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MY CIGNA-HEALTHSPRING STAR+PLUS NURSING FACILITY MEMBER HANDBOOK

Member Services
1-877-653-0327 (TTY: 7-1-1)
Monday to Friday
8 a.m. to 5 p.m. Central Time

January 2020

TEXAS STAR PLUS
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

MCDTX_20_81843

WELCOME TO BETTER HEALTH.

We're here to help in every way.

Thank you for choosing Cigna as your STAR+PLUS plan. We look forward to helping you improve your health, well-being and sense of security. Our goal is to help you live a healthier, happier life. This includes helping you get quality care that is easy to understand and able to meet your individual needs.

This Member Handbook can help you get the most from your STAR+PLUS plan. Please read it carefully and keep it in a safe, convenient place.

You will learn many important things from your Member Handbook, such as:

- The role of your Primary Care Provider (PCP).
- How to find out what drugs are covered on the preferred drug list.
- When you need a referral or prior authorization from your Primary Care Provider.
- Who to call and what to do if you become ill or injured.
- How to take advantage of preventive health services and other benefits.

At Cigna, we want you to be involved in your own health. Be sure to take an active role by carefully listening to and following the advice of your Primary Care Provider. It also means you should call us when you have a question about your health plan. We are always ready to help you.

If you have questions about your STAR+PLUS plan, please call Member Services at **1-877-653-0327 (TTY: 7-1-1)**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.

Also, this Member Handbook will be made available in audio, larger print, Braille or another language when a Member requests it or when Cigna identifies a Member who needs it.

On behalf of the entire Cigna family in Texas and the world, I welcome you. Let's work together to help you live a healthier, happier life.

Sincerely,

Brian Evanko
President, Government Business

CALL US WHEN YOU NEED HELP.

It is important that you know where to turn when you need help. Your team is ready to guide you in the right direction. If you need help or information, call Member Services at **1-877-653-0327 (TTY: 7-1-1)**. You can also reach our mental health crisis line 24 hours a day, 7 days a week by calling **1-800-959-4941**.

Important

If you have a life-threatening emergency or an emergency that poses a threat to the life or property of others, call **9-1-1** or go directly to the nearest emergency room.

Cigna Member Services

You can get immediate answers to questions about your benefits, the provider network or any other issues related to your plan. Please call Member Services at **1-877-653-0327 (TTY: 7-1-1)**, Monday to Friday 8 a.m. to 5 p.m. Central Time, excluding State approved holidays.

Bilingual or interpreter services

Cigna representatives are ready to help in English and Spanish. Cigna can provide interpreter and translation services in more than 170 languages. Please call Member Services at **1-877-653-0327 (TTY: 7-1-1)** for assistance.

Hearing impaired

If you are hearing impaired, please call **TTY: 7-1-1**. For more services, please call **TTY/Texas Relay** at **1-800-735-2989** (English) or **1-800-662-4954** (Spanish).

Alternate formats

This Member Handbook can be made available in audio, larger print, Braille or other languages at no cost. To make your request, call Member Services at **1-877-653-0327 (TTY: 7-1-1)**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.

After-hours

If you call after-hours, on a weekend or holiday, you can leave a voice message, and we will return your call on the next business day.

Service Coordination

Cigna provides Service Coordination. You and your Service Coordinator will work together to:

- Assess your health needs.
- Create a care plan.
- Coordinate your health care needs.
- Monitor your progress toward your health care goals.

You or your Nursing Facility nurse can call your Cigna Service Coordinator at **1-877-725-2688**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.

Behavioral health and substance abuse services

For questions about behavioral health and substance abuse services, call the behavioral health line at **1-877-725-2539**. If you have a mental health crisis, you can get help by calling our mental health crisis line at **1-800-959-4941**, 24 hours a day, 7 days a week. Qualified mental health professionals will be ready to:

- Answer your questions.
- Assess your mental health.
- Provide and coordinate services as needed.

They can also help in English and Spanish. Cigna can provide interpreter and translation services.

If you have an emergency, please call **9-1-1.**

Eye care

Members who only have Medicaid and no other insurance can get routine eye care services by calling Superior Vision at **1-888-886-1995**, Monday to Friday, 7 a.m. to 8 p.m. Central Time. If you need eye care for an illness or injury to your eye, call your Primary Care Provider for help first. You do not need a referral for specialty eye care from an ophthalmologist.

Dental care

Some Members may be eligible for limited dental services. To find out more about coverage, call DentaQuest at **1-855-418-1628**.

Non-emergency ambulance transportation

The Nursing Facility is responsible for providing routine non-emergency transportation services. If medically necessary, Cigna provides non-emergency ambulance transportation for Members that require this service.

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

Call Member Services at **1-877-653-0327** Monday to Friday, 8 a.m. to 5 p.m. Central Time.

Ombudsman Managed Care Assistance Team

The Health and Human Services Commission Office of the Ombudsman helps people with Medicaid managed care:

- Navigate the managed care system.
- Understand their Medicaid coverage.
- Understand their rights.
- Advocate for themselves.
- Resolve problems, including access to care.

Call the Ombudsman Managed Care Assistance Team at **1-866-566-8989 (TTY: 1-866-222-4306)** for assistance.

STAR+PLUS Helpline

The STAR+PLUS Helpline assists with joining a health plan or changing health plans.

For more information, call **1-800-964-2777 (TTY: 1-800-735-2989)**.

How do I prepare for an emergency or natural disaster?

For information on how to prepare for an emergency or disaster such as hurricanes and other tragic events, Members can call Texas 2-1-1 for assistance. Texas 2-1-1 is available 24 hours a day, 7 days a week. 2-1-1 can also help you connect with services that you may need, such as help finding food or housing, child care, crisis counseling or substance abuse treatment. Call 9-1-1 for immediate help in an emergency, or if you are in need of life-saving assistance.

Resource: **211texas.org/about-2-1-1/**

QUICK REFERENCE GUIDE

IMPORTANT PHONE NUMBERS FOR MEMBERS	
Member Services	**1-877-653-0327 (TTY: 7-1-1)**
Bilingual/interpreter services	**1-877-653-0327**
Service Coordination	**1-877-725-2688**
Behavioral health and substance abuse	**1-877-725-2539**
Mental health crisis line	**1-800-959-4941**
Eye care	**1-888-886-1995**
Dental care	**1-855-418-1628**
Medicaid prescription helpline	**1-877-653-0327**
Non-emergency ambulance transportation	**1-877-653-0327**

ADDITIONAL HELPFUL PHONE NUMBERS	
TTY/Texas Relay English	**1-800-735-2989**
TTY/Texas Relay Spanish	**1-800-662-4954**
Ombudsman Managed Care Assistance Team	**1-866-566-8989 TTY: 1-866-222-4306**
STAR+PLUS Program Help Line	**1-800-964-2777**
Texas Benefits Medicaid card	**1-855-827-3748**
2-1-1 Help in Texas	**2-1-1**

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DISCOVER THE CIGNA DIFFERENCE.

What is Cigna?

Cigna is a leading global health care company serving millions of people and communities around the world. You can feel confident when you put your trust in Cigna. We are one of the largest health care companies focused on Medicaid and Medicare.

What does Cigna-HealthSpring STAR+PLUS do?

Cigna works with the state of Texas to help people and families get health coverage in the Texas STAR+PLUS Program. STAR+PLUS is a Texas Medicaid managed care program that provides health care, acute care and Long Term Services and Supports. Through STAR+PLUS, Cigna provides Members with many quality health care services. We work closely with our network of health care professionals to ensure all our Members get personalized care and benefits that meet their health needs. Together, we give our Members more ways to get healthier – and stay healthier – with health care choices that offer quality care and better health outcomes.

Helpful hint

If you have questions, please call Member Services at **1-877-653-0327**. You can also call the phone numbers listed in the Quick Reference Guide.

What does Cigna offer?

Primary and specialty provider care

Medical supplies

Behavioral health and substance abuse services

Hospital care

Routine dental services

Eye care

Service Coordination

Member Services

Bilingual or interpreter services

Help for hearing impaired

ENJOY PEACE OF MIND WITH CIGNA.

How to use your ID card

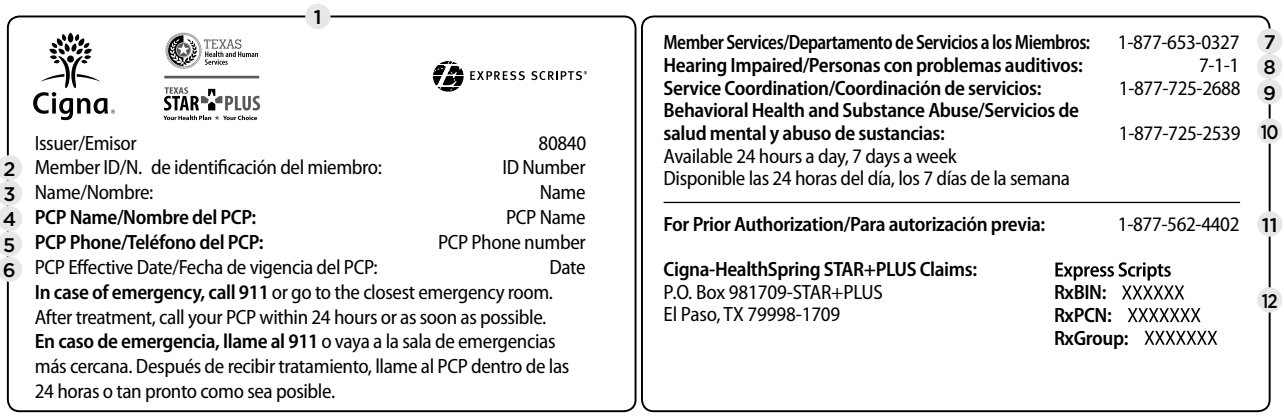
Your Cigna ID card tells doctors and hospitals that you are a Member of our health plan. Take your ID card every time you go to the following:

- Doctor's visit.
- Laboratory testing.
- Emergency room.
- Urgent care center.
- Long-term care services.

How to read your ID card

Below is a sample of the Cigna Medicaid-only eligibility ID card. If you have a Medicaid-only eligibility ID card, it will contain important information such as:

STAR+PLUS Member ID card - Medicaid-only



Front

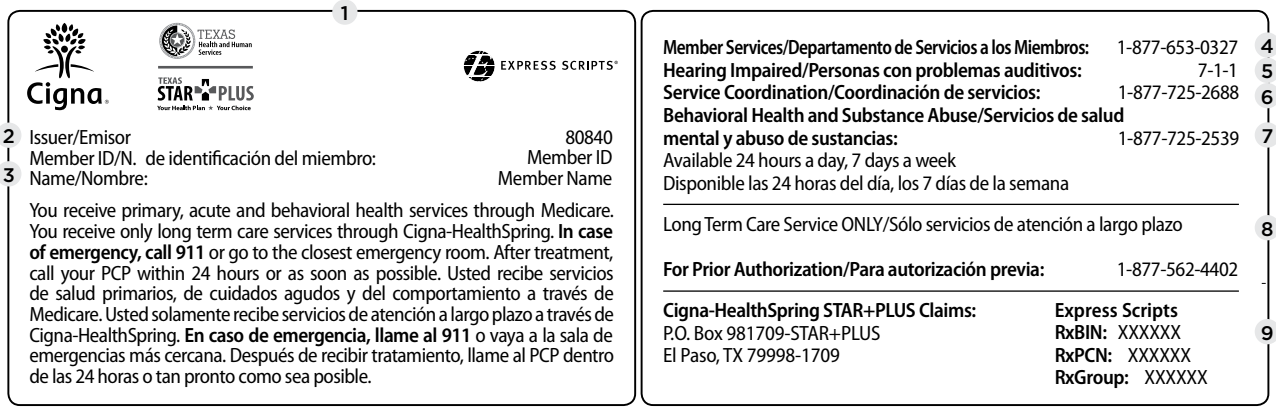
1. Cigna and STAR+PLUS logos.
2. Medicaid Member ID number, issued by the Health and Human Services Commission (HHSC).
3. Your name.
4. Name of your Primary Care Provider.
5. Phone number of your Primary Care Provider.
6. Date you were assigned to your Primary Care Provider.

Back

7. Member Services phone number, available Monday to Friday, 8 a.m. to 5 p.m. Central Time. Voice mail is available after 5 p.m. and on weekends.
8. **TTY** number for hearing-impaired Members. For additional hearing-impaired services, please call **TTY/Texas Relay** at **1-800-735-2989** (English) or **1-800-662-4954** (Spanish).
9. Service Coordination phone number.
10. Behavioral health line number.
11. Phone number a provider will call to get prior authorization for hospital visits, doctors' visits and long-term care services.
12. Address where providers will send claims.

Below is a sample of the Cigna Medicare and Medicaid dual-eligibility ID card. If you have a Medicare and Medicaid dual eligible ID card, it shows important information such as:

STAR+PLUS Member ID card - dual eligible



Front

1. Cigna and STAR+PLUS logos.
2. Medicaid Member ID number, issued by the Health and Human Services Commission (HHSC).
3. Your name.

Back

4. Member Services phone number, available Monday to Friday, 8 a.m. to 5 p.m. Central Time. Voice mail is available after 5 p.m. and on weekends.
5. **TTY** number for hearing-impaired Members. For additional hearing-impaired services, please call **TTY/Texas Relay** at **1-800-735-2989** (English) or **1-800-662-4954** (Spanish).
6. Service Coordination phone number.
7. Behavioral health line number.
8. Phone number a provider will call to get prior authorization for hospital visits, doctors' visits and long-term care services.
9. Address where providers will send claims.

How to replace your ID card

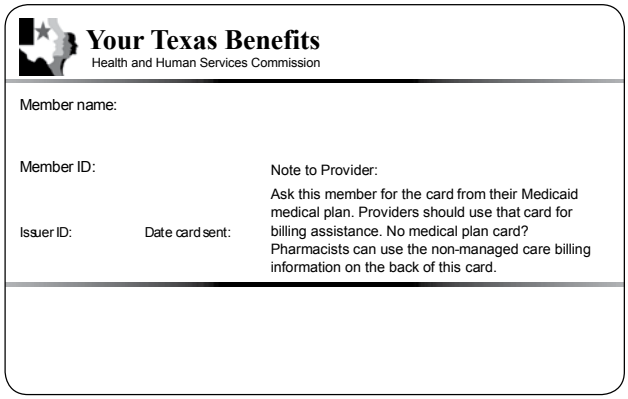
If you lose your Cigna ID card, please call Member Services at **1-877-653-0327**. We will send you a replacement card.

VALUABLE INFORMATION AT YOUR FINGERTIPS.

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

You will be issued one card, and will only receive a new card in the event of the card being lost or stolen. If your Medicaid ID card is lost or stolen, you can get a new one by calling toll-free **1-800-252-8263**, or by going online to print a temporary card at **www.YourTexasBenefits.com**.

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

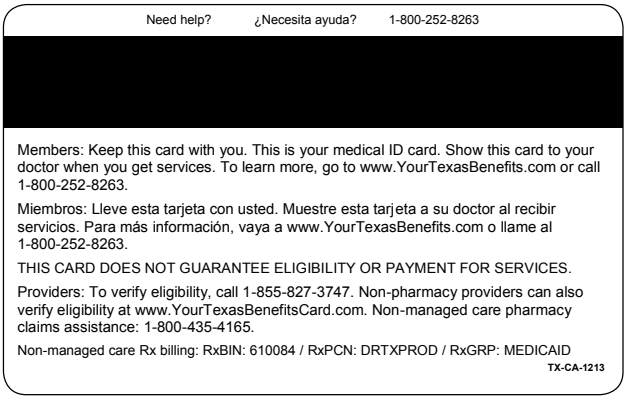

Your Texas Benefits
Health and Human Services Commission

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.


Need help? ¿Necesita ayuda? 1-800-252-8263

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 1-855-827-3747. Non-pharmacy providers can also verify eligibility at www.YourTexasBenefitsCard.com. Non-managed care pharmacy claims assistance: 1-800-435-4165.

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

TX-CA-1213

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

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

The back of the Your Texas Benefits Medicaid card has a website you can visit (**www.YourTexasBenefits.com**) and a phone number you can call toll-free (**1-800-252-8263**) if you have questions about the new card.

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

Your Texas Benefits Medicaid website: www.YourTexasBenefits.com

Adult Medicaid clients can now see their available health information online by visiting **www.YourTexasBenefits.com**.

You can:

- View your benefit and case information
- View, print, and order Medicaid ID cards.
- View your, or your family's, Texas Health Steps Alerts
- View available health information such as:
  - Health events
  - Prescription medicines
  - Past Medicaid visits
  - Vaccine information

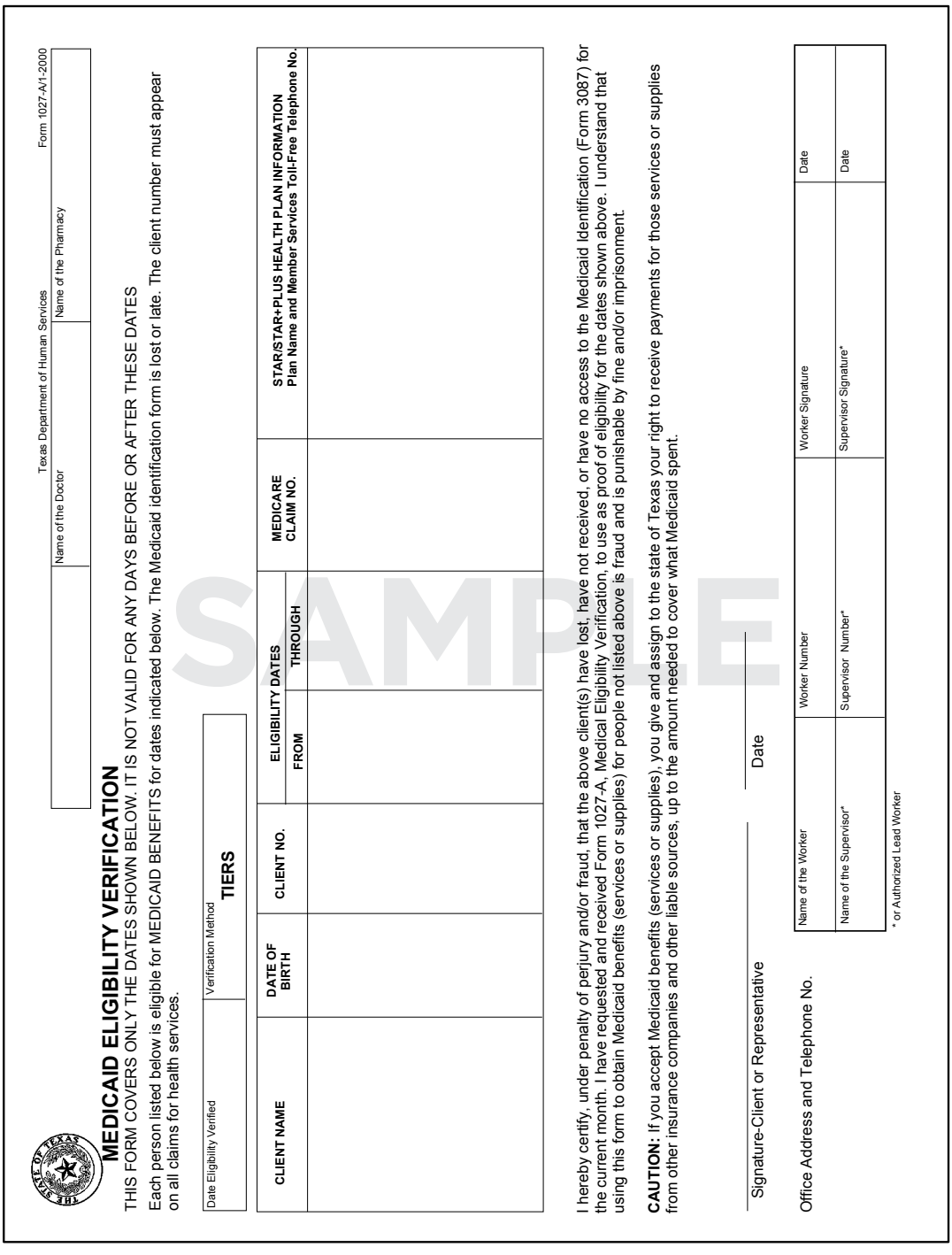
To access the portal, visit **YourTexasBenefits.com**.

- Click 'Log In'.
- Enter Your user name and password. If you don't have an account, click 'Create a new account'.
- Click on 'Manage'.
- Click 'Medicaid & CHIP Services' in the Quick Links section.
- Click on 'View Services and Available Health Information.

TEMPORARY VERIFICATION FORM (MEDICAID FORM 1027-A)

Medicaid Form 1027-A is your temporary ID card. You may have received it from Health and Human Services (HHS). Form 1027-A is your proof of Medicaid eligibility until you receive Your Texas Benefits Medicaid card. Please remember to present Your Texas Benefits Medicaid card with your Cigna ID card at all of your health care visits, and when receiving any long-term care services.

If you don't have Medicaid Form 1027-A or Your Texas Benefits Medicaid card, please call the Medicaid Hotline at **1-800-252-8263**. You can also apply for the temporary form in person at a Health and Human Services Commission (HHSC) benefits office. To find the nearest office, call **2-1-1** (pick a language and then pick option 2).



Texas Department of Human Services — Form 1027-A/1-2000

Name of the Doctor | Name of the Pharmacy

MEDICAID ELIGIBILITY VERIFICATION

THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES

Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid identification form is lost or late. The client number must appear on all claims for health services.

Date Eligibility Verified | Verification Method: TIERS

CLIENT NAME	DATE OF BIRTH	CLIENT NO.	ELIGIBILITY DATES FROM	ELIGIBILITY DATES THROUGH	MEDICARE CLAIM NO.	STAR/STAR+PLUS HEALTH PLAN INFORMATION Plan Name and Member Services Toll-Free Telephone No.

SAMPLE

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form 3087) for the current month. I have requested and received Form 1027-A, Medical Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

CAUTION: If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Signature-Client or Representative — Date

Office Address and Telephone No.

Name of the Worker	Worker Number	Worker Signature	Date
Name of the Supervisor*	Supervisor Number*	Supervisor Signature*	Date

* or Authorized Lead Worker

GET HELP IN THE LANGUAGE YOU UNDERSTAND.

Can someone interpret for me when I talk with my doctor?

Yes. When you get medical care, your doctor must provide an interpreter if you have limited English speaking or reading skills. If you are going to a doctor's visit where an interpreter is not available, please call Member Services at **1-877-653-0327**.

Who do I call for an interpreter?

If your doctor's office can't provide an interpreter, your doctor can call the Cigna provider line at **1-877-653-0331** for help. Our vendor TeleLanguage can provide interpreter and translation services in over 170 languages.

How far in advance do I need to call?

You should ask your doctor's office about scheduling interpreter services. If your doctor uses Cigna vendor language line services, no advance notice is required.

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

When you call to set up your doctor's visit, tell the person you are talking with that you need an interpreter with you. If they can't help, call Member Services at **1-877-653-0327**.

CHOOSE THE RIGHT DOCTOR TO MEET YOUR NEEDS.

What is a Primary Care Provider?

A Primary Care Provider can be called your PCP or main doctor. Your Primary Care Provider is the main doctor, nurse or clinic that gives you most of your health care. Your Primary Care Provider can also help coordinate other services you need.

Will I be assigned a Primary Care Provider if I have Medicare?

For STAR+PLUS Members who are covered by Medicare, no Primary Care Provider will be assigned.

How do I choose my Primary Care Provider?

When you enroll in Cigna, you need to choose your Primary Care Provider from the Provider Directory. If you need help choosing a Primary Care Provider, please call Member Services at **1-877-653-0327**.

How do I see my Primary Care Provider if she or he does not visit my nursing home?

Your Nursing Facility will arrange transportation for you. If you need further assistance, please contact Service Coordination at **1-877-725-2688**.

What type of provider can I choose as my Primary Care Provider?

You can choose the following types of providers as your Primary Care Provider:

- Doctors specializing in family practice.
- Doctors specializing in general practice.
- Doctors specializing in internal medicine.
- Physician Assistants (PAs).
- Advanced Practice Registered Nurses (APRNs) specializing in adult and family practice.
- Federally qualified health centers.
- Rural health clinics.
- Female Members and Members with gender-specific needs can also choose from the following:
  - Doctors specializing in Obstetrics/Gynecology (OB/GYN).
  - APRNs specializing in women's health.
- Members under age 21 can only choose from the following:
  - Pediatricians.
  - Family practitioners who treat children of the Member's age.
  - Certified Registered Nurse

Practitioners (CRNPs) specializing in pediatrics.

What if I cannot find a Primary Care Provider (PCP), Specialist, or Other Provider close to where I live?

Cigna is constantly updating its provider network to add new providers. On rare occasions there may not be a provider in your area that offers the medically necessary services that you need. If you are having problems locating a provider, contact one of the following:

- Member Services at **1-877-653-0327 (TTY: 7-1-1)**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.
- Your Service Coordinator directly or through the Service Coordination Team at **1-877-725-2688 (TTY: 7-1-1)**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.
- Your Primary Care Provider (PCP) if you are looking for a Specialist.

Whoever you contact will help you locate an in-network provider. If one is not available, Cigna will look into other options to make sure you receive the medically necessary services you need.

How can I change my Primary Care Provider?

If you would like to change your Primary Care Provider, you can call Member Services at **1-877-653-0327**. Please tell the representative that you want to change your Primary Care Provider. They can help you choose a new Primary Care Provider if you still need to choose one.

When will my Primary Care Provider change become effective?

If you ask to change your Primary Care Provider, the change will start on the business day after the request. The change will show up in the Cigna system within 3 business days. Cigna will mail you a new ID card within 5 business days of the request. The actual delivery time depends on the U.S. Postal Service.

Reminder

STAR+PLUS Members covered by Medicare will keep seeing their Medicare Primary Care Provider. You will not need to choose a new Primary Care Provider for STAR+PLUS.

Can a specialist ever be considered a Primary Care Provider?

You can choose a specialist to act as your Primary Care Provider. The specialist must be in the Cigna provider network and agree to handle all of the duties of a Primary Care Provider.

Can a clinic be my Primary Care Provider? (rural health clinic/federally qualified health center)

Yes, you can choose the following types of clinic to act as your Primary Care Provider.

- Federally qualified health centers.
- Rural health clinics.

How can I change my Primary Care Provider if I receive Medicare benefits?

Some Members may also have coverage for their Primary Care Provider visits through a Medicare Advantage plan. If you get Medicare benefits and STAR+PLUS, you need to call your Medicare plan to change your Primary Care Provider.

How many times can I change my/my child's Primary Care Provider?

There is no limit on how many times you can change your or your child's Primary Care Provider. You can change Primary Care Providers by calling us toll-free at **1-877-653-0327** or writing to:

Cigna
Attention: Membership Accounting
PO Box 20012
Nashville, TN 37202

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

Your request to change your Primary Care Provider can be denied if:

- The provider is not age- or gender-appropriate.

- The provider is not in the Cigna network.
- The provider is not accepting new patients.

If you can't get your choice of Primary Care Provider at the time of enrollment, we will assign you to a Primary Care Provider close to your home. At other times, a Member Services representative can tell you why you did not get the Primary Care Provider you chose. You can call Member Services to ask for a different Primary Care Provider or to ask why you did not get your choice.

When should I call to make an appointment?

It is best if you call early in the day when you need care. If you wait until the evening to call your Primary Care Provider, you may not be able to schedule a visit as soon as you want.

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

When you go to a doctor's visit, have lab tests done, go to the emergency room or urgent care center, or receive long-term care services, you must bring the following:

- Your valid Cigna ID card, valid picture ID card and either:
  - Your Texas Benefits Medicaid Card, or
  - Your Medicaid temporary verification form (Medicaid Form 1027-A).

Can my Primary Care Provider switch me to another Primary Care Provider for non-compliance?

Yes, your Primary Care Provider can ask to switch you to another Primary Care Provider for the following reasons:

- Non-compliance to treatment.
- Failure to call before missing office visits.
- Failure to follow Primary Care Provider's advice.
- Failure to get along with your Primary Care Provider.
- Threatening behavior.

All requests are individually reviewed by Cigna. You will be told of the decision in writing within 10 days. We will ask you to call Member Services to pick a new Primary Care Provider. If you don't pick a new Primary Care Provider, Cigna will pick one for you. We will write to tell you of the change. If your Primary Care Provider no longer able or willing to be part of Cigna's provider network, you will be assigned to a new Primary Care Provider. You will get a new Cigna ID card. If you get a new Primary Care Provider, you will get one that is near your home. The new Primary Care Provider will be suitable for your age and gender.

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

If you want to go to a different provider in the provider network, the services are covered.

Please note: For STAR+PLUS Members who are covered by Medicare, no Primary Care Provider will be assigned.

Tip: Always keep your ID cards with you in a safe, convenient place. Your ID card is important to ensure a quick, easy and satisfying experience.

Remember: For most services, you should see the Primary Care Provider you picked when you joined Cigna.

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

If you get sick during the evening, weekend or on a holiday you should call your Primary Care Provider at the phone number on the front of your Cigna ID Card. Your Primary Care Provider is available 24 hours a day, 7 days a week so that you can get the help you need. When leaving a voicemail message on a machine, or with an answering service, be sure to:

- Leave a phone number where your Primary Care Provider can call you back.
- Your Primary Care Provider should call you back within 30 minutes.
- If you don't get a call back, you can go to the nearest urgent care center.

- Your Provider Directory has a listing of urgent care centers and acute care hospitals.
- Your Nursing Facility will arrange transportation for you. If you need further assistance, please contact Service Coordination at **1-877-725-2688**.

What is the physician incentive plan?

Cigna rewards doctors for treatments that are cost-effective for people covered by Medicaid. 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 Member Services at **1-877-653-0327**, Monday to Friday, 8 a.m. to 5 p.m. Central Time to learn more about this.

The incentive plan is designed to provide payments to the Primary Care Provider for meeting certain quality measures.

GET THE HELP YOU NEED TO MAKE CHANGES.

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, but not more than once a month.

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

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

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

Who do I call?

To change your health plan, please call the Texas STAR+PLUS program helpline at **1-800-964-2777**.

How many times can I change health plans?

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

When will my health plan change become effective?

If you call to ask 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.

Can Cigna ask that I get dropped from their health plan (for non-compliance)?

Yes, Cigna can ask the Texas Health and Human Services Commission (HHSC) to remove you from our health plan for not following the rules when:

- Cigna takes reasonable measures to help your behavior through education and/or counseling, and
- You continue to refuse to meet the program rules and restrictions.

If the HHSC Disenrollment Committee agrees to remove you, Cigna will help with the process. If you feel that the HHSC Disenrollment Committee has wrongly dropped you, you can ask for an appeal from the Disenrollment Committee.

GET THE SUPPORT YOU NEED.

What is Service Coordination?

Specialized services/care process that includes, but is not limited to:

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

What will a Service Coordinator do for me?

The Cigna Service Coordinator can:

- Visit with you 4 times per year to get to know you and your health care, long-term care and behavioral health needs.
- Assist you with moving back home if you desire to.
- Help you find services that are not normal Medicaid benefits. This could be help with getting food or electricity from community resources if you plan to move back home.
- Help you get services you need.
- Help coordinate your care with the Nursing Facility.
- Help develop a care plan specific to your needs and goals
- Help find resources that help with special health care needs.
- Help you understand your health care benefits.

How can I talk with a Service Coordinator?

You will get a letter with your Service Coordinator's name and the phone number to the Service Coordination line. You can call your Cigna Service Coordinator at **1-877-725-2688**, Monday to Friday, 8 a.m. to 5 p.m. Central. You can also call Member Services at **1-877-653-0327**.

GET MORE BENEFITS AND SERVICES.

What are my health care benefits?

The following list shows the health care services and benefits that you receive as a Member of Cigna-HealthSpring STAR+PLUS. You can receive all the covered services you need that are medically necessary and covered under your benefit plan.

- 72-hour supplies of emergency prescriptions.
- Emergent or Medically Necessary Ambulance services.
- Behavioral health services including:
  - Inpatient mental health services for adults.
  - Outpatient mental health services for adults.
  - Detoxification services.
  - Psychiatry services.
  - Counseling services for adults (age 21 and older).
  - Substance use disorder treatment services (*see note*).
- Birthing services provided by a licensed birthing center.
- Birthing services provided by a physician or advanced practice nurse in a licensed birthing center.
- Cancer screening, diagnostic and treatment services.
- Chiropractic services.
- Dialysis.
- Drugs and biologicals provided in an inpatient setting.
- Emergency services.
- Family planning services.
- Health education related to obesity.

- Hospital services, inpatient and outpatient.
- Inpatient acute.
- Laboratory services.
- Medical checkups and comprehensive care program services for children birth through age 20 through the Texas Health Steps Program.
- Nursing Facility Long Term Care Services.
- Nursing Facility Add On Services.
- OB/GYN.
- Optometry, eyeglasses and contact lenses, if medically necessary.
- Mastectomy, breast reconstruction, and related follow up procedures, including outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient or outpatient setting for:
  - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
  - Surgery and reconstruction on the other breast to produce symmetrical appearance;
  - Treatment of physical complications from the mastectomy and treatment of lymphedemas.
  - Prophylactic mastectomy to prevent the development of breast cancer.
  - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Outpatient acute.
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals.
- Outpatient drug programs.
- Podiatry.
- Prenatal care.
- Preventive services including a yearly wellness checkup for Members age 21 and older.
- Primary care services.
- Radiology, imaging and X-rays.
- Relocation Services.
- Service Coordination.
- Specialized Durable medical equipment.
- Specialty physician services.
- Transplantation of organs and tissues.
- Vision, Medicaid-only.

How do I get these services?

Your Primary Care Provider can give you most of the care you need or refer you to another provider for specialized care. You can also call your Primary Care Provider and let the office know what service you need. If you have questions about your Cigna benefits, call Member Services at **1-877-653-0327**.

NOTE - Substance use disorder treatment services

Outpatient services such as:

- Assessment.
- Detoxification services.
- Counseling treatment.
- Medication-assisted therapy.

Residential services such as:

- Detoxification services.
- Substance use disorder treatment (including room and board).
- Mental health rehabilitative services that reduce a Member's disability resulting from severe mental illness and serious emotional, behavioral or mental disorders.
- Targeted case management services that assist Members with getting access to needed medical, social, educational, and other services and supports.

Are there any limits to any covered services?

Generally, you can receive all medically necessary Medicaid-covered services that you need to stay healthy. Some services need to be reviewed by Cigna before a doctor or hospital can perform the service. If you have questions about your covered services by Cigna, call Member Services at **1-877-653-0327**.

Remember

If you receive Medicare and Medicaid, Medicare covers your health care benefits.

What are Long Term Services and Supports (LTSS) benefits?

If you return to the community you may be eligible for the following LTSS benefits:

- Day activity and health services.
- Personal assistance services.

Some Members may be eligible for additional LTSS benefits known as Home and Community Based Services (HCBS) or STAR+PLUS Waiver services, such as:

- Adaptive aids and medical equipment such as wheelchairs, walkers and canes.
- Adult foster care.
- Assisted living services.
- Cognitive rehabilitation services.
- Dental services.
- Emergency response services.
- Employment assistance service helps people locate paid employment in the community.
- Supported employment service is provided to a person who has paid employment in a setting that includes non-disabled workers to help him or her sustain that employment.
- Home delivered meals.
- In-home nursing services
- Medical supplies
- Minor home modifications.
- Protective supervision.
- Respite care services.
- Physical therapy, occupational therapy, speech therapy.
- Transitional assistance services.

In addition to the above, some Members may be eligible for additional LTSS benefits known as Community First Choice and Habilitation Services:

- Day Habilitation services.
- Personal assistance services.
- Supported Employment

How do I get these services?

When you are ready to return home, you and your Service Coordinator will complete a Nursing Facility health risk assessment and create a plan of care that helps to identify services that meet your health care needs. Some of these services may include those services in the list above. If you are eligible for these services and the service is medically necessary for you to return home, you will work with your Cigna Service Coordinator and Primary Care Provider to get services in place.

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

If you have questions about your LTSS benefits, call your Service Coordinator at **1-877-725-2688** or Member Services at **1-877-653-0327**.

What are my Nursing Facility LTSS Benefits?

LTSS Benefits are services provided to members in a community based setting such as your home. These benefits would be discussed with your Service Coordinator if you choose to return home. Services such as; Personal Attendant Services, Day Activity Health Services, Home Delivered Meals, Minor Home Modifications, Nursing Services, etc. During your skilled Nursing Facility or long term care stay you are not eligible for LTSS benefits.

How would my benefits change if I moved into the Community?

If you move back into the community, your benefits may change, and you may qualify for more benefits. Other benefits you may receive include those listed under LTSS benefits such as home health care, mental health rehabilitation services or targeted case management. You may also qualify for other Long Term Services and Supports benefits, like adaptive aids, medical supplies, minor home modifications or Emergency Response Systems (ERS).

Your Service Coordinator can help you understand your benefits. You can call your Service Coordinator at **1-877-725-2688** or Member Services at **1-877-653-0327**.

What are my Acute Care benefits?

Your Acute Care benefits are the same as your health care benefits listed on page 11.

How do I get these services?

Your Primary Care Provider can give you most of the care you need or refer you to another physician or provider for more specialized care when needed.

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

If you have questions about your Cigna benefits, or need help obtaining information about covered services, you can find out more by calling your Service Coordinator at **1-877-725-2688** or Member Services at **1-877-653-0327**.

What extra benefits do I get as a Member of Cigna?

As a Member of Cigna, you get additional benefits called Value-added Services. These Value added Services may be different than those for Community Members.

What Value-added Services can Cigna-HealthSpring STAR+PLUS Dual (covered by Medicare and Medicaid) Members get?

- Members who are enrolled in the Federal Lifeline free Smart Phone program will receive free outbound calls to the Cigna Member Services phone number that will not count toward monthly minute allotment. Members who opt in will receive relevant Health Related text messages from the plan.
- $20 gift card for Diabetic Members that complete annual A1C test. Limit 1 gift card per Member per year.
- $25 gift card for members that complete recommended Cervical Cancer Screening. Limit 1 gift card per Member per year.

What Value-added Services can Cigna-HealthSpring STAR+PLUS Medicaid-only Members get?

All of Value-added Services for Dual Members plus:

- Extra dental services for adults:
  - Up to $500 each year for checkups, X-rays, cleanings, fillings and simple tooth extractions for Members 21 and older.
- Extra vision benefits for Members 21 years and older:
  - An eye exam, a pair of eyeglasses and an additional allowance of up to $100 for enhanced frame selection every 12 months. $100 allowance does not apply to contact lenses, add-ons (tints, AR, coatings, etc.), replacement eyewear, or sunglasses.
- $30 gift card for Members that complete an annual physical or wellness visit along with any of the laboratory tests or health screenings shown in the Good Health Rewards Program brochure or on the STAR+PLUS member website and recommended by the provider. Limit 1 gift card per Member per year.

How can I get these benefits?

To learn more about benefits, please call Member Services at **1-877-653-0327**.

What health education classes does Cigna offer?

Cigna offers Dementia Training to the Nursing Facility residents and family as well as instruction on medication adherence. We also provide health education in written materials on the following subjects:

- Diabetes - high blood sugar.
- Chronic Obstructive Pulmonary Disease (COPD) – lung disease.
- Congestive Heart Failure (CHF).
- Asthma breathing problems.
- Coronary Artery Disease (CAD) – heart disease
- Kidney disease.

Your Service Coordinator can provide you the health education materials during their visit with you or upon request by calling **1-877-725-2688**. You can also call Member Services at **1-877-653-0327**.

What services can I still get through regular Medicaid, but are not covered by Cigna?

- Preadmission Screening and Resident Review (PASRR) –PASRR is a federal requirement to help determine whether an individual is not inappropriately placed in a nursing home for long term care. Qualifying for this service means that you can get other specialized services in the Nursing Facility from your Local Intellectual and Development Disability Authority. Call your Service Coordinator if you need more information.
- Hospice.

LOOK TO US TO HELP CARE FOR YOUR EYES.

How do I get eye care services?

Members with Medicaid only can get routine eye care services by calling Superior Vision at **1-888-886-1995**, Monday to Friday, 7 a.m. to 8 p.m. Central Time. If you need eye care for an illness or injury to your eye, you or your Nursing Facility nurse can call your Primary Care Provider for help first. You do not need a referral for specialty eye care from an ophthalmologist.

Important

If you have an emergency, call **9-1-1** or go directly to the nearest emergency room.

DEPEND ON US TO HELP WITH TRANSPORTATION.

Cigna Transportation services for Nursing Facility Residents

What transportation services are offered?

The Nursing Facility is responsible for providing routine non-emergency transportation services. If medically necessary, Cigna provides non-emergency ambulance transportation for Members that require this service.

How do I get this service?

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

For assistance, call Member Services at **1-877-653-0327** Monday to Friday, 8 a.m. to 5 p.m. Central Time.

GET HELP WITH YOUR PRESCRIPTIONS.

What are my prescription drug benefits?

Cigna is responsible for prescription drug coverage. The Prescription Drug Program does not limit the number of prescriptions allowed each month for Medicaid-only Members enrolled in STAR+PLUS. If you have concerns related to your prescriptions, Cigna can help you with questions regarding your Prescription Drug Program benefit. You can call Member Services at **1-877-653-0327** for questions regarding prescription drugs or visit **cigna.com/starplus/members/pharmacy**.

How do I get my medications?

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

How do I find a network drug store?

If you need help finding a Medicaid Pharmacy, call Member Services at **1-877-653-0327**. We will help you find a pharmacy close to you.

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

You have to go to a Cigna pharmacy. Call us if you are out of state and need emergency prescriptions. We can help you find a network pharmacy. Call Member Services at **1-877-653-0327**.

What do I bring with me to the drug store?

When you go to the pharmacy, you should bring:

- Your Cigna ID card.
- Your Texas benefits ID card.
- The original, signed prescription your doctor gave you.

If you are refilling your prescription, or if your doctor's office faxed your prescription to the pharmacy, you will only need your ID cards.

What if I need my medications delivered to me?

The Medicaid Prescription Drug Program pays qualified community retail pharmacies for pharmaceutical delivery services. Cigna-HealthSpring STAR+PLUS will make sure that you get free outpatient pharmaceutical deliveries from community retail pharmacies in the service delivery area. This is in addition to mail order delivery and is not a substitute for delivery from a qualified community retail pharmacy unless you ask for mail order delivery. To learn more, call **1-877-653-0327**.

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

You can call Member Services at **1-877-653-0327**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.

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

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

Call Cigna Member Services at **1-877-653-0327** for help with your medications and refills.

What if I lose my medications?

If your prescription medication is lost or stolen, we can help. Your pharmacy can call Cigna. They can get authorization from us. They can ask us to give early refill prescriptions. Call Member Services at **1-877-653-0327** for help.

What is Medication Synchronization?

Some medications can be filled by your drug store before their refill date. This can be used to help you fill your medications at the drug store at the same time. This may be helpful if you are taking many medications, and are having to refill the medications on different days.

Which medications may I request to fill early?

Medications that can be filled early include medications taken to help with certain illnesses such as high blood pressure, high cholesterol, and diabetes.

How can I request to fill a medication early?

If you would like to fill a medication early, you can ask your pharmacist to do so. Your pharmacist will make sure that filling your medication early is safe. If he/she feels doing so will be safe, he/she can fill the medication for you.

You, your pharmacist, or your doctor can also call Cigna at **1-877-653-0327**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.

What if I also have Medicare?

If you have Medicare in addition to STAR+PLUS, your Medicare will be your primary coverage. This means that Medicare is always the first insurance to use. STAR+PLUS will not change your Medicare coverage.

How do I get mosquito repellent spray to prevent Zika virus?

Medicaid pays for mosquito repellent spray (up to 2 cans/bottles per month) if you meet any of the below requirements.

- Female age 10–55 years old.
- Male age 14 and older.
- Pregnant.

You can get mosquito repellent spray from any network pharmacy. If you need help finding a network pharmacy, call Member Services at **1-877-653-0327**.

You do not need a prescription from your doctor in order to get mosquito repellent spray from your pharmacy. However, if your pharmacy recommends getting a prescription, you can call your Primary Care Provider's office and request that they send the pharmacy a prescription.

For more information, please visit **cigna.com/starplus**.

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

To learn more call Cigna Member Services at **1-877-653-0327**.

UNDERSTAND BEHAVIORAL HEALTH.

What are behavioral health services?

Behavioral health refers to the care and treatment of Members with:

- Mental health concerns.
- Drugs or alcohol dependence.

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

For routine help, call the behavioral health line at **1-877-725-2539**. Cigna covers medically necessary substance abuse and behavioral health care.

How do I get emergency help for mental health or substance abuse issues?

If you have a mental health crisis, you can get help by calling the mental health crisis line at **1-800-959-4941**.

Qualified mental health professionals are ready 24 hours a day to:

- Answer your questions.
- Assess your mental health.
- Provide and coordinate services you need.
- Speak with you in English or Spanish.
- Speak with you in other languages when you ask.

Do I need a referral for this?

No, a referral from your Primary Care Provider is not necessary to receive mental health and substance abuse services.

Important

If you have a life-threatening emergency or an emergency that poses a threat to the life or property of others, call **9-1-1** or go directly to the nearest emergency room.

What are mental health rehabilitative services and mental health targeted case management?

- Mental health rehabilitative services are services that may help reduce a Member's disability resulting from severe mental illness or serious emotional, behavioral or mental disorders.
- Targeted Case Management are services that assist Members with getting access to needed medical, social, educational, and other services and supports. These services help the member maintain independence in the home and community.

How do I get these services?

To learn more, call your Behavioral Health Case Manager at **1-877-725-2539** or Member Services at **1-877-653-0327**.

What behavioral health services are available?

- Education over the phone or face-to-face.
- Planning and coordination of behavioral health services.
- Outpatient services with a licensed psychiatrist, psychologist, social worker and counselor.
- Inpatient psychiatric hospitalization.
- Partial hospitalization services.
- Residential care.
- Mobile crisis intervention services.
- Stabilization and observation services.
- Electroconvulsive therapy.

What outpatient substance abuse services are available?

The following outpatient substance abuse services are offered:

- Assessment.
- Detoxification.
- Counseling treatment.
- Medication-assisted therapy.

What is a Behavioral Health Case Manager?

You will have a Cigna Service Coordinator to manage your total health care needs. If you also have a behavioral health condition, you can also have a Behavioral Health Case Manager to help manage your condition. These two professionals will work together to manage your total health care.

What if I am already in treatment?

If you are already getting treatment, ask your mental health provider if they are a Cigna provider for the STAR+PLUS program.

- If the answer is "yes," you don't have to do anything.
- If the answer is "no," call Member Services at **1-877-653-0327** to find a provider.

Can a local mental health authority clinic be my behavioral health care provider?

Yes. You can keep getting care from the local mental health authority clinic in the county where you live.

KNOW THAT WE RESPECT YOUR PRIVACY.

How do I get family planning services?

If you are age 18 and older, family planning services such as birth control and counseling are private. You don't need to ask your Primary Care Provider to get these services. The Texas Women's Health Program offers family planning services that fit the way you live. You can go to any family planning provider who takes Medicaid. We can help you find the care you need. Please call **1-877-653-0327.**

Do I need a referral for this?

No, you don't need to ask your Primary Care Provider to get family planning services.

Where do I find a family planning services provider?

You can find the locations of family planning services providers near you online at **https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/womens-health-services/family-planning** or you can call Cigna at **1-877-653-0327** for help finding a family planning provider.

P.S.

You should never feel like you are all alone. Call Cigna at **1-877-653-0327** for help.

MAKE CHOICES THAT MEET YOUR INDIVIDUAL NEEDS.

ATTENTION FEMALE MEMBERS

What if I need OB/GYN care?

Cigna allows you to pick an OB/GYN but this doctor must be in the same network as your Primary Care Provider.

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

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

You can also receive these services from your Primary Care Provider. Ask your Primary Care Provider if he or she can give you OB/GYN care. You can call Member Services for help in choosing an OB/GYN. If you have Medicare coverage, you don't have to pick an OB/GYN in the Cigna network.

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

Yes. You have the right to choose an OB/GYN.

How do I choose an OB/GYN?

You can get help choosing an OB/GYN in these ways:

- Pick an OB/GYN from the Cigna provider directory.
- Ask your Primary Care Provider to help you pick an OB/GYN.
- Call Member Services to ask for help in choosing an OB/GYN.

If I do not choose an OB/GYN, do I have direct access?

Yes. To learn more, call Member Services at **1-877-653-0327**.

Will I need a referral?

No. You will not need a referral to see your OB/GYN.

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

You can be seen within 14 days. If you have problems scheduling a visit within 14 days, please call Member Services at **1-877-653-0327.**

Can I stay with my OB/GYN if they are not with Cigna?

Your OB/GYN should be a part of the Cigna provider network. However, if your current OB/GYN is not in the network and you are:

- Pregnant with less than 12 weeks until your due date:
  - You can keep going to see your current OB/GYN through your postpartum checkup.
  - Your current OB/GYN needs to call Cigna for authorization.
- Pregnant with more than 12 weeks until your due date:
  - You need to pick an OB/GYN from the Cigna network of providers.

To learn more, call Member Services at **1-877-653-0327** or your Service Coordinator at **1-877-725-2688**.

Keep in mind

We handle all matters with confidence and focus on protecting your private information.

What does medically necessary mean?

(1) For Members age 21 and over, non-behavioral health related health care services that are:

a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;

b. provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;

c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

d. consistent with the diagnoses of the conditions;

e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

f. not experimental or investigative; and

g. not primarily for the convenience of the Member or provider; and

(2) For Members age 21 and over, behavioral health services that:

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

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

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

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

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

f. are not experimental or investigative; and

g. are not primarily for the convenience of the Member or provider.

Cigna will determine medical necessity for Nursing Facility Add-on Services and Acute Care Services only. Nursing Facility Add-on Services include, but are not limited to emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, and audio communication devices.

What is routine medical care?

Routine medical care is:

- The treatment of most minor illnesses and injuries.
- Regular medical checkups.

When you need routine medical care, you should tell your nurse and they will schedule a visit. Your Primary Care Provider will treat you at the Nursing Facility or their office. Your Primary Care Provider can refer you to another provider if needed.

How soon can I expect to be seen?

When your Primary Care Provider is called for routine medical care, they can schedule a visit within 14 days. If you have problems scheduling a doctor's visit within 14 days of request, please call your Service Coordinator at **1-877-725-2688**.

Are non-emergency dental services covered?

Cigna is not responsible for paying for routine, dental services provided to Medicaid Members.

Cigna is responsible, however, for paying for treatment and devices for craniofacial anomalies.

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 throats.
- Muscle sprains and strains.

What is an urgent care clinic?

An urgent care clinic is an office-based practice that meets urgent care needs. An urgent care clinic is available when your Primary Care Provider may not be available, such as after-hours or during weekends and holidays. Some multispecialty clinics offer this service.

What should I do if I need urgent medical care?

For urgent care, you should notify your nurse at the Nursing Facility. They will call your doctor to assist with your urgent need. For more help, call us toll-free at **1-877-653-0327**.

How soon can I expect to be seen?

You should be able to see your doctor within 24 hours for your urgent care needs. Your nurse at the Nursing Facility will assist with the doctor's visit.

What is emergency medical care?

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

Emergency Medical Condition means:

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

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Emergency Behavioral Health Condition means:

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

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

Emergency Services and Emergency Care means:

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

How soon can I expect to be seen?

Getting emergency room care depends on how serious your condition is when you arrive. If the emergency room doctor thinks you can be treated outside the emergency room, you may be sent back to the Nursing Facility for continued treatment. You should be seen as soon as possible in an emergency. The hospital staff will decide how quickly you need to be seen. Emergency services must be provided when you arrive at service delivery site including at non-network and out-of-area facilities.

Do I need a prior authorization?

You do not need a prior authorization for emergency medical care.

Are emergency dental services covered?

Cigna covers limited emergency dental services for the following:

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

Cigna is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, provider, and related medical services (e.g., anesthesia and drugs).

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

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

What do I do if I need emergency dental care?

If you need emergency dental services, you or your nurse can call us toll-free at **1-877-653-0327** Monday to Friday, 8 a.m. to 5 p.m. Central Time. If after hours you can be taken to the hospital emergency room by your Nursing Facility.

What is post-stabilization?

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

What if I get sick when I am out of the Nursing Facility and traveling out of town?

If you need medical care when traveling, call us toll-free at **1-877-653-0327** and we will help you find a doctor. If you need emergency services while traveling, go to a nearby hospital and then call us toll-free at **1-877-653-0327**.

What if I am out of the state?

If you need medical care when traveling, show the provider you visit your Texas Medicaid card and Cigna ID card and ask the provider to call us to request an authorization. If you have questions you can call Member Services at **1-877-653-0327.** If you need emergency care, go to a nearby hospital and then call the number above.

What if I am out of the country?

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

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

A specialist is a doctor who treats specific health problems, such as a heart doctor, a skin doctor or a bone doctor. Your Primary Care Provider can help you decide when you need to see a specialist. You can see a Cigna OB/GYN, eye doctor, dentist, mental health provider or get family planning services without talking to your Primary Care Provider.

What is a referral?

A referral may be needed from your Primary Care Provider to get some services. Your Primary Care Provider must provide routine specialty care referrals on a timely basis, based on the urgency of your medical condition, but no later than 30 days after request if a referral is required. Always ask your Primary Care Provider if you need a referral to get the services you need.

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

Cigna specialists will schedule a visit with you as shown below.

- If you have had an emergency room visit, the specialist doctor may see you immediately.
- If you have an urgent health care need, the specialist doctor will see you within 24 hours of your request.
- If you have a routine health care need, the specialist doctor will see you within 30 days of your request for a referral from your Primary Care Provider, if a referral is required. Routine specialty care must be provided within 60 days of authorization, if authorization is required.

What services do not need a referral?

You should always call your Primary Care Provider to find out if the services you need require a referral. You don't need a referral for:

- Behavioral health.
- OB/GYN.
- Family planning.

How can I ask for a second opinion?

You can get a second opinion about the use of any health care services. You can get a second opinion from a network provider or from a non-network provider (if a network provider is not available). There is no cost for a second opinion. If you need help finding a network provider for care or a second opinion, you can call:

- Your Primary Care Provider.
- Your Service Coordinator at **1-877-725-2688**.
- Cigna Member Services at **1-877-653-0327**.

GET HELP MAKING TOUGH DECISIONS.

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

You can call your Service Coordinator to get help with special health care needs. We can tell you about services and resources to meet your needs. It is important to tell your Primary Care Provider that you have special needs. The best way to tell your Primary Care Provider about your special needs is during your doctor's visit. Your Primary Care Provider and Service Coordinator can help you get:

- Access to needed specialists.
- Materials prepared in a way you understand.
- Preadmission Screening and Resident Review (PASRR) Specialized Services.
- Specialized Medical equipment.
- Assistive technology services for adults.

To learn more, please call your Service Coordinator at **1-877-725-2688**. If you are hearing impaired, please call **TTY: 7-1-1**. For additional hearing impaired services, please call TTY/Texas Relay at **1-800-735-2989** (English) or **1-800-662-4954** (Spanish).

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

Under federal law, you have the right to fill out an advance directive. You should fill out an advance directive to make sure you get the kind of care you want. Call Member Services at **1-877-653-0327**, Monday to Friday, 8 a.m. to 5 p.m. Central Time. A Service Coordinator can provide help.

What are advance directives?

Advance directives are documents that state:

- What kind of treatment you want or don't want.
- What actions you want carried out if you become too sick to make decisions about your care.
- Who should make health care decisions for you if you are too sick to decide for yourself.

How do I get an advance directive?

If you would like information or have questions about creating an advance directive, call a Cigna Service Coordinator at **1-877-725-2688**.

What do I do with an advance directive?

After you create your advance directive, you can take it or mail it to your doctor and let your Service Coordinator know. Your doctor will know what kind of care you want.

How do I change or cancel an advance directive?

You can change your mind at any time after you have signed an advance directive. Call your doctor and Service Coordinator to remove the advance directive from your medical record. You can also make changes in the advance directive by filling out and signing a new one.

Important

Cigna can't offer legal advice or serve as a witness. Talk to your family, your Primary Care Provider or your Service Coordinator to help with an advance directive.

GET ANSWERS TO QUESTIONS YOU MAY HAVE.

What if I get a bill from my Nursing Facility?

Call the doctor's office to make sure they have your correct Medicaid information on file. All of the information your doctor needs to bill for the services is on your ID card.

Who do I call?

You can also call Member Services at **1-877-653-0327**, Monday to Friday, 8 a.m. to 5 p.m. Central Time.

What information will they need?

You may be asked for your Cigna ID and other personal information to verify your identity and protect the information on the bill you received. If you need additional assistance please call Member Services at **1-877-653-0327**.

Hint

To avoid billing mix-ups, always bring your ID card to a doctor's visit.

What is applied income?

It is the Member's personal income that the Member must provide to the Nursing Facility as part of their cost sharing obligation as a Medicaid beneficiary.

What are my responsibilities?

Any time Medicaid is billed by the Nursing Facility, the Member must give their applied income to the facility. The amount is determined by the total amount of monthly income divided by the number of days the Member resides in the facility each month. The Member is allowed to keep $60 for themselves for personal needs.

If you need additional assistance please call Cigna Member Services at **1-877-653-0327**.

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and call Cigna Member Services at **1-877-653-0327**. Before you get Medicaid services in your new area, you must call Cigna, unless you need emergency services. You will continue to get care through Cigna until HHSC changes your address.

What happens if I lose my Medicaid coverage?

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

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

Your social worker in the Nursing Facility can help you fill out and submit your application.

To learn more visit **https://www.YourTexasBenefits.com.**

LEARN MORE IF YOU HAVE MEDICARE AND MEDICAID.

What if I also have Medicare?

If you have Medicare and STAR+PLUS, Medicare will be your main coverage. This means that your Medicare coverage is always the first insurance to use. STAR+PLUS will not change your Medicare coverage.

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

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

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

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

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

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

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

Important

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

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

e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

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

Member responsibilities:

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

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at **www.hhs.gov/ocr**.

LET'S WORK TOGETHER TO FIX A PROBLEM.

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

We want to help. If you have a complaint, please call us toll-free at **1-877-653-0327** to tell us about your problem. A Cigna Member Services Advocate can help you file a complaint. Just call Member Services at **1-877-653-0327**. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the Cigna complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free **1-866-566-8989**.

If you would like to make your complaint in writing, please send it to the following address:

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

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

Who do I call?

If you or your authorized representative need help filing your complaint, a Cigna Member Services representative or a Cigna Member Advocate can help you. You can call Member Services at **1-877-653-0327**.

Can someone from Cigna help me file a complaint?

If you or your authorized representative need help filing your complaint, a Cigna Member Services representative or a Cigna Member Advocate can help you. You can call Member Services at **1-877-653-0327**.

How long will it take to process my complaint?

We will send you a letter within 5 business days of receiving your complaint. This letter will let you know that we received your complaint.

We will send you another letter within 30 calendar days of receiving your complaint. This letter will let you know what actions we took to address your complaint.

What are the requirements and timeframes for filing a complaint?

You can file a complaint over the phone or in writing at any time.

STAND UP FOR YOUR RIGHTS.

What can I do if my doctor asks for a service or medicine for me that is covered but Cigna denies or limits it?

You or your authorized representative can file an appeal with Cigna. Your provider can be your authorized representative.

How will I find out if services are denied?

You will receive a letter if a covered service is:

- Not approved.
- Delayed.
- Reduced or limited.
- Stopped.

What is the timeframe for an appeal?

The timeframe for an appeal is:

- You or your authorized representative must file your appeal request within 60 days from the date Cigna did not approve the service.
- Within 5 business days of receiving your request, Cigna will send you or your authorized representative written confirmation that your request has been received.
- Cigna will send you or your authorized representative a written decision within 30 days from the date we received your appeal request.
- Your appeal request can be extended up to 14 calendar days if you or your authorized representative asks for an extension, or if Cigna shows how the need for more information or a delay is in your best interest.
- If the timeframe is extended, Cigna will send you or your authorized representative written notice of the reason for the delay if you did not ask for the delay.

Important

If Cigna does not receive your appeal filing form within 60 days of the date of the decision letter, your appeal will not be reviewed.

Help is always there.

If you have any questions, just call Member Services at **1-877-653-0327.**

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

You or your authorized representative has the right to ask for an appeal if a covered service is:

- Not approved.
- Delayed, limited, or stopped.
- If a payment for a covered service is not approved in whole or in part.

How can I keep getting services while my appeal is in process?

The letter you receive will tell you how you can keep getting benefits while your appeal is in process. To keep getting these services, you must:

- File your appeal request and ask that your services keep going on or before the later of:
  - 10 calendar days from the date of the health plan's decision letter, or
  - The day the health plan's letter says your services will be reduced or end.
  - If your appeal is not resolved in your favor, you may be required to pay the cost of services furnished while your appeal is pending.

Can I file my appeal verbally?

If you appeal verbally over the phone, Cigna will send you an appeal filing form to complete, which must be signed and returned to Cigna. The appeal filing form must be:

- Received by Cigna no later than 60 days after the date of decision letter.
- Completed and signed by you or your representative, unless you have asked for an Expedited appeal.

Can someone from Cigna help me file an appeal?

Yes. A Cigna Member Advocate can help you file an appeal if necessary. Call Member Services at **1-877-653-0327**.

When can I ask a State Fair Hearing to review my appeal?

You or your authorized representative can ask for a State Fair Hearing after the decision on your appeal. For more information you can turn to the State Fair Hearing Section on page 32.

KNOW HOW TO ASK FOR A RUSH APPEAL.

What is an Expedited Appeal?

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

How do I ask for an Expedited Appeal?

For medical services, you or your authorized representative can mail or fax a request to:

Cigna Appeals and Complaints Department
PO Box 211088
Bedford, TX 76095
Fax: **1-877-809-0783**

For help, call Member Services at **1-877-653-0327**.

How do I ask for a prescription drug/ pharmacy Expedited Appeal?

For prescription drug/pharmacy services, you or your authorized representative can mail or fax a request to:

Cigna-HealthSpring STAR+PLUS Appeals
PO Box 24207
Nashville, TN 37202
Fax: **1-866-593-4482**

For help, call Member Services at **1-877-653-0327**.

Does my request have to be in writing?

No, you or your authorized representative can ask for an Expedited Appeal by calling a Member Services representative at **1-877-653-0327**, Monday to Friday, 8 a.m. to 5 p.m. Central Time excluding State-approved holidays.

What are the timeframes for an Expedited Appeal?

We will tell you or your authorized representative of our decision within 72 hours. Unless your request relates to an ongoing emergency or denial of continued hospitalization, the timeframe for telling you or your authorized representative of the outcome of the Expedited appeal can be extended up to 14 calendar days. This timeframe can be extended if you or your authorized representative asks for an extension or Cigna shows that there is a need for more information and how the delay is in your best interest. If the timeframe is extended, Cigna must give you or your authorized representative a written notice of the reason for delay if you or your authorized representative did not ask for the delay.

What is the timeframe for an emergency Expedited Appeal?

If your Expedited Appeal request is for an ongoing emergency or denial of continued hospitalization, then we will tell you no later than 1 business day after receiving your request.

What happens if Cigna denies the request for an Expedited Appeal?

If Cigna determines your health or life is not in serious jeopardy and denies the request for an Expedited Appeal, Cigna will:

- Call you or your authorized representative to tell you a standard appeal process and timeframe will be followed.
- Follow up with you or your authorized representative with a written notice within 2 calendar days.

Who can help me file an Expedited Appeal?

A Cigna Member Services representative or Member Advocate can help you or your authorized representative file an Expedited Appeal. Call Member Services at **1-877-653-0327**, Monday to Friday, 8 a.m. to 5 p.m. Central Time, excluding State-approved holidays.

KNOW HOW TO ASK FOR A STATE FAIR HEARING

Can I ask for a State Fair Hearing?

If you, as a member of the health plan, disagree with the health plan's decision to deny your appeal, you have the right to ask for a fair hearing. You must follow the health plans appeal process before requesting a State Fair Hearing. You may also request a fair hearing if the health plan fails to make a decision on your appeal within the required time frame . If you, as a member of the health plan, disagree with the health plan's decision to deny your expedited appeal, you may request an expedited Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge an appeal decision made by your health plan, you or your representative must ask for the fair hearing within 120 days of the date of the health plan's appeal letter with the decision. If you do not ask for the fair hearing within 120 days, you may lose your right to a fair hearing.

To ask for a fair hearing, you or your representative should either send a letter to the health plan at:

Cigna Appeals and Complaints Department - Fair Hearing
PO Box 211088
Bedford, TX,76095

Or call Member Services at **1-877-653-0327**.

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if your services were continued through your appeal and if you ask for a fair hearing by 10 calendar days following the MCO's mailing of the appeal decision letter.

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

Where do I send my request for a State Fair Hearing?

To ask for a State Fair Hearing, you or your authorized representative can mail or fax a letter to:

Cigna Appeals and Complaints Department – Fair Hearing
PO Box 211088
Bedford, TX 76095
Fax: **1-877-809-0783**

For help, call Member Services at **1-877-653-0327**.

Where do I send my request for a State Fair Hearing related to prescription drugs/pharmacy?

To ask for a Fair Hearing for prescription drugs/pharmacy, you or your authorized representative can mail or fax a letter to:

Cigna-HealthSpring STAR+PLUS Appeals
PO Box 24207
Nashville, TN 37202
Fax: **1-866-593-4482**

For help, call Member Services at **1-877-653-0327**.

Can I keep getting services that are not approved if I filed for a State Fair Hearing?

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision if your services were continued during the appeal process and you asked for a Fair Hearing on or before 10 days from the date of the health plan's appeal decision letter.

If the Fair Hearing is not resolved in your favor, you may be required to pay the cost of services furnished while your fair hearing is pending.

If you ask for a State Fair Hearing, you will get information telling you the date, time and location of the hearing. Most State Fair Hearings are done by phone. At that time, you or your representative can say why you need the service the health plan did not approve. A final decision is made within 90 days from the date you ask for the hearing.

Who can I talk to about a State Fair Hearing?

You can call Member Services at **1-877-653-0327**.

REPORT 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, and 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 benefit. This includes taking Social Security or Supplemental Security Income (SSI) checks, abusing a joint checking account, and taking property and other resources.

Reporting Abuse, Neglect and Exploitation

The law requires that you report suspected Abuse, Neglect or Exploitation, including unapproved use of restraints or isolation that is committed by a provider. Call **9-1-1** for life-threatening or emergency situations.

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

Report to the Health and Human Services (HHS) by calling **1-800-458-9858** if the person being abused, neglected or exploited lives in or receives services from a:

- Nursing Facility.
- Assisted living facility.
- Adult day care center.
- Licensed adult foster care provider.
- 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.

KNOW WHEN TO DO THE RIGHT THING.

Do you want to report Waste, Abuse or Fraud?

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

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

To report waste, abuse or fraud, choose one of the following:

- Call the OIG hotline at **1-800-436-6184**;

- Visit **https://oig.hhsc.state.tx.us/** Click the box labeled "Report Fraud" and then click "Continue to IG's Fraud Report Form" to complete the online form; or

› You can report directly to your health plan:

Cigna
2208 Hwy 121, Ste. 210
Bedford, TX, 76021
Phone: **1-877-653-0327**

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

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

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

When reporting about someone who gets benefits, include:

› The person's name.
› The person's date of birth, Social Security number or case number if you have it.
› The city where the person lives.
› Specific details about the waste, abuse or fraud.

TERMS AND DEFINITIONS.

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

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

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

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

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

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

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

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

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

Grievance – A complaint to your health insurer or plan.

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

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

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

Hospice Services – Services to provide comfort and support for 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.

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 when there are no other providers, your health insurer can contract to pay a non-participating provider.

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

Physician Services – 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, which provides and pays for your health-care services.

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

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

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

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

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

Primary Care Provider – A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health-care services.

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

Rehabilitation Services and Devices – Health-care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

Skilled Nursing Care – Services from licensed nurses in your own home or in a nursing home.

Specialist – A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

GET HELPFUL INFORMATION ALL YEAR LONG.

As a Member of Cigna you can ask for and get the following information each year:

- Information about network providers – at a minimum primary care providers, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal, and Fair Hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits.
- How you get after-hours and emergency coverage and limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services, and post stabilization services.
  - The fact that you do not need prior authorization from your PCP for emergency care services.
  - In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- Cigna's practice guidelines.

KNOW THAT DISCRIMINATION IS AGAINST THE LAW.

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

Cigna:

- 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 Member Services. If you believe that Cigna 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 grievance with:

Cigna
Attn: Appeals, Complaints and Grievances Department
PO Box 211088
Bedford, Texas 76095
1-877-653-0327 (TTY: 7-1-1),
7 days a week, 8 a.m. to 8 p.m. Central Time.
Fax: **1-877-809-0783**

You can file a grievance in writing by mail or fax. If you need help filing a grievance, Member Services 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, 800-537-7697 (TDD)

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

GET HELP IN THE LANGUAGE YOU UNDERSTAND.

English – ATTENTION: If you speak English, language assistance services, free of charge are available to you. Call 1-877-653-0327 (TTY 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-653-0327 (TTY 711).

Chinese – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-653-0327 (TTY 711)。

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-653-0327 (TTY: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-653-0327 (TTY: 711) 번으로 전화해 주십시오.

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-653-0327 (TTY: 711).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-653-0327 (телетайп: 711).

Arabic ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1-877-653-0327 (رقم هاتف الصم والبكم 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-653-0327 (ATS : 711).

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-653-0327 (TTY: 711).

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-653-0327 (TTY: 711).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-653-0327 (TTY: 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-877-653-0327 (TTY: 711) まで、お電話にてご連絡ください。

Farsi **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-653-0327 (TTY: 711) تماس بگیرید.

Hindi – ध्यान दें: अगर आप हिंदी बोलते हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-877-653-0327 (TTY 711) पर कॉल करें।

Gujarati – સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-653-0327 (TTY: 711).

Urdu خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-877-653-0327 (TTY: 711). ک

Lao – ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການໃຫ້ຄວາມຊ່ວຍເຫຼືອດ້ານພາສາຈະໃຫ້ບໍລິການຟຣີແກ່ທ່ານ. ໂທ: 1-877-653-0327 (TTY 711).

Greek – ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-653-0327 (TTY: 711).

Cigna®

TEXAS STAR PLUS
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-653-0327 (TTY: 7-1-1), Monday to Friday, 8 a.m. to 5 p.m. Central Time.

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