superior healthplan™

STAR+PLUS

Member Handbook

SuperiorHealthPlan.com

SHP_202512027 07_2025

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 staff 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
Ombudsman Managed Care Assistance Team	1-866-566-8989
Texas STAR+PLUS Program Helpline	1-800-964-2777
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
Superior Medical Ride Program Provided by SafeRide	1-855-932-2318
Teladoc (Telehealth Services)	1-800-835-2362
Eye Care (Centene Vision Services)	1-866-897-4785
Dental Care	1-888-308-4766
Behavioral Health	1-877-277-9772
Alcohol/Drug Crisis Line	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, text or chat 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 life, limb or sight.

Service Coordination

Superior's Service Coordinators are available to help you coordinate your medical and behavioral health care. We can also help you understand your services and benefits. Please call us at 1-877-277-9772. To learn more about Service Coordination, please see page 33.

Numbers to Remember

Superior Medical Ride Program
Non-Emergency Medical Transportation (NEMT) Services

Superior's Medical Ride Program (NEMT services) provides transportation to non-emergency health-care appointments for members who have no other transportation options. Transportation services for Superior members are provided by SafeRide. Call 1-855-932-2318 (TTY 7-1-1), 8:00 a.m.-6:00 p.m. Central Standard Time (CST), Monday-Friday to request a ride. To find out where your ride is, call 1-855-932-2319, 4:00 a.m. to 8:00 p.m. CST, Monday-Saturday. SafeRide has staff that speak English and Spanish and can also provide interpreter services if you speak another language. If you are deaf/hard of hearing, call TTY 7-1-1 for help. Please see page 20 for more information.

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:

1557 Coordinator **PO Box 31384, Tampa, FL 33631** **1-855-577-8234 | TTY: 711 | FAX: 1-866-388-1769** **SM_Section1557Coord@centene.com**	**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, our 1557 Coordinator 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

This notice is available at Superior HealthPlan's website: SuperiorHealthPlan.com/non-discrimination-notice.html

Language Assistance

ENGLISH:	To help you understand the information provided, language assistance services, including written translation, oral interpretation, as well as auxiliary aids and services, and other alternative formats are available to you free of charge by calling the number on the back of your Superior ID card (TTY: 1-800-735-2989).
SPANISH:	Para ayudarle a comprender la información facilitada, tiene a su disposición servicios de asistencia lingüística gratuitos, que incluyen traducción escrita, interpretación oral, así como ayudas y servicios auxiliares y otros formatos alternativos por llame al número que figura en el reverso de su tarjeta de identificación de Superior (TTY: 1-800-735-2989).
VIETNAMESE:	Để giúp quý vị hiểu thông tin được cung cấp, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ, bao gồm dịch thuật văn bản, thông dịch nói, cũng như các công cụ và dịch vụ phụ trợ và các định dạng thay thế khác. Để nhận dịch vụ và sự trợ giúp này, quý vị hãy gọi đến số điện thoại ghi ở mặt sau thẻ Superior ID (TTY: 1-800-735-2989).
CHINESE:	为了帮助您理解所提供的信息，我们免费为您提供语言协助服务，其中包括笔译、口译、辅助工具及服务、以及其他替代形式。要获得这些服务，请拨打您Superior会员卡背面的电话号码（文本电话：1-800-735-2989）。
KOREAN:	제공된 정보에 대한 귀하의 이해를 돕기 위해 서면 번역, 구두 통역, 보조 도구 및 서비스, 기타 대체 형식을 포함한 언어 지원 서비스를 무료로 제공합니다. 이를 이용하시려면 Superior ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 1-800-735-2989).
ARABIC:	تتوفر لك خدمات المساعدة اللغوية لمساعدتك على فهم المعلومات المقدمة، بما في ذلك الترجمة الكتابية، والترجمة الشفوية، بالإضافة إلى المساعدات والخدمات المساعدة، وأشكال بديلة أخرى مجانًا. للحصول على ذلك، اتصل بالرقم الموجود على ظهر بطاقة الهوية الخاصة بك (الهاتف النصي: 1-800-735-2989).
URDU:	فراہم کردہ معلومات کو سمجھنے میں آپ کی مدد کرنے کے لیے، زبان کی مدد کی خدمات، بشمول تحریری ترجمہ، زبانی تشریح، نیز معاون امداد اور خدمات، اور دیگر متبادل فارمیٹس آپ کے لیے مفت دستیاب ہیں۔ اسے حاصل کرنے کے لیے، اپنے سپیریئر شناختی کارڈ کے پچھلے نمبر پر کال کریں (TTY: 1-800-735-2989)۔

Language Assistance

TAGALOG:	Upang matulungan kang maunawaan ang ibinigay na impormasyon, ang mga serbisyo ng tulong sa wika, kabilang ang nakasulat na pagsasalin, pasalitang interpretasyon, gayundin ang mga karagdagang tulong at serbisyo, at iba pang mga alternatibong format ay available para sa iyo na walang bayad. Para makuha ito, tawagan ang numero sa likod ng iyong Superior ID card (TTY: 1-800-735-2989).
FRENCH:	Pour vous aider à comprendre les informations fournies, des services d'assistance linguistique, y compris la traduction écrite, l'interprétation orale, ainsi que des aides et services auxiliaires, et d'autres formats alternatifs sont à votre disposition gratuitement. Pour en bénéficier, appelez le numéro au dos de votre carte d'identité Superior (TTY : 1-800-735-2989).
HINDI:	प्रदान की गई जानकारी को समझने में आपकी सहायता के लिए, लिखित अनुवाद, मौखिक व्याख्या, साथ ही अतिरिक्त सहायता एवं सेवाओं व अन्य वैकल्पिक प्रारूपों सहित भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। इसे पाने के लिए अपने Superior आईडी कार्ड के पीछे दिए गए नंबर पर कॉल करें (TTY: 1-800-735-2989) ।
PERSIAN:	برای کمک به درک شما از اطلاعات ارائه شده، خدمات کمک زبان، از جمله ترجمه کتبی، ترجمه شفاهی، و همچنین کمک ها و خدمات کمکی، و سایر قالب های جایگزین به صورت رایگان در اختیار شما قرار می گیرند. برای دریافت آن، با شماره پشت کارت شناسایی Superior خود تماس بگیرید (TTY: 1-800-735-2989).
GERMAN:	Zum besseren Verständnis der bereitgestellten Informationen stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung, einschließlich Übersetzungs- und Dolmetschleistungen, Hilfsmittel und -dienste sowie anderer alternativer Formate. Rufen Sie dazu die Nummer auf der Rückseite der Superior Mitgliedsausweiskarte an (TTY: 1-800-735-2989).
GUJARATI:	આપવામાં આવેલી માહિતી સમજવામાં આપની મદદ કરવા, લેખિત અનુવાદ, મૌખિક અર્થઘટન, સાથે સહાયક મદદો અને સેવાઓ સહીતની ભાષા સહાયતા સેવાઓ અને અન્ય વૈકલ્પિક ફોર્મેટો આપના માટે વિનામૂલ્યે ઉપલબ્ધ છે. તે મેળવવા, આપના Superior આઈડી કાર્ડની પાછળની બાજુએ આપેલા નંબર પર કોલ કરો (TTY: 1-800-735-2989).
RUSSIAN:	Если вы говорите на русском языке, для вас доступны бесплатные услуги письменного и устного перевода, и другой языковой поддержки. Позвоните по номеру, указанному на обратной стороне Вашей членской карты Superior (номер с поддержкой телетайпа: 1-800-735-2989).
JAPANESE:	ご案内する情報のご理解に役立つよう、翻訳文や口頭での通訳のほか、補助的な援やサービス、その他の代替形式を含む言語支援サービスを無料でご利用いただけます。ご利用の際は、お持ちのSuperior IDカードの裏面に記載されている番号にお電話ください（TTY:1-800-735-2989）.
LAOTIAN:	ເພື່ອຊ່ວຍທ່ານເຂົ້າໃຈຂໍ້ມູນທີ່ໃຫ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ຊຶ່ງລວມມີການແປເອກະສານ, ລ່າມແປພາສາປາກເປົ່າ, ພ້ອມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອໃຫ້ແກ່ທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອຂໍເອົາການຊ່ວຍເຫຼືອນີ້, ໃຫ້ໂທຫາເບີທີ່ຢູ່ດ້ານຫຼັງຂອງບັດ Superior ID ຂອງທ່ານ (TTY: 1-800-735-2989).

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Member Handbook Questions

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

Introduction

About

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

You will get your health care from doctors, hospitals and clinics that are in Superior's network of contracted providers. You can get regular checkups, sick visits, well care and specialty care from a Superior STAR+PLUS provider when you need it.

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

You must use a Superior contracted 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. Show both the Superior member ID card and Medicaid ID card to your doctor so they know you are covered by Superior's STAR+PLUS program.

You are getting this member handbook because you were approved for Medicaid under the STAR+PLUS program. You either chose Superior as your MCO or you were assigned to Superior. If you do not understand the member handbook or need help reading it, call Superior Member Services at 1-877-277-9772. We can answer your questions about benefits and services available to you. You can get this handbook in English, Spanish, audio, larger print, Braille, CD or in other language formats if you need it.

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.
- Call your doctor first if you have a medical problem that is NOT life threatening or call Superior's 24-hour nurse advice line at 1-877-277-9772.
- If you cannot get your doctor, call Superior at 1-877-277-9772.
- 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 and Mobile App

Superior's Secure Member Portal and Mobile App are convenient and secure tools 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.

For more information see page 2.

Introduction

Superior Member Portal and Mobile App

Stay Connected

Superior makes it easy to access your account information wherever you are — on a computer or your smart device. It's easy to log in, convenient to use, and available 24/7. Manage your plan anytime, anywhere.

Online Member Portal

Set up your account in 3 easy steps

1. Go to Member.SuperiorHealthPlan.com.
2. Register with your email address, birth date and member ID (found on your Superior ID card).
3. Verify your account through email.

Member Mobile App

Set up your account in 3 easy steps

1. Search "Health Insurance Portal" in the App Store or Google Play.
2. From the "state" dropdown menu, select "Texas."
3. Use your Superior member portal login or create an account to get started.

- Access your ID card. View a digital version of your Superior Member ID card at any time.
- Search for care. Find doctors and urgent care near you, change your primary care provider, and more.
- View your benefits. See the specific plan benefits and services available to you.
- Take your health assessment. Let us know your health needs to better serve you.
- Send us a message. Get in touch with us through secure messaging if you need help.

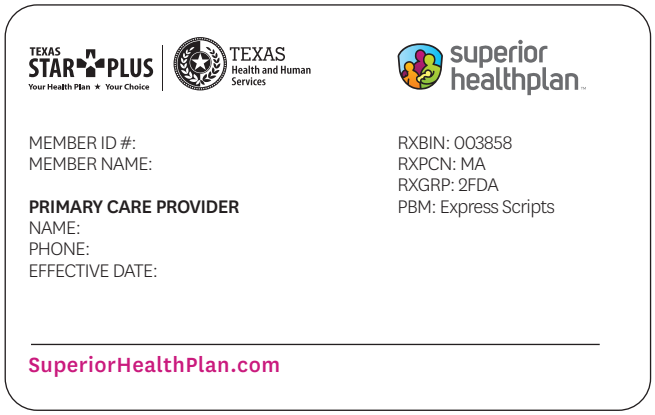
For questions, call Member Services at 1-877-277-9772.

Introduction

Your Superior Member ID Card

You should receive your Superior HealthPlan member 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. You can also access your ID card at any time on the Superior Secure Portal or Member Mobile App. For more details, see page 2.

Example of Superior HealthPlan STAR+PLUS member ID Card



Always carry your Superior member ID card with you and show it to the doctor, clinic or hospital to get the care you need. Your provider 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 Superior's Secure Member Portal or Member Mobile App and print a temporary ID card, save a digital version of your ID card or request your ID card by mail. See page 2 to learn more.

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

The Texas Health and Human Services Commission (HHSC) will send your Medicaid ID card. More information about your Medicaid ID card is on the next page.

If you are dual-eligible (you get both Medicaid and Medicare), your Superior member 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.

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 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. They will provide you with a Temporary Verification Form – Form 1027-A. You can use this form until you receive another card.

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

Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your medical and dental information through the secure online network, call toll-free at 1-800-252-8263 or opt out of sharing your health information at www.YourTexasBenefits.com.

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

- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - Medicare (QMB, MQMB)
  - Healthy Texas Women Program (HTW)
  - Hospice
  - STAR+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 YTB Medicaid card has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call toll-free (1-800-252-8263) if you have questions about the new card. If you forget your card, your doctor, dentist or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

The YourTexasBenefits.com Medicaid Client Portal

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

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

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

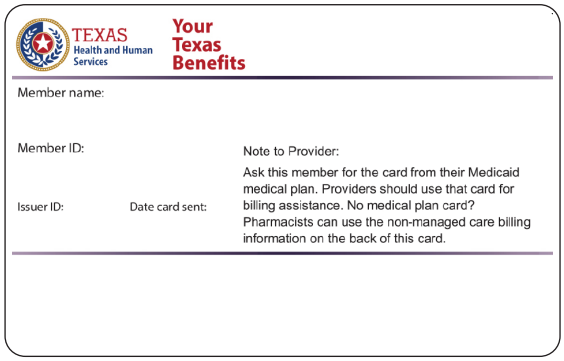
- Click **Log In**.
- Enter your User name and Password. If you don't have an account, click **Create a new account**.

Medicaid

- Click **Manage**.
- Go to the "Quick links" section.
- Click **Medicaid & CHIP Services**.
- Click **View services and available health information**.

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

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


TEXAS Health and Human Services

Your Texas Benefits

Member name:

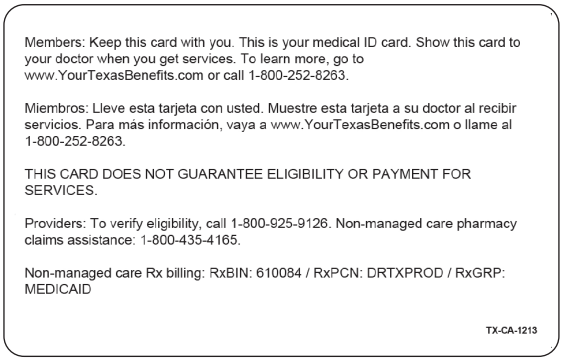
Member ID:

Issuer ID:

Date card sent:

Note to Provider:

Ask this member for the card from their Medicaid medical plan. Providers should use that card for billing assistance. No medical plan card? Pharmacists can use the non-managed care billing information on the back of this card.


Members: Keep this card with you. This is your medical ID card. Show this card to your doctor when you get services. To learn more, go to www.YourTexasBenefits.com or call 1-800-252-8263.

Miembros: Lleve esta tarjeta con usted. Muestre esta tarjeta a su doctor al recibir servicios. Para más información, vaya a www.YourTexasBenefits.com o llame al 1-800-252-8263.

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES.

Providers: To verify eligibility, call 1-800-925-9126. Non-managed care pharmacy claims assistance: 1-800-435-4165.

Non-managed care Rx billing: RxBIN: 610084 / RxPCN: DRTXPROD / RxGRP: MEDICAID

TX-CA-1213

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.

> ***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.

How do I renew my Medicaid coverage? What do I have to do if I need help with completing the renewal application?

To renew your Medicaid coverage, look for an envelope marked "time sensitive" from Texas Health and Human Services Commission (HHSC). It will include a letter. You will get this three (3) to four (4) months before your benefits end. You will need to sign a renewal form. You may also be asked to provide more information. The easiest way to do this or to sign the renewal form is to go to www.YourTexasBenefits.com. If you don't take any action by the due date listed in the letter, your benefits might end. Call Superior Member Services at 1-877-277-9772 if you have questions about renewing your Medicaid benefits.

What do I have to do If I move?

As soon as you have your new address, give it to the local HHSC benefits office by calling 2-1-1 and Superior's Member Services team 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 HHSC changes your address.

Medicaid

What happens if I lose 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. The back of the Your Texas Benefits Medicaid card has a website you can visit, www.YourTexasBenefits.com, if you have questions about your Medicaid coverage. You can also call the STAR+PLUS Program Helpline at 1-800-964-2777.

What is the Medicaid Lock-in Program?

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

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

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 picked a doctor from our list of providers to be your Primary Care Provider (PCP). This person will:

- Make sure 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.

Can a specialist be my PCP?

Superior will allow specialists to act as a PCP for members who have a special health-care need. Specialists must be approved by Superior before they can be your PCP. Tell your specialist if you would like them to be your PCP. Or call Superior Member Services at 1-877-277-9772 to ask for help.

If you are a woman, you may pick an obstetrician (OB) or gynecologist (GYN) as your PCP. Call Superior at 1-877-277-9772 to find an OB/GYN provider that is also a PCP. You will need to pick a PCP for each eligible family member. You can pick from:

- Pediatricians (only see children)
- General/family practice (they see all ages)
- Internal medicine (they usually see adults)
- OB/GYNs (they see women)
- Federally Qualified Health Centers/Rural Health Clinics

Can a clinic be my PCP? (RHC/FQHC)

Yes. Superior lets you pick a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as your PCP. An FQHC is a nonprofit clinic that provides care to people that live where there aren't many providers available. An RHC provides care to people that live in less populated areas where there aren't many providers available. If you have any questions, call Superior at 1-877-277-9772.

What if I choose to go to another doctor who is not my PCP?

If you go to a doctor that is not signed up as a Superior PCP, Superior will not pay that doctor and you will get billed for the services.

Your PCP is your doctor and they have the job of taking care of you. They keep your medical records, coordinate with any specialists that are involved in your care, know what medications you are taking and are the best people to make sure you are getting the care you need. This is why it is very important that you stay with the same doctor.

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 Superior at 1-877-277-9772. We can help you pick a new doctor. You might change your doctor because:

- The office is too far from your home.
- There is a long waiting time in the office.
- You can't talk to your doctor after hours.

Accessing Care - Primary Care Providers

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 many times can I change my PCP?

There is no limit on how many times you can change your PCP. You can change PCPs by calling us toll-free at 1-877-277-9772 or writing to Superior. Members can mail the Primary Care Provider (PCP) Change Request Form to:

Superior HealthPlan
Attn: Member Services
5900 E. Ben White Blvd.
Austin, TX 78741

The form can also be faxed to 1-866-918-4447.

The PCP Change Request Form is available online at SuperiorHealthPlan.com under Member Resources and Helpful Forms & Links.

More information on how to change your PCP is available in Superior's Secure Member Portal. Visit Member.SuperiorHealthPlan.com to learn more.

Are there any reasons why my request to change a PCP may be denied?

If you ask to change your doctor, it can be denied because:

- The new doctor you chose will not take more patients.
- The new doctor you chose is not a Superior PCP.

Can my PCP move me to another PCP for non-compliance?

Yes. If your doctor feels that you are not following their medical advice or if you miss a lot of your appointments, your doctor can ask that you go to another doctor. Your doctor will send you a letter telling you that you need to find another doctor. If this happens, call Superior at 1-877-277-9772. We will help you find a new doctor.

What if my doctor leaves the network of Superior providers?

If your doctor decides they no longer want 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.

If your doctor leaves your area, call Superior at 1-877-277-9772 and we 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 SuperiorHealthPlan.com. Just click on "Find a Provider." If you need assistance, call Superior at 1-877-277-9772.

What if I have an out of network provider?

Superior will pay a member's existing out of network provider for covered services until records, clinical information, and care can be transferred to an in network provider, or until such time as the member is no longer enrolled in STAR+PLUS, whichever is shorter. Superior will allow pregnant members past the 24th week of pregnancy to remain under the care of their current OB/GYN through the postpartum checkup, even if the provider is out of network.

Accessing Care - Primary Care Providers

What if there is not an in network provider available?

If covered services are not available within Superior's network, Superior will provide members with timely and adequate access to out of network providers of covered services for as long as those services are necessary and are not available within the network. Superior is not obligated to provide members with access to out of network providers of covered services if such services become available.

Continuity of Care and Out of Network Providers: For newly enrolled members, Superior will ensure that care is not disrupted or interrupted. For members transferring from another MCO, Superior will honor existing authorizations and service plans for up to 90 days after the transition to Superior or until Superior has evaluated and assessed the members needs.

Physician Incentive Plan

Superior HealthPlan rewards doctors for treatments that reduce or limit services to people covered by Medicaid. However, doctors in an incentive plan do not reduce or limit medically necessary services. You have the right to know if your primary care provider (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 is a specialist? What if I need to see a 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. Your doctor is the only one that can give you a referral to see a specialist. If you have a visit, or receive services from a specialist without your doctor's referral, or if the specialist is not a Superior provider, you might be responsible for the bill. In some cases, an OB/GYN can also give you a referral for related services.

What services do not need a referral?

You do not need a referral from your Primary Care Provider (PCP) for:

- True emergency services
- OB/GYN care
- Behavioral health services
- Routine vision services
- Routine dental services (for children)
- Family planning services
- Substance use disorder treatment

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 three (3) weeks for an 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 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.

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.

Accessing Specialty Care

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 make sure 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.

What if I go to the emergency room?

If you need urgent or emergency attention, you should get medical care right away and then you or the doctor should call Superior as soon as possible. If you are unsure if you need to go to the emergency room, you can call Superior's 24-hour nurse advice line, at 1-877-277-9772. Our nurses are ready to help you 24 hours a day, 7 days a week.

Superior Health Tip

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

Accessing Care - Nursing Facilities

What do I do if I want to go into a nursing facility?

Call your Service Coordinator if you think you might want to go into a nursing facility. Your Service Coordinator can work with you to find out what help you need.

What are the costs of a nursing facility? What do I have to pay for?

The cost of a nursing facility depends on where you live and the services you get. Nursing facilities provide for your medical, social and psychological needs. That includes:

- Room and board
- Social services
- Over-the-counter drugs, medical supplies and equipment
- Rehabilitative services
- Personal needs items such as soap, toilet paper and lotion

If you like items or brands other than what the nursing facility has, you may have to buy those yourself. You will have a set amount you pay the nursing facility for room and board. This is called your "applied income." That amount will depend on how much income you get. It is important that you always pay the nursing facility your applied income on time and in full. You can keep $75 each month for things like haircuts, stamps or clothes. If necessary, the nursing facility can set up a trust fund to deposit your $75.

There are other things you may have to pay for yourself. One is called a "bed hold." If you are gone from the nursing facility, you can pay them to hold your spot. Your nursing home can give you details. They can also tell you how much that will cost.

Will my STAR+PLUS benefits change if I am in a nursing facility?

No. Your Medicaid health benefits and services will not change if you go into a nursing facility.

If I am in a nursing facility, how do I find my Service Coordinator?

Each nursing facility has its own Service Coordinator. If you move to a new nursing facility, you will have a new Service Coordinator. The nursing facility can tell you the name of your Superior Service Coordinator. They can give you the phone number for your Service Coordinator. You can also call Superior Service Coordination at 1-877-277-9772 for thier name and phone number.

Where can I find a list of nursing facilities?

To find a nursing facility close to you, call Superior Member Services at 1-877-277-9772.

What if I want to change health plans?

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

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

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

Accessing Care - Just for Women

What if I need OB/GYN services and specialty care, including oncology?

You can get OB/GYN services and specialty care, including oncology, from your doctor. You can also pick an OB/GYN, specialty care, or oncology 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 needs. 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.

Superior allows you to pick any OB/GYN, whether that doctor is in the same group 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 are not limited to:

- One well-woman checkup each year. (Breast exams, mammograms, pap tests)
- Care related to pregnancy.
- Care for any female medical condition.
- 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 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 as 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 OB/GYN is not with Superior, please call Member Services at 1-877-277-9772. We will work with your doctor so they can keep seeing you, or we will be more than happy to help you pick a new doctor within the plan.

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.

Accessing Care - Pregnant Women and New Mothers

What if I am pregnant? Who do I need to call?

If you think or know you are pregnant, make an appointment to see your doctor or an OB/GYN. They will be able to confirm if you are pregnant or not and discuss the care you and your unborn child will need. When you know that you are pregnant, call Superior at 1-877-277-9772. Superior will provide you with a pregnancy Care Manager who will make sure you get you the medical care you need during your pregnancy.

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

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

What other services and education does Superior offer pregnant women?

Superior also has a special program to help you with your pregnancy called Start Smart for Your Baby®. This program can help answer your questions about childbirth, newborn care and eating habits. Superior also hosts educational virtual baby showers to teach you more about your pregnancy and new baby. For more information please visit our website at SuperiorHealthPlan.com/MemberEvents or call Member Services at 1-877-277-9772.

You may also connect with your care team through the Wellframe Care app. Wellframe is an application for your smartphone or tablet. Your Superior nurse can answer questions about your pregnancy or help you find extra resources. The Wellframe app sends you daily tips and advice to help you and your baby stay healthy. You can also send a private message to your nurse at any time. You'll know just what to do and feel better supported as you get further along. To install, download the Wellframe app from wellframe.com/download on your smartphone or tablet and select Create My Account.

Where can I find a list of birthing centers?

To find a birthing center close to you, call Member Services at 1-877-277-9772 or visit our "Find a Provider" tool at SuperiorHealthPlan.com.

How do I sign up my newborn baby?

If you are a Superior member when you have your baby, your baby is enrolled with Superior on their date of birth. Superior gets information from the hospital to add your baby as a new Superior member. The hospital will also notify Medicaid about the baby's birth. However, it is important that you contact the Department of State Health Services (DSHS) office to also report the birth of your baby. This will help make sure the baby's Medicaid enrollment is processed as soon as possible so your baby can get all the health care they need.

How and when do I tell my health plan? How and when do I tell my Case Worker?

You should let Superior know as soon as possible about the birth of your baby. We may already have the information about your baby's birth, but call us just in case. We will verify the correct date of birth for your baby with you, and also confirm that the name we have for your baby is correct. Call your Case Worker after your baby is born. You do not have to wait until you get your baby's Social Security number to get your baby signed up.

Can I choose my baby's Primary Care Provider (PCP) before the baby is born? Who do I call?

You can pick your baby's doctor even before they are born. Superior can even help you pick a doctor for your baby. Just call us at 1-877-277-9772.

Please note: This does not apply to STAR+PLUS members who are dual-eligible.

How and when can I change my baby's PCP or doctor?

As soon as Superior knows you are pregnant, we send you information about your pregnancy and your unborn baby. Superior will ask you to choose a doctor for your baby, even before the baby's birth. This will ensure that your baby's doctor will check the baby while in the hospital, and then take care of your baby's health-care needs after you and the baby are discharged from the hospital.

Accessing Care - Pregnant Women and New Mothers

If you have not selected a doctor for the baby before birth, you will be contacted to select a doctor for your baby. After the baby is thirty (30) days old, you can also change the doctor for the baby if you want a different doctor than the one you originally chose.

Please note: This does not apply to STAR+PLUS members who are dual-eligible.

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

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

Maternal Mental Health Resources

At Superior, we understand the importance of mental health, especially during and after pregnancy. We are committed to providing our members with access to the resources and support they need for optimal mental well-being.

In compliance with legislation and the Texas Health and Human Services Commission's (HHSC) Maternal Mental Health Network (MMHN) initiative, Superior has made it easier for members to locate providers who specialize in maternal mental health services.

Finding a Provider

Effective July 2024, members can locate providers that offer maternal mental health services using Superior's find-a-provider tool on our website. When using the tool, members can search providers who treat postpartum depression or anxiety through the Modalities and Disorders Treated feature. This feature narrows the member's search results to providers who are equipped to address maternal mental health conditions.

Screening and Referral

Superior has developed internal policies and procedures to identify members who may have a maternal mental health condition. If you screen positive for a maternal mental health condition, we will document the result and refer you for confirmation of diagnosis, treatment, and necessary follow-up care.

Support and Assistance

If you have any questions about accessing maternal mental health services or need assistance finding a provider, our Member Services team can help. For more information, contact Member Services at 1-877-277-9772 or visit our website at SuperiorHealthPlan.com.

Remember, your mental health is just as important as your physical health. Superior is dedicated to supporting you throughout and after your pregnancy.

Accessing Care - Special Health Programs

Healthy Texas Women Program

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

To learn more about services available through the Healthy Texas Women Program, write, call or visit the program's website:

Healthy Texas Women Program
P.O. Box 149021
Austin, TX 78714-9021
Phone: 1-877-541-7905 (toll-free)
Website: https://www.healthytexaswomen.org/htw-program
Fax: 1-866-993-9971

Texas Health and Human Services Commission (HHSC) Primary Health Care Services Program

The HHSC Primary Health Care Services Program serves women, children and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a co-payment, but no one is turned down for services because of a lack of money.

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

- Diagnosis and treatment.
- Emergency services.
- Family planning.
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services) and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the Healthy Texas Women Find a Doctor Locator at https://www.healthytexaswomen.org/find-doctor. To learn more about services you can get through the Primary Health Care program, email, call or visit the program's website:

Website: https://hhs.texas.gov/services/health/primary-health-care-services-program
Phone: 1-512-776-5922
1-800-222-3986 (toll-free)
Email: PrimaryHealthCare@hhs.texas.gov

Healthy Texas Women Breast & Cervical Cancer Services Program

The Breast and Cervical Cancer Services Program provides primary, preventive, and screening services to women age 18 to 64 years whose income is at or below the program's income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with HHSC. Community health workers will help make sure women get the preventive and screening services they need, such as clinical breast examination, mammogram, pelvic examination and pap test.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit https://www.healthytexaswomen.org/find-doctor.

Accessing Care - Special Health Programs

To learn more about services you can get through the Healthy Texas Women Breast and Cervical Cancer Services Program, visit the program's website, call, or email:

Website: https://www.healthytexaswomen.org/healthcare-programs/breast-cervical-cancer-services
Phone: 1-512-776-7796
Fax: 1-512-776-7203
Email: BCCSProgram@hhs.texas.gov

Healthy Texas Women Family Planning Program

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

To find a clinic in your area visit https://www.healthytexaswomen.org/find-doctor. To learn more about services you can get through the Family Planning program, visit the program's website, call or email:

Website: www.healthytexaswomen.org/family-planning-program
Phone: 1-800-335-8957
Email: famplan@hhs.texas.gov

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 44.

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. Superior staff can set up a three-way call between you, your Authorized Representative, or your Legally Authorized Representative (LAR) and a provider's office to schedule an appointment.

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 visits?

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. You should also bring a list of your current medications.

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 24-hour 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 www.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 or injured when out of town or traveling?

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?

If you are outside of the United States and need medical care, any health-care services you receive will not be covered by Superior. Medical services performed out of the country are not covered by Medicaid.

What if I am a Traveling Farm Worker?

You can get your checkup sooner if you are leaving the area. Call Superior at 1-877-277-9772 to get help scheduling an appointment.

Telehealth is Offered at No Cost

You can get easy access to a doctor when you want to see one without leaving your home. Avoid the ER and Urgent Care with 24-hour access to in-network providers for non-emergency health issues. Learn more about telehealth on page 21.

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 program helpline at 1-800-964-2777. You can change health plans as often as you want. 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. If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

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

What if I am in a nursing facility and want to change health plans?

If you are in a nursing facility you can change health plans as often as you want, but not more than once a month. You can change your health plan by calling the Texas STAR+PLUS program helpline at 1-800-964-2777.

Can Superior HealthPlan ask that I leave the plan?

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 else 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. The Texas Health and Human Services Commission (HHSC) 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 Care Managers that can help. Just call Member Services 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 people who speak different languages and can also 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 Medical Ride Program Non-Emergency Medical Transportation (NEMT) Services

What is Superior Medical Ride Program (NEMT)?

Superior's Medical Ride Program (NEMT services) provides transportation to non-emergency health-care appointments for members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. Superior is required to facilitate the most cost-effective mode of transportation that meets a member's individual need. These trips do NOT include ambulance trips, non medical appointments, or visits to providers who are not enrolled as a Medicaid provider. Transportation services for Superior members are provided by SafeRide.

What services are offered by Superior's Medical Ride Program?

There are many types of transportation services included in Superior's Medical Ride Program. They include:

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

If you need an attendant to travel to your appointment with you, Superior's Medical Ride Program will cover the transportation cost of your attendant.

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

Making Care Easier - Help to Access Health Care

Ride Monitoring and Responsible Use

It is Superior's goal is to make sure you have access to necessary transportation services. As part of our responsibility, we monitor usage patterns to identify opportunities to help you.

How do I get a ride?

You can request NEMT services through Superior's Medical Ride Program provided by SafeRide. If you need a ride, call SafeRide. SafeRide has staff that speak English and Spanish and can also provide interpreter services if you speak another language.

You should request your NEMT services (rides) as early as possible, and at least two working (business) days before you need the ride. In certain circumstances, you may request the NEMT service (ride) with less than two working (business) days' notice. These circumstances include:

- Being picked up after being discharged from a hospital;
- Trips to the pharmacy to pick up a medication or approved medical supplies;
- Trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

SafeRide

Appointments/Call Center: 1-855-932-2318; TTY: 7-1-1

Hours: 8:00 a.m.-6:00 p.m. CST, Monday-Friday

Where's My Ride: 1-855-932-2319; TTY: 7-1-1

Hours: 4:00 a.m.-8:00 p.m. CST, Monday-Saturday

How do I find out where my ride is?

You can call 1-855-932-2319 to find out the status of your ride.

How do I change or cancel my ride?

You must notify SafeRide prior to the approved and scheduled trip if your medical appointment is cancelled. To cancel your ride, log into SafeRide's member portal (https://superior.member.saferidehealth.com/login) or call SafeRide at 1-855-932-2318 to change or cancel your ride. Please call 24 hours in advance to change or cancel your ride.

Who do I call if I have a complaint about the transportation program?

If you have any problems with Superior's Medical Ride Program, call SafeRide at 1-855-932-2318.

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. As a Superior member, there is no cost for a telehealth visit with an in-network Superior provider.

Telehealth and telemedicine services 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 www.teladoc.com/Superior or calling 1-800-835-2362 (TTY: 711).

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

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 them most.

You now have full access to your health records on your mobile device. This allows you to manage your health better and know what resources are available to you.

*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 the webpage below.

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.

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).

Superior will be happy to help you make an appointment. Just call us at 1-877-277-9772.

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 them. It is much easier to call your doctor with your medical problems if they know 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. You also can call our 24-hour nurse advice line at 1-877-277-9772 for help with getting the care you need.

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 www.teladoc.com/Superior.

How soon should I expect to be seen for urgent care?

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 behavioral health condition?

An 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; or
- Which renders the member incapable of controlling, knowing or understanding the consequences of their actions.

What is an emergency medical condition?

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

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. You can also use the Superior Mobile App or Secure Member Portal to find a provider.

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, flu and fever
- 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. Call 1-877-277-9772.

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 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.

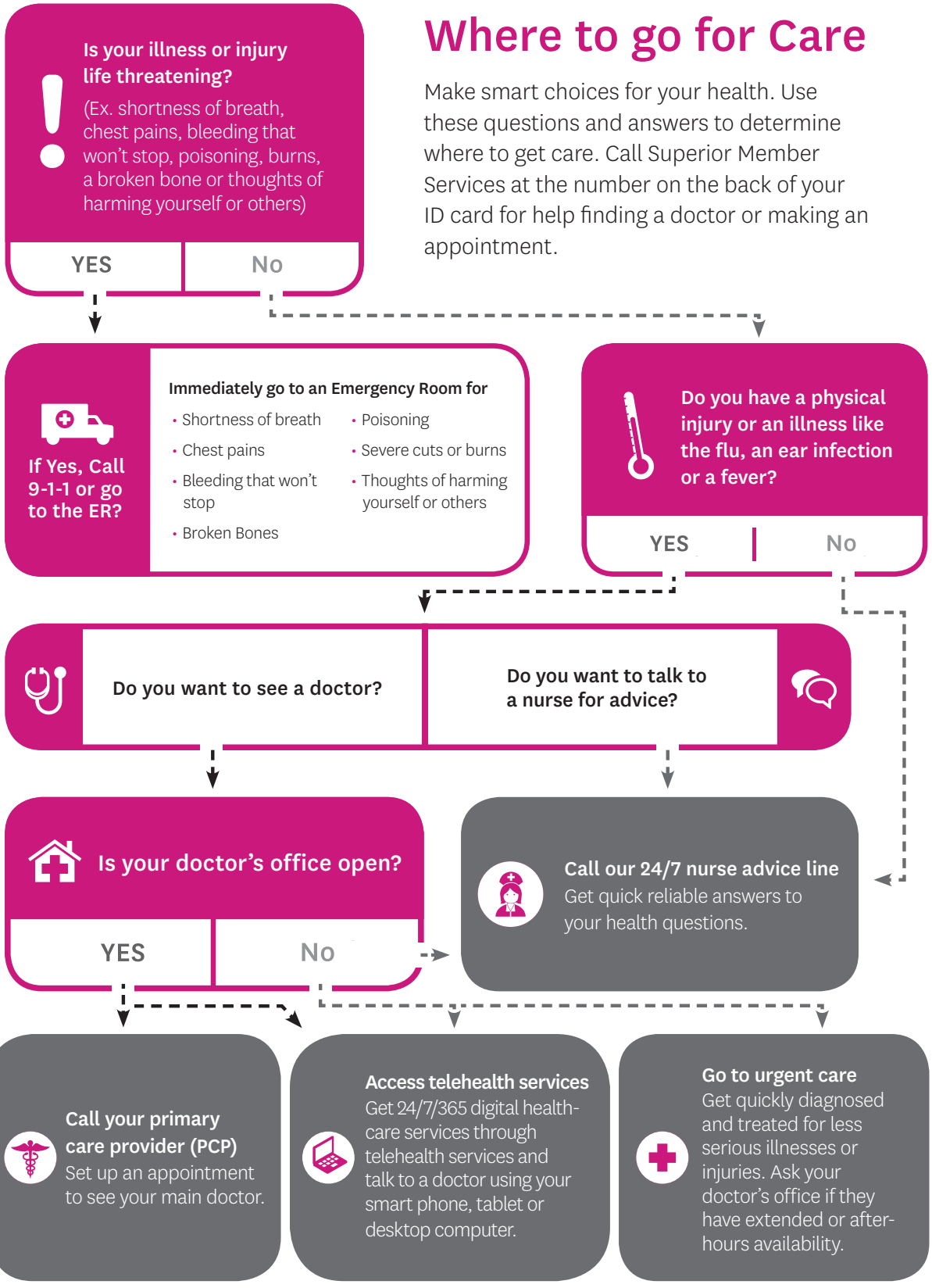
Immediately go to an ER if you have:

- 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.

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 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.

What is post-stabilization care?

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

What does medically necessary mean?

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

Medically necessary means:

(1) For members over age 20, non-behavioral health-related health-care services that are:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/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 over age 20, behavioral health services that:

(a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(d) are the most appropriate level or supply of service that can safely be provided;

(e) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the member or provider.

Superior is on Facebook

Superior wants to make sure you're as healthy as can be! Check out Superior's Facebook page for healthy tips and other helpful information at www.Facebook.com/SuperiorHealthPlan.

Benefits and Services

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.

All of these health-care benefits are called acute care benefits. This means that the benefits/services 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.

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
- Cancer screening, diagnostic, and treatment service
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Family Planning services
- Home health-care services (requires a referral)
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures
- 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
- Telemonitoring
- 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

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.

What services am I eligible for as a Medicaid Breast and Cervical Cancer (MBCC) member?

MBCC members are eligible for the full array of benefits under the STAR+PLUS program as detailed in this handbook. MBCC members, ages 18-20, may be eligible for additional benefits. Call Superior at 1-877-277-9772 for any specific benefit questions.

Call Superior 24 Hours a Day

Have a health question? Call Superior's nurse advice line 24 hours a day, 7 days a week. Just call 1-877-277-9772.

Benefits and Services

Are there any limits to any covered services?

Most Medicaid services for children (under 21 years of age) do not have any limits. Some Medicaid services for adults (more than 21 years old) 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 services are not covered by STAR+PLUS?

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

- Services received from a Provider not enrolled in Medicaid.
- Services or items only for cosmetic purposes.
- Items for personal cleanliness and grooming.
- Services decided to be experimental or for research.
- Gender-affirming surgery.
- Care that is not medically necessary.
- Services not approved by the Primary Care Provider (PCP), unless the PCP approval is not needed (i.e. family planning and behavioral health).
- 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 is Case Management for Children and Pregnant Women (CPW)?

Case Management for Children and Pregnant Women (CPW) is a case management program that provides health related case management services to children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and have health problems or are at a high risk for getting health problems. Case Management for Children and Pregnant Women is managed by Superior HealthPlan.

Case Management for Children and Pregnant Women

Need help finding and getting services? You might be able to get a CPW Case Manager to help you.

Who can get a CPW Case Manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and have health problems or are at a high risk for getting health problems.

What do CPW Case Managers do?

A CPW Case Manager will visit with you and then:

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

What kind of help can you get?

CPW Case Managers can conduct in-person visits for you/your family needs. CPW Case Managers can help you:

- Get medical and dental services with the right doctors.
- Get medical supplies or equipment.
- Find the right community resources for your needs.
- Access and address education/school related issues.
- Process the application of SSI and appeal an SSI denial.
- Develop service plans for your unmet needs.
- Ensure needs identified in your service plan are being met.
- Work on school or education issues.
- Work on other problems.

CPW Case Managers cannot:

- Provide health care or health education.
- Provide clinical, medical or therapy services.
- Give you a medical or mental health diagnosis.
- Determine a need for a specialist.

Who will help with my ongoing CPW activities?

Superior has nurses, behavioral health clinicians and social workers to provide case management for you. You may receive case management services from a CPW provider contracted with Superior or Superior's Care Management staff. Superior will help decide who will provide you with case management.

How can I get a CPW Case Manager?

Contact Superior Member Services for more information about CPW Case Management services at 1-877-277-9772 or call Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8 a.m. to 8 p.m.

What are my long-term services and supports (LTSS) benefits?

Long-term care services and supports 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 the providers that are right for your conditions and needs. Although a referral is not required, Superior does require an in-home assessment before any services can be authorized. To get these services, call Member Services at 1-877-277-9772.

There are two long-term care service and support benefits that all Superior STAR+PLUS members may be able to get:

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

There are other long-term care benefits that some Superior STAR+PLUS members can get based on their medical need. These are called Home and Community Based Services (HCBS) STAR+PLUS Waiver. These are:

- Adaptive aids and medical equipment
- Adult foster care
- Assisted living
- Cognitive Rehabilitation Therapy
- Consumer Directed Personal Attendant Services
- Emergency Response Services (ERS) – emergency call button
- Employment Assistance and Supported Employment
- Home delivered meals
- Medical supplies
- Minor home modifications
- Nursing services (in home)
- Personal Attendant Services (PAS)
- Physical Therapy, Occupational Therapy and Speech Therapy
- Protective supervision
- Respite care
- Service responsibility choice for Personal Attendant Services
- Some dental care
- Transition Assistance Services

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.

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 (Consumer Directed Services, Service Responsibility, Agency). 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.

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.

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

Benefits and Services

These are the services you can manage in CDS:

- Attendant Care
- CFC Habilitation
- CFC Personal Assistance Service
- Cognitive Rehabilitation Therapy
- Nursing
- Occupational Therapy
- Physical Therapy
- Respite Care
- Speech Therapy

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 department 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.

What if I need Durable Medical Equipment (DME) or other products normally found in a pharmacy?

Some Durable Medical Equipment (DME) and products normally found in a drug store are covered by Medicaid. For all members, Superior pays for nebulizers, ostomy supplies and other covered supplies and equipment if they are medically necessary.

Call 1-877-277-9772 for more information about these benefits.

Applied Behavior Analysis (ABA) Services

Applied Behavior Analysis (ABA) services are available for Superior Medicaid members with Autism Spectrum Disorder (ASD). The symptoms of ASD include restricted, repetitive patterns of behavior, interests, or activities and shortcomings in social communication and social interaction. These symptoms usually start in early childhood.

What Services are Provided?

ABA services must be prior authorized through Superior HealthPlan as a medically necessary service, required to treat, correct or improve the member's condition. A diagnosis of Autism Spectrum Disorder alone does not support the medical necessity of ABA. Licensed Behavior Analyst (LBA) is a new Medicaid provider type that will be providing these services. ABA services include ABA initial evaluation, re-evaluation, individual treatment, group treatment, parent/caregiver/family education and training, and interdisciplinary team meetings. Please contact your/your child's doctor, visit SuperiorHealthPlan.com, or call Member Services to locate a Medicaid enrolled LBA provider in your area available to deliver these services.

Benefits and Services

Who is Eligible for Services?

Medicaid managed care members in the STAR, STAR Health, STAR Kids and STAR+PLUS Medicaid for Breast and Cervical Cancer (MBCC) Program under the age of 21 with ASD are eligible for these services, if medically necessary. For more information, visit Superior's Autism Help webpage. (https://www.superiorhealthplan.com/members/medicaid/health-wellness/autism-help.html)

Behavioral Health Services (Mental Health and Substance Use Disorders)

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

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 team. Superior has a group of mental health and substance use disorder specialists to help you.

You do not have to get a referral from your doctor for these services. We 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 should I 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, text or chat 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 Superior network, we will work with the provider to keep caring for you until medical records can be transferred to a new doctor.

Collaborative Care Model

The Collaborative Care Model (CoCM) coordinates care for member's 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 member's wellbeing. CoCM helps manage Behavioral Health conditions as chronic diseases, instead of treating acute symptoms.

Benefits and Services

CoCM services focus on:

- **Patient-Centered Team Care**. Partnership between all team members using shared care plans that include the member's 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 member's personal goals and clinical outcomes.
- **Evidence-Based Care**. Health care that is based on the best available, current, effective and relevant information.

Dental Care

How do I get dental services?

Your Medicaid dental plan provides dental services that help prevent tooth decay and services that fix dental problems. Call your Medicaid dental plan to learn more about the dental services they offer. Superior covers emergency dental service you get in a hospital or ambulatory surgical center. This includes services the doctor provides and other services you might need, like anesthesia.

For questions or dentist information, call: DentaQuest 1-888-308-4766

Are emergency dental services covered by Superior?

Superior covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

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

What do I do if 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.

Eye Care

How do I get eye care services?

In Medicaid, eye care services are different for adults and children. If you are over 21, you can get an eye exam and glasses every two (2) years. You cannot get your glasses replaced if you break or lose them.

With Superior, you get extra vision benefits too. Call Centene Vision Services, Superior's vision provider, at 1-888-756-8768 to find out how. Members that have Supplemental Security Income (SSI)-related Medicaid Assistance Only are not able to get the extra vision benefits.

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 Centene 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 Centene Vision Services 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.

Special Services

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 you to:

- Identify your needs.
- Work with you, your family or community supports, your doctor(s) and other providers to develop a service plan.
- Help make sure you receive your services on time.
- Make sure you have a choice of providers and access to covered services.
- Coordinate Superior-covered services with social and community support services.

Superior wants you to be safe and healthy, to be involved in your service plan and to help you live where you choose. We will assign a Service Coordinator to any Superior STAR+PLUS member who asks for one. We will also offer a Service Coordinator to Superior members if a review of your needs for health and support services shows that they might be able to help.

How can I talk to a Service Coordinator?

If you would like to speak with a Superior Service Coordinator, call 1-877-277-9772.

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.

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

If you are receiving LTSS benefits your Superior Service Coordinator will continue to visit you in your home to perform required assessments for these services.

What are In-Lieu of Services and Settings?

Partial Hospitalization Services and Intensive Outpatient Services

Superior understands there may be times when inpatient hospital admission is needed for members experiencing mental health or substance use disorder (SUD) issues. When these services are needed, they are ordered by your doctor. More information about inpatient hospital admissions, which include behavioral health admissions, is found in the Accessing Specialty Care section of your member handbook.

For some members, outpatient services may be an alternate option to an inpatient hospital admission. These outpatient services include either outpatient Partial Hospitalization Program (PHP) services or Intensive Outpatient (IOP) services. PHP and IOP services that are medically necessary are available to Superior adult members, aged 21 and older for outpatient care as “In Lieu Of Services” instead of an inpatient admission. PHP and IOP services are also available for Medicaid members under the age of 21 as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, known in Texas as Texas Health Steps services.

- **PHP services** provide a structured day program of outpatient behavioral health services. PHP may provide services for mental health, SUD, or both. These services are similar to short-term hospital inpatient programs. The treatment level is more intense than outpatient day treatment or psychosocial rehabilitation.
- **IOP services** are used to treat issues that do not require SUD detoxification or 24-hour supervision. IOP services are generally less intense than PHP services. IOP may be delivered for mental health, SUD, or both. IOP services are organized non-residential services providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for 4-12 weeks, but less than 24 hours per day.

Special Services

How do I get In-Lieu of Services and Settings?

The member's doctor must provide an order to get PHP or IOP services from one of Superior's network providers if the doctor believes this is the best care for the member, instead of an inpatient admission. Superior requires prior authorization for both PHP and IOP services. If the member's doctor believes that the best treatment is PHP or IOP instead of being admitted to an inpatient hospital, the doctor will discuss this option with the member, and confirm the member's agreement with, or refusal of the proposed IOP or PHP treatment, instead of an inpatient admission. Members can refer to the Rights and Responsibilities section of their member handbook by visiting SuperiorHealthPlan.com/Handbook. This section will explain the member's right to agree to or refuse treatment, and the right to actively participate in treatment decisions.

The member's doctor will issue an order for the proposed IOP or PHP treatment and a prior authorization request will be sent to Superior to have the services authorized for approval by or before treatment. Superior will review the prior authorization request to confirm if the PHP or IOP service requested is medically necessary and appropriate for the member.

The member's doctor may also determine that PHP or IOP may be an appropriate 'step down' level of care for a member who is discharging from an inpatient psychiatric hospital, when appropriate. In addition, neither the doctor nor Superior will require that IOP or PHP services are received before an inpatient admission is ordered or approved, when a member's treatment is required in an inpatient hospital.

Members can access a listing of providers available in Superior's network to provide PHP and IOP services through SuperiorHealthPlan.com/FindAProvider by clicking Search Medicaid or CHIP Providers or Search STAR Health Providers. For assistance with locating an IOP or PHP provider in the member's area or to get a paper copy of a provider directory at no cost, call Member Services at 1-877-277-9772.

When and how do I file for an appeal for Partial Hospitalization Services and Intensive Outpatient Services?

If a requested Partial Hospitalization or Intensive Outpatient service that requires authorization is denied or limited, Superior will send you a letter. You have the right to appeal Superior's decision if Medicaid covered services that require authorization 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/your child needs.
- Is denying coverage for care you think should be covered.
- Is providing a partial approval for a covered service.

You, a provider or someone else acting on your/your child's behalf can appeal an action.

You can ask for an internal health plan appeal within 60 Days from the date of Superior's Notice of Adverse Benefit Determination letter. A Superior Member Services Advocate can help you file an appeal or answer questions about the status of an appeal. Just call Member 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.
- Psychiatric partial and inpatient hospital services (for members 21 and over).
- Non-hospital and inpatient residential detoxification, rehabilitation and half-way house.
- Crisis services 24 hours a day, 7 days a week.

Special Services

- Medications for mental health and substance use disorder care.
- Lab services.
- Referrals to other community resources.
- Targeted Case Management.
- Mental Health Rehabilitation.
- Counseling services for adults.
- Transitional health-care services.

Bonus Behavioral Health Services:

- **Behavioral Health Emergency Room (ER) Follow-up Incentive Program**. $20 reward for members who complete a follow-up visit with a health care professional within 7 days of an ER visit for substance use disorder. Members are eligible to receive this Value-added Service 1 time per year. Excludes STAR+PLUS members who are dual-eligible.
- **Extra Help Getting a Ride**. Rides to behavioral health community supports and services such as a ride to the local library, community events that support mental health, AA/NA meetings, and more. Rides are provided on a case-by-case basis to STAR+PLUS members who do not reside in an ICF-IID residential home. This Value-added Service must receive prior authorization from Service Coordination.
- **Inpatient Follow-up Incentive Program**. $20 reward for members who have been admitted to an inpatient facility for a mental health or substance abuse diagnosis and go to a follow up doctor visit within 7 days of leaving the hospital. Members are eligible to receive this Value-added Service 1 time per year. Excludes STAR+PLUS members who are dual-eligible.
- **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.

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.

Person-Centered Planning

As a member in a community setting, person-centered planning gives you the chance to have greater independence in your community through self-direction. It incorporates your individual perceptions and experiences, preferences, and choices. You can control how you receive your services and what providers you want to use. You can also make sure your medical and non-medical needs are met. Person-centered planning is meant to help you reach your personal goals. It also allows you to have the quality of life and level of independence you want.

You will work with your Service Coordinator during your person-centered planning and choose the people you want to be included in the process.

Your person-centered plan will include topics like:

- Your strengths and preferences.
- Your goals and desired outcomes.
- The services and supports that are important to you and that meet the needs identified through your functional assessment.
- The way you want your services to be provided and your chosen providers of those services.

You will be given a signed copy of your easy to understand, agreed upon plan. You can also get a copy for the people you want to be included in your planning. Some of the forms that the Service Coordinator may complete as part of the person-centered process are the Medical Necessity Level of Care, Individual Services Plan, Functional Needs Assessment and Self-Directed Services Assessment (if applicable).

The person-centered service plan and appropriate forms will be reviewed and revised every 12 months, when your needs change, or at your request.

Special Services

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. Some of these services and agencies include:

- State and federal agencies - HHSC, public health departments, SUD, mental health, IDD, hospice, rehabilitation, income support, nutritional assistance, family support agencies.
- Social service agencies - Area agencies on aging, residential support agencies, independent living centers, supported employment agencies.
- City and county agencies - Welfare departments, housing programs, emergency medical services.
- Civic and religious organizations - Volunteer and service groups, faith organizations.
- Consumer groups, advocates, and councils - Legal aid offices, member and family support groups, caregiver support, permanency planning.
- Affordable housing programs - Section 811, local housing authorities, homeless service agencies.

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

Help for Special Health-Care Needs

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, 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.
- Will follow your progress and make sure you are getting the care you need.
- Answer your health-care questions.

What is Community First Choice (CFC)?

Community First Choice (CFC) is a Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities. You need to meet requirements intellectual or developmental disabilities or a related condition, mental health conditions, and/or physical health conditions who also have a need for CFC services as determined by a functional assessment. You need to meet requirements for institutional level of care from a facility like a Nursing Home, Intermediate Care Facility or Institution for Mental Disease. You may be able to get these services if you live in a community-based home.

CFC helps members with daily living needs. CFC services include:

- Personal Attendant Services (PAS): Help with daily living activities and health-related tasks.
- Habilitation: Services to help learn new skills and care for yourself.
- Emergency Response Services (ERS): Help if you live alone or are alone for most of the day.
- Support Management: Training on how to select, manage and dismiss attendants.

Your Superior Service Coordinator will be able to help schedule an assessment for CFC if you think you need these services. For more information, you can call Member Services at 1-877-277-9772.

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

Special Services

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.

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 can 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 feels 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.

Disease Management

Asthma Program

If you have asthma, Superior has a 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.

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.

Chronic Obstructive Pulmonary Disease (COPD) Program

If you have Chronic Obstructive Pulmonary Disease (COPD), Superior has a 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.
- May make a whistling sound when they breathe.
- Have tightness in their chest.
- Have shortness of breath throughout the day that gets worse after physical activity.
- May feel tired doing normal day to day activities.

Special Services

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.

Chronic Pain Program

If chronic pain 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 chronic physical pain conditions.
- Have a diagnosis of substance use disorder or other behavioral health condition.
- Need education and/or support.

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.

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.
- Have had a change in your medicine.
- Are having to go to the doctor more often because of heart failure.
- Want to learn more about how to live well with your heart failure.

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.

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.

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.

Special Services

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:

- 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 or emergency room.

Lifestyle Programs

If you have difficulty managing your stress or weight, and/or unable to quit smoking and you would like help, Superior has programs that can assist you. Call Superior at 1-877-277-9772 if you:

- Are a current tobacco user with an interest in quitting in the next 30 days (including pregnant women).
- Have a lack of physical activity.
- Have poor nutrition.
- Have perceived high stress levels.

Perinatal Depression

If you are experiencing depression during pregnancy or up to two months after delivery that 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:

- Take a medication for depression.
- Have been diagnosed with depression.
- Have symptoms or reports of depression.

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.

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.

Electronic Visit Verification

What is Electronic Visit Verification (EVV)?

Electronic visit verification (EVV) is a computer-based system that electronically verifies when service visits occur. It also documents the exact time services begin and end. EVV is required for most home and community-based services provided by Superior, including Personal Attendant Services (PAS), In-Home Respite Services, Community First Choice (CFC) PAS, Habilitation, Medicaid Home Health Care Services (HHCS), and Consumer Directed Services (CDS).

The Texas Health and Human Services Commission (HHSC) implemented EVV to verify that members receive the services authorized for their support and for which the state is being billed. Time will be logged using an HHSC-approved EVV System and one of three EVV time recording methods. These methods include:

- Mobile telephone application
- Member's home landline telephone
- Approved alternative device

How does EVV work?

Your attendant will clock in using one of the HHSC approved time recording methods when he or she begins providing your services. He or she will then clock out when the services are completed. EVV will help make sure you, as a member, get all your authorized services.

What if I don't have a home landline phone?

If you don't have a landline phone in your home and the attendant does not have access to the mobile phone application, please tell the agency that provides your services. The agency will install an alternative device in your home so your attendant can accurately record the time services begin and end. If you are unsure if your phone is a landline, please request an alternative device. Member's personal cell phones are not an acceptable replacement for a home landline.

The alternative device can be installed anywhere in the home that is convenient for access to the attending provider. The device must remain inside the home at all times. If the device malfunctions or somehow gets lost, please let your attendant know as soon as possible. They can then request a replacement from the selected EVV vendor and the alternative device will be re-installed.

Only CDS employers have the option to allow their employees to use the CDS employer's personal cell phone. If a CDS employer chooses to let his or her CDS employees use the CDS employer's personal cell phone for EVV, the CDS employer will be responsible for cell phone charges. CDS employers must document their request to use the CDS employer's personal cell phone or to request additional landline numbers for the EVV system.

Please note, the use of a member's personal cell phone is not allowed and your attendant should never ask to use your cell phone to call in and out.

Do I have to participate in EVV?

Yes. You must do one of the following:

1. Let your attendant use your home landline phone if they do not have access to the mobile phone application to access the EVV system; OR
2. Let the agency that provides your services install the alternative device. That way, your attendant can use the device to record a timestamp for when they begin and end their authorized services for you.

How do I find out more about EVV?

If you have any questions about EVV, please contact your Superior Service Coordinator or contact Superior Member Services. Information about EVV is also on the Superior website at SuperiorHealthPlan.com. Click on "Medicaid & CHIP Plans," then on "Member Resources." You can also visit the HHSC EVV website at https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification.

Family Planning

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

Superior provides family planning services to all members. This includes members under the age of 18. 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.

Superior allows freedom of choice to its members to choose any in-network or out-of-network Medicaid participating family planning 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 https://www.healthytexaswomen.org/healthcare-programs/family-planning-program, or you can call Superior at 1-877-277-9772 for help in finding a family planning provider.

Superior Health Tip

Medicines can be safe if you take them correctly. They can help you get better when you are sick. Medicines 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.

If you have any questions about your medications please contact your doctor.

Pharmacy Services

What are my prescription drug benefits?

You get unlimited prescriptions through your Medicaid coverage if you go to a drug store that takes Superior members. There are some medications that may not be covered through Medicaid. The drug store can let you know which medications are not covered, or help you find another medication that is covered. You can also ask your doctor or clinic about what medications are covered, and what is best for you. Call Superior at 1-877-277-9772 if you have questions.

How do I get my medications?

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

All prescriptions you get from your doctor can be filled at any drug store that is in network with Superior. If you need help finding a drug store, call Superior at 1-877-277-9772.

How do I find which medications are on the formulary?

In order to be covered, a medication should be included on the Texas Medicaid Formulary. The formulary is listed on the Texas Vendor Drug website. (https://www.txvendordrug.com/formulary) You can request a paper copy of the formulary at no cost. The paper copy will be sent to you within five (5) Business Days of your request. Please call Superior toll free at 1-877-277-9772 if you have any questions.

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

If you have trouble getting your medications, please call Member Services at 1-877-277-9772.

How do I find a network drug store? What do I bring with me to the drug store?

Prescriptions for members are provided through drug stores contracted with Superior. You can get your prescriptions filled at most drug stores in Texas, such as CVS (which includes locations inside of Target), HEB, Walmart and Randalls. If you need help finding a drug store, call Superior at 1-877-277-9772. A list is also available online at 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.

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

Superior has many contracted drug stores that can fill your medications. It is important that you show your Superior member ID card at the drug store. If the drug store tells you they do not take Superior members, you can call Superior 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?

Superior also offers 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 stores that may offer home delivery service in your area.

What if I lose my medication(s)?

If you lose your medications, you should call your doctor or clinic for help. If your doctor or clinic is closed, the drug store where you got your medication should be able to help you. You can also call Superior's Member Services team at 1-877-277-9772. We can help you get the medications you need.

Pharmacy Services

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

If your doctor cannot be reached to approve a prescription, you may be able to get a three (3)-day emergency supply of your medication. Please have your drug store call the pharmacy help desk for assistance. Call Superior at 1-877-277-9772 for help with your medications and refills.

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 plan. Under Medicare, you have choices. Make sure the Medicare drug 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.
- Plans may require you to pay a copay for each prescription.
- There's no limit on the number of prescriptions you can fill each month.

How do I get my medications if I am in a Nursing Facility?

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 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. 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 drug store.

What if I am in the Medicaid Pharmacy Lock-in Program and I need to change my Lock-in pharmacy?

In the event you need medicine that your Lock-in pharmacy does not have, your Lock-in pharmacy is closed, you are currently not near your Lock-in pharmacy, or need any other assistance getting your medicine, please contact Superior by calling Member Services at 1-877-277-9772. A dedicated member of our team will review your request and provide assistance.

How do I receive my medication if I am in the Medicaid Lock-in Program during an emergency?

In the event you need medicine that your Lock-in pharmacy does not have, your Lock-in pharmacy is closed, you are currently not near your Lock-in pharmacy, or need any other assistance getting your medicine, please contact Superior HealthPlan by calling the Member Services at 1-877-277-9772. A dedicated member of our team will review your request and provide assistance.

What other items do my pharmacy benefits cover?

When covered by Texas Medicaid, Superior pays for medically necessary prescribed over-the-counter drugs, vaccines, COVID-19 at home test kits, vitamins and minerals.

Call 1-877-277-9772 for more information about these benefits.

Extra Benefits and Services

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

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

- **24-hour Emergency Response Services**. Superior will provide round-the-clock emergency response services (ERS) for up to 6 months when a member is discharged from a hospital, resulting from an acute inpatient hospital stay, or from a nursing facility back into the community setting. This is a Value-added Service for all Superior STAR+PLUS non-HCBS Waiver and non-CFC members who do not reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). ERS must be preauthorized by Superior's Service Coordination Department.
- **Behavioral Health Emergency Room (ER) Follow-up Incentive Program**. $20 reward for members who complete a follow-up visit with a health care professional within 7 days of an ER visit for substance use disorder. Members are eligible to receive this Value-added Service 1 time per year. Excludes STAR+PLUS members who are dual-eligible.
- **Careopolis and Kiddopolis**. An online "caring community" enabling members to engage friends, family and caregivers as it relates to their healing or healthcare journey. Members create and manage private online accounts through Careopolis and Kiddopolis to enhance connections with friends and loved ones.
- **Cervical Cancer Screening Incentive Program**. $50 reward for current Superior female STAR+PLUS members ages 18 to 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.
- **Diabetes Testing Incentive Program**. $20 reward every 6 months for STAR+PLUS members with diabetes who do not reside in an ICF-IID residential home or nursing facility. Members must complete a blood sugar test (HbA1c) with a result less than 8 to receive rewards. This Value-added Service is limited to two $20 rewards per year. Excludes STAR+PLUS members who are dual-eligible.
- **Extra Dental Benefits**.
  - $750 annually towards exams and cleanings, x-rays, fluoride treatments or a simple extraction for non-dual, non-HCBS Waiver STAR+PLUS members. Limited to members in Dallas, Hidalgo, MRSA Central and Travis.
  - $500 annually towards exams and cleanings, x-rays, fluoride treatments or a simple extraction for non-dual, non-HCBS Waiver STAR+PLUS members in Nueces.
  - $250 annually in dental services towards exams, x-rays, cleanings and fluoride treatments for non-dual, non-HCBS Waiver STAR+PLUS members. Limited to members in Lubbock and MRSA West.
  - Non-dual members in Lubbock and West SDA's may receive a Dental Care Kit to keep teeth and gums healthy. Kit includes a toothbrush, toothpaste and dental floss. This Value-added Service is available upon request.
- **Extra Foot Doctor (Podiatry) Services**. $50 reward for STAR+PLUS members with diabetes or a history of foot ulcers, that complete 2 podiatry office visits, 1 vascular surgeon office visit and a comprehensive foot exam within a year. Limited to one $50 reward per year. Excludes STAR+PLUS members who are dual-eligible.
- **Extra Help Getting a Ride**. Ride assistance for members when Medicaid transportation is not available. Rides must be pre-authorized and scheduled at least two (2) business days before the appointment. Travel must be within the service delivery area and not to exceed 30 miles, one way. Travel reimbursement, ambulance and emergency transport are excluded. This includes:
  - Rides to behavioral health community supports and services such as a ride to the local library, community events that support mental health, AA/NA meetings, and more. Rides are provided on a case-by-case basis to non-dual STAR+PLUS members who do not reside in an ICF-IID residential home. This Value-added Service must receive prior authorization from Service Coordination.
  - Rides for STAR+PLUS members enrolled in health or safety education classes including diabetes self-management education. Educational classes are limited to 2 roundtrip rides per year. Service Coordination must approve utilization. Excludes STAR+PLUS members who are dual-eligible.

  - Rides for STAR+PLUS members enrolled in "A Matter of Balance" fall prevention classes. "A Matter of Balance" transportation limited to 8 roundtrip rides per lifetime. This is for members who do not reside in a nursing facility. Service Coordination must approve utilization.
  - Rides for members attending in-person nutritional counseling. This is for members who do not reside in a nursing facility. Nutritional counseling rides are limited to 4 roundtrip rides per year. Service Coordination must approve utilization.
  - Rides for members accessing their dental Value-added Service benefits. Limited to 2 roundtrip rides per year. Service Coordination must approve utilization. Excludes STAR+PLUS members who are dual-eligible.
  - Rides for members to a local benefits office. Benefits office visit rides limited to 1 roundtrip ride per year. Service Coordination must approve utilization.

- **Extra Vision Services**. Members are eligible to receive a $150 allowance per year towards a choice of upgraded eyeglass frames and lenses or contact lenses not covered by Medicaid. This allowance may not be used towards replacement eyewear or sunglasses. Coverage is for new frames and lenses and does not cover additional features such as tints and coating. The member will be responsible for any Medicaid non-covered vision charges over $150. Excludes STAR+PLUS members who are dual-eligible.
- **Fall Prevention Program Graduation Incentive**. STAR+PLUS members not residing in an ICF-IID residential home or nursing facility can earn a $50 reward upon attending and graduating from an 8-week fall prevention program called "A Matter of Balance." Members will learn to control their fear of falling, set goals to increase exercise to promote strength and balance and change their environment to reduce fall risk factors. Participating members are subject to the rules and regulations set forth by the program and its sponsor organization, as applicable. Members must provide verification of graduation to be eligible. Limited to one per member lifetime.
- **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 all interested members by providing GED preparatory materials and identifying available testing centers close to the member. Members must be enrolled with Superior for at least 60 days to be eligible. This Value-added Service is limited to one per member lifetime.
- **Help for members with Asthma**. Members enrolled in Asthma Disease Management are offered enhanced asthma care. Participating members get an allergy-free mattress cover and pillowcase to help control asthma symptoms when enrolled in Asthma Disease Management for 60 days. Members are eligible to receive this Value-added Service one time per year. Excludes STAR+PLUS members who are dual-eligible.
- **Home-delivered Meals**. Non-HCBS Waiver members who do not reside in an ICF-IID residential home have access to 10 home-delivered prepared meals per year following discharge from an acute inpatient hospital stay or from a nursing facility back into the community setting. Home-delivered meals must be preauthorized by Superior's Service Coordination Department.
- **In-home Respite Services**. Non-HCBS Waiver members with certain complex and chronic conditions will have access to up to 16 hours of in-home respite services each year. This is available to all STAR+PLUS non-HCBS waiver members who do not reside in an ICF-IID residential home. Services must be preauthorized by Superior's Service Coordination Department.
- **Intellectual and Developmental Disabilities (IDD) Camp Allowance**. Up to $100 each year for STAR+PLUS (IDD) members not residing in an ICF-IID residential home or nursing facility to enroll in a camp. To help promote opportunity and increased independence members are eligible to receive this Value-added Service one time per year. Participating members are subject to the rules and regulations set forth by the organization, as applicable. Value-added Service must be authorized by Superior's Service Coordination Department 90 days prior to the start date. Member is responsible for the remaining balance to be paid to the organization/camp.

Extra Benefits and Services

- **Inpatient Follow-up Incentive Program**. $20 reward for members who have been admitted to an inpatient facility for a mental health or substance abuse diagnosis and go to a follow up doctor visit within 7 days of leaving the hospital. Members are eligible to receive this Value-added Service 1 time per year. Excludes STAR+PLUS members who are dual-eligible.
- **Joy for All™**. Eligible STAR+PLUS non-dual members can receive a Joy for All™ battery-operated plush companion pet. Members must:
  - Be enrolled in MIND at Home or Cognitive Adaptation Training Care Management for 60 days, and
  - Have a diagnosis of dementia or Alzheimer's.

  Value-added Service must be authorized by Superior's Service Coordination Department. Limited to one per member lifetime.
- **My Health Pays® Rewards Program**. Superior's My Health Pays® is a rewards program that offers financial, non-cash incentives that reward pregnant members for completing healthy activities related to their pregnancy and delivery. Excludes STAR+PLUS members who are dual-eligible. Pregnant members can receive rewards for completing these activities following confirmation of the visit:
  - $100 for prenatal visit within the first trimester or 42 days of enrollment with Superior.
  - $50 for postpartum visit within 7-84 days of delivery.
- **Nicotine Recovery Program**. Online tool to support smoking cessation.
- **Nutritional Services**. STAR+PLUS members who do not reside in an ICF-IID residential home or nursing facility have access to up to 4 nutritional visits per year with a registered dietitian. This is available to members who have a BMI value of 32 or higher and 18.5 or lower, an ER or hospital discharge in the last 6 months and a diagnosis of diabetes, cardiovascular disease or COPD. This Value-added Service may have additional restrictions and limitations.
- **Online Mental Health Resources**. Online tool to support mental health and overall well-being.
- **Over-the-Counter (OTC) Items**. $120 yearly allowance ($30 per quarter) for STAR+PLUS members who do not reside in an ICF-IID residential home for commonly-used OTC items mailed to a member's home or purchased at participating stores. This benefit covers items that do not need a prescription and are not otherwise covered by Medicaid. Members will select from a catalog of items supplied by Superior. Members can place orders online at https://www.cvs.com/benefits, by calling the vendor's toll-free number, or purchased at participating stores. Unused balances are not carried over from quarter to quarter. The total cost of items must be less than or equal to the program allowance in order for the items to be shipped to the member's home. For in-store purchases, member may pay amounts in excess of the benefit. Products may not be returned. OTC items may be ordered for the member only. Excludes STAR+PLUS members who are dual-eligible.
- **Short-Term Phone Assistance**. A Connections Plus pre-programmed phone with unlimited talk and text is available for qualifying members enrolled in Care Management, who do not have access to a phone and do not qualify for the federal Lifeline program. Superior Service Coordination must approve requests for Connections Plus.
- **Start Smart® For Your Baby Program**. Superior's award-winning Start Smart® program for pregnant women. This program offers a $25 reward and educational materials for members attending a virtual educational baby shower hosted by Superior. Pregnant women can earn this Value-added Service one time per pregnancy.
- **Weight Watchers® Program**. To promote weight management and improve health, nutrition and wellness, Superior will offer STAR+PLUS members a 3-month subscription for Weight Watchers® online program. Members must have a BMI value of 30 or higher and a primary diagnosis of diabetes, prediabetes, hypertension or heart disease to qualify. BMI and diagnosis must be verified to be eligible. Members who are pregnant or have a diagnosis of bulimia nervosa are not eligible. Member must have online access.

Value-added Services may have restrictions and limitations. These Value-added Services are effective 9/1/25-8/31/26. For an up-to-date list of these services, go to SuperiorHealthPlan.com/VAS. For questions, call Member Services at 1-877-277-9772.

Extra Benefits and Services

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. The Superior Member Advocate staff can teach you how to use Superior's services. They can visit you at home, talk to you on the phone or send you information by mail. They will help you with things like:

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

Superior Member Advocates 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's Member Advocates 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.

Helpful Information

For help finding community supports such as food and nutrition, housing, education and employment services use the online social services resource directory found here: https://www.superiorhealthplan.com/members/medicaid/resources.html

Health Education

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 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 the Wellframe Care App which can help you learn about living well with chronic illnesses, healthy eating tips, finding exercise you enjoy and more. You can find this at SuperiorHealthPlan.com/Wellframe by logging in to Superior's Member Portal.

What health education classes does Superior offer?

Superior wants you to lead a healthy life. That is why we started the Superior Health Education program. This program gives you facts to help make better health choices for you and your family.

Superior classes include:

- Member Advisory Group meetings to help you learn more about your benefits and services. You also have the opportunity to provide feedback about how Superior is helping with your health-care needs. You can find out more about these meetings by calling 1-877-277-9772 or visiting SuperiorHealthPlan.com.
- Start Smart for Your Baby® - A special program for pregnant women that includes education classes, Care Management and educational baby showers. For more information about Superior's baby showers, please visit our website at SuperiorHealthPlan.com.
- A Matter of Balance - Members will learn to control their fear of falling, set goals to increase exercise to promote strength and balance and change their environment to reduce fall risk factors.
- Educational virtual baby showers to teach you more about your pregnancy and new baby. For more information, please visit our website at SuperiorHealthPlan.com/MemberEvents or call Member Services at 1-877-277-9772.
- Superior wants to help keep you and your loved ones healthy. That's why we created a series of short videos offering important health tips. These videos cover many topics, including asthma management, caregiver resources, diabetes support and more. Learn more at SuperiorHealthPlan.com/WellnessOnDemand.

Superior can also help you find other health education classes offered within the community that can help you and your family.

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

What health education classes are offered by other agencies?

Superior will also let you know about other health education classes offered within the community that can help you and your family. Some community health education programs are:

- Diabetes education classes
- Nutrition classes for the whole family
- CPR classes
- Healthy diet classes

If you need extra help because you are pregnant, or if you have asthma or another serious medical condition, call Superior at 1-877-277-9772. They will refer you to Superior's Care Management program. It has registered nurses who can help you manage your illness. The nurses will work with you and your doctor(s) to coordinate your care and make sure you have what you need to help keep you healthy.

Advance Directives

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.

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 is a document that lets you name someone else to make decisions about your health care in case you are not able to make those decisions yourself.
- **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.

Member Billings

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

If you have Medicaid, you should not be billed for any services covered by Medicaid. Please remember to always show your Medicaid ID card and Superior member ID card before you see your doctor. 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 go to a provider who is not enrolled in Texas Medicaid and/or is not signed up as a Superior provider, Superior may not pay that provider and you may get billed for the services. You will need to pay for services not covered by Medicaid. It is your responsibility to determine which services are covered and which are not.

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 Texas Medicaid & Healthcare Partnership (TMHP) if you have traditional Medicare coverage. There are also some Medicare non-covered acute care services and supplies that are covered by Medicaid.

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

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

Superior Health Tip

If you have diabetes, there are certain tests you need at least once a year. These include your Hemoglobin A1c and cholesterol screening. You should also have your eyes and kidneys checked at least once a year. Call your doctor to schedule an appointment!

Getting Help with Benefits and Services

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

We want to help. If you have a complaint, please call us toll-free at 1-877-277-9772 to tell us about your problem. Your Legally Authorized Representative can file a complaint for you as well.

You can also file a complaint through our website. Go to https://www.superiorhealthplan.com/members/medicaid/resources/complaints-appeals.html. You can also use Superior's complaint form. A copy of the complaint form can be printed from Superior's website. You can send the form to:

Superior HealthPlan
Attn: Complaints
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?

A Superior Member Advocate can help you file a complaint. Just call Member Services at 1-877-277-9772 (TTY 1-800-735-2989). 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 https://www.superiorhealthplan.com/members/medicaid/resources/complaints-appeals.html 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 the most within a few days. Superior will have a written answer within 30 Days of the date you submit your complaint.

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 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 Texas Health and Human Services Commission (HHSC) 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 submit your complaint at: hhs.texas.gov/managed-care-help.

What is the MDCP/DBMD escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.

Help can include answering questions about State Fair Hearings and continuing services during the appeal process.

Getting Help with Benefits and Services

When should members call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call 1-844-999-9543 and they will work to connect you with the right people.

Is the escalation help line the same as the HHSC Office of the Ombudsman?

No. The MDCP/DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 1-866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representatives or your legal representative can call.

Can members call any time?

The escalation help line is available Monday through Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.

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.
- Is providing a partial approval for a covered service.

Most of the acute care services you get such as doctor's visits, lab and x-ray services and medications, are Medicare covered services if you are a dual-eligible member. 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 doctor, a friend, a relative, lawyer or another spokesperson can request an appeal of an Adverse Benefit Determination. Your Service Coordinator can help 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 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?

You will have sixty (60) Days from the date of Superior's Notice of Adverse Benefit Determination letter to appeal the decision. 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 all of the following are met:

- 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 HHSC.

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

If you are eligible for both Medicare and Medicaid and need to request an emergency appeal for Medicare acute care services, please follow the emergency review process for your Medicare Plan/Program.

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 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. A Superior Member Advocate 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 they are 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 contacting Superior and 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, including an In-Lieu-Of Service and Setting, 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. You may withdraw the State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

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 HHSC, 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 Commission (HHSC) 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 appeal.

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

To ask for a State Fair Hearing, your 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.

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 HHSC State Fair Hearing 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 the 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 State Fair 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. HHSC will give you a final decision within 90 Days from the date you asked for the State Fair Hearing.

Getting Help with Benefits and Services

Can I ask for an Emergency State Fair Hearing?

To qualify for an emergency State Fair Hearing through HHSC, 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.

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. If your MCO offers In-Lieu-Of Services and Settings, you have the right to:
   a) Be given information about the In-Lieu-Of Services and Settings you can get and how to request them.
   b) Be told why any In-Lieu-Of Services and Settings were reduced or denied.
   c) Choose to refuse to receive In-Lieu-Of Services and Settings instead of other Covered Services.
6. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, 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) MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind with Multiple Disabilities Program.
   c) Get a timely answer to your complaint.
   d) Use the plan's appeal process and be told how to use it.
   e) Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   f) 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.
7. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   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.

8. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or to prevent you from leaving or is to punish you.
9. You have a right to know that doctors, hospitals and others who care for you can advise you about your health status, medical care and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
10. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals and others cannot require you to pay co-payments or any other amounts for covered services.
11. 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.

Rights and Responsibilities

Additional member responsibilities while using Superior's Medical Ride Program:

1. When requesting NEMT services through Superior's Medical Ride Program, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

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 SuperiorHealthPlan.com/QualityImprovement.
- Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- Information about In-Lieu-Of Services and Settings, if offered by your MCO, including amount, duration and scope of benefits and the policy on referrals.
- How 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.

Your Right to Privacy

The following notice describes how medical facts about you are to be used and disclosed and how you can get access to these facts. Please review it carefully.

At Superior HealthPlan, your privacy is important to us. We will do all we can to protect your health records. You may get a copy of our privacy notice at SuperiorHealthPlan.com or by calling Member Services at 1-877-277-9772. By law, we must protect your health records and send you this notice. This notice tells you how we use your health records. It describes when we can share your records with others. It explains your rights about the use of your health records. It also tells you how to use those rights and who can see your health records. This notice does not apply to facts that do not identify you.

When we talk about your health records in this notice, it includes any facts about your past, present or future physical or mental health while you are a member of Superior HealthPlan. This includes providing health care to you. It also includes payment for your health care while you are our member.

Please note: HHSC also has a privacy notice outlining their rules for your health records. You can find that notice on our website at SuperiorHealthPlan.com. Other health plans and health-care providers have other rules when using or sharing your health records. We ask that you get a copy of their privacy notices and read it carefully.

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. Superior will work to deal with your physical and mental health or substance use disorder treatment giving them the best care they need.

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 01.01.2026
Revised 09.01.2025

For help to translate or understand this, please call 1-800-783-5386. Deaf and hard of hearing TTY: 1-800-735-2989.
Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-866-896-1844. (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 affect 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, this includes information related to race, ethnicity, language, gender identity, and sexual orientation. 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 are also committed in keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. 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, including your Primary Care Physician (PCP), 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 healthcare operations. This includes the following:
  - Quality assessment and improvement activities.
  - Reviewing the competence or qualifications of healthcare professionals.
  - Case management and care coordination.
  - Detecting or preventing health-care fraud and abuse.

  Your race, ethnicity, language, sexual orientation, and gender identity are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with health care providers. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

  This information helps us to:
  - Better understand your health-care needs.
  - Know your language preference when seeing healthcare providers.
  - Providing health-care information to meet your care needs.
  - Offer programs to help you be your healthiest.

  This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.
- **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.

Notice of Privacy Practices

- **Underwriting Purposes** – We may use or disclosure 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.
- **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 disclosure 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.
- **Substance Use Disorder Records (SUD)** - We will not use or disclose your SUD records in legal proceedings against you unless:
  - We receive your written consent, or
  - We receive a court order, you've been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal document requiring a response.
- **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, and 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
- To 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 purposed 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 you 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 using the information 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-year 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 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) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**.

  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.

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: 1-877-398-9461
Relay Texas (TTY): 1-800-735-2989

HHSC Privacy Notice: https://www.hhs.texas.gov/health-human-services-agencies-notice-privacy-practices

Electronic Visit Verification

TEXAS Health and Human Services

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

Form 1718
April 2023

Electronic Visit Verification (EVV) is a computer-based system that electronically documents and verifies service delivery for certain Medicaid service visits.

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, which is a small electronic device placed and kept 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.

Reference section 7000 Clock In and Clock Out Methods from the EVV Policy Handbook 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.

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

Abuse, Neglect and Exploitation

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

What are Abuse, Neglect and Exploitation?

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

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

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

Reporting Abuse, Neglect 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 Health and Human Services Commission (HHSC) 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 and 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 and Abuse, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184
- Visit https://oig.hhs.texas.gov/report-fraud-waste-or-abuse and click the "OIG Fraud Reporting Form" box to complete the online form.
- You can report directly to your health plan:

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

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

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

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

Glossary of Terms

- **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.
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SuperiorHealthPlan.com