Healthy Options Medical Benefit Book

22-542(X) (Rev. 04/12)

If the enclosed information is not in your primary language, please call 1-800-562-3022 (TDD/TTY only: 1-800-848-5429)
ENG

Yog tas cov ntaubntawv kws tuaj nrug nuav tsi yog koj yaam lug tes thov hu rua 1-800-562-3022 (TDD/TTY xwb: 1-800-848-5429)
HMG

Afai o lenei faaaliga e le o alu atu i lau gagana masani, faamolemole vala'au mai i le telefoni: 1-800-562-3022 (Mo e e le lelei le faalogo pe gugu, vala'au mai i le telefoni 1-800-848-5429)
SAM

Если прилагаемая информация не на вашем родном языке, позвоните, пожалуйста, по телефону 1-800-562-3022 (телефон только для лиц с плохим слухом (TDD/TTY): 1-800-848-5429)
RUS

Якщо прикладена інформація не на вашій рідній мові, подзвоніть, будь ласка, по телефону 1-800-562-3022 (телефон тільки для осіб з поганим слухом (TDD/TTY): 1-800-848-5429)
UKR

동봉한 안내자료가 귀하의 모국어로 준비되어 있지 않으면 1-800-562-3022 (청각장애자/시각장애자용: 1-800-848-5429)로 연락하십시요.
KOR

Dacă informaţiile alăturate nu sunt în limba dumneavoastră natală vă rugăm să sunaţi la 1-800-562-3022 (numai pentru TDD/TTY: 1-800-848-5429)
ROM

ይህ መልእክት በሚያውቁት ቋንቋ ካልሆነ እባክዎን በ 1-800-562-3022 [ቲዲዲ/ቲቲዋይ ብቻ 1-800-848-5429] ይደውሉ።
AM

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TIG

Si la información adjunta no está en su idioma primario, por favor llame al 1-800-562-3022 (Para TDD/TTY solamente, llame al 1-800-848-5429).
SP

ຖ້າຫາກວ່າຂ່າວສານອັນນີ້ບໍ່ແມ່ນພາສາທີ່ທ່ານຮູ້ຈັກ, ກະຣຸນາໂທຣະສັປໄປຫາ 1-800-562-3022 (TTY/TDD ເທົ່ານັ້ນ: 1-800-848-5429).
LA

Nếu tin tức đính kèm không có ngôn ngữ của quí vị, xin gọi 1-800-562-3022 (TDD/TTY mà thôi: 1-800-848-5429)
VN

如果隨附的資料不屬你的母語，請打電話 1-800-562-3022（TDD/TTY 專線 1-800-848-5429）。
CHI

បើពត៌មានដែលភ្ជាប់ទៅនេះមិនមែនជាភាសាដើមរបស់អ្នកទេ,សូមទូរស័ព្ទ 1-800-562-3022, (សំរាប់ TDD/TTY, ងងឹតឬថ្លង់: 1-800-848-5429)
CAM

Kung ang nakalakip na impormasyon ay hindi sa inyong pangunahing wika, pakitawagan po ang 1-800-562-3022 (TDD/TTY lamang: 1-800-848-5429)
TA

اگر اطلاعات ضميمه به زبان شما نمي باشد، لطفا به اين شماره 1-800-562-3022 (براي TDD/TTY (1-800-848-5429)
FA

Washington State Health Care Authority

Welcome to Healthy Options!

This book explains the Medicaid Healthy Options program. Please read the book to find out:

- How the Health Care Authority pays for your medical care;
- The differences between Healthy Options managed care, PCCM, and fee-for-service;
- How to choose a Healthy Options health plan;
- Information about each Healthy Options health plan;
- How to change your managed care health plan;
- Well-child doctor visits, childhood immunizations, and follow-up care benefits;
- Your medical benefits and how to get services;
- Your rights and responsibilities;
- Other important information you need to know.

If you have questions:

- Use the "Webform" or send us an email found at the website: http://hrsa.dshs.wa.gov/contact/default.aspx

- Call 1-800-562-3022 or 1-800-848-5429 TTY/TDD or 711 (for people with hearing or speech equipment). The call is free.

Washington State Health Care Authority

Using the Automated System to Hear Available Health Plans:

Shortcut

Health Plan Enrollment

1-800-562-3022

Press 6 for clients, Then Press 2

What will I hear?

The automated system will play the current health plan information for the person calling or for another family member.

When choosing to hear available health plans, the system will play the plan names and toll free numbers. If family members have different choices, the call will be transferred to an agent.

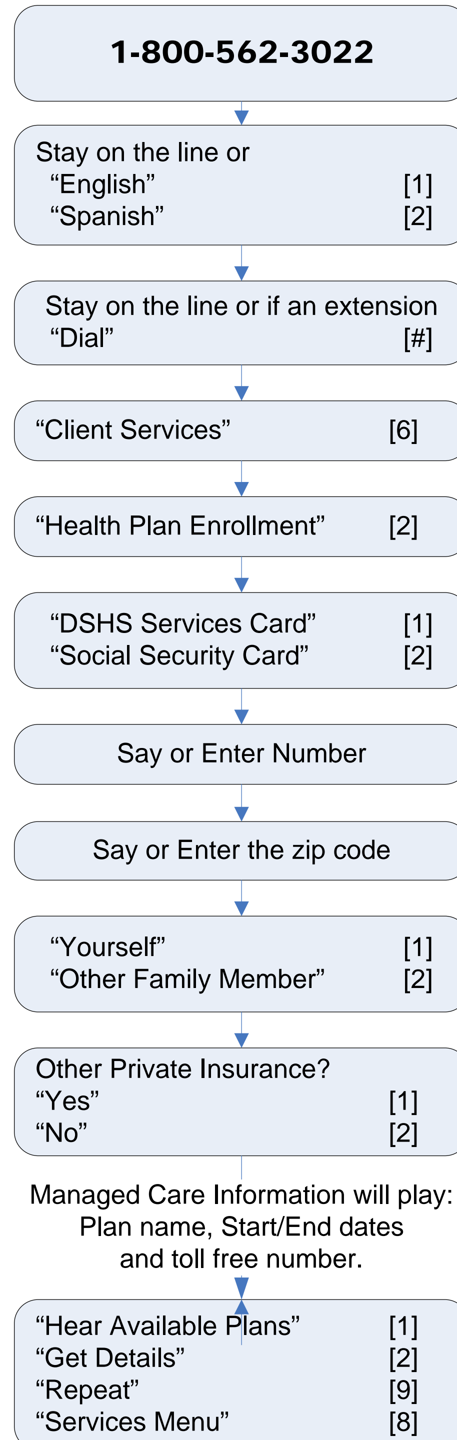
If choosing to "Get Details" information about the current managed care program will be played.

If confirming an assigned plan or enrolling in a different plan, more details can be given:

- Doctor or clinic name
- Pregnancy due date
- Surgery date
- Special needs or chronic condition
- General health rating

How

You can speak or press the number in brackets [ ]. You can key ahead anytime.



Washington State Health Care Authority

Client ID Number:
Name:
Address:

Enrollment Form

Easy as 1-2-3!

1. Please mark one box to show how you want to get health care for the people in your family.

- ☐ AMG
- ☐ CCC
- ☐ CHPW
- ☐ MHC
- ☐ UHC
- ☐ FEE FOR SERVICE
- ☐ PCCM CLINIC ____________

2. Write the name of the doctor or clinic you would like for each person. All doctors and clinics you list must be in the plan you choose above. Call the doctors to see if they are with the health plan.

Client ID	Client Name (Last, First, MI)	How would you rate this person's Health? Excellent	Very Good	Good	Fair	Poor	Special Health Condition or Developmental Delay? Yes	No
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								
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Doctor or Clinic:								
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								

3. Is anyone above pregnant or having surgery?

☐ Pregnant Family Member's Client ID: ____________ Due Date: ____________

Doctor or clinic: ____________

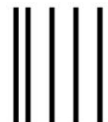
☐ Scheduled for surgery Family Member's Client ID: ____________ Date: ____________

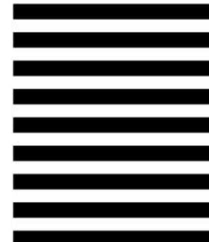
Choose ONE way to let us know your choice.

- Sign up on line: www.WAProviderOne.org
- Call our automated system anytime: 1-800-562-3022
- Fill out, fold and return with the Business Reply address on the outside (no stamp needed)
- Fill out and then fax to: **1-866-668-1214**

If you have questions call 1-800-562-3022,
Monday – Friday 7:00 a.m. to 5:00 p.m.
TTY/TDD users call 711 or 1-800-848-5429

Provider One Number





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WASHINGTON STATE HEALTH CARE AUTHORITY
PO BOX 45505
OLYMPIA WA 98599-9992

Washington State Health Care Authority

If it is hard for you to read or understand this book, please call Medicaid Customer Service at 1-800-562-3022. We can help by giving you the information in an alternative format, such as **larger** print, Braille format, or have it read to you in your primary language. This book is also available in Spanish at no cost to you. The TTY/TDD line is 711 or 1-800-848-5429 for people who have difficulties with hearing or speech. Your phone must be equipped to use this line.

Important Phone Numbers

Medicaid Customer Service	1-800-562-3022
Amerigroup (AMG)	1-800-600-4441
Coordinated Care Corporation (CCC)	1-877-644-4613
Community Health Plan (CHPW)	1-800-440-1561
Molina Healthcare of Washington, Inc. (MHC)	1-800-869-7165
United Healthcare Community Plan (UHC)	1-877-542-8997

Send your questions or comments to the Washington State Medicaid Customer Service using the website at:

http://hrsa.dshs.wa.gov/contact/default.aspx

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How do you get your health care?

HCA is the Washington State agency called the Health Care Authority. This state agency provides for your health care in different ways, depending on where you live or what services you get. This book gives you information about how to get your health care when you are enrolled in a Healthy Options managed care program.

Healthy Options health plans: The Health Care Authority contracts with health insurance plans to cover most of your medical care. When you are enrolled in Healthy Options, you pick a plan and go to one clinic or doctor who will be your Primary Care Provider (PCP). Your PCP will give you the care you need or have you go to a specialist. You may still get some services your health plan does not provide through the state's fee-for-service program such as long term care services, alcohol and substance abuse services, dental care, inpatient psychiatric care or transportation for health care appointments.

Health care from a tribal or urban Indian clinic: If you are American Indian or Alaska Native, you may be able to sign-up for the Primary Care Case Management (PCCM) program. PCCM health services are provided through a tribal or urban Indian clinic. The providers at the clinic know your culture, community, and health care needs. They will give you the care you need or send you to a specialist. If you have questions about the PCCM program, talk to your tribal or urban Indian clinic staff to see if this is a good choice for you.

Fee-for-service (not in a health plan or PCCM): If you are not enrolled in a health plan or PCCM, you will have to use doctors, hospitals, or pharmacies that see patients on the state's medical assistance program. This program is called fee-for-service (FFS). Sometimes it is hard to find providers who will see patients on the fee-for service program.

How do you know if you are eligible for health care services?

Each family member on medical assistance gets a Services card. Your Services card is a permanent card that is activated while you are eligible for medical assistance. The card only includes your name and identification number. You may also need to show a picture ID to prevent unauthorized use of the card. Your providers will verify your eligibility for medical services. If you lose the Services card, call Medicaid Customer Service at 1-800-562-3022 and follow the voice response prompts to ask for a new Services card.

How do doctors know which health plan you have?

When you are enrolled in a health plan, you will also get an identification (ID) card from your health plan. You should have ***both*** your Services card and your health plan ID card to:

- Get health care services
- Make, cancel, or check appointments, and
- Order or pick up prescriptions

Please call your plan's customer service number if any information on the card is wrong, or the card is lost, stolen, or needs to be replaced.

Do you have to be in a health plan?

Enrollment in one of the contracted managed care plans is mandatory for the following groups of people getting Categorically Needy care:

- Families receiving Temporary Aid to Needy Families (TANF) benefits and/or eligible for continued medical benefits,
- Pregnant women,
- Children through age 19 eligible under the Apple Health for Kids program
- Blind and Disabled persons (under age 65) who are:
  - NOT eligible for Medicare and
  - NOT living in an institution or long term care nursing facility;

NOTE: Children in Foster Care may enroll in a health plan voluntarily.

There are some situations when you don't have to be in a health plan. You must let us know *before* you get in a health plan if one or more of the following situations apply to your case.

- **You have other health insurance** besides Medicaid or become eligible for Medicare.
- **You are homeless** and you will live in a shelter or temporary address for less than four months.
- **You don't speak English or you are deaf or hearing impaired** AND you want to see a doctor or other medical provider who speaks your language AND the health plan does not have a provider available who can speak your language AND no interpreter is available.

- **You are American Indian or Alaska Native.** People who are American Indian or Alaska Native do not have to sign up for a health plan. As an American Indian/Alaska Native, you can choose to sign up for a health plan, a PCCM clinic, or choose fee-for-service. If you are American Indian or Alaska Native, call 1-800-562-3022 and let us know.
- **You are enrolled or choose to enroll in** Washington's Program of All-Inclusive Care for the Elderly (PACE).
- **On a case-by-case basis,** if you have a verifiable medical condition and changing doctors or health plans would interrupt your treatment and place your health at risk.

What happens if some people in your household are American Indian or Alaska Native and others are not?

Usually, family members who are not American Indian or Alaska Native must be in a health plan. There is one exception. If a family member is American Indian or Alaska Native AND signs up for a Tribal clinic, the other family members may also sign-up for the same Tribal clinic if the Tribal clinic approves. Check with your local Tribal clinic. (See the list of Tribal clinics in this book.)

What are your choices?

Why should you choose a health plan?

With a health plan you have access to medical advice 24 hours a day and guaranteed access to a Primary Care Provider and specialists. In a health plan, your primary care provider will help you get preventive care and refer you to specialists if you need them. Also, you may get some extra services like wellness programs with special gifts, such as bike helmets or car seats for your children. To find out more about the health plans, please call the numbers listed on the plan information pages in this book.

Why should you choose Primary Care Case Management (PCCM) if you are American Indian/Alaska Native?

If you are American Indian/Alaska Native you can have your care managed by a provider who knows your culture, community and health care needs. If you have questions about the PCCM program, talk to your clinic staff to see if this is a good choice for you.

Why should you choose a health plan or PCCM if you live in an area where you can choose FFS?

When you are not in a health plan or PCCM, you may have trouble finding a provider who will give you medical care and bill HCA for payment (fee-for-service). With a health plan or PCCM, you don't have to worry about trying to find a doctor. You may choose a doctor with the plan or one will be assigned to you. Plus, your doctors will work together to manage all your health needs. If you need to see a specialist, they will arrange it for you without having to find a specialist on your own who accepts fee-for-service patients.

What happens if you do not tell us your choice?

HCA will pick a plan or PCCM clinic for you. If a plan has been picked for you, you may not be able to use the doctors, hospitals, and other providers you want. Please call your doctor, pharmacy and specialist to see which plans they accept. If HCA makes a choice you don't want, you can change your plan by going on-line at www.WAProviderOne.org/client or call Medicaid Customer Service at 1-800-562-3022.

Does everyone in your family have to be in the same health plan?

Yes, everyone in your family who is eligible for enrollment in a managed care program has to be in the same health plan unless:

- Your family has American Indian/Alaska Native members, or
- A family member is enrolled in the Patient Review and Coordination (PRC) program.

NOTE: If you are enrolled in the PRC program, you need to stay with the same health plan for one year. You will remain in the PRC program whether you are enrolled in a health plan, PCCM or use fee-for-service.

How can you find out more about the plans you can choose from?

Check the Enrollment Form in the front of this book to see which health plans are available for you to choose from. Then, look for more information about the health plan(s) in this book. The health plan pages include:

- Where to call if you have questions, and
- How to learn more about what each plan offers.

What if you have doctors, specialists, hospitals, or pharmacies you would like to use?

If there are doctors, specialists, hospitals or pharmacies you would like to use, find out which health plans they accept and sign up with that health plan. Some providers are with more than one health plan. Remember, the hospitals you can use also depend on which hospitals your doctor and health plan uses.

How do you choose your PCCM?

If you are American Indian/Alaska Native, you should choose the tribal or urban Indian clinic you already go to. See the list of participating PCCM Tribal clinics in this book.

How do you sign up for either a health plan or PCCM?

If you want a different plan than the one HCA chose for you, go on-line to www.WAProviderOne.org/client; call us using the automated telephone system and tell us which plan you want; or just fill out the Enrollment Form in this book and drop it in the mail. You don't even need a stamp!

Can you change your health plan?

Yes! In most cases, you can change health plans at any time. The change will be effective the next month. Go on-line to www.WAProviderOne.org/client or call Medicaid Customer Service and use the automated telephone system to tell us which plan you want.

> **NOTE**: If you are enrolled in the Patient Review and Coordination program, you need to stay with the same health plan for one year.

What happens if you move?

If you move, you may need to change how you get your care. Be sure to call the Community Service Office (CSO) at 1-877-501-2233 to let them know you moved. Also, call your health plan. They will tell you if you need to make changes to your health plan.

How do you get medical care from your health plan?

After you are signed up, your health plan will send you a plan ID card and assign you to your choice of a Primary Care Provider (PCP). Make an appointment with your PCP for a check-up. Be sure to bring both your Services Card and Health Plan ID cards.

How do you get care in an emergency or when you are away from home?

Emergency care: An emergency is a sudden or severe health problem that needs treatment right away. If you think you have an emergency, no matter where you are, call 911 or go to the nearest location where emergency providers can help you. Emergencies are covered anywhere in the United States. As soon as possible, call your PCP or health plan to arrange for follow-up care with your PCP after the emergency is over. Your PCP or health plan can help arrange the follow-up care.

Urgent care is care you get when you think you have a health problem that needs care right away, but your life is not in danger. Urgent care is covered anywhere in the United States. If you think you need to be seen quickly, go to an urgent care center that works with your health plan. You can also call your PCP's office or the health plan's 24-hour Nurse Advice Line.

Medical care away from home: If you need medical care that is not an emergency or urgent, or need to get prescriptions filled while you are away from home, call your PCP or your health plan for advice. They will help you get the care you need. Routine or preventive care, like a scheduled provider visit or well-exam, is not covered when you are outside of your service area (county).

How do you get care after hours?

Most health plans have a toll-free phone number to call and get medical advice from nurses 24 hours a day. The phone number to call is listed on the health plan's information page in this book. Call your PCP's office or health plan's Nurse Advice Line for advice on how to reach a provider after hours.

How soon will a health plan provider see you?

How soon your health plan must get you in to see your provider depends on the care you need. You should expect to see a health plan provider within the following timelines:

- **Emergency**: Available 24 hours per day, seven days per week. An emergency is when someone has a sudden or severe medical problem and needs care right away. Call your PCP for any follow-up care after an emergency care visit.
- **Urgent**: Office visits with your PCP or other provider within 48 hours. Urgent care is for medical problems that need care right away, but your life is not in danger.
- **Routine Care**: Office visits with your PCP or other provider within 10 days. Routine care is planned, regular, provider visits for medical problems that are *not* urgent or an emergency.
- **Preventive Care**: Office visits with your PCP or other provider within 30 days. *Examples of preventive care* are physical exams, such as well-child care; annual women's health care; and immunizations (shots).

Nurse Advice Line: Most health plans have a toll-free phone number to call and get medical advice from a nurse 24-hours day. The phone number to call is listed on the health plan's information page in this book.

Can you go to any doctor, pharmacy, or hospital that you want?

No - You must use doctors and other medical providers who work with your health plan. Health plans also have certain hospitals and pharmacies you must use. For all of the plans, the hospitals you can use depend on which hospitals your doctor uses. Call the plan's customer service line or visit their website to get a provider directory or get more information about their doctors, hospitals and pharmacies. The directory of providers, pharmacies and hospitals, includes:

- The service provider's name, location and phone number;
- The specialty and medical degree;
- The languages spoken;
- Any limits on the kind of patients (adults/children etc.) the provider sees, and
- If they are accepting new patients.

Who will take care of most of your health care needs?

You will go to a Primary Care Provider (PCP) in your plan for most or all of your care. Your PCP can be a doctor, nurse practitioner or physician assistant. If you need care from a specialist or other provider, your PCP will help you find the right provider and coordinate your care with your health plan for any referrals.

Can you change your PCP?

Yes! You may choose a different PCP as long as the new PCP is with your health plan. To do this, call your health plan. Most PCP changes will take place the first day of the next month.

Can you and others in your family have different PCPs?

Yes! You and your family members can have different PCPs as long as all of them are in the health plan you pick. Call your health plan to choose the PCP you want.

How do you get care from a specialist?

Your PCP must refer you for most of your specialty care. There are some exceptions, so check with your plan to be sure. If you think you need specialty care, contact your PCP. If you or your PCP thinks that you need specialty care, your PCP will refer you to a specialist who works with your health plan. For more information about specialists call your plan's customer service. Your health plan can give you a list of contracted specialists.

What if you need to go to the hospital?

All planned surgeries and other non-emergency hospital visits must be approved by your health plan in advance. Your provider and the hospital will call your health plan to arrange for your visit. If you need a list of hospitals that work with your health plan, call your plan's customer service.

How do you get prescriptions filled? Can you use any pharmacy?

The health plans contract with many pharmacies. You must get your drugs at one of these pharmacies. Call your health plan's customer service number and ask them to send you a list of their contracted pharmacies.

Will your health plan cover all drugs prescribed?

All health plans use a list of approved drugs. This is called a "formulary." The list is put together by a group of providers and pharmacists. To make sure your drugs will be paid for, your PCP or provider should prescribe drugs to you from this list. You do not have a copay for drugs covered by your health plan. Certain drugs on the list will need approval from your health plan before you get the drugs.

You can call your health plan and ask for:

- A copy of the formulary (drug list).
- Information about the group of providers and pharmacists who created the formulary.
- A copy of the policy on how your health plan decides what drugs are covered.

How do you get medical equipment or medical supplies?

All health plans cover medical equipment or supplies, when they are medically necessary and prescribed by a health care provider. Most equipment and supplies require approval in advance by your health plan. Be sure to call the plan first.

How do you get mental health care?

If you need mental health care, your PCP and health plan can help coordinate your care with a mental health provider. All health plans cover 20 hours of outpatient treatment per calendar year for children up to 18 years of age. Adults (19 and older) are limited to 12 hours of outpatient treatment per calendar year. Health plans also cover evaluations and, if needed, psychological testing.

Your PCP might think your mental health needs are better served through your local Community Mental Health Agency. If so, your PCP will send you there for an evaluation. Based on the evaluation results, you may continue to get all your mental health care needs from the Community Mental Health Agency. Mental health drugs prescribed to you while getting care from a Community Mental Health Agency are covered fee-for-service as part of that care. If you do not meet the access standards for care from the Community Mental Health Agency, your PCP and health plan will help you get needed care.

What if you have special health care needs or long-term illness?

If you have special health care needs, you may be eligible for extra benefits in a health plan's disease management program. You may also get direct access to specialists who can help you get needed care. In some cases the health plan may allow you to use your specialist as your PCP. You can get more information about care coordination and care management from your health plan.

What if you need long term care services?

If you are eligible and need long term care services, they will be provided through the Medicaid fee-for-service program. To get more information about long term care services call 1-800-422-3263.

What if you have a medical service, such as surgery that is already scheduled?

Call the health plan you are choosing right away to let them know about the medical service so they can help you get needed care. There is also a place on the Enrollment Form to tell us this information.

Can you get women's health care, without a referral from your PCP?

Yes! You do not need a referral (permission) from your PCP to get maternity or other women's health care as long as the provider you choose is in your health plan.

What is EPSDT?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a preventive health care benefit for children and youth. The program provides complete, periodic health screenings to clients under age 21. The screenings can help identify potential physical and/or behavioral health conditions. Diagnostic testing and medically necessary treatment to correct or improve physical and mental illnesses or conditions are also available through the EPSDT program. EPSDT encourages early and continuing access to health care for children and youth. EPSDT includes:

Screening – When requested, screenings are done according to a recommended schedule to fully assess each child's health status and find possible health problems. A screening includes all of the following elements:

- Complete health and developmental history.
- A full physical examination.
- Appropriate behavioral health and substance abuse screening.
- Health education and counseling based on age and health history.
- Appropriate vision testing.
- Appropriate hearing testing.

- Appropriate laboratory testing.
- Dental screening services.
- Immunizations (shots).

All EPSDT screening elements must be performed or ordered for the visit to be considered an EPSDT screening.

Diagnosis – When a health care risk is identified in an EPSDT screening, additional tests may be done to determine if further evaluation or treatment is needed.

Treatment – When a health care condition is diagnosed as a result of an EPSDT screening, the provider(s) will:

- Treat the client if it is within the provider's scope of practice; or
- Refer the client to an appropriate provider for treatment which may include:
    - Additional testing or specialty evaluations, such as developmental assessment, comprehensive mental health, and substance abuse evaluation, or nutritional counseling.

Treating providers communicate the results of their services to the referring EPSDT screening provider(s). If there is a need for a more complete evaluation of the client's health or condition, that evaluation, diagnosis, and medically necessary treatment is provided to the client.

Children may receive medically necessary covered health care services with or without an EPSDT screening. Certain covered health care services may require prior authorization. A current EPSDT screening is required before non-covered services may be requested and authorized. All non-covered services require prior authorization.

What are your medical benefits?

Medicaid covers many benefits and services when medically necessary whether you get health care through a Managed Care health plan, a PCCM clinic, or Fee-for-Service. Some of the benefits covered by the health plans are listed below. Check with your provider or your health plan if a service you need is not listed as a benefit.

For some services, you may need to get a referral (from your PCP) and/or approval from your health plan before you get the services. Otherwise, your health plan might not pay for the service. Some services are **limited** by number of visits or supply/equipment items. Each health plan has a process to review your or your provider's request for a *Limitation Extension.* Each health plan also has a process to review your or your provider's request for a medically necessary noncovered service as an *Exception to Rule* request. Remember to call your health plan's customer service number *before* you get medical services or ask your PCP to help you get the care you need.

NOTE: This list is provided for general information only and does not guarantee that the service will actually be covered.

Benefits/services covered by your health plan/PCCM:

Benefit/Service	Comments
Ambulance Services	For emergencies only or when transporting between facilities.
Antigen (allergy serum)	Allergy shots
Audiology Tests	Hearing tests
Biofeedback Therapy	Limited to plan requirements
Birth Control	See Family Planning Services.
Birth Defects	See Cosmetic Surgery.
Blood Products	Includes blood, blood components, human blood products and their administration.
Breast Pumps	
Chemotherapy	
Chiropractic Care for children	Benefit is for children only (age 20 and under) with referral from PCP after being seen for an EPSDT (well child care) screening. See Spinal manipulations.
Contraceptives	See Family Planning.
Cosmetic Surgery	**ONLY WHEN** - the surgery and related services and supplies are provided to correct physiological defects from birth, illness, physical trauma or for mastectomy reconstruction for post-cancer treatment.
Diabetic Supplies	
Dialysis	
Emergency Services	Available 24 hours per day, 7 days per week anywhere in the United States. An emergency is when someone has a serious medical problem and needs care right away.
EPSDT (means Early Periodic Screening, Diagnosis and Treatment)	EPSDT includes regular checkups to make sure people under 21 years old get the preventive care they need to catch and treat health problems at an early stage. These EPSDT screenings (well child care) include: • A complete physical exam with health, mental health screening, and developmental history • Immunizations (shots) and lab tests • Screens for: Vision; Hearing; Dental Care; Mental Health; and Substance Abuse.
Eye Exams	You must use the plan's provider network. Limited to **one** exam every 12 months for children age 20 and under and every 24 months for adults 21 and over. Can be more frequent if determined to be medically necessary by the health plan. **NOTE:** *For children - Eyeglasses, Contact Lenses, & hardware fittings are covered separately under the FFS program.*

Benefit/Service	Comments
Family Planning Services	You have a choice using the plan's network of providers or going to the local health department or family planning clinic.
Healthcare Services (Office Visits, Preventive Care, Specialty Care)	Must use participating providers with plan. Plans may require approved referrals – Call the health plan for specific questions.
Health Education and Counseling	**Examples:** Health education for conditions such as diabetes and heart disease.
Hearing Exams	Hearing exams are covered by health plan's network of providers. **NOTE:** *For children - Hearing aids are covered separately under the FFS program.*
HIV/AIDS screening	You have a choice of going to a Family Planning clinic, the local health department or going to your PCP for the screening.
Home Health Care	Must be approved by health plan
Hospital, Inpatient and Outpatient services	Must be approved by health plan for all non-emergent care
Immunizations/ Vaccinations	
Lab and X-ray Services	
Mammograms	See Women's Health Care.
Maternity & Prenatal Care	See Women's Health Care.
Medical Equipment	Most equipment must first be approved by the health plan. Call the health plan for specific details.
Medical Supplies	Most supplies must first be approved by the health plan. Call the health plan for specific details.
Mental Health, Outpatient Treatment	Limited benefit based on medical need. The benefit through the health plan covers: • Up to 12 hours of treatment per calendar year for adults age 19 and older. • Up to 20 hours of treatment per calendar year for children age 18 and younger. • Mental Health medication management by your PCP or mental health provider. • Psychological testing, evaluation and diagnosis: ✓ Once every 12 months for adults 21 and over and children under age 21 when not ordered by an EPSDT screening visit. ✓ As often as needed if identified by an EPSDT (well-child care) screening for children 20 years old and under.
Nutritional Therapy	Covered for children 20 years old or younger when medically necessary and referred by the provider after an EPSDT visit.
Occupational Therapy	**LIMITED benefit: Check with health plan.** HCA covers the service fee-for-service for children when provided in an approved Neurodevelopmental Center. See http://www.doh.wa.gov/CFH/cshcn/docs/ndclistonweb.pdf
Organ Transplants	Call the health plan for specific details.

Benefit/Service	Comments
Osteopathic Manipulative Therapy	**LIMITED benefit:** Ten (10) osteopathic manipulations per calendar year are covered by the health plan, only when performed by a plan Doctor of Osteopath (D.O.).
Oxygen & Respiratory Services	
Pharmacy Services	Must use participating pharmacies. The health plan's have their own drug formulary (list). Call your health plan for specific information and list of pharmacies.
Physical Therapy	**LIMITED benefit: Check with health plan.** HCA covers the service fee-for-service for children when provided in an approved Neurodevelopmental Center. See http://www.doh.wa.gov/CFH/cshcn/docs/ndclistonweb.pdf
Podiatry	**LIMITED benefit: Check with health plan**
Pregnancy Terminations, Involuntary (miscarriage)	
Private Duty Nursing	
Radiology & Medical Imaging Services	
Reconstructive Surgery after Mastectomy	
Sexually Transmitted Diseases (STD) Treatment	You have a choice of going to your PCP, the local health department or family planning clinic.
Skilled Nursing Facility (SNF)	
Smoking Cessation	Smoking Cessation is covered for all clients based on the health plan's policies.
Speech Therapy	**LIMITED benefit: Check with health plan.** HCA covers the service fee-for-service for children when provided in an approved Neurodevelopmental Center. See http://www.doh.wa.gov/CFH/cshcn/docs/ndclistonweb.pdf
Sterilizations, age 21 and over.	Must complete sterilization form 30 days prior or meet waiver requirements. Reversals not covered.
Tuberculosis (TB) Screening & Follow-up treatment	You have a choice of going to your PCP or to the local health department.
Women's Health Care	Services must be obtained from the health plan's network of providers and includes follow-up treatment for any problems discovered.

You have a choice to get some services from your PCP/PCCM clinic or go directly to a local health department or family planning clinic. You do not need a referral (permission) from the health plan to get the following services:

- Family Planning services and birth control
- HIV and AIDS testing
- Immunizations
- Sexually transmitted disease treatment and follow-up care
- TB screening and follow-up care

Benefits covered under the fee-for-service program:

The following benefits and services are covered by Medicaid fee-for-service program even when you are enrolled in a health plan. Your health plan and PCP can help coordinate your care with other community-based services and programs. If you have a question about a benefit or service not listed here, call your health plan's Customer Service line or Medicaid Customer Service.

Benefit/Service	Comments
Alcohol and substance abuse services, inpatient, outpatient & detoxification	Must be provided by DSHS certified agencies. Call 1-877-301-4557 for specific information.
Long-term care services and services for people with Developmental Disabilities	These services must be approved by the Aging and Disability Services Administration (ADSA). Call 1-800-422-3263.
Dental Services	You will need to use a dental provider who has agreed to be a Medicaid provider.
Eyeglasses and fitting services	Covered for children 20 years old and younger. You will need to use a provider who has agreed to be a Medicaid provider.
Hearing Aid Devices	Covered for children 20 years old and younger. You will need to use a provider who has agreed to be a Medicaid provider.
Early Support for Infants and Toddlers (ESIT) from birth to age 3.	Call 1-800-322-2588 for information
Maternity Support Services	Part of the First Steps Program – Call 1-800-322-2588
Outpatient Mental Health, Inpatient Psychiatric Care and Crisis services	All mental health services when received from a Community Mental Health Agency. Inpatient psychiatric care must be authorized by a mental health professional from the local Community Mental Health Agency. For more specific information call 1-800-446-0259.
Prenatal Genetic Counseling	
Pregnancy Terminations, Voluntary	Includes termination and follow-up care for any complications.
Sterilizations, under age 21	Must complete sterilization form 30 days prior or meet waiver requirements. Reversals not covered.
Surgical Procedure for weight loss or reduction	Must be approved by the HCA fee-for-service program.
Transportation, for medical appointments	HCA pays for transportation services to and from needed non-emergency healthcare appointments. If you have a current Services Card, you may be eligible for transportation. Call the transportation provider (broker) in your area to learn about services and limitations. Your regional broker will arrange the most appropriate, least costly transportation for you. A list of Brokers can be found at http://maa.dshs.wa.gov/Transportation/Phone.htm.

Some Services are excluded and NOT paid for:

The examples in the list below are called exclusions, meaning these services are **not** available under your benefit plan, even if *medically necessary*. These services are not available from your plan, PCCM clinic or the fee-for-service program. If you get any of these services you may have to pay for them yourself. If you have questions about a benefit or service, call your health plan's Customer Service.

Services Excluded	Comments
Alternative Medicines	Acupuncture, Christian Science practice, faith healing, herbal therapy, homeopathy, massage, massage therapy, or naturopathy.
Chiropractic care for adults	
Cosmetic or plastic surgery	Such as tattoo removal; face lifts; ear or body piercing; or hair transplants
Diagnosis and treatment of infertility, impotence, and sexual dysfunction.	
Gender reassignment surgery	
Marriage counseling and sex therapy	
Personal comfort items	
Nonmedical equipment	Modifications to your living space are not covered as medical benefits.
Physical exams needed for employment, insurance, or licensing	
Services not allowed by federal or state law	
Weight reduction and control services	This includes: weight loss drugs, products, gym memberships, or equipment for the purpose of weight reduction.

Do you have to pay for health care services?

Usually not. You have no copays… But if you get a service that is ***not covered*** by your health plan, PCCM or fee-for-service program you might have to pay.

To make sure you are not billed:

- Always carry **both** your Services card and your health plan ID card with you.
- Know the name of your health plan, Primary Care Provider (PCP), and/or Primary Care Case Management (PCCM) provider.
- Know your health plan and PCCM rules for getting care. There are times when you can be billed. If you don't follow the rules of your health plan or PCCM, such as going to a specialist without getting a referral, you may be billed for the service.

You may have to pay if:

- A service you get is not covered;
- A service you get is not Medically Necessary;
- You get care from a provider who does not work with your health plan (unless it is an emergency or pre-approved by your health plan);
- You sign an agreement to pay form; and
  - You get specialty care or equipment without a referral from your PCP; or
  - You get care that requires prior authorization, before it is approved.

If you are not in a health plan but getting care that is covered by the fee-for service program, call the provider to be sure they will HCA for the service.

If you get a bill for a service you believe is covered, or a service you believe is non-covered, call your health plan or PCCM first. They will explain the process for submitting the bill to the health plan. If you still need help, call the Medicaid Customer Service at 1-800-562-3022.

What are your rights and responsibilities?

You have the right to:

- Help make decisions about your health care, including refusing treatment.
- Be informed about all treatment options available regardless of cost.
- Get a second opinion from another provider in your health plan.
- Get services without having to wait too long.
- Be treated with respect and dignity. Discrimination is not allowed. No one can be treated differently or unfairly because of their race, color, national origin, sex, sexual preference, age, religion, creed or disability.
- Speak freely about your health care and concerns without any bad results.
- Have your privacy protected and information about your care kept confidential.
- Ask for and get copies of your medical records.
- Ask for and have corrections made to your medical records when needed.
- Ask for and get information about:
  - Your health care and covered services
  - Your doctor and how referrals are made to specialists and other providers
  - How the health plan pays your providers for your medical care
  - All options for care and why you are getting certain kinds of care
  - How to get help with filing a grievance or complaint about your care
  - Your health plan's organizational structure including policies and procedures, practice guidelines, and how to recommend changes.
- Receive the Members' Rights and Responsibilities at least yearly.

You have the responsibility to:

- Help make decisions about your health care, including refusing treatment.
- Keep appointments and be on time. Call the office if you are going to be late or if you have to cancel the appointment.
- Give your providers information they need to get paid for providing services to you.
- Show your providers the same respect you want from them.
- Bring your Services card and health plan ID card to all of your appointments.
- Learn about your health plan and what services are covered.
- Use health care services when you need them.
- Know your health problems and take part in making agreed upon treatment goals as much as possible.
- Give your providers and health plan complete information about your health so you can get the care you need.
- Follow your provider's instructions for care that you have agreed to.
- Use health care services appropriately. If you do not, you may be enrolled in the Patient Review and Coordination Program. In this program, you are assigned to one primary care provider, one pharmacy, one prescriber for controlled substances, and one hospital for non-emergent care. You also stay in the same plan for at least 12 months.

What if you are unhappy with your health plan?

You have the right to file a grievance or appeal a decision if you are not happy with the way you have been treated or have been denied a medical service. The plan will help you file a grievance or an appeal.

> **NOTE:** The information in this section applies to you ***only*** if you are enrolled in a Healthy Options health plan. If you are enrolled in PCCM, call HCA at 1-800-562-3022 for help.

Grievances or complaints can be about:

- A problem with your doctor's office,
- Getting a bill from your doctor, or
- Any other problems you may have getting health care.

Your health plan must let you know by phone or letter that they received your grievance or complaint within five working days. The plan must address your concerns as quickly as possible not taking more than 45 days.

Things to know if a medical service is denied…there are time limits.

A **denial** is when your health plan does not approve or pay for a service that either you or your doctor asked for. When your health plan denies a service, it will send you a letter about the denied service. The letter will let you know your rights and actions you can take if you or your doctors do not agree with the plan's decision. After you get a denial letter, you have 90 days to ask for an appeal of the plan's decision. The plan will reply in writing telling you they received your request within 5 working days.

An **appeal** is when you ask the health plan to review your case because you disagree with their denial. With written consent, you can have someone appeal on your behalf. You only have 10 days to ask for an appeal if you want to keep getting a service that you are already getting while the plan reviews its decision. Your plan will review and decide your appeal within 14 days. Your plan must tell you if it needs more time (up to 30 days) to make a decision. The plan must get your written permission to take more than 30 days to make a decision. In any case an appeal decision must be made within 45 days.

NOTE: If you keep getting a service during the appeal process and you lose the appeal, you may have to pay for the services you received.

Is it urgent? For urgent medical conditions, you or your doctor can ask for an expedited (quick) review or hearing. If your medical condition requires it, a decision will be made about your care within 72 hours. To ask for an expedited appeal, tell your plan why you need the faster decision. If the health plan denies your request, your appeal will be reviewed in the same time frames outlined above. Your plan must make reasonable efforts to give you prompt oral notice if it denies your request for an expedited appeal. Your plan must provide written notice within 2 calendar days of its decision.

If you disagree with the appeal decision from the plan, you have the right to ask for an administrative hearing within 90 days. A **hearing** is when you ask an Administrative Law Judge (ALJ) to review your case after your plan denied your appeal. DO NOT ask for a hearing before you get the plan's decision about your appeal.

To ask for a Hearing:

- Call the Office of Administrative Hearings (www.oah.wa.gov) at 1-800-583-8271, or send a letter to P.O. Box 42489, Olympia, Washington, 98504-2489.
- Tell the Office of Administrative Hearings the reason for the hearing, what service was denied; the date it was denied; and the date that the appeal was denied. Also, be sure to give your name, address, and phone number.

You may talk with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer call the NW Justice CLEAR line at 888-201-1014, weekdays from 9:15 a.m. until 12:15 p.m., and Tuesdays from 3:30 p.m. until 6:15 p.m., or visit http://www.nwjustice.org/

You will get a letter telling you the decision from the hearing. If you disagree with the hearing decision, you have the right to ask your plan for a review of your case by an **Independent Review Organization (IRO)**. An IRO is a group of doctors, who do not work for your plan. You have 180 days to call your plan and ask for a review by an IRO after you get the hearing decision letter.

If you still do not agree with the decision of the IRO, you can ask to have a Review Judge from the **Board of Appeals** to review your case. You only have 21 days to ask for the review after getting your IRO decision letter. The decision of the Review Judge is final. To ask for a Review Judge to review your case:

- Call 1-877-351-0002 (TTD only: 360-664-6178), or
- Write to the HCA Review Judge at P.O. Box 45803 Olympia, WA 98504-5803.

Other Important Information

What happens if you have other health insurance?

Coordination of benefits happens when you have more than one health insurance plan at the same time. Please let the Coordination of Benefits Section at HCA know if you have other health insurance. Call 1-800-562-3022 ext 16134. HCA will verify your primary insurance coverage. If your primary insurance coverage is comparable (similar) to your managed care covered services, HCA will disenroll you from the managed care program.

Your health plan must coordinate benefits with your primary insurance until you are disenrolled. To cover any co-pays or deductibles, be sure to call your plan's customer service number and let them know you have other insurance.

Third-party liability is when another party must pay for the health care you get because of an injury or accident. It is also called ***subrogation***. For example, your auto insurance may pay if you are injured in an auto accident. Or workers' compensation may pay if you are hurt on the job. If you have an accident or injury, let your health plan know by calling the health plan's Customer Service center. The health plan will work with the party responsible for the accident/injury to recover any payments made on your behalf. If you get an insurance settlement, you may need to refund the health plan for any bills it paid related to the injury or accident.

How do health plans review new technology?

All health plans review new equipment, drugs and procedures to decide if they should be covered on a case by case basis. Some new equipment, drugs and procedures are still being tested to see if they really help. If they are still being tested they are called experimental or investigational. These services are covered after research and the plans determine they are more helpful than harmful. If you want to know more about this, call your health plan's Customer Service center.

How can you help stop health care fraud and abuse?

Health care fraud takes money from health care programs and leaves less money for real medical care. Here are some ways you can help stop fraud:

- Always carry a picture ID with you.
- Be careful about giving out your Social Security number.
- Do not give your Services card or health plan ID card or number to anyone other than a health care provider, clinic, or hospital, and only when receiving care.
- Never let anyone borrow your Services card or health plan ID card or number.
- Never sign a blank insurance form.

If you think fraud has taken place, report it to the state by calling:

- (800) 562-6906 to report Medicaid fraud
- (866) 363-4276 (866 END-HARM) to report physical/mental abuse, neglect or financial exploitation of a child or vulnerable adult

What are Advance Directives?

An Advance Directive puts your choices for health care into writing. The advance directive tells your doctor and family:

- What kind of health care you do or do not want if :
  - You lose consciousness,
  - You can no longer make health care decisions, or
  - You cannot tell your doctor or family what kind of care you want for any other reason.
- If you want to donate your organ(s) after your death.
- If you want someone else, a friend or family member, to decide about your health care if you can't.

Having an advance directive means your loved ones or your doctor can make medical choices for you based on your wishes. There are three types of advance directives in Washington State. These include:

(1) Durable Power of Attorney for Health Care. This names another person to make medical decisions for you if you are not able to make them for yourself.
(2) Healthcare Directive (living will). This is a written statement that tells people whether or not you want treatments to prolong your life.
(3) Organ Donation request.

Talk to your doctor, family, friends, and those close to you. Put decisions about your medical care in writing now. You can cancel an advance directive at any time. Your health plan, doctor, or hospital can give you more information about advance directives if you ask. You can also:

- Ask to see your plan's policies on advance directives, and
- File a grievance with your plan or DSHS if your directive is not followed.

Do health plans have quality improvement programs?

Yes! If you want a copy of your health plan's Quality Improvement Program description or progress report, please call your plan's Customer Service center.

How does a health plan pay providers?

Call your health plan for information on how they pay your providers. Each health plan makes medical necessity decisions about your health care based on what you need and your benefit coverage. Health plans cannot reward providers, employees, or other people to deny or limit your health care or encourage over-use or under-use of tests or treatments.

Is your Privacy Protected by the health plans?

Yes! All health plans are required by law to protect your health information. Health plans, like HCA, use and share protected health information about you to provide your health benefits. We use and share your information to carry out treatment, payment, and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private.

PHI stands for **P**rotected **H**ealth **I**nformation. PHI refers to health information such as medical records that include your name, member number, or other identifiers used or shared by health plans. Health plans and HCA share PHI for the following reasons:

- Treatment - Includes referrals between your PCP and other health care providers.

- Payment - Your health plan may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical needs.
- Health Care Operations - Your health plan may use or share PHI about you to run the plan's business. For example, it may use information from your claim to let you know about a health program that could help you. Your PHI may also be used to see that claims are paid right.

Health plans may use or share your PHI ***without*** getting written authorization (approval) from you when:

✓ Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:
  - The information is directly related to the family or friend's involvement with your care or payment for that care; and
  - You have either orally agreed to the disclosure or have been given an opportunity to object and have not objected.

✓ The law allows HCA or your health plan to use and share your PHI for the following reasons:
  - When the U. S. Secretary of the Department of Health and Human Services (DHHS) requires the plan to share your PHI.
  - Public Health and Safety: This may include helping public health agencies to prevent or control disease.
  - Health Care Oversight: Your PHI may be used or shared with government agencies. They may need your PHI for audits.
  - Research: Your PHI may be used or shared for research in certain cases, when approved by a privacy or institutional review board.
  - Legal or Administrative Proceedings: Your PHI may be used or shared for legal proceedings, such as in response to a court order. Your PHI may also be shared with funeral directors or coroners to help them do their jobs.
  - Law Enforcement: Your PHI may be used or shared with police to help find a suspect, witness or missing person. Your PHI may also be shared with other legal authorities, if we believe that you may be a victim of abuse, neglect or domestic violence.
  - Government Functions: Your PHI may be shared with the government for special functions, such as national security activities.
  - Workers Compensation: Your PHI may be used or shared to obey Workers Compensation laws.

Your written authorization (approval) is ***required*** for all other reasons not listed above. You may cancel a written approval that you have given to your health plan. However, your cancellation will not apply to actions taken before the cancellation.

If you believe your health plan violated your rights to privacy of your PHI, you can:

- Call your health plan and file a complaint. The plan will not take any action against you for filing a complaint. The care you get will not change in any way.
- File a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to:

  Office for Civil Rights
  U.S. Department of Health and Human Services
  2201 Sixth Avenue – Mail Stop RX-11
  Seattle, WA 98121

Remember: This information is only an overview. Each health plan is required to keep your PHI private and give you written information annually about the plan's privacy practices and your PHI. Please refer to your health plan's Notice of Privacy Practices for additional details. You may also contact your health plan for more information.

PRIMARY CARE CASE MANAGEMENT (PCCM) Clinics For American Indian or Alaska Native family members.

TRIBE	NAME AND LOCATION(S) OF CLINIC	PHONE NUMBER
Any tribe	Seattle Indian Health Board – Seattle	206-324-9360
Any tribe	NATIVE Health Clinic – Spokane	509-483-7535
Colville	Inchelium & Sanpoil Valley Health Center – Inchelium and Keller	509-722-7006
Colville	Colville Indian Health Center* - Nespelem and Omak	509-634-2900
Lower Elwha	Lower Elwha Health Center – Port Angeles	360-452-6252
Lummi	Lummi Tribal Health Center - Bellingham	360-384-0464
Nooksack	Nooksack Community Clinic - Everson	360-966-2106
Puyallup	Takopid Health Center – Tacoma	253-593-0232
Quileute	Quileute Health Center – LaPush	360-374-9035
Quinault	Roger Saux Health Center – Taholah	360-276-4405
Shoalwater Bay	Shoalwater Bay Wellness Center – Tokeland	360-267-0119
Spokane	David C. Wynecoop Memorial Clinic* - Wellpinit	509-258-4517
Tulalip	Tulalip Tribes Health Center – Tulalip	360-651-4511
Yakama	Yakama Indian Health Center* - Toppenish & White Swan	509-865-2102

*Federally recognized tribal status must be verified to receive services at this site.

Amerigroup is proud to serve eligible Medicaid members in Washington. We're a managed care organization. And we'll help arrange for you and your family to continue getting the Medicaid benefits you need to stay healthy. We offer these benefits through the Healthy Options program.

Our family of health plans has been helping families like yours across the country since 1996. All of us at Amerigroup are committed to helping you and your family be as healthy as you can be. Now we want to help you get:

- The right doctor for your needs
- 24/7 help on the phone if you need to speak with a nurse or need help finding a doctor
- Health checkups, screenings and more

Special services we offer - Helping our members get the best possible health care is our number one priority. It's what we do every day at Amerigroup.

- Our **disease management** program provides support for members who are managing difficult health conditions like asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and Coronary Artery Disease (CAD) – we have special programs and care managers who will:
  - Listen and take the time to understand your needs
  - Help you establish health goals and set up a plan to reach them and
  - Give you the resources you need to help improve your quality of life

To learn more, call 1-888-830-4300 and ask to speak with a disease management care manager.

- When you call **Amerigroup On Call** at 1-866-864-2544, you can **reach a nurse 24 hours a day, 7 days a week**:
  - For answers to questions about your health
  - For help reaching a doctor after hours or setting up an urgent-care appointment

- **Taking Care of Baby and Me®** offers pregnant members and new moms educational materials and up to $65 in gift cards for completing prenatal care and a postpartum checkup

- **Text4Baby** offers pregnant members and new moms a free mobile information service to help them care for their health and give their babies the best possible start

- Our program for kids, **Healthy Families**, offers families with children ages 7–13 coaching and support in setting up health goals related to nutrition and activity

- Qualified members receive **free cell phones** through SafeLink and up to 250 minutes of service each month, **plus:**
  - **100 extra bonus minutes** when choosing to receive free health text messages
  - **Unlimited wellness text messages** from Amerigroup, plus reminders to renew your benefits on time and
  - **Unlimited minutes** when calling our Member Services department and Amerigroup On Call

How to contact us

When you need help, we're here for you. Our Member Services department is ready to answer any questions you may have about your benefits and services. Call 1-800-600-4441, Monday through Friday from 8:00 a.m. to 5:00 p.m. Pacific time, except for holidays.

For members who do not speak English, we offer oral interpretation services for all languages. These services are free of charge. If you need these services, call Member Services toll free at 1-800-600-4441. If you are deaf or hard of hearing, call the AT&T Relay Service toll free at 1-800-855-2880. If you call after 5:00 p.m., you can leave a voice mail message. One of our Member Services representatives will call you back the next working day.

How to choose a primary care provider

All Amerigroup members must have a family doctor, also known as a Primary Care Provider or PCP. As an Amerigroup member, you should pick a PCP. If you don't choose a PCP, we will assign one to you. If we assign a PCP to you, you can pick another one of your choice at any time. Just call Member Services at 1-800-600-4441 or log on to www.myamerigroup.com/WA. You and your Amerigroup family members do not have to have the same PCP.

When you need a referral

It's always best to ask your PCP for a referral for any Amerigroup service. But you can get some services without a referral from your PCP, including preventive and routine women's health services, needed services for complex conditions that require a special course of treatment, routine shots, and emergency care.

How to get prescriptions filled

Amerigroup has a preferred drug list of commonly prescribed drugs. Your PCP or specialist can choose from this list of drugs to help you get well and stay well. You can get prescriptions filled at any Amerigroup network pharmacy. For a complete list of Amerigroup network pharmacies:

- See the provider directory that comes with your new member packet
- Go to www.myamerigroup.com/WA or
- Call Member Services for help at 1-800-600-4441

Online and automated self-service features

You can take advantage of these services online at www.myamerigroup.com/WA or with our automated self-service line 24 hours a day, 7 days a week by calling 1-800-600-4441. You can:

- Choose or find a PCP in the Amerigroup network
- Change your PCP
- Request an ID card
- Update your address or phone number
- Request a provider directory

Questions? Amerigroup is a culturally diverse company. We welcome all eligible individuals into our health care programs, regardless of health status. If you have questions or concerns, please call 1-800-600-4441 (TTY 1-800-855-2880) and ask for extension 34925. Or visit www.myamerigroup.com/WA.

You are important to us. Your health is important to us. As a part of Washington's Healthy Options program, we provide all of the standard healthcare benefits that you expect – and we give you more!

Coordinated Care Corporation is committed to your health. Our care programs are designed to work with your doctor and with other experienced, local healthcare professionals to make sure that you get the proper care that you need, when you need it.

Contact Us or Find a Primary Care Provider:
You can contact us for all of your needs, questions or concerns. Customer service hours of operation: Mon-Fri, 8:00 a.m. – 5:00 p.m. Pacific Standard Time Customer service phone number: (877) 644-4613. Visit our website at: www.CoordinatedCareHealth.com

Our Member Services representatives are ready to help you with questions, such as finding or changing a Primary Care Provider (PCP). You can call us at (877) 644-4613 or go to our website to find providers in our network.

More help with Coordinated Care benefits and services...
Make your transition to Coordinated Care a breeze by using our **MemberConnections®** program. Available by phone or even a visit to your house, our representatives can help you by providing you more information about:

- **Your health benefits**
- **Access to services**
- **Access to counseling**
- **Assistance with transportation**
- **Choosing or changing doctors**

More help managing difficult conditions. We understand the health challenges people face in life. We're here to help. We have special programs and care coordinators to help individuals with:

- Asthma
- Heart Disease
- Depression
- Quitting Smoking
- Diabetes
- Weight Management
- Sickle Cell Anemia
- Pain Management

More answers, whenever you need them. We also provide all of our members with **NurseWise**®, a free health information line with registered nurses on call 24 hours a day, every day of the year. Emergency or non-emergency, our nurses can give advice on any of your health-related questions. They can also help you make an appointment with your doctor, help you understand your medications, and more.

More help for moms and babies..Start Smart for Your Baby® provides special benefits and support for keeping pregnant members, new moms, and their babies healthy. This includes:

- Home monitoring, information, and assistance for members with a very difficult or high-risk pregnancy
- Educational books and materials
- Rewards for doctor visits

More rewards for taking care of your health. Our **CentAccount**® program provides dollar rewards loaded to a prepaid MasterCard®. You earn rewards by completing easy healthy behaviors. Rewards can be used at stores and pharmacies that accept MasterCard for health-related items. They can also be used to pay for childcare, utilities, public transportation, cell phones and home phones.

And More –

Health Library – Access to our award winning book series and other material for adults, teens and children that cover a range of topics such as diabetes, pregnancy, sickle cell, teen issues, and more.

Telemonitoring – Eligible members get devices to help check on their health problems at home. Some examples of these devices are: a pulse oximeter to check oxygen levels, a blood pressure monitor, and a glucometer to check blood sugar levels.

Fluvention – Our program promoting flu prevention and what to do if you get the flu.

COMMUNITY HEALTH PLAN
of Washington
Committed to your health.

Community Health Plan of Washington is a local, not-for-profit organization founded in 1992 by a network of community health centers across Washington State.

Community Health Plan of Washington returns savings to communities across the state to reinvest in community health center facilities and expanded access to care.

Community Health Plan of Washington has been exclusively devoted to providing safety net health care coverage to Washington families for 20 years.

TO GET INFORMATION about Healthy Options with Community Health Plan of Washington

You can visit our website: www.chpw.org. You can read or download information about:

- Your medical and prescription coverage
- What to do if you need care when your clinic is closed or you are outside your area
- What to do if you get a bill
- How we decide about your care and what to do if you disagree with our decision
- Improving your health and wellness
- And more

You can contact the Community Health Plan of Washington customer service team. Call us at 1-800-440-1561, Monday – Friday 8 am – 5 pm, or email customercare@chpw.org. If you are hearing or speech impaired, please call TTY Relay: Dial 7-1-1.

You can find a provider, pharmacy, clinic, or hospital in our network. Visit the Community Health Plan of Washington website at www.chpw.org. Click the Providers tab and select the type of search you want. To get a printed report or have someone search for you, contact our customer service team. (Contact information above.)

You can search our formulary (approved drug list) to find out if your prescription is covered. Visit our website, www.chpw.org. Click the Providers tab and select Formulary Search. To get a printed report or have someone search for you, please contact our customer service team. (Contact information above.)

FREE Nurse Advice Line 24 hours a day, 7 days a week

All Community Health Plan members can call the free Nurse Advice Line to get health care information 24 hours a day, 7 days a week. To speak to a nurse, call toll free 1-866-418-1002 (voice) or 1-866-418-1006 (TTY for speech or hearing impaired).

The nurses can help you when you have questions about health concerns or need health information. Nurse Advice Line staff can help you decide what kind of care to seek. You might be able to treat the condition at home, you might need to see your doctor, or you might need to get urgent or immediate care.

REWARDS for getting prenatal &well child care on time

The Community Health Plan of Washington Children First™ program rewards pregnant women and children who get scheduled care on time.

Pregnant women who get prenatal check-ups on time can get a FREE car seat. Children from newborn to age 13 who get well child check-ups and preventive care on time can get FREE rewards at each check-up, such as:

- Children's books
- School backpack
- Booster seat
- Baby welcome kit
- Diapers
- Bike helmet
- School supplies
- Safety locks
- Thermometer
- School clothes
- Dental kit

For more information about Children First, please talk to your doctor or contact Community Health Plan of Washington at 1-800-461-5832. If you are hearing or speech impaired, please call TTY Relay: Dial 7-1-1.

Since 1980 Molina Healthcare has been a leader in providing quality health care to those who depend on government assistance. Our commitment to our members has made us a national leader in providing affordable health care to families and individuals. During this time, we have become one of the most experienced managed health care companies in the country.

We provide health care through Medicaid and Medicare, among other government programs. Currently we provide health care assistance to approximately 1.7 million members in ten states. Molina is accredited by National Committee of Quality Assurance (NCQA), a private non-profit organization dedicated to improving health care quality.

Molina Member Services

We are open Monday through Friday from 8:00 a.m. until 5:00 p.m. at (800) 869-7165 to answer your questions and concerns such as how to:

- Find a Primary Care Provider (PCP) in your area
- Change your PCP
- Find benefit information
- Access Utilization Management (UM) staff to discuss Prior Authorization or denial information
- File a Grievance or Appeal

If you call after business hours, you can leave a message and we will call you back the next business day. You can also contact us through our website at www.MolinaHealthcare.com.

We can help you if you do not speak English. If you need help in another language, choose your language at (800) 869-7165. If your language is not listed, we will use an interpreter. This service is at no cost to you. If you are hearing impaired please use TTY at (877) 665-4629.

Nurse Advice Line

When you have questions about your health care call your PCP or our 24-hour Nurse Advice Line at (888) 275-8750 English or (866) 648-3537 Spanish.

Group Practices

Some PCPs and specialists are in a Network Group Practice. If a PCP is in a network group, Molina's Provider Online Directory shows the name of the Network Group Practice under the PCP's address. Your PCP will refer you to specialists and facilities in the Network Group Practice.

Prescriptions

Molina has contracts with most pharmacies. You must get your drugs from one of these pharmacies. Call Member Services at (800) 869-7165 or visit www.MolinaHealthcare.com for more information.

Molina Extra Services

- Pregnant women who complete our prenatal program can receive a gift card for a car seat or booster seat
- Pregnant women who complete our after delivery program can receive a gift card
- Children who complete a yearly well-child exam can receive a gift
- Members ages 15 and over may qualify for a weight control program
- Members with complex care needs may qualify for the Keep In Touch (KIT) program which provides a cell phone to stay in contact with caregivers

Disease Management & Case Management

Molina has programs to help our members manage chronic diseases and other special health care needs such as:

- Asthma
- Diabetes
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disorder (COPD)
- Multiple/complex care needs

Services include newsletters, vital care tips, disease education, and care coordination. You can be referred to these services by:

- Self-referral
- Provider or caregiver referral
- Outreach by case manager based on claims information

For more information or to self-refer please call Member Services at (800) 869-7165.

Stop Smoking Program (Free and Clear®)

Smoking is a risk factor for your health and those around you. Our Free and Clear® stop smoking program can make it easier to quit.

If you would like to enroll or if you have questions, please call the Washington State Quit Line at: (877) 270-7867 English, (877) 266-3863 Spanish, (877) 777-6534 TTY.

Molina Website

The Molina website is a great place to find information you need. Go to www.MolinaHealthcare.com and click on Members, then choose Washington and you can:

- Search for a provider
- Request a temporary ID card
- Request to change your PCP
- Read about your benefits
- Check our approved list of prescription drugs
- Read health and wellness information

Welcome Washington members! UnitedHealthcare Community Plan is committed to making a difference in each member's health. We provide benefits and healthcare assistance that you need to help you take charge of your health and take good care of yourself and your family.

Over the past 29 years, UnitedHealthcare Community Plan has grown to become the nation's largest provider of affordable healthcare to individuals with:

- Medicaid
- Children's Health Insurance Program (CHIP)
- Blind and Disabled coverage, and
- Dual Medicare-Medicaid coverage

Today, we serve more than 3.4 million members in 26 states and the District of Columbia.

Strong in Washington

In Washington, we have long-standing relationships with a large network of local providers and community organizations, which help give our members access to:

- Children's health programs – Sesame Street™, Health E. Hound, 4-H, more
- Special Needs Member Engagement, Coordinated Care and Case Management
- Healthy First Steps™ helps ensure that pregnant women get the self-care and baby-care they need throughout pregnancy and after the baby arrives
- Free health education programs – obesity, diabetes, high blood pressure, more

Look for us in your clinics and communities, and we will look forward to best serving you!

One # for Easy Access to Answers: 1-877-542-8997

We are pleased to offer one easy toll-free phone number to call with any of your questions. Please feel free to call our Member Service Center at **1-877-542-8997**, between 8 a.m. and 8 p.m. Monday through Friday for any needs including:

- Answers about your health care benefits
- Help finding a doctor
- Translations into your language or access to an interpreter
- Information about our doctors and care facilities
- Help if you get a medical bill
- Information about community resources available to you

Visit Us Online Anytime

Visit the UnitedHealthcare Community Plan Member Website anytime at: http://www.uhccommunityplan.com. Choose "Washington" from the state drop-down menu to help you:

- Search for a provider
- Access Healthy Options and Basic Health handbooks
- Read about your benefits
- Request a temporary ID card
- Request to change your Primary Care Provider (PCP)
- Find translated materials and additional translation services
- Check our approved list of prescription drugs and more

After you are a member, you can also visit www.myuhc.com to access and manage your individual plan information, track your prescriptions, view your health assessments and much more.

Translation Services

UnitedHealthcare Community Plan supports free translation services for any language. If you need translation or interpreter services, please call the Member Service Center at **1-877-542-8997.** From speech or hearing impaired, **TTY 711**.

24/7 Nurseline™ Toll-Free Number

Twenty-four hours a day, seven days a week, our registered nurses are available to answer your health questions over the phone, at **1-877-440-9409**. For speech or hearing impaired, **TTY 711**.

How to get a Primary Care Provider (PCP)

Your PCP is an important part of your medical care team. When you sign up for this plan, you will be assigned a PCP. If for any reason you want to change your PCP, call Member Services, at **1-877-542-8997**. You can choose a PCP from the UnitedHealthcare Community Plan Provider Directory or Member Services can send you a list of our providers free of charge.

How to get Referrals to Specialist

To access our large network of specialists, your PCP must refer you for most specialty care. For more information about specialists, call Member Services, at 1-877-542-8997.

Getting Your Medicines and Pharmacy Services

We have contracts with most pharmacies. Call Member Services, at 1-877-542-8997, or visit us at http://www.uhccommunityplan.com/ for more information.

Glossary of Important Terms

Term	Definition
Advance Directive	Puts the patient's choices for health care into writing. It may also name someone to speak for the patient if he or she is not able to speak. May include a Durable Power of Attorney for Health Care or a Directive to Physicians or both.
Appeal	When the member asks the health plan to review a denied service or a denied referral for a service.
Basic Health Plus (BH Plus)	A Medicaid managed care program for children who are under age 19, live in Basic Health households and meet the eligibility guidelines for Medicaid. This program allows children to get extra services, such as dental and eyeglasses, not covered by Basic Health.
Children's Health Insurance Program (CHIP)	CHIP is a medical program for kids under 19 with family incomes too high for Medicaid. People on this plan will pay a premium for each child.
COB	Coordination of benefits. Happens when the member is covered by more than one health insurance plan at the same time. The primary insurance plan must pay first for all covered benefits. All HCA medical programs are secondary to the primary insurance coverage.
CSO	Community Service Office where medical eligibility determinations are made. Local offices are found throughout the State. See the website at for specific locations and phone numbers. https://fortress.wa.gov/dshs/f2ws03esaapps/onlinecso/findservice.asp
Durable Power of Attorney for Health Care	An advance directive that names another person to make decisions for a patient if the patient is not able to make decisions for herself or himself.
Emergency	A situation when someone has a sudden or severe medical problem that needs medical care right away.
First Steps	A program for pregnant women that provides: ▪ Nursing services ▪ Social work services ▪ Health education and counseling ▪ Transportation for maternity care appointments ▪ Nutritional services
Formulary	A list of prescription drugs developed by doctors and pharmacists. Drugs are placed on the formulary based on a review of their safety, effectiveness, and cost. Formulary drugs are approved for use or coverage by the plan and will be given to covered enrollees by drug stores in the network.
Grievance	A spoken or written complaint about anything that an enrollee is not happy with except for a denied service.
HCA	Washington State Health Care Authority. The HCA administers the State's Basic Health Plan and the federal Medicaid medical assistance programs.

Term	Definition
Healthy Options Program	The name given to the HCA Medicaid Managed Care medical assistance program.
ID card and Services card	ID Cards from health plans and Services cards from HCA are sent to all covered family members. Patients must show their plan ID card and the Services card when they get care or when they go to the drug store.
IRO	Independent Review Organization.
Living Will	A document that gives the patient's instructions for the kind of care he or she wants to get if he or she is seriously ill and not able to communicate.
Managed Care	A health care program where enrollees pick a plan and go to one clinic or doctor who will be your Primary Care Provider (PCP). Your PCP will give you the care you need or have you go to a specialist. In Medicaid, you may still get some services that your health plan does not provide through fee-for-service.
Maternity Benefits Program	A Medicaid program for pregnant women who are Basic Health members and meet the income guidelines for Medicaid. This program allows pregnant women extra services not covered by Basic Health with no co-pays, no premiums, and no waiting for pre-existing conditions.
Medicaid	The state and federal health care program for low-income eligible people.
Medical Necessity	Each health plan makes Medical Necessity determinations by evaluating health care services for diagnosis, treatment of an illness, injury, disease, or its symptoms. A medically necessary service must be: • In line with current standards of practice (evidence based) • An effective treatment for the patient's illness, injury, or disease. • No more expensive than other equally effective services. • Not primarily for the patient's or the doctor's convenience.
Prior Authorization	The review and approval of requested services by a health plan. Some services require a prior authorization from the health plan before the service can be paid.
Referral	The primary method used to get specialty care. Some services require a referral from the PCP before the specialty provider can be paid.