follow up visit as soon as possible.

Remember to call Superior at 1-877-277-9772 and let us know about the emergency care you received. Superior defines an emergency as a condition in which you think you have a serious medical condition, or not getting medical care right away will be a threat to your/your child's life, limb or sight.

Service Coordination

Service Coordination is a special kind of care management that is done by a Superior Service Coordinator. All STAR+PLUS Nursing Facility members will be assigned a Service Coordinator. If you have questions about this service, call 1-877-277-9772.

Statement of Non-Discrimination

Superior HealthPlan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Superior does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Superior:

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

If you need these services, contact Superior at the number on the back of your Superior member ID Card. (Relay Texas/TTY: 1-800-735-2989).

If you believe that Superior has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint with:

Superior HealthPlan Complaints Department 5900 E. Ben White Blvd. Austin, TX 78741	**Or**	Call the number on the back of your Superior member ID card. Relay Texas/TTY: 1-800-735-2989 Fax: 1-866-683-5369

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Superior is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

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

Language Assistance

ENGLISH:	Language assistance services, auxiliary aids and services, and other alternative formats are available to you free of charge. To obtain this, call the number on the back of your Superior ID card (TTY: 1-800-735-2989).
SPANISH:	Servicios de asistencia de idiomas, ayudas y servicios auxiliares, y otros formatos alternativos están disponibles para usted sin ningún costo. Para obtener esto, llame al numero al dorso de su tarjeta de identificación Superior (TTY: 1-800-735-2989).

SPANISH:	ATENCIÓN: Si usted habla español, disponemos de servicios lingüísticos gratuitos para usted. Llame al número al dorso de su tarjeta de identificación Superior (TTY: 1-800-735-2989).
VIETNAMESE:	XIN LƯU Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp hoàn toàn miễn phí cho quý vị. Hãy gọi số ở mặt sau trên thẻ ID thành viên Superior của quý vị (TTY: 1-800-735-2989).
CHINESE:	注意：如果您讲中文，可免费获得语言协助服务。请拨打您Superior会员卡背面的电话号码（文本电话：1-800-735-2989）。
KOREAN:	알림: 귀하께서 한국어를 사용하신다면, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Superior 회원 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 1-800-735-2989).
ARABIC:	تنبيه: إذا كنت تتحدث اللغة العربية، فلدينا خدمات معاونة لغوية مجانية من أجلك. اتصل بالرقم الموجود على ظهر بطاقة عضوية Superior الخاصة بك (جهاز الاتصال للصم والبكم: 1-800-735-2989)
URDU:	فرمائیں: اگر آپ اردو زبان بولتے ہیں، تو زبان میں معاونت کی خدمات آپ کو مفت میں دستیاب ہیں۔ اپنے Superior ممبر آئی ڈی کارڈ کی پشت پر موجود نمبر پر کال کریں (ٹی ٹی وائی: 1-800-735-2989)۔
TAGALOG:	BIGYANG-PANSIN: kung nagsasalita ka ng Tagalog, may mga serbisyong pantulong sa wika na libre para sa iyo. Tawagan ang numero sa likod ng iyong ID card ng miyembro ng Superior (TTY: 1-800-735-2989).
FRENCH:	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont offerts gratuitement. Appelez le numéro au dos de votre carte d'identification Superior (ATS : 1-800-735-2989).
HINDI:	ध्यानार्थ: यदि आप हिन्दी बोलत ह, तो भाषा सहायता सवाएं, आपक लिए निःशल्क उपलब्ध ह। आपक Superior सदस्य आईडी काड क पीछ दिए गए नंबर पर कॉल कर (TTY: 1-800-735-2989)।

Language Assistance

PERSIAN:	توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک رسانی زبانی، به صورت رایگان، آماده خدمت رسانی به شما هستند. با شماره واقع در پشت کارت شناسایی عضویت Superior خود (TTY: 1-800-735-2989) تماس بگیرید.
GERMAN:	HINWEIS: Wenn Sie Deutsch sprechen ist kostenlose Unterstützung in Ihrer Landessprache für Sie verfügbar. Rufen Sie die Nummer auf der Rückseite der Superior Mitgliedsausweiskarte an (TTY: 1-800-735-2989).
GUJARATI:	ધ્યાન આપોઃ જો તમે ગુજરાતી, ભાષા બોલતા હો તો સહાયતા સેવા, વિના મૂલ્યે, આપના માટે ઉપલબ્ધ છે. આપના Superior સભ્યપદ આઈડી કાર્ડ પાછળ આપેલા નંબર પર કોલ કરો (TTY: 1-800-735-2989)
RUSSIAN:	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Подзвоніть за номером, вказаним на зворотній стороні Вашої членської картки Superior (номер телетайпу: 1-800-735-2989).
JAPANESE:	お知らせ：日本語でのサポートを無料でご利用いただけます。Superior会員IDカードの裏面に記載の番号（TTY：1-800-735-2989）にお電話ください
LAOTIAN:	ການຸນາໃຫ້ຄວາມສົນໃຈ: ຖ້າທ່ານເວົ້າພາສາ(ລາວ) ບໍຣິການຄວາມຊ່ວຍເຫຼືອພາສາມີໃຫ້ທ່ານໂດຍບໍ່ເສຍເງີນ. ໃຫ້ໂທຫາເລກທີ່ຢູ່ດ້ານຫຼັງຂອງ Superior ບັດຊະມາຊິກທ່ານ (1-800-735-2989)

Table of Contents

Introduction

About Your Health Plan 1
Your Superior Member ID Card 2

Medicaid

Your Texas Benefits Medicaid ID Card 3
Medicaid and Private Insurance 4
Loss of Medicaid Coverage 5
Medicaid Lock-in Program 5

Accessing Care - Primary Care Providers

Your Primary Care Provider 6
Changing Primary Care Providers 6
Doctor Requested/Caused Changes in Primary Care Providers 6
Physician Incentive Plan 6

Accessing Specialty Care

Referrals to Special Doctors 7
Getting Permission for Specialty Medical Services 7
Asking for a Second Opinion 8
Getting Admitted to a Hospital 8

Accessing Care - Just for Women

Getting OB/GYN Care 9
Choosing an OB/GYN 9

Accessing Care - Appointments

Making an Appointment 10
What You Will Need to Bring With You to the Doctor 10
Getting Medical Care After the Doctor's Office is Closed 10
Getting Care When You are Out of Town or Traveling 10
Getting Care if You Move 10

Accessing Care - Changing Health Plans

Changing Health Plans 11
Being Asked to Leave Superior HealthPlan 11

Making Care Easier – Help to Access Health Care

Interpreter Services 12
Transportation Services 12
Telehealth Services 13
Secure Member Portal 14
Digital Health Records 14

Care Defined

Routine Medical Care 16

Table of Contents

Urgent Medical Care 16
Emergency Medical Care 16
Post-Stabilization Care 17
Care Defined 18
Medical Necessity 20

Benefits and Services

Your Benefits 21
Services Limits 21
Services Not Covered 22
Long Term Services and Supports (LTSS) 22
Consumer Directed Services (CDS) 23

Special Services

Behavioral Health (Mental Health and Chemical Dependency)

Behavioral Health Services 25
Getting Help for Behavioral Health and Drug Problems 25
How to Know if You Need Help 25
What to Do in a Behavioral Health Emergency 25
What to Do if You Are Already in Treatment 25
Bonus Behavioral Health Services 26
Collaborative Care Model 27

Service Coordination 27
Eye Care 28
Dental Care 28
Emergency Dental Care 28
Help for Special Health Care Needs 29
Care Management 29
Disease Management 30
Asthma Program 30
Diabetes Program 30
Heart Disease Program 30
COPD Program 31
Congestive Heart Failure Program 31
Depression Program 32
Bipolar Disorder and Schizophrenia Programs 32
Substance Use Disorder Program 32
Pregnancy Substance Use Program 33

Family Planning

How to Get Family Planning Services 34

Table of Contents

Finding a Family Planning Provider 34

Pharmacy Services

Getting Prescriptions 35

Extra Benefits and Services

Extra Benefits for Superior Members 37
Help to Understand Your Benefits 38
New Treatments to Serve You 38
Health Education 38

Advance Directives

What to Do if You are Too Sick to Make a Medical Decision 40

Member Billings

What to Do if You Get a Bill from the Doctor 41

Getting Help with Benefits and Services

Making a Complaint 42
Getting Help to File a Complaint 42
Denied or Limited Services 43
Asking for an Internal Health Plan Appeal 43
Getting Help to File an Internal Health Plan Appeal 43
Timeframes for the Appeals Process 43
Continue Current Authorized Services 44
Emergency Appeals 44
External Appeals 45
External Medical Reviews 45
State Fair Hearings 46

Rights and Responsibilities

Member Rights 49
Member Responsibilities 50
Information Available to Members 51
Confidentiality 52

Notice of Privacy Practices 53

Electronic Visit Verification (EVV) Rights and Responsibilities 59

Reporting Abuse, Neglect and Exploitation 65

Fraud, Waste and Abuse

Reporting Fraud and Abuse by a Provider 66
Reporting Fraud and Abuse by a Medicaid Recipient 66

Glossary of Terms 67

Introduction

About

Superior HealthPlan is a Managed Care Organization (MCO) that offers health care for Texans in the STAR+PLUS Nursing Facility program. Superior works with Texas Health and Human Services (HHS) and with many doctors, clinics and hospitals to give you the care you need.

You will get all medically necessary health care while living in a nursing facility that are in Superior's network of providers.

Superior has providers for you when your doctor or Primary Care Provider (PCP) sends you to a hospital, lab or specialist.

You must use a Superior provider to get your health services.

You will get a Superior Member ID card. It will have your doctor's name and office phone number. Carry this ID card and your Medicaid ID card with you all the time.

If you do not understand the member handbook or need help reading it, call Superior Member Services at 1-877-277-9772. We can tell you how to use our services and will answer your questions. You can get this handbook in English, Spanish, audio, larger print, Braille, CD or in other language formats if you need it.

Your health plan information is available online at www.SuperiorHealthPlan.com. You can also request printed copies of this information from Member Services. To learn more, call Superior Member Services at 1-877-277-9772.

Remember:

- Carry your Medicaid ID card and Superior Member ID card with you at all times.
- Choose a PCP that is able to provide care in your nursing facility.
- We are here to help you 24 hours a day, 7 days a week.

Thank you for choosing Superior HealthPlan!

Stay Connected with Superior's Member Portal

Superior's member web portal is a convenient and secure tool to help you manage your health care. By creating a free account, you can:

- View your health history.
- Print a temporary ID card.
- Review your health benefits.

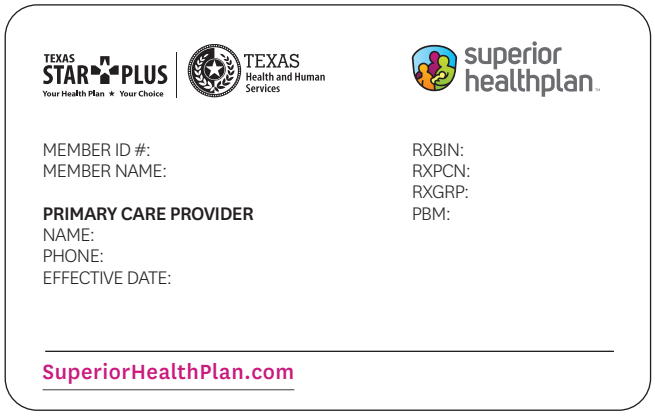
Visit www.SuperiorHealthPlan.com and click on "For Members." Then, click "Login".

Introduction

Your Superior Member ID card

You should receive your Superior HealthPlan ID card in the mail as soon as you are enrolled with Superior. Here's what the front and back of the Superior Member ID card looks like. If you did not get this card, please call Superior at 1-877-277-9772.

Superior HealthPlan STAR+PLUS Nursing Facility ID Card



Always carry your Superior Member ID card with you to get the care you need. They will need the facts on the card to know that you are a Superior member. Do not let anyone else use your Superior Member ID card.

Your Superior Member ID card is in English and Spanish and has:

- Member's name.
- Member's ID number.
- Doctor's name and phone number.
- 24 hours a day/7 days a week toll-free number for Superior Member Services.
- 24 hours a day/7 days a week toll-free number for Behavioral Health Services.
- Directions on what to do in an emergency.

If you lose your Superior Member ID card, change your name or need to pick a new doctor or PCP call Superior at 1-877-277-9772. You will get a new ID card. You can also login to the member portal and print a temporary ID card. From the member portal you can save a digital version of your ID card or request ID card by mail as well.

Your health plan information is available on line at www.SuperiorHealthPlan.com. You can also request printed copies of this information from Member Services.

Texas Health and Human Services (HHS) will send your Medicaid ID card. If you have not received your Medicaid ID card, call HHS at 1-800-252-8263.

If you are dual eligible, (you get both Medicaid and Medicare), your ID card will not show your doctor's name and phone number. That is because you will be able to go to your Medicare doctor. Your ID card will say "Long term services and supports only." We will explain long term care services in this handbook.

Medicaid

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 you 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.YourTexasBenefits.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 program you're in if you get:
  - Medicare (QMB, MQMB)
  - Healthy Texas Women Program (HTW)
  - Hospice
  - STAR+PLUS
  - 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.

The YourTexasBenefits.com Medicaid Client Portal

The Medicaid Client Portal lets you do all of the following for anyone who is part of your case:

- View, print and order a Your Texas Benefits Medicaid card
- See your medical and dental plans
- See your benefit information
- See Texas Health Steps alerts
- See broadcast alerts
- See diagnoses and treatments
- See vaccines

Medicaid

- See prescription medicines
- Choose whether to let Medicaid doctors and staff see your available medical and dental information

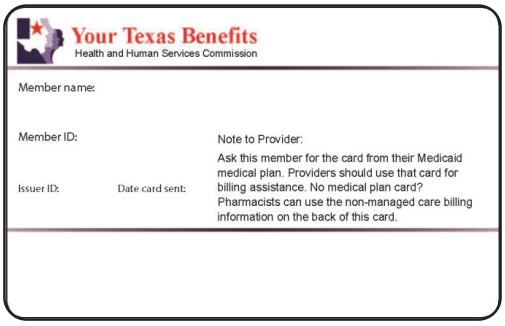
To access the portal, go to www.YourTexasBenefits.com.

- 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. Legally Authorized Representatives can view anyone who is a part of their case.

If you lose the Your Texas Benefits Medicaid ID card, you can get a new one by calling toll-free at 1-800-252-8263. They will provide you with a temporary form called a Temporary Verification Form – Form 1027-A. You can use this form until you receive another card.

Remember: You must carry your Superior member ID card and your Medicaid ID card at all times.



Medicaid and Private Insurance

What if I have other insurance in addition to Medicaid?

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

- Your 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.

Medicaid

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 (PCP) you had before.

What is the Medicaid Lock-in Program?

You may be placed 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 placed 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 that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more call Superior at 1-877-277-9772.

Accessing Care - Primary Care Providers

What is a Primary Care Provider?

When you signed up with Superior, you or your nursing facility picked a doctor from our list of providers to be your Primary Care Provider (PCP). This person will:

- Make sure that you get the right care.
- Give you regular checkups.
- Write prescriptions for medicines and supplies when you are sick.
- Tell you if you need to see a specialist.

Will I be assigned a doctor if I have Medicare?

If you are dual eligible, Medicare pays your doctor. That means you do not need to choose a PCP in STAR+PLUS. You can keep seeing the Medicare doctor you have been seeing for your health care.

How can I change my PCP?

If you are not happy with your doctor, talk to them. If you still are not happy, call your Superior Service Coordinator at 1-877-277-9772. They can help you pick a new doctor.

When will a PCP change become effective?

Once you have changed your doctor, you will get a new Superior Member ID card with their name and office phone number. This change will be effective the month after you ask. Sometimes, depending on the circumstances, we may be able to change your doctor right away.

How do I see my PCP if he or she does not visit my nursing home?

Your nursing facility will provide you with transportation to and from your appointments if you need to leave the facility. A Service Coordinator can also assist you if you need assistance with transportation.

What if my doctor leaves the network of Superior providers?

If your doctor decides he/she no longer wants to participate in the network of Superior providers, and that doctor is treating you for an illness, Superior will work with your doctor to keep caring for you until your medical records can be transferred to a new doctor in the Superior network of providers.

If your doctor leaves your area, call Superior at 1-877-277-9772 and they will help you pick another doctor close to you. You will also get a letter from Superior telling you when your doctor's last day as a Superior network provider will be and asking you to call Superior so we can help you pick a new doctor.

Where can I find a list of Superior providers?

The Superior HealthPlan provider directory is a list of Medicaid and Medicare PCPs, physicians, hospitals, drug stores and other health-care providers that are available to you. You may find this list at www.SuperiorHealthPlan.com. Just click on "Find a Provider." If you need assistance, call Superior at 1-877-277-9772.

Physician Incentive Plan

A physician incentive plan rewards doctors for treatments that are cost-effective for people covered by Medicaid. You have the right to know if your PCP (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call 1-877-277-9772 to learn more about this.

Accessing Specialty Care

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

Your doctor might want you to see a special doctor (specialist) for certain health-care needs. While your doctor can take care of most of your health-care needs, sometimes they will want you to see a specialist for your care. A specialist has received training and has more experience taking care of certain diseases, illnesses and injuries. Superior has many specialists who will work with you and your doctor to care for your needs.

If you are dual eligible, you can continue to see the Medicare specialist(s) of your choice.

What is a referral?

The doctor will talk to you about your needs and will help make plans for you to see the specialist that can provide the best care for you. This is called a referral. Since your nursing facility will help manage your care, you don't need a referral for your needed services.

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

In some situations, the specialist may see you right away. Depending on the medical need, it may take up to a few weeks after you make the appointment to see the specialist.

Does Superior need to approve the referral for specialty medical services?

Some specialist referrals may need approval from Superior to make sure the specialist is a Superior specialist, and the visit to the specialist or the specialty procedure is needed. In these cases, the doctor must first call Superior. If you or your doctor are not sure what specialty services need approval, Superior can give you that information. Superior will review the request for specialty services and respond with a decision.

What is prior authorization? How do I learn more?

Some medical services require approval from Superior. This is called prior authorization. You can learn more about what services require prior authorization by visiting www.SuperiorHealthPlan.com. Click on "Medicaid & CHIP Plans" and "Member Resources." You can also call Member Services at 1-877-277-9772. Our staff is available from 8 a.m. to 5 p.m., Monday through Friday, except for state-approved holidays.

Accessing Specialty Care

How do I ask for a second opinion?

You have the right to a second opinion from a Superior provider if you are not satisfied with the plan of care offered by the specialist. Your PCP should be able to give you a referral for a second opinion visit. If your doctor wants you to see a specialist that is not a Superior provider, that visit will have to be approved by Superior.

What if I need to be admitted to a hospital?

If you need to be admitted to a hospital for inpatient hospital care, your doctor must call Superior to let us know about the admission.

If you are dual eligible, you must follow rules for your Medicare plan for hospital admissions.

Superior will follow your care while in the hospital to ensure that you get the proper care. The discharge date from the hospital will be based only on medical need to remain in the hospital. When medical needs no longer require hospital services, Superior and your doctor will set a hospital discharge date.

If you or your doctor do not agree with a decision to discharge you from the hospital, you have the right to ask for a review of the decision. This is called an appeal. Your appeal rights are also described in this handbook in the appeals section.

If you have an admission through the emergency room:

If you need urgent or emergency admission to the hospital, you should get medical care right away. Your nursing facility will notify Superior as soon as possible to tell us of the admission.

Superior Health Tip

Use the spoon, cup, or dropper included with your liquid medicine to make sure you get the right dose.

Accessing Care - Just for Women

What if I need OB/GYN care?

You can get OB/GYN services from your doctor. You can also pick an OB/GYN specialist to take care of your female health needs. An OB/GYN can help with pregnancy care, yearly checkups or if you have female health concerns. You do not need a referral from a doctor for these services. Your OB/GYN and doctor will work together to make sure you get the best care. Women's health specialists include, but are not limited to:

- Obstetricians
- Gynecologists
- Certified Nurse Midwives

Do I have the right to choose an OB/GYN as my Primary Care Provider? Will I need a referral?

Superior has some OB/GYN providers that can be your Primary Care Provider (PCP). If you need help picking an OB/GYN, call Superior at 1-877-277-9772.

Attention Female Members

Superior allows you to pick any OB/GYN, whether that doctor is in the same network as your PCP or not. You have the right to pick an OB/GYN without a referral from your PCP. OB/GYN services include, but not limited to:

- One well-woman checkup each year. (Breast exams, mammograms, pap tests)
- Care for any female medical condition.
- Care related to pregnancy.
- Referrals to a special doctor within the network.

How do I choose an OB/GYN?

You may pick an OB/GYN provider from the list in the Superior provider directory on Superior's website at www.SuperiorHealthPlan.com. Just click on "Find a Provider." Superior allows you to pick an OB/GYN, whether or not that doctor is in the same group at your PCP. If you need help picking an OB/GYN, call Superior at 1-877-277-9772. If you are pregnant, your OB/GYN should see you within two (2) weeks of your request. Once you choose an OB/GYN, you should go to the same OB/GYN for each visit so they will get to know your health-care needs.

If I don't choose an OB/GYN as my PCP, do I have direct access?

If you do not choose an OB/GYN as your main doctor, you can still get most services from a Superior OB/GYN without calling your doctor, or getting approval from Superior. All family planning services, OB care and routine GYN services and procedures can be accessed directly through the Superior OB/GYN you choose.

Can I stay with an OB/GYN who is not with Superior?

If your/your daughter's OB/GYN is not with Superior, please call Member Services at 1-877-277-9772. We will work with your doctor so he or she can keep seeing you, or we will be more than happy to help you pick a new doctor within the plan.

How soon can I be seen after contacting my OB/GYN for an appointment?

If you are pregnant, the doctor should see you within two (2) weeks of your request for an appointment.

Accessing Care - Appointments

How do I make an appointment?

You can call your doctor's office to make an appointment. If you need help making an appointment or if you need help with transportation, an interpreter or other services, call Superior at 1-877-277-9772.

Please keep your appointment. If you cannot keep your appointment, let the office know as soon as you can. This will give them time to put another patient in that appointment time.

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

If you are visiting a doctor outside the nursing facility, you must take your current Medicaid ID card and your Superior Member ID card with you when you get any health-care services. You will need to show your Medicaid ID card and Superior Member ID card each time.

How do I get medical care after the doctor's office is closed?

If your doctor's office is closed, your doctor will have a number you can call 24 hours a day and on weekends. Your doctor can tell you what you need to do if you are not feeling well. If you cannot reach your doctor or want to talk to someone while you wait for your doctor to call you back, call Superior's nurse advice line at 1-877-277-9772. Our nurses are ready to help you 24 hours a day, 7 days a week. You can also call Teladoc for non-emergency medical issues when your PCP's office is closed. Teladoc is open 24 hours a day, 7 days a week at 1-800-835-2362. Or visit teladoc.com/Superior. If you think you have a real emergency, call 911 or go to the nearest emergency room.

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

If you need medical care when traveling, call us toll-free at 1-877-277-9772 and we will help you find a doctor. If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at 1-877-277-9772.

What if I am out of state?

If you have an emergency out of state, go to the nearest emergency room for care. If you get sick and need medical care while you are out of state, call your Superior doctor or clinic. Your doctor can tell you what you need to do if you are not feeling well. If you visit a doctor or clinic out of state, they must be enrolled in Texas Medicaid to get paid. Please show your Texas Medicaid ID card and Superior Member ID card before you are seen. Have the doctor call Superior for an authorization number. The phone number to call is on the back of your Superior Member ID card.

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 HHS benefits office by calling 2-1-1 and call Superior HealthPlan Member Services at 1-877-277-9772. Before you get Medicaid services in your new area, you must call Superior, unless you need emergency services. You will continue to get care through Superior until HHS changes your address.

Accessing Care - Changing Health Plans

What if I want to change health plans? Who do I call?

You can change your health plan by calling the Texas STAR+PLUS Nursing Facility 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 a residential detoxification facility for SUD, you will not be able to change health plans until you have been discharged.

How many times can I change health plans? When will my health plan change become effective?

You can change health plans as many times as you want, but not more than once a month. 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 June 1.

Can Superior HealthPlan ask that I get dropped from their health plan (for non-compliance, etc.)?

Yes. Superior might ask that a member be taken out of the plan for "good cause." "Good Cause" could be, but is not limited to:

- Fraud or abuse by a member.
- Threats or physical acts leading to harming of Superior staff or provider.
- Making threats or mistreating a staff person.
- Sending digital communication that is inappropriate, threatening or graphic.
- Theft.
- Letting someone use your ID card.
- Repeatedly missing appointments.

Superior will not ask you to leave the program without trying to work with you. If you have any questions about this process, call Superior at 1-877-277-9772. Texas Health and Human Services (HHS) will decide if a member can be told to leave the program.

Superior Health Tip

If you are having trouble managing your care, Superior has Service Coordinators that can help. Just call Service Coordination at 1-877-277-9772 for help.

Making Care Easier - Help to Access Health Care

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

Superior has staff that speak English and Spanish. If you speak another language or are deaf/hard of hearing and need help, please call Member Services at 1-877-277-9772 (TTY 1-800-735-2989).

You can also call Member Services at 1-877-277-9772 if you need someone to go to a doctor's visit with you to help you understand the language. Superior works closely with companies that have lots of people who speak different languages and can serve as sign language interpreters.

How far in advance do I need to call? How can I get a face-to-face interpreter in the provider's office?

Member Services will help you set up the doctor's visit. They will get someone to go to the visit with you. Superior recommends you call at least two (2) Business Days (48 hours) before your visit to coordinate for a face-to-face interpreter.

Superior Transportation Services for Nursing Facility Residents

What transportation services are offered?

The nursing facility is responsible for providing routine non-emergency transportation services. If medically necessary, Superior provides non-emergency ambulance transportation for members who require this service. Superior HealthPlan's Medical Ride Program is available to members in the nursing facility that need a ride to their dialysis appointment.

How do I get these services?

To get non-emergency ambulance transportation, your provider must contact Superior to request authorization for these services.

To request transportation to dialysis appointments you can call SafeRide provided by Superior HealthPlan toll-free at 1-855-932-2318.

SafeRide's transportation specialists are available to take requests by telephone on weekdays from 8:00 a.m. to 6:00 p.m. Central Standard Time (CST).

SafeRide requires at least two (2) Business Day's advance notice for most requests, but will attempt to accommodate urgent requests. Members should call in their request as far in advance as possible.

Who do I call for a ride to a medical appointment?

If you need a ride to an appointment, call Superior Member Services at 1-877-277-9772.

Making Care Easier - Help to Access Health Care

Telehealth Services

What are Telehealth Services?

Telehealth services are virtual health-care visits with a provider through a mobile app, online video or telephone. Most providers in Superior's network can offer telehealth services for certain health-care needs. Ask your provider if they offer telehealth services. Superior members can access doctors as needed by phone and/or video for non-emergency medical issues. You can receive medical advice, a diagnosis and a prescription when appropriate.

Superior treats telehealth services with in-network providers in the same way as face-to-face visits with in-network providers.

- A telehealth visit with an in-network Superior provider does not require prior authorization.
- A telehealth visit with an in-network Superior provider is subject to the same co-payments, co-insurance and deductible amounts as an in-person visit with an in-network provider.

Telehealth and telemedicine services from are available to you when your PCP's office is closed. You can receive medical help for illnesses such as:

- Colds, flu and fever
- Sinuses, allergies
- Respiratory infections
- Pink eye
- Rash, skin conditions
- Behavioral Health*

With telehealth services, you can make an appointment for a time that works with your schedule. Use the information below to get started:

1. Most providers in Superior's network can offer telehealth services for certain health-care needs. Ask your provider if they offer telehealth services.
2. For 24/7 help, you can sign up and activate your Teladoc account by visiting Teladoc.com/Superior or calling 1-800-835-2362 (TTY: 711).

*Behavioral Health telehealth services are currently only offered through Teladoc. Behavioral Health services through Teladoc are only available to Superior members 18 years and older at this time.

Making Care Easier - Help to Access Health Care

Secure Member Portal

What is the Secure Member Portal?

We want you to get the most from your health insurance. Superior's Secure Member Portal is a convenient and secure tool to help you manage your health care. You are able to use and view your account wherever you are on a computer or your smartphone.

To create your member account please visit Member.SuperiorHealthPlan.com.

All you need to register is:

- Your date of birth and
- Your member ID number (found on your Superior ID card).

By creating a free account, you can:

- Check your eligibility.
- Find a provider.
- Change your Primary Care Provider (PCP).
- Check your rewards balance.
- Keep your profile current, and more.

A digital version of your ID card is also available from the Secure Member Portal to access at any time. You can show your digital ID card when you see the doctor* and use your coverage. There is no more waiting for your printed card (or a replacement) to come in the mail. The digital ID card:

- Is easy to download.
- Can be saved on your smartphone:
  - Android: save to camera roll
  - iPhone: save to mobile wallet
- Can be viewed through your account or you can print a copy.

Visit Member.SuperiorHealthPlan.com to explore these new features.

*__Note__: Be sure to talk with your doctor to confirm they will accept your digital ID card.

Digital Health Records

What are My Options for Managing My Digital Health Records?

In 2021, a new federal rule made it easier for Superior members* to manage their digital medical records. This rule is called the Interoperability and Patient Access rule (CMS-9115-F) and makes it easier to get your health records when you need it most.

You now have full access to your health records on your mobile device. This allows you to manage your health

Making Care Easier - Help to Access Health Care

better and know what resources are available to you.

*Beginning in 2022, the Payer-to-Payer Data Exchange portion of this rule will allow former and current members to request that their health records go with them as they switch health plans. For more information about this rule, visit the Payer-to-Payer Data Exchange section found on this webpage.

The New Rule Makes it Easy to Find Information** on:

- Claims (paid and denied)
- Pharmacy drug coverage
- Specific parts of your clinical information
- Health-care providers

**You can get information for dates of service on or after January 1, 2016.

For more information, please visit https://www.superiorhealthplan.com/members/medicaid/resources/interoperability-and-patient-access.html.

Helpful Information

To help you get and stay well, visit our helpful forms and links webpage: https://www.superiorhealthplan.com/members/medicaid/resources/helpful-links.html.

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 will see you within two (2) weeks (sooner if they can).

You must see a Superior provider for routine and urgent care. You can always call Superior at 1-877-277-9772 if you need help picking a Superior provider.

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

What should I do if 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 Superior Medicaid. For help, call us toll-free at 1-877-277-9772.

If your PCP's office is closed, you can also call Teladoc for non-emergency medical issues. Teladoc is open 24 hours a day, 7 days a week at 1-800-835-2362. Or visit teladoc.com/Superior.

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 Superior Medicaid.

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

Emergency medical care is provided for emergency medical conditions and emergency behavioral health conditions. Emergency wait time will be based on your medical needs and determined by the emergency facility that is treating you.

What is an emergency, emergency medical condition, and an emergency behavioral health condition?

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

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Care Defined

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

- Requires immediate intervention and/or medical attention without which the member would present an immediate danger to themselves or others.
- Which renders the member incapable of controlling, knowing or understanding the consequences of their actions.

What are emergency services or emergency care?

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 and/or emergency behavioral health condition, including post-stabilization care services.

Do I need prior authorization?

You do not need prior authorization from your Primary Care Provider (PCP) for emergency medical care.

What is post-stabilization care?

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

Helpful Information

If you have diabetes, try to get your HbA1c under 7%. Need more information about managing your diabetes? Call Superior at 1-877-277-9772.

Care Defined

Where should I go for care?

When you get sick or hurt, you have several options to get the care you need. Use our "Find a Provider" tool at SuperiorHealthPlan.com to locate a doctor in Superior's network or call Member Services at 1-877-277-9772.

Do you need to see your Primary Care Provider (PCP)?

Your PCP is your main doctor. Call the office to schedule a visit if you don't need immediate medical care.

See your PCP if you need:

- Help with colds, flus and fevers
- Care for ongoing health issues like asthma or diabetes
- An annual wellness exam
- Vaccinations
- General advice about your overall health

Do you need to see your psychiatrist?

Your psychiatrist is your primary behavioral health doctor. Call the office to schedule a visit if you don't need immediate psychiatric care.

See your psychiatrist if you:

- Have changes in mood that last more than 3 days
- Have changes in sleep pattern
- Need medication refills

If you have thoughts of harming yourself or others, call 911 or go to the Emergency Room (ER).

Do You Need To Call Our 24/7 Nurse Advice Line?

Our 24/7 nurse advice line is a free health information phone line. Nurses are available to answer questions about your health and get help for you.

Contact our 24/7 nurse advice line if you need:

- Help knowing if you should see your PCP or psychiatrist
- Help caring for a sick child
- Answers to questions about your physical health or behavioral health

Do you need to call Telehealth?

Telehealth offers convenient, 24-hour access to in-network health-care providers for non-emergency health issues. You can get medical advice, a diagnosis or a prescription by phone or video. Use Telehealth anytime or schedule an appointment wherever and whenever you need it.

Contact Telehealth for illnesses such as:

- Sinus problems and allergies
- Colds, the flu and fevers
- Upper respiratory infections
- Rash and skin problems

Do you need to go to an urgent care center?

If you cannot wait for an appointment with your PCP, an urgent care center can give you fast, hands-on care for more immediate health issues. Go to an in-network urgent care center if you have an injury or illness that must be treated within 24 hours.

Visit your nearest urgent care for:

- Sprains
- Ear infections
- High fevers
- Flu symptoms with vomiting

Urgent care centers can offer shorter wait times than the Emergency Room (ER).

Do you need to go to the Emergency Room (ER)?

Go to the ER if your illness or injury is life-threatening. Call 911 right away if you have an emergency or go to the nearest hospital.

Immediately go to an ER if you have:

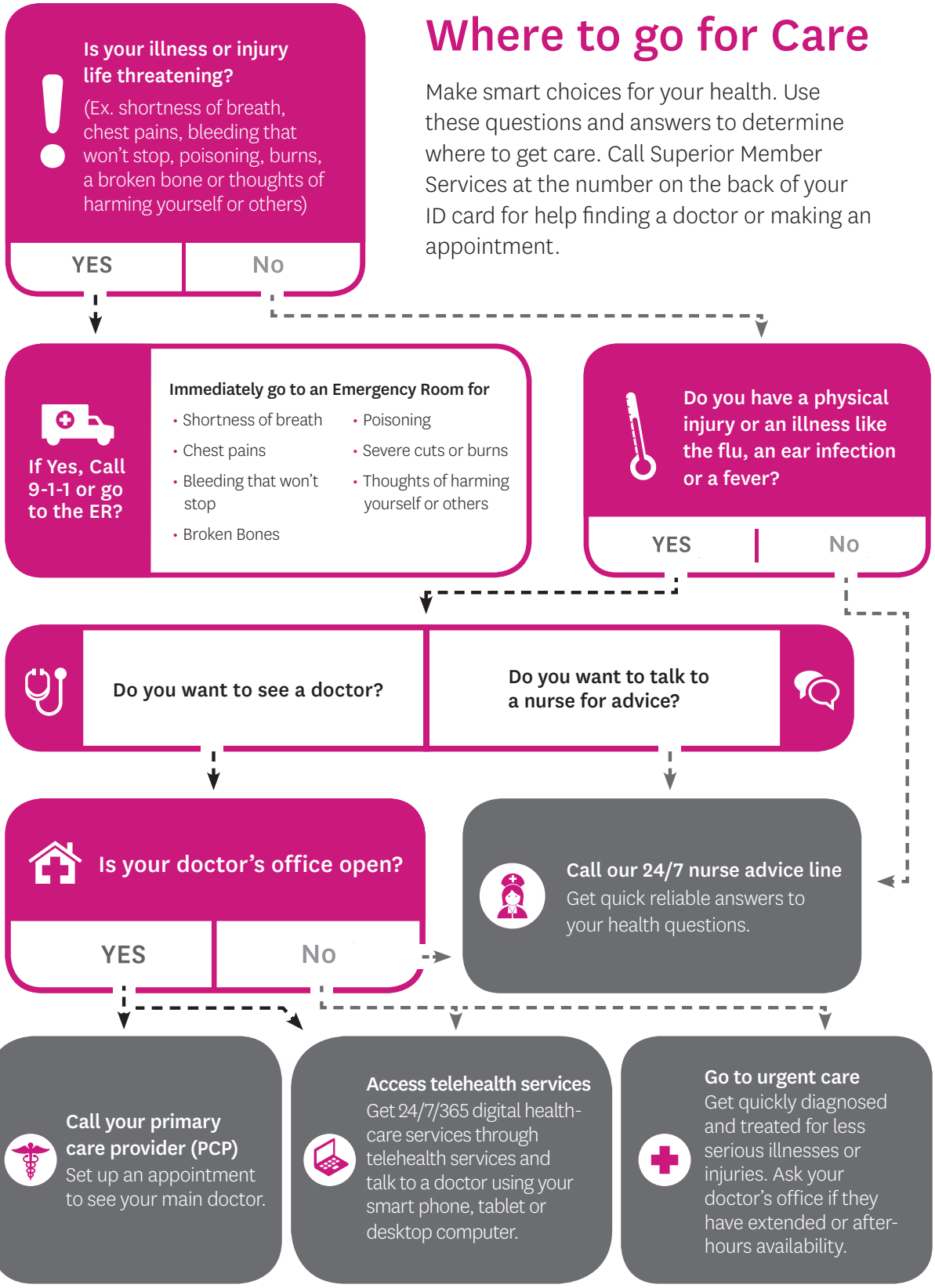
- Chest pains
- Bleeding that won't stop
- Shortness of breath
- Broken bones
- Poisoning
- Severe cuts or burns
- Thoughts of harming yourself or others

Remember to bring your member ID card and Medicaid ID card with you when you see your PCP, visit an urgent care center or go to the ER.

Care Defined

Where to go for Care

Make smart choices for your health. Use these questions and answers to determine where to get care. Call Superior Member Services at the number on the back of your ID card for help finding a doctor or making an appointment.



Care Defined

What does medically necessary mean?

Covered services for STAR+PLUS Nursing Facility members must meet the STAR+PLUS Nursing Facility definition of "medically necessary."

Medically necessary means:

(1) For members age 21 and over, 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

(2) For members age 21 and over, 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.

Superior will determine medical necessity for nursing facility add-on services and acute care services only. Nursing facility add-on services include, but are not limited to emergency dental services, customized power wheel chairs and audio communication devices.

Benefits and Services

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

Many benefits are covered for members who live in a nursing facility. These include basic health services (acute care) and long-term care services. Residents who get Medicaid and Medicare (dual eligibles) will get their basic health services through Medicare and their long-term services through STAR+PLUS Medicaid.

Are there any limits to any covered services?

Some Medicaid services for adults (21 years and older) do have limits, such as inpatient behavioral health care, home health services and therapy services. If you have questions about limits on any covered services, ask your doctor, or call Superior at 1-877-277-9772. We will tell you if a covered service has a limit.

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

Your doctor will work with you to make sure you get the services you need. These services must be given by your doctor or referred by your doctor to another provider. Here is a list of some of the medical services you can get from Superior:

- A once a year well check up for patients 21 years and over
- Ambulance services
- Audiology services (including hearing aids)
- Behavioral health services
- Birthing center services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Family planning services
- Home health-care services (requires a referral)
- Laboratory
- Medical checkups
- Nursing facility care
- Optometry, glasses, and contact lenses if medically necessary
- Podiatry services
- Prenatal care
- Prescription medications
- Primary care services
- Radiology, imaging and x-rays
- Specialty doctor services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Unlimited prescriptions
- Vision services

In addition, there are other services you can get through Medicaid including:

- Transportation to doctor visits
- Women, Infants and Children (WIC) services

All of these health-care benefits are called “acute care” benefits. That means they are for when you are sick or trying to keep from becoming sick. Acute care benefits are things like doctors, hospitals and labs. You use them for medical or mental health care.

Remember: If you are dual eligible, these health-care benefits are covered by Medicare. You can still go to your Medicare doctor for the services you need.

What number do I call to find out more about these services?

To learn more about your acute care benefits, call Superior at 1-877-277-9772.

Benefits and Services

What services are not covered by STAR+PLUS Nursing Facility?

The following is a list of some of the services not covered by the STAR+PLUS Nursing Facility program or Superior:

- Services or items only for cosmetic purposes.
- Items for personal cleanliness and grooming.
- Services decided to be experimental or for research.
- Gender-affirming surgery.
- Services not approved by the Primary Care Provider (PCP), unless the PCP approval is not needed (i.e. family planning, Texas Health Steps and behavioral health).
- Care that is not medically necessary.
- Abortions except as allowed by state law.
- Infertility services.

You will be held responsible for non-Medicaid covered services. It is your responsibility to determine which services are covered or not.

Remember: If you have any questions on what is or what is not a covered service, please call Superior Member Services at 1-877-277-9772.

What services can I still get through Medicaid but are not covered by Superior?

- Preadmission Screening and Resident Review (PASRR) - PASRR is a federal requirement to help determine whether an individual is not inappropriately placed in a nursing home for long-term care.
- Hospice Program - This program provides members who are terminally ill with care to relieve pain or other medical problems.

What are Long-Term Services and Support (LTSS)?

Long-term care services are benefits that help you stay safe and independent in your home or community. Long-term care services help you with functional needs like bathing, dressing, taking medicine or preparing meals. They are just as important as acute care services. Superior offers direct access to specialists that are right for your conditions and needs. You do not need a referral from a doctor for these services. To get these services, call Member Services at 1-877-277-9772.

What are my Nursing Facility LTSS benefits?

If you choose to leave the nursing facility and live in a community setting, there are two long-term care benefits that all eligible Superior members can get:

- Personal Attendant Services (PAS)
- Day Activity and Health Services (DAHS)

What options do I get to choose from when my services can be self-directed?

For each service that has the option to be self-directed, you must choose one of the below. You may choose a different option for each of these services or the same option for all of them. If you need help choosing, your Service Coordinator is here to help you.

Benefits and Services

Consumer Directed Services

Consumer Directed Services (CDS) gives you a way that you can have more choice and control over some of the long-term support services you get. As a STAR+PLUS member, you can choose the CDS option if you decide to move back into your community.

With CDS you can:

- Find, screen, hire and fire (if needed) the people who provide services to you (your staff)
- Train and direct your staff

These are the services you can manage in CDS:

- Attendant Care
- CFC Habilitation
- CFC Personal Assistance Services
- Cognitive Rehabilitation Therapy
- Employment Assistance
- Nursing
- Occupational Therapy
- Physical Therapy
- Respite Care
- Speech Therapy
- Support Consultation
- Supported Employment

If you choose to be in CDS, you will contract with a Financial Management Services Agency (FMSA). The FMSA will help you get started and give you training and support if you need it. The FMSA will do your payroll and file your taxes.

Contact your Service Coordinator to find out more about CDS. You can call our Service Coordination team at 1-877-277-9772.

Service Responsibility Option

In the service responsibility option (SRO), you or your legally authorized representative must choose an in-network agency who is the employer of record. You would then select your personal attendant, nurse or therapist from the agency's employees. You provide input when setting up the schedule and manage the services. You are also able to supervise and train your staff. You can request a different personal attendant, nurse or therapist. The agency will help you with this request. The agency establishes the payment rate and benefits. They also provide payroll, substitute (back-up) and file tax reports. These are the services that can be managed in SRO:

- CFC Personal Assistance Services
- CFC Habilitation
- Personal Assistance Services
- Respite Care

Agency Option

In the agency model, you or your legally authorized representative choose an agency to hire, manage and fire (if needed) the person providing services. You must pick an in-network agency. You and your Service Coordinator will set up a schedule and send it to the agency you chose. You are able to supervise and train your staff. You can request a different personal attendant. The agency will help you with this request. The agency establishes the payment rate and benefits. They also provide payroll, substitute (back-up) and file tax reports.

How do I get these benefits? What number do I call to get these services?

Superior is committed to helping our members find the appropriate care. If you have any questions about long-term care services, please call us at 1-877-277-9772.

Benefits and Services

How would my benefits change if I move into the community?

There will not be any changes to your benefits. Your basic health-care benefits will be covered by Superior whether or not you live in a nursing facility.

More Services For Your Health

Superior members can get bonus benefits in addition to their regular benefits. These are called Value-added Services. Find out what you may be able to get on page 37.

Special Services

Behavioral Health Services

How do I get help if I have mental health, alcohol or drug problems, or if I have behavioral health issues?

Behavioral health refers to mental health and substance use disorder (alcohol and drug) treatment. Sometimes talking to friends or family can help you work out a problem. When that is not enough, you should call your doctor or Superior's behavioral health-care team. We have a group of mental health and substance use disorder specialists to help you.

Do I need a referral?

You do not have to get a referral from your doctor for these services. Superior will help you find the best provider for you. Call 1-877-277-9772 to get help right away, 24 hours a day, 7 days a week.

How do I know if I need help?

Help might be needed if you:

- Can't cope with daily life.
- Feel very sad, stressed or worried.
- Are not sleeping or eating well.
- Want to hurt yourself or others or have thoughts about hurting yourself.
- Are troubled by strange thoughts (such as hearing voices).
- Are drinking or using other substances more.
- Are having problems at work or at home.
- Seem to be having problems at school.

When you have a mental health or substance use disorder problem, it is important for you to work with someone who knows you. We can help you find a provider who will be a good match for you. The most important thing is for you to have someone you can talk to so you can work on solving the problems.

What to do in a behavioral health emergency?

You should call 911 if you are having a life-threatening behavioral health emergency. You can also go to a crisis center or the nearest emergency room. You do not have to wait for an emergency to get help. Call 1-877-277-9772 for someone to help you with depression, mental illness, substance use disorder or emotional questions.

The 988 Suicide and Crisis Lifeline provides 24/7, confidential support to people in suicidal crisis or mental health-related distress. Call 988 if you are experiencing behavioral health related distress including: thoughts of suicide, mental health, substance use crisis, or any other kind of emotional distress.

What do I do if I am already in treatment?

If you are already getting care, ask your behavioral health provider if they are in the Superior network. If the answer is yes, you do not need to do anything. If the answer is no, call 1-877-277-9772. We will ask your provider to join our network. We want you to keep getting the care you need. If the provider does not want to join the network, we will work with the provider to keep caring for you until medical records can be transferred to a new doctor.

Special Services

What are Mental Health Rehabilitation Services and Mental Health Targeted Case Management? How do I get these services?

These are services that help members with severe mental illness, behavioral or emotional problems. Superior can also help members get better access to care and community support services through Mental Health Targeted Case Management.

To learn more about these services, call 1-877-277-9772.

Superior offers these services:

- Education, planning and coordination of behavioral health services.
- Outpatient mental health and substance use disorder services.
- Non-hospital and inpatient residential detoxification, rehabilitation and half-way house.
- Crisis services 24 hours a day, 7 days a week.
- Medications for mental health and substance use disorder care.
- Lab services.
- Referrals to other community resources.
- Transitional health-care services.
- Targeted Case Management.
- Mental Health Rehabilitation.

Bonus Behavioral Health Services:

- Online mental health resources through a website and mobile app that offers a range of resources to support mental health and overall well-being. Members can also engage in personalized e-Learning programs to help address depression, anxiety, stress, chronic pain, substance use and sleep issues.

Note: Superior wants to help you stay healthy. We need to hear your concerns so that we can make our services better. Call 1-877-277-9772. TTY users (deaf/hard of hearing) can call 1-800-735-2989. For Superior dual eligible members, mental health care is paid for by Medicare. You can continue to see any Medicare provider. You do not have to use a Superior provider for these services.

Superior Health Tip

To stay up to date on the Coronavirus (COVID-19), visit SuperiorHealthPlan.com/Coronavirus.

Special Services

Collaborative Care Model

The Collaborative Care Model (CoCM) coordinates care for members between a community Behavioral Health Care Manager (BHCM) and a consulting psychiatrist with the participation of a primary care provider. The team share roles and tasks, and together are responsible for a members wellbeing. CoCM helps manage Behavioral Health conditions as chronic diseases, instead of treating acute symptoms.

CoCM services focus on:

- **Patient-Centered Team Care**. Partnership between all team members using shared care plans that include the members personalized goals.
- **Population-Based Care**. Monitoring of members to make sure they are getting the personalized attention they need for improvement.
- **Measurement-Based Treatment to Target**. Regular review and measurement of the members personal goals and clinical outcomes.
- **Evidence-Based Care**. Health care that is based on the best available, current, effective and relevant information.

Service Coordination

What is Service Coordination? What will a Service Coordinator do for me?

Service Coordination is a special kind of care management that is done by a Superior Service Coordinator. A Service Coordinator will work with your nursing facility by:

- Identifying the physical, mental or long term needs of the member.
- Addressing any unique needs of the member that could improve outcomes and health/well-being.
- Assisting the member to ensure timely and coordinated access to array of services and/or covered Medicaid eligible services.
- Partnering with the nursing facility to ensure best possible outcomes for the member's health and safety.
- Coordinating the delivery of services for members who are transitioning back to the community.

Superior wants you to be safe and healthy, to be involved in your service plan, and to live where you pick. We will assign a Service Coordinator to all Superior STAR+PLUS Nursing Facility members.

How can I talk to a Service Coordinator?

If you would like to speak with a Superior Service Coordinator, call 1-877-277-9772. Our staff is available from 8 a.m. to 5 p.m., Monday through Friday, except for state-approved holidays. You can also reach a nurse 24 hours a day, 7 days a week. They can answer your health questions after hours and on weekends.

How often will I talk with a Service Coordinator?

You will receive a letter in the mail from your Service Coordinator. The letter will detail how often and what type of contact you will have, based on your health-care needs. It will also give you the name and direct phone number of your coordinator. Your Service Coordinator will come visit with you within the first 30 Days you are in your nursing facility. They will come back every quarter after that.

If you would like Service Coordination, or have questions, please call 1-877-277-9772.

Special Services

Eye Care

How do I get eye care services?

In Medicaid, eye care services include:

- An eye exam and glasses every two (2) years. You can not get your glasses replaced if you break or lose them.

With Superior, you get extra vision benefits, too. Your nursing home can help you find a provider.

You do not need a referral from your doctor to see the eye doctor for routine eye care. Some eye doctors can also treat you for eye diseases that do not need surgery. You can get these eye care services from Envolve Vision Services. To pick an eye doctor, call Superior at 1-877-277-9772 or Envolve Vision Services at 1-888-756-8768 for help.

If you are dual eligible, Medicaid pays for your eye care services most of the time. You can go to any Medicaid eye doctor. You do not have to go to an Envolve Vision or Superior eye doctor. If you have certain types of eye disease or injury to your eye, Medicare will pay. Your eye doctor will know if Medicaid or Medicare pays for your service

Dental Care

What do I do if I need emergency dental care?

During normal business hours, call your main dentist to find out how to get emergency services. If you need emergency dental services after the main dentist's office has closed, call us toll-free at 1-877-277-9772 or call 911.

Are emergency dental services covered?

Superior 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.
- Drugs for any of the above conditions.

Superior is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. Superior will pay for hospital visits, physician visits and related medical services. This includes anesthesia and prescription drugs.

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling.
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration).
- Open or closed reduction of fracture of the maxilla or mandible.
- Repair of laceration in or around oral cavity.
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts.
- Incision and drainage of cellulitis.
- Root canal therapy. Payment is subject to dental necessity review and pre and post-operative x-rays are required.
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Special Services

Are non-emergency dental services covered?

Superior is not responsible for paying for routine dental services provided to Medicaid members. Superior is responsible, however, for paying for treatment and devices for craniofacial anomalies.

What other services can Superior help me with?

Superior cares about your health and well being. We have many services and agencies that we work with to help get you the care you need. To learn more about these services, call Superior at 1-877-277-9772.

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

If you have special health-care needs, like a serious ongoing illness, disability, or chronic or complex conditions, just call Superior at 1-877-277-9772. We can help you make an appointment with one of our doctors that cares for patients with special needs. Superior offers direct access to specialists that are right for your conditions and needs. You do not need a referral from a doctor for these services. We will also refer you to one of our Care Managers who will:

- Help you get the care and services you need.
- Develop a plan of care with the help of you and your doctor.
- Follow your progress and make sure you are getting the care you need.
- Answer your health-care questions.

Care Management

Superior has experienced nurses who can help you understand problems you may have, like:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Transplants
- Using the emergency room frequently
- Being in the hospital often
- Wounds that won't heal
- Multiple diseases or conditions

Our nurses will help you stay healthy and get you the care you need. We help you find care close to you. We will work with your doctor to improve your health. The goal of our program is to learn what information or services you need. We want you to become more independent with your health. Please call us at 1-877-277-9772 to talk to a nurse. Our staff is available from 8 a.m. to 5 p.m., Monday through Friday, except for state-approved holidays. You can also reach a nurse 24 hours a day, 7 days a week. They can answer your health questions after hours and on weekends.

You can have Care Management if you decide to leave your nursing facility and go back into your community. Although our nurses can help you, we know you may not want this. If you don't want to be in the Care Management program, you are able to quit at any time by calling your nurse. Also:

- Superior nurses may contact you if a doctor asks us to call you, if you ask us to call, or if Superior thinks we can help you.
- We may ask you questions about your health.
- We will give you information to help you understand how to get the care you need.
- We will talk to your doctor and other people who treat you, to get you care.
- You should call us at 1-877-277-9772 if you want to talk to a nurse about being in this program.

Special Services

Disease Management

Your nursing facility's care team will ensure you are getting all of the care you need. If you choose to relocate back into the community, Superior has disease management programs available to you. These include:

- Asthma Program
- Diabetes Program
- Heart Disease Program
- COPD Program
- Congestive Heart Failure Program
- Depression Program
- Bipolar Disorder and Schizophrenia Programs
- Substance Use Disorder Program
- Pregnancy Substance Use Program

Details about each of these programs are provided below. Superior will work with you and your caregiver if you have one to help you get the care you need.

Asthma Program

If you have asthma, Superior has special program that can help you. Asthma is a disease that makes it hard to breathe. People with asthma have:

- Have shortness of breath.
- Make whistling sound when they breathe.
- Cough a lot, especially at night.
- Have a tightness in their chest.

Call Superior at 1-877-277-9772 if you:

- Have been in the hospital for asthma during the past year.
- Have been in the emergency room in the past two months for asthma.
- Have been in the doctor's office three or more times in the past six months for asthma.
- Take oral steroids for asthma.

Diabetes Program

If you have diabetes, Superior has a special program that can help you. Diabetes is a disease of high blood sugar. If the blood sugar stays high, it can cause problems in many parts of the body. People with high blood sugar may:

- Feel tired, sleepy or bad.
- Have to use the bathroom a lot.
- Be very thirsty.
- Or may not feel any different at all.

Call Superior at 1-877-277-9772 if you:

- Are newly diagnosed with diabetes.
- Have had recent visits to the emergency room or hospital for diabetes.
- Have had a change in diabetes medicine.
- Have been started on insulin.
- Want to know more about what to eat and how to shop for groceries.
- Want to know how to avoid problems with your eyes and kidneys.
- Want to know how to take good care of your feet.

Heart Disease Program

If you have heart disease, Superior has a special program that can help you. Heart disease is a life threatening disease that includes many conditions such as coronary artery disease, heart attack and congestive heart disease, to name a few. People with these diseases could experience:

Special Services

- Shortness of breath
- Irregular heart beats
- A faster heart beat
- Weakness or dizziness
- Nausea
- Sweating
- Discomfort, pressure, heaviness, or pain in the chest

Call Superior at 1-877-277-9772 if you:

- Have been to the hospital for heart disease in the past year.
- Have had any recent visits to the emergency room for heart disease.
- Are on new medication for your heart.
- Feel weak or dizzy.
- Are experiencing discomfort in your chest.
- Are having irregular heartbeats.

If you think you need emergency care, please contact 911 or go to the nearest hospital/emergency room.

COPD Program

If you have Chronic Obstructive Pulmonary Disease (COPD), Superior has special program that can help you. COPD is a progressive lung disease that makes it hard to breathe over time. People with COPD:

- May have a cough that won't go away that brings up phlegm.
- Have shortness of breath.
- Have tightness in their chest.
- May make a whistling sound when they breathe.
- Have shortness of breath throughout the day that gets worse after physical activity.
- May feel tired doing normal day to day activities.

Call Superior at 1-877-277-9772 if you:

- Have been newly diagnosed with COPD.
- Have had recent visits to the emergency room or hospital for COPD.
- Currently smoke or have in the past.
- Have been exposed to secondhand smoke.
- Lived or worked in an area with bad air quality (like factories or construction sites).
- Want to learn more about how to manage your COPD.

Congestive Heart Failure Program

If you have heart failure, Superior has a special program that can help you. Heart failure is a disease in which your heart may not beat well enough to keep up with what the body needs. People with heart failure may:

- Have shortness of breath with activity.
- Have swelling in their legs, feet, ankles, hands, and/or belly.
- Have shortness of breath when lying down or trying to sleep.
- Gain weight because the body is holding on to fluid.
- Feel weak or tired doing normal daily activities.

Special Services

Call Superior at 1-877-277-9772 if you:

- Are newly diagnosed with heart failure.
- Have had recent visits to the emergency room or hospital for heart failure.
- Are having to go to the doctor more often because of heart failure.
- Have had a change in your medicine.
- Want to learn more about how to live well with your heart failure.
- Have tried to reduce or stop use and have not been successful.

Depression Program

If you have felt down or depressed and would like help in managing those symptoms, Superior has a program that can help you.

Call Superior at 1-877-277-9772 if you have felt down and/or have some of the common symptoms of depression including:

- Trouble with sleep
- Appetite increase or decrease
- Little interest or pleasure in doing things

Bipolar Disorder and Schizophrenia Programs

If you have been diagnosed with Bipolar Disorder or Schizophrenia and would like help managing your symptoms, Superior has a program that can help you. People who have not addressed their behavioral health symptoms may have trouble addressing their physical health concerns. Common symptoms that impact one's ability to reach their goals are:

- Disturbances in sleep
- Difficulty concentrating and/or focusing
- Unexplained periods of high energy or fatigue

Call Superior at 1-877-277-9772 if you:

- Want to understand your diagnosis better.
- Would like to learn more about treatment for your diagnosis.
- Need assistance finding and/or making an appointment with a behavioral health provider.
- Have difficulty receiving medications or attending appointments.

Substance Use Disorder Program

If alcohol or drug use has interfered with your ability to reach your goals and you would like help, Superior has a program that can assist you.

Call Superior at 1-877-277-9772 if you:

- Have considered reducing use.
- Family and/or friends have expressed concern about your use.
- Want to know more about treatment options.
- Have tried to reduce or stop use and have not been successful.

Special Services

Pregnancy Substance Use Program

If alcohol or drug use has interfered with your behaviors and you would like help, Superior has a program that can assist you. Call Superior at 1-877-277-9772 if you are pregnant and:

- Would like education and resources to help reduce or stop your use.
- Family and/or friends have expressed concern about your use.
- Want to know more about treatment options.
- Have tried to reduce or stop use and have not been successful.

Family Planning Services

How do I get family planning services?

Superior gives family planning services to all members. Family planning services are kept private. You should talk to your doctor about family planning. Your doctor will help you pick a family planning provider. If you do not feel comfortable talking to your doctor, call Superior at 1-877-277-9772.

Do I need a referral for this?

Superior allows freedom of choice to its members to choose any in-network or out of network provider. You do not need a referral from your doctor to seek 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 www.healthytexaswomen.org, or you can call Superior at 1-877-277-9772 for help in finding a family planning provider.

Member Handbook Questions

If you have questions or concerns about anything in your member handbook, call Member Services at 1-877-277-9772.

Pharmacy Services

What are my prescription drug benefits?

You get unlimited prescriptions through your Medicaid coverage when the nursing facility uses a drug store that generally services nursing facilities and is in the Superior network. There are some medications that may not be covered through Medicaid. The pharmacy will work with the doctor and nursing facility to let them know which medications are not covered, or help them find another medication that is covered.

How do I get my medications?

Medicaid pays for most medication your doctor says you need. Your doctor will write a prescription and send the prescription for you by calling, faxing or submitting by electronic means to the nursing facility to order, fill, dispense and administer to you.

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

The drug store that services your nursing facility will work with your doctor and/or the pharmacy help desk if there are problems getting your medications. They will do this for you.

How do I find a network drug store? What do I bring with me to the drug store? What does the nursing facility need to give to the pharmacy?

Superior provides prescriptions for all its members through drug stores contracted with Superior. Drug stores that service nursing facilities are also contracted with Superior. You can get your prescriptions filled at most drug stores in Texas if you are not in a nursing facility. If you are in a nursing facility, the nursing facility will work with the doctor and have your medications filled at a contracted drug store. If you are not currently in a nursing facility and need help finding a drug store, call Superior at 1-877-277-9772. A list is also available online at www.SuperiorHealthPlan.com.

Remember:
Always take your Superior Member ID card and your Medicaid ID card with you to the doctor and to the drug store. Your nursing facility will need a copy of the same Superior Member ID card and your Medicaid ID card to share with the pharmacy that services the nursing facility.

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

Superior has many contracted drug stores that can fill your medications, including those which service nursing facilities as provided by Superior. It is important that you show your Superior Member ID card at the drug store and to your nursing facility. The nursing facility will share this information with the drug store. The drug store may also choose to contract with Superior. If you are not currently in a nursing facility and the drug store tells you they do not take Superior members, you can call Member Services at 1-877-277-9772. We can help you find a drug store that can fill your medications for you. If you choose to have the drug store fill your medications and they do not take Superior members, you will have to pay for the medication.

What if I need my medications delivered to me?

Drug stores that service nursing facilities arrange the delivery of medications directly to the facility. If you are not currently in a nursing facility, Superior can send you many medications by mail. Some Superior drug stores offer home delivery services. Call Member Services at 1-877-277-9772 to learn more about mail order or to find a drug store that may offer home delivery service in your area.

Pharmacy Services

What if I lose my medication(s)?

It is not normal for a nursing facility to lose your medication. However, if this happens Superior would work with the nursing facility and drug store to help you. If you are not currently in a nursing facility and you lose your medications, call your doctor or clinic for help. If your doctor or clinic is closed, the drug store where you got your medication should be able to help. You can also call Superior Member Services at 1-877-277-9772.

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

If your doctor cannot be reached to approve a prescription, the drug store servicing your nursing facility may be able to get a three (3)-day emergency supply of your medication. The drug store can call the pharmacy help desk if needed.

What if I also have Medicare?

If you have Medicare and Medicaid (you are dual eligible), your prescription drugs are now paid by a Medicare drug (Rx) plan. Under Medicare, you have choices. Make sure the Medicare plan you are with meets your needs. If you have questions or want to change plans you can call 1-800-633-4227 (1-800-MEDICARE).

Remember under Medicare:

- You have a choice of prescription drug plans.
- All plans require you to pay for each prescription.
- There's no limit on the number of prescriptions you can fill each month.

If you are in a nursing facility, your drugs will be provided to you by the nursing facility as they are today. The drug store that is used by your nursing facility will continue to bill your Medicare plan if you have Medicare, and will bill Superior HealthPlan for your Medicaid covered drugs.

What if I also have other primary insurance?

If you have other primary insurance, please show both your primary insurance and your Medicaid insurance at the drug store and nursing facility. The drug store should run the primary insurance first, then the Medicaid insurance. Medicaid is the payer of last resort and should not be the only card presented to the pharmacy.

Superior Health Tip

Medicines can be safe if you take them correctly and can help you get better when you are sick. They can also keep a health problem under control.

Here are a few tips on how to use medicine safely:

- Read and follow the directions on the label.
- Take the exact amount written on the label.
- Take each dose around the same time each day.
- Use the same pharmacy for all of your prescriptions.
- Don't share your medicine or take someone else's medicine.

Extra Benefits and Services

What extra benefits and services do I get as a member of Superior HealthPlan? How do I get these?

As a member of Superior, you are able to get extra benefits and services in addition to your regular benefits. These are called Value-added Services. These include:

- **24-hour Nurse Advice Line**. Access Superior's 24-hour nurse advice line. Call 1-877-277-9772 to contact a registered nurse for health questions 24 hours a day, 7 days a week.
- **Careopolis™**. An online "caring community" enabling members to engage friends and family as it relates to their healing or healthcare journey. Members create and manage private online accounts to enhance connections with friends and loved ones.
- **GED Support Services**. Superior supports members with an IDD diagnosis in achieving goals that improve their quality of life by offering access to resources to help pass the General Educational Development (GED) test. Superior will assist interested members by providing GED preparatory materials and identifying available testing centers close to the member. Members must be enrolled with Superior for 60 days to be eligible. This Value-added Service is limited to one per member lifetime.
- **Nicotine Recovery Program**. Online nicotine recovery program through a web and mobile app that offers a wide variety of resources to help members meet their nicotine recovery goals. This online resource provides ideas, information and education such as expert videos, interactive activities and stories of hope.
- **Nursing Facility Welcome Kit**. Welcome kit for all dual and non-dual members who are entering a nursing facility for the first time. Welcome kits will include personal items such as a shower cap, blanket, non-slip socks, coffee cup, water bottle, lighted magnifying glass, tote bag, Sudoku game and crossword puzzles. Members will receive the welcome kit within 30 days of entering the facility.
- **Online Mental Health Resources**. Online mental health resources through a website and mobile app that offers a range of resources to support mental health and overall well-being. Members can also engage in personalized e-Learning programs to help address depression, anxiety, stress, chronic pain, substance use and sleep issues.
- **Online Social Services Resource Directory**. Online social services resource directory for members through (https://www.superiorhealthplan.com/members/medicaid/resources.html) to help locate community supports such as food and nutrition, housing, education and employment services.

Note: The Value-added Services listed below do not apply to dual-eligible members.

- **Cervical Cancer Screening Incentive Program**. $50 reward for female STAR+PLUS members ages 21-64, at average risk for cervical cancer, who complete a recommended cervical cancer screening. Limited to one $50 reward per year. Excludes STAR+PLUS members who are dual-eligible.
- **Enhanced Dental Benefits**. Non-dual, non-HCBS Waiver STAR+PLUS members in Dallas and Nueces may receive $500 annually towards exams and cleanings, x-rays, fluoride treatments or a simple extraction.
- **Extra Dental Benefits**. Non-dual, non-HCBS Waiver STAR+PLUS members may receive $250 annually in dental services towards exams, x-rays, cleanings and fluoride treatments. Excludes members in Dallas and Nueces.
- **Extra Vision Services**. Members are eligible to receive a $150 allowance once per year towards a choice of upgraded eyeglass frames and lenses or contact lenses not covered by Medicaid. Coverage is for new frames and lenses and does not cover additional features such as tints and coating. This allowance may not be used towards replacement eyewear or sunglasses. The member will be responsible for any Medicaid non-covered vision charges exceeding $150.

Extra Benefits and Services

- **Trualta**. Online resource for eligible members and their caregivers to help with entering or discharging from facilities. Specifically, members that are discharging from or at risk of entering a nursing facility (NF), assisted living facility (ALF), adult foster care (AFC), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Institutions for Mental Disease (IMD, state hospitals), inpatient psychiatric facility (IPF) and are dependent on caregivers for their activities of daily living. Members must be diagnosed with IDD, schizophrenia, schizoaffective, bipolar, major depression, Alzheimer's, dementia, COPD, diabetes or hypertension. Trualta is a personalized, skills-based training platform for family members caring for aging loved ones living at home. Members must be referred by Service Coordination or Case Management. Excludes STAR+PLUS members who are dual-eligible.

Value-added Services may have restrictions and limitations. These Value-added Services are effective 9/1/22-8/31/23. For an up-to-date list of these services, go to www.SuperiorHealthPlan.com. For questions, call Member Services at 1-877-277-9772.

How can I learn more about the benefits and services that are available?

Superior wants to make sure you are linked to quality health care and social services. Your Service Coordinator can teach you how to use Superior's services. They can visit you at home, talk to you on the phone or send you facts by mail. They will help you with things like:

- How to pick a doctor
- The STAR+PLUS Nursing Facility program
- Transportation services
- How to use Superior services
- How to use your member handbook
- Preventive, urgent and emergent care
- Visits to specialists
- Complaint and appeal procedures
- Leaving the program procedures

Superior Member Connections can give you resources to help you get food, housing, clothing and utility services. To learn more, or to see what classes are being offered at this time, please call Superior Member Connections staff at 1-877-277-9772.

Finding new treatments to better care for you

Superior has a committee of doctors that review new treatments for people with certain illnesses. They review information from other doctors and scientific agencies. The new treatments that are covered by Texas Medicaid are shared with Superior's doctors. This allows them to provide the best and most current types of care for you.

What else does Superior offer for members to learn about health care?

Superior has a lot of information available for you online. This includes a quarterly member newsletter. You can find this at www.SuperiorHealthPlan.com by clicking on "Medicaid & CHIP Plans" and then on "Medicaid News & Newsletters."

There are also interactive health lessons and tools available for you online. This includes our On.Target plans that can help you learn about living well with chronic illnesses, healthy eating tips and more. You can find this at www.SuperiorHealthPlan.com by logging in to Superior's Member Portal. Click "Tell Us About Your Health" and then on "Wellness Assessment".

What health education classes does Superior offer?

Superior wants you to lead a healthy life. If you chose to relocate back into the community, Superior can help you find health education classes available to you. Some community health education programs are:

Extra Benefits and Services

- Nutrition classes
- CPR classes
- Healthy diet classes

Remember:
If you have any questions on what is or what is not a covered service, call Superior at 1-877-277-9772.

Advance Directives

What are advance directives? How do I get an advance directive?

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 advance directive can also say who can make decisions for you if you are not able to.

Through this document, you will have the right to make decisions about your health care, like what kinds of health care, if any, you will or will not accept. If you sign either of these documents, your doctor will make a note in your medical records so that other doctors know about it.

Superior wants you to know your rights so you can fill out the papers ahead of time. These are the types of advance directives you can choose under Texas law:

- **Directive to Doctor (Living Will)** – A living will tells your doctor what to do. It helps you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. In the State of Texas you can make a living will. Your doctor must follow your living will in case you become too sick to decide about your care.
- **Durable Power of Attorney for Health Care** – This form gives the person who signs it power. This person can make decisions about your health care if you are not able to.
- **Declaration of Mental Health Treatment** – This tells your doctor about the mental health care you want. In the State of Texas you can make this choice. It expires three (3) years after you sign it or at any time you pick to cancel it, unless a court has considered you incapacitated.
- **Out-of-Hospital Do Not Resuscitate** – This tells your doctor what to do if you are about to die. In the State of Texas your doctor must follow this request if you become too sick.

When you talk to your doctor about an advance directive, he or she might have the forms in their office to give you. You can also call Superior at 1-877-277-9772 and we will help you get one.

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

All adults in hospitals, nursing homes, behavioral health facilities and other health-care places have rights. For example, you have the right to know what care you will get, and that your medical records will always be private.

A federal law gives you the right to fill out a form known as an “advance directive.” An advance directive is a living will or power of attorney for health care when a person is not able to make a decision on their own because of their health. It gives you the chance to put your wishes in writing about what kind of health care you want or do not want, under special, serious medical conditions when you might not be able to tell your wishes to your doctor, the hospital, or other staff.

Superior Health Tip

Obesity can cause many health problems or make existing conditions worse. If you are worried about your weight, talk to your doctor.

Member Billings

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

If you have Medicaid, you should not be billed for any services covered by Medicaid. Your nursing facility should make sure that all of the providers who provide your care in the nursing facility are enrolled in Texas Medicaid. If you see providers outside of the nursing facility, they should be enrolled in Texas Medicaid and also contracted with Superior. If you get a bill from a Medicaid provider, call Member Services at 1-877-277-9772.

When you call, give the Member Services staff:

- Date of service
- Your patient account number
- Name of provider
- Phone number on the bill
- Total amount of bill

Note: If you see a provider who is not enrolled with Texas Medicaid and/or is not signed up as a Superior provider, Superior may not pay that doctor and you may get billed for the services.

What is applied income? What are my responsibilities? What do I do if I get a bill from my nursing facility?

Applied income is the member's personal income that the member must provide to the nursing facility as part of their cost sharing obligation as a Medicaid beneficiary. Any time Medicaid is billed by the nursing facility, the member must give their applied income to the facility. The amount is determined by the total amount of monthly income divided by the number of days the member resides in the facility each month. The member is allowed to keep $60 for themselves for personal needs.

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

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

If you are covered by both Medicare and Medicaid (dual eligible), you cannot be billed for Medicare "cost-sharing," which includes deductibles, co-insurance or co-payments that are covered by Medicaid. Those expenses should be billed to and reimbursed by your Medicare Advantage Plan (MAP) if you have a managed Medicare plan, or TMHP if you have traditional Medicare coverage. There are also some Medicare non-covered acute care services and supplies that are covered by Medicaid, and should be billed to and reimbursed by TMHP.

Getting Help with Benefits and Services

What should I do if I have a complaint about my health care, my provider, my Service Coordinator or my health plan? Who do I call?

We want to help. If you have a complaint, please call us toll-free at 1-877-277-9772 to tell us about your problem. Members may file complaints to Superior verbally or in writing, at any time. There are a variety of ways in which a member complaint can be filed. Your doctor, nursing facility or Legally Authorized Representative can file a complaint for you as well. Verbal complaints will be accepted by our Member Services staff by calling 1-877-277-9772. Written complaints can be filed online through Superior's website. Go to www.SuperiorHealthPlan.com and click on "Contact."
A written complaint can also be mailed or faxed to:

Superior HealthPlan
Attn: Complaint Department
5900 E. Ben White Blvd.
Austin, TX 78741
Fax: 1-866-683-5369

Interpreter services are provided free of charge. Please call Member Services at 1-877-277-9772 (TTY: 1-800-735-2989) for assistance.

Can someone from Superior help me file a complaint?

Your Service Coordinator can help you file a complaint. Just call 1-877-277-9772. A Superior Member Advocate can also help you file a complaint. Just call Member Services at 1-877-277-9772. You may also file a complaint face-to-face with any representative from Superior who will document your complaint within 24 hours of receipt on your behalf.

What are the requirements and timeframes for filing a complaint?

You can file a complaint at any time. A complaint may be filed over the phone, by mail, online at www.SuperiorHealthPlan.com or by fax at 1-866-683-5369.

How long will it take to process my complaint?

Most of the time we can help you right away, or at most within a few days. When a complaint is received, you will receive written confirmation within five (5) Business Days. Superior then has thirty (30) Days to resolve your complaint in writing.

Do I have the right to meet with a complaint appeal panel?

If you are not satisfied with Superior's response to your complaint, you have the right to meet with a complaint appeal panel. The panel is made up of members, providers and Superior staff. The panel will meet with you, and a final response to your complaint will be completed within thirty (30) Days of receiving your written request for an appeal.

If I am not satisfied with the outcome, who else can I contact?

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

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

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

How will I find out if Medicaid covered services are denied or limited? What can I do if my doctor asks for a service for me that's covered by Superior, but Superior denies or limits it?

Superior will send you a letter if a requested service is denied or limited. If you disagree with the decision, you may file an appeal.

You have the right to appeal Superior's decision if Medicaid covered services are denied, reduced, suspended or ended. You may also appeal Superior's denial of a claim, in whole or in part. Superior's denial is called an "Adverse Benefit Determination." You can appeal the Adverse Benefit Determination if you think Superior:

- Is stopping coverage for care you think you need.
- Is denying coverage for care you think should be covered.
- Provides a partial approval of a request for a covered service.

If you have both Medicaid and Medicare (dual eligible), most of the acute care services you get while in a nursing facility such as doctor's visits, lab and x-ray services and medications, are Medicare covered services. The appeal process for these services may have different timeframes. Medicare covered services would follow the grievance and appeal process for Medicare covered services that are provided to you by your Medicare plan. Please contact your Medicare plan to get information about your Medicare grievance and appeal process.

Internal Health Plan Appeals

When do I have the right to ask for an internal health plan appeal?

You can ask for an internal health plan appeal within 60 Days from the date of Superior's Notice of Adverse Benefit Determination letter.

Can someone from Superior help me file an internal health plan appeal?

You, your provider, a friend, a relative, lawyer or another spokesperson can request an appeal of an Adverse Benefit Determination. Your Service Coordinator can assist you with any questions you have about filing an appeal. Just call 1-877-277-9772 (TTY: 1-800-735-2989). A Superior Member Advocate can also help you. Just call Member Services at 1-877-277-9772 (TTY: 1-800-735-2989). Your nursing facility or Legally Authorized Representative can file an appeal for you as well. Interpreter services are provided free of charge. Please call Member Services at 1-877-277-9772 (TTY: 1-800-735-2989) for assistance.

What are the timeframes for the internal health plan appeal process for denied Medicaid covered services?

Superior will acknowledge your appeal by sending you a letter within five (5) Business Days of receipt of your appeal, complete the review of the appeal and send you an appeal response letter within thirty (30) Days after receipt of the initial written or oral request for appeal. An additional 14 Days may be added to process the appeal, if you request an extension or Superior shows that there is a need for additional information and how the delay is in the member's interest. If more time is needed for Superior to gather facts about the requested

service, you will receive a letter with the reason for the delay. If you do not agree with Superior's decision to extend the timeframe for the decision on your appeal, you can file a complaint.

How can I continue my current authorized services while my appeal is being processed?

You can ask to continue current authorized services when you appeal Superior's Adverse Benefit Determination. To continue receiving a service that is being ended, suspended or reduced, your request to continue a service must be made within ten (10) Days of the date of Superior's Notice of Adverse Benefit Determination letter, or before the date the currently authorized services will be discontinued, whichever is later. Superior will keep providing the benefits while your appeal is being reviewed, if:

- Your appeal is sent in the needed time frame.
- Your appeal is for a service that was denied or limited, that had been previously approved.
- Your appeal is for a service ordered by a Superior-approved provider.

If Superior continues or reinstates benefits at your request and the request for continued services is not approved on appeal, Superior will not pursue recovery of payment for those services without written permission from HHS.

Does my internal health plan appeal request have to be in writing?

You can call or request in writing to let us know you want to appeal an Adverse Benefit Determination. You, your provider, a friend, a relative, lawyer or another spokesperson can request an appeal and complete the appeal form on your behalf. If you have questions about the appeal form, Superior can help you. Call Superior at 1-877-277-9772 for more information.

What is an internal health plan emergency appeal?

An internal health plan emergency 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 health or life.

How do I ask for an internal health plan emergency appeal? Does my request have to be in writing?

You, your provider, or your legal authorized representative can ask for an internal health plan emergency appeal by calling Superior at 1-877-398-9461. Internal health plan emergency appeals do not have to be in writing.

You can ask for an internal health plan emergency appeal in writing and send it to:

Superior HealthPlan
Attn: Medical Management
5900 E. Ben White Blvd.
Austin, Texas 78741
Fax: 1-866-918-2266

What are the timeframes for an internal health plan emergency appeal? What happens if Superior denies my request for an emergency appeal?

We will notify you of the internal health plan emergency appeal decision within 72 hours, unless your appeal is related to an ongoing emergency or denial of continued hospitalization. If your appeal is about an ongoing emergency or denial of a continued hospital stay, you will be notified of the appeal decision within one (1)

Business Day. If Superior determines that your emergency appeal request does not meet the emergency appeal criteria, Superior will let you know right away. Your appeal will be processed as a standard appeal with a response provided within thirty (30) Days.

Who can help me file an internal health plan emergency appeal?

You, your provider, a friend, a relative, lawyer or another spokesperson can file an internal health plan emergency appeal on your behalf. Your Service Coordinator can help you with any questions you have about filing an emergency appeal.

External Appeals

After a Medicaid member has completed the internal health plan appeal process related to an adverse benefit determination, more appeal rights are available to a member if he/she is not satisfied with the health plan's appeal decision. After the health plan's appeal decision is completed, members have additional external appeal rights, including a State Fair Hearing, with or without an External Medical Review. The details for both the State Fair Hearing and External Medical review appeal rights and process are included in the sections below.

External Medical Review

Can I ask for an External Medical Review?

If you, as a member of Superior, disagree with our internal appeal decision, you have the right to ask for an External Medical Review. An External Medical Review is an optional, extra step you can take to get the case reviewed before the State Fair Hearing occurs. You may name someone to represent you by writing a letter to Superior telling us the name of the person you want to represent you. A provider may be your representative. You or your representative must ask for the External Medical Review within 120 days of the date Superior mails the letter with the internal appeal decision. If you do not ask for the External Medical Review within 120 days, you may lose your right to an External Medical Review. To ask for an External Medical Review, you or your representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of Superior's Internal Appeal Decision letter and mail or fax it to Superior by using the address or fax number at the top of the form; or
- Call Superior at 1-877-398-9461.

If you ask for an External Medical Review within 10 days from the time you get the appeal decision from Superior, you have the right to keep getting any service Superior denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If you do not request an External Medical Review within 10 days from the time you get the appeal decision from Superior, the service Superior denied will be stopped.

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

Once the External Medical Review decision is received, you have the right to withdraw the State Fair Hearing request. If you continue with the State Fair Hearing, you can also request the Independent Review Organization

be present at the State Fair Hearing. You can make both of these requests by contacting Superior at 1-877-398-9461 or the HHS Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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

Can I ask for an emergency External Medical Review?

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

State Fair Hearings

How can I ask for a State Fair Hearing?

You must complete the internal health plan appeal process through Superior HealthPlan prior to requesting a State Fair Hearing. **If you disagree with Superior's appeal decision, you have the right to ask for a State Fair Hearing from Texas Health and Human Services (HHS) with or without an External Medical Review through an Independent Review Organization (IRO).** You can ask for an External Medical Review and a State Fair Hearing, but you cannot request only an External Medical Review. You may also request a State Fair Hearing with or without an External Medical Review if Superior does not make a decision on your appeal within the required time frame. You may represent yourself at the State Fair Hearing, or name someone else to be your representative. This could be a provider, relative, friend, lawyer, or any other person. You may name someone to represent you by writing a letter to Superior telling us the name of the person that you want to represent you.

You or your representative must ask for a State Fair Hearing within 120 Days of the date of the notice telling you that we are denying your internal health plan appeal.

You have the right to keep getting any service the health plan denied or reduced, based on previously authorized services, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of: (1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or (2) the day the health plan's internal appeal decision letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped. If Superior continues or reinstates benefits at your request and the request for continued services is not approved by the State Fair Hearing officer, Superior will not pursue recovery of payment for those services without written permission from HHS.

To ask for a State Fair Hearing, you or your representative should call or write Superior:

Superior HealthPlan
ATTN: State Fair Hearings Coordinator
5900 E. Ben White Blvd. Austin, TX 78741
1-877-398-9461

You can ask for a State Fair Hearing without an External Medical Review. See External Medical Review process above.

Getting Help with Benefits and Services

What happens after I request a State Fair Hearing?

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. You can also contact the HHS State Fair Hearings officer if you would like the hearing to be held in-person.

During the hearing, you or your representative can tell why you need the service or why you disagree with Superior's Adverse Benefit Determination. You have the right to examine, at a reasonable time before the date of the State Fair Hearing, the contents of your case file and any documents to be used by Superior at the hearing. Before the State Fair Hearing, Superior will send you all of the documents to be used at the State Fair Hearing. It is important that you or your representative attend the State Fair Hearing in person or by phone.

HHS will give you a final decision within 90 Days from the date you asked for the hearing.

Can I ask for an Emergency State Fair Hearing?

To qualify for an emergency State Fair Hearing through HHS, you must first complete Superior's internal appeals process. If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling us at 1-877-398-9461. The State Fair Hearing Officer will provide a response on your emergency State Fair Hearing request within three (3) Business Days.

Other Available Resources for Members

Consumer Rights and Services

Consumer Rights and Services (CRS) is an area at HHS that receives complaints regarding long-term care services provided to individuals in any type of facility or setting. Complaints come from a variety of sources and in several formats.

A complaint allegation (an assertion that a requirement of licensure or certification has been violated) can come directly from individuals or residents, family members, health-care providers, advocates, law enforcement or other state agencies. Report sources may be oral or written.

A self-reported incident is an official notification to the state survey and licensing agency from a Texas HHS-regulated provider that the physical or mental health or welfare of an individual or member has been, or may be, adversely affected by mistreatment, neglect or abuse. These reports also include injuries of unknown source and exploitation or misappropriation of individual or member property.

Contact information:

CRS website: https://hhs.texas.gov/about-hhs/your-rights/consumer-rights-services
Telephone Number: 1-800-458-9858

Long-Term Care Ombudsman

The State Long-Term Care (LTC) Ombudsman program operates through Texas HHS, advocates for the rights of people who live in nursing homes and assisted living facilities so they receive optimal quality of care and achieve high quality of life. The LTC Ombudsman identifies, investigates and resolves complaints that may adversely affect the health, safety, welfare or rights of people who live in nursing facilities or assisted living facilities. Across Texas, through 28 Area Agencies on Aging, certified ombudsmen serve members, their families and friends. Professional staff supervises the volunteers.

Getting Help with Benefits and Services

Contact information:

LTC Ombudsman website: https://apps.hhs.texas.gov/News_info/ombudsman/

A list of the 28 Area Agencies on Aging and their contact information can be found at: https://apps.hhs.texas.gov/contact/aaa.cfm.

Managed Care Compliance and Operations

Managed Care Compliance and Operations (MCCO) at Texas HHS in the managed care division receives complaints, inquiries or disenrollment requests either directly from providers and members or via secondary sources, such as the Office of the Ombudsman, Legislative offices (External Relations Division), Member Advocates (family), Vendor Drug Program, Department of Family and Protective Services or other stakeholders.

MCCO uses a mailbox designated to receive MCO-related inquiries, which is "HPM_Complaints@hhsc.state.tx.us."

HHS Office of the Ombudsman

The Health and Human Services's Office of the Ombudsman helps people when the agency's normal complaint process cannot or does not satisfactorily resolve the issue.

The Office of the Ombudsman's services includes:

- Conducting independent reviews of complaints concerning agency policies or practices.
- Ensuring policies and practices are consistent with the goals of Texas Health and Human Services.
- Ensuring individuals are treated fairly, respectfully and with dignity.
- Making referrals to other agencies, as appropriate.

Contact information:

Website: https://hhs.texas.gov/about-hhs/your-rights/hhs-office-ombudsman
Telephone: 1-877-787-8999

Rights and Responsibilities

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 (PCP). 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 PCP.
   b) Choose any health plan you want that is available in your area and choose your PCP from that plan.
   c) Change your PCP.
   d) Change your health plan without penalty.
   e) Be told how to change your health plan or your PCP.
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.
   c) Be given information about your health, plan, services and providers.
   d) Be told about your rights and responsibilities.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   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, internal health plan appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   a) Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
   b) Get a timely answer to your complaint.
   c) Use the plan's appeal process and be told how to use it.
   d) Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   e) Ask for a State Fair Hearing with or without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   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 to prevent you from leaving, 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 make recommendations about Superior's Member Rights and Responsibilities policies.

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 PCP quickly.
   c) Make any changes in your health plan and PCP 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 PCP first for your non-emergency medical needs.
   g) Be sure you have approval from your PCP 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 PCP and learn about service and treatment options. That includes the responsibility to:
   a) Tell your PCP 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.

As a member of Superior HealthPlan, you can ask for and get the following information each year:

- Information about Superior and our network providers – at a minimum primary care doctors, specialists and hospitals in our service area. This information will include names, addresses, telephone numbers, languages spoken (other than English), identification of providers that are not accepting new patients and qualifications for each network provider such as:
  - Professional qualifications
  - Specialty
  - Medical school attended
  - Residency completion
  - Board certification status
  - Demographics
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, internal health plan appeal, External Medical Review and State Fair Hearing procedures.
- Information about Superior's Quality Improvement Program. To request a hard copy, call Member Services at 1-877-277-9772 or visit our website at www.SuperiorHealthPlan.com.
- Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits available. This is designed to make sure you understand the benefits to which you are entitled.
- How members can get benefits, including authorization requirements, family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those 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 PCP 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 the 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 PCP.
- Superior's practice guidelines.

Confidentiality

When you talk to someone, you share private facts. Your provider can share these facts only with staff helping with your care. These facts can be shared with others when you say it is okay.

Agency employees are trained and required to protect the privacy of health information that identifies you. An agency doesn't give employees access to health information unless they need it for a business reason. Business reasons for needing access to health information include making benefit decisions, paying bills, and planning for the care you need. The agency will punish employees who don't protect the privacy of health information that identifies you.

Notice of Privacy Practices

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.

Effective 07.01.2017

Revised 08.21.2019

For help to translate or understand this, please call 1-877-277-9772. Deaf and hard of hearing TTY: 1-800-735-2989.

Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-877-277-9772. (TTY: 1-800-735-2989).

Interpreter services are provided free of charge to you.

Covered Entities Duties:

Superior HealthPlan is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Superior HealthPlan is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in effect and notify you in the event of a breach of your unsecured PHI. Superior HealthPlan may create, receive or maintain your PHI in an electronic format and that information is subject to electronic disclosure.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Superior HealthPlan reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Superior will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website.

Internal Protections of Oral, Written and Electronic PHI:

Superior protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Notice of Privacy Practices

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- **Treatment** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- **Payment** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - Processing claims
  - Determining eligibility or coverage for claims
  - Issuing premium billings
  - Reviewing services for medical necessity
  - Performing utilization review of claims
- **Health-Care Operations** - We may use and disclose your PHI to perform our health-care operations. These activities may include:
  - Providing customer services
  - Responding to complaints and appeals
  - Providing case management and care coordination
  - Conducting medical review of claims and other quality assessment
  - Improvement activities

  In our health-care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its health-care operations. This includes the following:
  - Quality assessment and improvement activities
  - Reviewing the competence or qualifications of health-care professionals
  - Case management and care coordination
  - Detecting or preventing health-care fraud and abuse
- **Group Health Plan/Plan Sponsor Disclosures –** We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- **Fundraising Activities** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- **Underwriting Purposes** – We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

Notice of Privacy Practices

- **Appointment Reminders/Treatment Alternatives** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- **As Required by Law** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- **Public Health Activities** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- **Victims of Abuse and Neglect** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- **Judicial and Administrative Proceedings** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - An order of a court
  - Administrative tribunal
  - Subpoena
  - Summons
  - Warrant
  - Discovery request
  - Similar legal request
- **Law Enforcement** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - Court order
  - Court-ordered warrant
  - Subpoena
  - Summons issued by a judicial officer
  - Grand jury subpoena

  We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.
- **Coroners, Medical Examiners and Funeral Directors** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- **Organ, Eye and Tissue Donation** - We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
  - Cadaveric organs
  - Eyes
  - Tissues
- **Threats to Health and Safety** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- **Specialized Government Functions** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:

- To authorized federal officials for national security
- To intelligence activities
- The Department of State for medical suitability determinations
- For protective services of the President or other authorized persons

- **Workers' Compensation** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- **Emergency Situations** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- **Inmates** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- **Research** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization:

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

- **Sale of PHI** – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- **Marketing** – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- **Psychotherapy Notes** – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health-care operation functions.

Individuals Rights:

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us. Our contact information is at the end of this Notice.

- **Right to Revoke an Authorization** - You may revoke your authorization at any time. The revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- **Right to Request Restrictions** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or health-care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request.

If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- **Right to Request Confidential Communications** - You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered.
- **Right to Access and Received Copy of your PHI** - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review, or if the denial cannot be reviewed.
- **Right to Amend your PHI** - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- **Right to Receive an Accounting of Disclosures** - You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- **Right to File a Complaint** - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights online at https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html, by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989).

  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.
- **Right to Receive a Copy of this Notice** - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Race, Ethnicity and Language Information:

Superior is committed to keeping your race, ethnicity and language (REL) information confidential. We use some of the following methods to protect your information:

- Maintaining paper documents in locked file cabinets

Notice of Privacy Practices

- Requiring that all electronic information remain on physically secure media
- Maintaining your electronic information in password-protected files

We may use or disclose your REL information to perform our operations as your Managed Care Organization. These activities may include:

- Assessing health care disparities
- Designing intervention programs
- Designing and directing outreach materials
- Informing health care practitioners and providers about your language needs

We will never use your REL information for underwriting, rate setting or benefit determinations or disclose your REL information to unauthorized individuals.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Superior HealthPlan
Attn: Privacy Official
5900 E. Ben White Blvd.
Austin, TX 78741

Toll Free Phone Number: 1-800-218-7453
Relay Texas (TTY): 1-800-735-2989

HHS Privacy Notice: https://www.hhs.gov/hipaa/filing-a-complaint/index.html

Electronic Visit Verification

TEXAS Health and Human Services

Electronic Visit Verification (EVV)
Responsibilities and Additional Information
(Managed Care Organization)

Form 1718
March 2021-E

Electronic visit verification (EVV) is an electronic system used to document and verify that personal care Medicaid services have been provided to persons authorized to receive those services.

The Texas Health and Human Services Commission (HHSC) requires a service provider or a consumer directed services (CDS) employee who provides one of these services to use EVV to clock in when the service begins and to clock out when the service ends.

A service provider or CDS employee uses one of the following three methods to clock in and clock out:

- The service provider's or CDS employee's personal smartphone or tablet.
- Your home phone landline only if you approve.
- An EVV alternative device, a small electronic device that is placed and remains in your home in an agreed upon location.

The service provider is not permitted to use your personal smart phone or tablet.

The CDS employee may use the CDS employer's smart phone or tablet, if the CDS employer has authorized the CDS employee to use their smart phone or tablet.

Section I – Your Responsibilities

You have the following responsibilities regarding the use of EVV:

- You must allow your service provider or CDS employee to clock in and clock out of the EVV system using one of the methods listed above.
- Do not clock in or clock out of the EVV system for your service provider or CDS employee at any time.
  - Immediately tell your provider agency or CDS employer if your service provider or CDS employee asks you to clock in or clock out of the EVV system for the service provider or employee.
- If your service provider or CDS employee is using an EVV alternative device to clock in and clock out:
  - Immediately tell your provider agency or CDS employer if the EVV alternative device is damaged or removed from your home, or if someone has tampered with the device; and
  - Return the alternative device to your provider agency or CDS employer when you are no longer receiving Medicaid services that require EVV.

Your failure to perform these responsibilities may result in a referral of Medicaid fraud to the HHSC Office of Inspector General.

Please see the EVV Electronic Verification Methods Policy for more information.

Section II – Additional Information

- Your personal information in the EVV system is private and confidential and may only be disclosed as allowed by federal and state laws, rules and regulations.
- Your service provider or CDS employee may use your home phone to clock in and clock out of the EVV system only if you approve.
- You can ask for an interdisciplinary meeting or service plan team meeting with your managed care organization's (MCO) service coordinator about concerns using EVV.

Electronic Visit Verification

If you have a complaint related to EVV, you may submit the complaint to the HHS Office of the Ombudsman:

- by phone at 877-787-8999;
- by fax at 888-780-8099; or
- by mail at:

HHS Office of the Ombudsman
P.O. Box 13247
Austin, Texas 78711-3247

Visit the HHSC EVV website for more information.

Electronic Visit Verification

Section III – Frequently Asked Questions (FAQ)

Do I have to participate in EVV?

Yes, if you get services that require EVV. You must allow your service provider or CDS employee to clock in when they begin and clock out when they end services using one of the acceptable methods. EVV is required for certain home and community-based services, such as Personal Service Provider Services, Protective Supervision, Personal Care Services, In-home Respite, Flexible Family Support and Community First Choice.

How do service provider and CDS employees clock in and clock out?

Service providers and CDS employees must use one of the following acceptable methods to clock in and clock out of the EVV system:

- EVV mobile method
- Your home phone (but only with your permission)
- EVV alternative device

You aren't allowed to clock in or clock out of the EVV system for the service provider or CDS employee for any reason. If you clock in or clock out for your service provider or CDS employee, a Medicaid fraud referral may be made to the Office of Inspector General, which may end up affecting your ability to get services.

What if I don't have a home landline or I don't want my service provider or CDS employee to use my home landline?

If you don't have a home landline, or don't want your service provider or CDS employee to use your home landline, tell this to your service provider or CDS employee as soon as possible.

The following are two options available other than your home landline that your service provider or CDS employee may use to clock in and clock out.

Option 1

Your service provider or CDS employee may use their mobile device to clock in and clock out of the EVV system.

Option 2

Your program provider, financial management services agency (FMSA), or CDS employer may order an EVV alternative device for your service provider or CDS employee. The device must:

- Be placed or affixed in your home by your program provider or CDS employer.
- Be in an area where your service provider or CDS employee can reach it.
- Always remain in your home.

Can I receive services in the community with EVV?

Yes. EVV doesn't change the location for where you get services. You can get services in accordance with your service plan and the existing program rules, at home and in the community.

Who do I contact with questions or concerns?

Please contact your provider agency representative or MCO service coordinator if you have any questions or concerns.

Visit the HHSC EVV website for more information.

Electronic Visit Verification

Section IV – Acknowledge Statement

I certify:

☐ I have read and understand my responsibilities for EVV.

☐ I was given an oral explanation of this form and given a copy.

Failure to follow your responsibilities may result in a Medicaid fraud referral or your services may be denied, suspended or terminated.

Signature - Member or Legally Authorized Representative	Date
Signature - Family Member or Caregiver (optional)	Date
Signature – MCO Service Coordinator	Date

Reporting Abuse, Neglect and Exploitation

You have the right to respect and dignity, including freedom from Abuse, Neglect and Exploitation.

What are Abuse, Neglect and Exploitation?

Abuse is mental, emotional, physical, or sexual injury, or failure to prevent such injury.

Neglect results in starvation, dehydration, overmedicating or under medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care and personal hygiene.

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

Reporting Abuse, Neglect or Exploitation

The law requires that you report suspected Abuse, Neglect or Exploitation, including unapproved use of restraints or isolation that is committed by a provider.

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

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

Report to Texas HHS by calling 1-800-458-9858 if the person being abused, neglected, or exploited lives in or receives services from a:

- Nursing facility;
- Assisted living facility;
- Adult day care center;
- Licensed adult foster care provider; or
- Home and Community Support Services Agency (HCSSA) or Home Health Agency.

Suspected Abuse, Neglect or Exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

Report all other suspected Abuse, Neglect or Exploitation to DFPS by calling 1-800-252-5400.

Report Electronically (non-emergency):

Go to https://txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

Helpful Information for Filing a Report

When reporting Abuse, Neglect or Exploitation, it is helpful to have the names, ages, addresses and phone numbers of everyone involved.

Fraud, Waste and Abuse

Do you want to report Fraud, Waste or Abuse?

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 Fraud, Waste or Abuse, which is against the law.

For example, tell us if you think someone is:

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

To report Fraud, Waste or Abuse, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184
- Visit https://oig.hhsc.state.tx.us/and click the red "Report Fraud" box to complete the online form; or
- You can report directly to your health plan at:

  Superior HealthPlan
  Attn: Compliance Department
  5900 E. Ben White Blvd.
  Austin, TX 78741
  1-866-685-8664

To report Fraud, Waste or Abuse, gather as much information as possible.

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

- Name, address and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and the number 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 Fraud, Waste or Abuse.

Glossary of Terms

- **Appeal** - A request for your managed care organization to review a denial or a grievance again.
- **Complaint** - A grievance that you communicate to your health insurer or plan.
- **Copayment** - A fixed amount (for example, $15) you pay for a covered health-care service, usually when you receive the service. The amount can vary by the type of covered health-care service.
- **Durable Medical Equipment (DME)** - Equipment and supplies ordered by a health-care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.
- **Emergency Medical Condition** - An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.
- **Emergency Medical Transportation** - Ground or air ambulance services for an emergency medical condition.
- **Emergency Room Care** - Emergency services you get in an emergency room.
- **Emergency Services** - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
- **Excluded Services** - Health-care services that your health insurance or plan doesn't pay for or cover.
- **Face-to-face** – Interactions taking place in-person or via audio and visual communication methods that meets the requirements of the Health Insurance Portability and Accountability Act. Face-to-face does not include audio-only communication.
- **Grievance** - A complaint to your health insurer or plan.
- **Habilitation Services and Devices** - Health-care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.
- **Health Insurance** - A contract that requires your health insurer to pay your covered health-care costs in exchange for a premium.
- **Home Health Care** - Health-care services a person receives in a home.
- **Hospice Services** - Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
- **Hospitalization** - Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
- **Hospital Outpatient Care** - Care in a hospital that usually doesn't require an overnight stay.
- **In-Person** - An interaction within the physical presence of another person. Does not include audio-visual or audio-only communication.
- **Medically Necessary** - Health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
- **Network** - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health-care services.
- **Non-participating Provider** - A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider, instead of a participating provider. In limited cases such as there are no other providers, your health insurer can contract to pay a non-participating provider.
- **Participating Provider** - A provider who has a contract with your health insurer or plan to provide covered services to you.
- **Physician Services** - Health care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Glossary of Terms

- **Plan** - A benefit, like Medicaid, to pay for your health-care services.
- **Pre-authorization** - A decision by your health insurer or plan before you receive it that a health-care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or pre-certification. Preauthorization isn't a promise your health insurance or plan will cover the cost.
- **Premium** - The amount that must be paid for your health insurance or plan.
- **Prescription Drug Coverage** - Health insurance or plan that helps pay for prescription drugs and medications.
- **Prescription Drugs** - Drugs and medications that by law require a prescription.
- **Primary Care Physician** - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health-care services for a patient.
- **Primary Care Provider** - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health-care services.
- **Provider** - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health-care professional, or health-care facility licensed, certified, or accredited as required by state law.
- **Rehabilitation Services and Devices** - Health-care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.
- **Skilled Nursing Care** - Services from licensed nurses in your own home or in a nursing home.
- **Specialist** - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
- **Urgent Care** - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Notes

5900 E. Ben White Blvd.
Austin, TX 78741

SuperiorHealthPlan.com