



WEST VIRGINIA MEDICAID MANAGED CARE MEMBER HANDBOOK

SFY 2022

(July 1, 2021 – June 30, 2022)

HELP IN YOUR LANGUAGE

If you do not speak English, call us at 1.888.613.8385. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.

Spanish: “Si usted no habla inglés, llámenos al 1.888.613.8385. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.”

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1.888.613.8385 (TTY 711).

Table of Contents

Welcome	1
About Your Plan	1
Contact Us	2
What You Should Know	3
Confidentiality	3
Discrimination	3
Definitions	5
Your Rights	9
Your Responsibilities	11
Steps to Your Getting Care	11
Your Member ID Card	11
Choosing Your Primary Care Provider (PCP)	13
How to Schedule an Appointment	13
What If I Receive a Bill or Have to Pay for Care?	14
Changing Your PCP	14
Where to Get Medical Care	14
Routine Care	14
Teladoc 24/7 Services	15
Urgent Care	15
Emergency Care	15
Your Benefits	16
Covered Services	16
More Information about Your Coverage	25
Well-child Visits	25
Dental Services	25
Behavioral Health Services	26
Court Ordered Services	27
Services Not Covered	27
Getting Your Benefits	30
Referrals and Specialty Care	30

Service Authorizations	30
Prior Authorizations.....	31
Out-of-Network Services	32
New Technology	32
Cost Sharing.....	32
Access and Availability Guide	33
Letting Us Know When You're Unhappy	34
Appeals	34
Grievances.....	35
Keeping your Appeals and Grievances	36
Fair Hearings	36
Complaints.....	37
Reporting Fraud	37
Our Policies	37
Advance Directives.....	37
Ending Your Membership.....	38
Appropriate Treatment of Minors	38
Third Party Liability.....	39
Recommending Changes in Policies or Services	39
Changes to Your Health Plan.....	39
Accreditation Report	40
Important Contact Information.....	41

WELCOME

Welcome to The Health Plan's Medicaid managed care program! We are glad that you have enrolled with us. The Health Plan operates in all 55 counties of West Virginia. This handbook will provide you with the information you need to know about your health care plan, also known as a managed care plan. Please read this handbook from cover to cover to understand the way your plan works. This handbook will help you get the most from The Health Plan. It will answer many of the questions that come up about your benefits and the services offered by The Health Plan. You can also ask us any questions you may have by calling us at 1.888.613.8385. If you are speech or hearing impaired, please dial 711.

Disclaimer: Please know that during COVID-19 some of your medical, dental or behavioral health providers may have limited operating hours or special requirements in place to be seen. WV Medicaid members are still able to complete your visit during this time and are encouraged to do so. Please contact your doctor ahead of your appointment to see if they have any specific guidelines in place as part of your appointment so you can be best prepared (example: calling your doctor from the parking lot to let him/her know you've arrived rather than waiting inside the office). Providers have taken many steps to help reduce the spread of COVID-19 and to put your safety first, while still being able to provide you with the care you need.

ABOUT YOUR PLAN

The Health Plan has a contract with the West Virginia Department of Health and Human Resources [DHHR]. Under managed care, we are able to select a group of health care providers to form a provider network. Usually provider networks are made up of doctors and specialists, hospitals, and other health care facilities. Our providers help to meet the health care needs of people with Medicaid. The Provider Directory can be found on our website at findadoc.healthplan.org. If you want a provider directory hard copy, need larger print or a different format please call 1.888.613.8385.

If you want additional information on your provider such as:

- Professional qualifications and specialty
- Medical school attended
- Residency completion
- Board certification status

Contact Member Services at 1.888.613.8385 or visit these websites:

- West Virginia Board of Medicine at WVDHHR.org/wvbom
- American Medical Association (AMA) at ama-assn.org

CONTACT US

You can call Member Services toll-free anytime you have a question about your health plan or a health problem. It will speed up the process if you have your member identification (ID) number with you when you call. You can also visit our website, healthplan.org, for other information.

Member Services Department
Hours of Operation: Monday – Friday, 8:00 a.m. to 5:00 p.m.
Address: 1110 Main Street, Wheeling WV 26003
Toll-free: 1.888.613.8385
TTY: 711
Online: healthplan.org/medicaid

You can call or visit us online to:

- Ask questions about services and benefits, eligibility, claims, prior authorization requests, or utilization management (more information on utilization management procedures is available upon request)
- Change your primary care provider (PCP) or get help choosing a provider
- File a complaint
- Replace a lost member ID card
- Get help with referrals
- Let us know if you are pregnant
- Let us know if you give birth to a new baby
- Ask about any change that might affect you or your family's benefits
- Let us know about any changes to personal information
- Request interpreter services or help for people with disabilities

If you do not understand or speak English, we can help. Please call Member Services toll-free at 1.888.613.8385 (TTY: 711). We can answer questions about your benefits in your language. We have free interpreter services and can help you find a health care provider who can communicate with you in any language.

For people with disabilities, we can help. The Health Plan offers services so that you can communicate effectively with us and your provider. We have access to free sign language interpreter services and a TTY phone number: 711. We can

offer this handbook and all written materials including, but not limited to provider directories, appeal and grievances notifications, and denial notifications in many formats, such as large print, a CD or audiotape for listening to plan information, or braille at no cost to you. Please call Member Services toll-free at 1.888.613.8385 to ask for materials in another format.

For other important phone numbers, please see the list in the back of this handbook.

WHAT YOU SHOULD KNOW

CONFIDENTIALITY

We respect your rights to privacy. We will never give out your medical information or social security number without your written permission, unless required by law. To learn more about your rights to privacy, please call Member Services at 1.888.613.8385 or visit our website at healthplan.org/medicaid.

DISCRIMINATION

Your benefits must comply with the 1964 Civil Rights Act. Discriminatory administration of benefits because of sex, race, color, religion, national origin, ancestry, age, political affiliation, or physical, developmental, or mental challenges is not allowed. If you have questions, complaints, or want to talk about whether you have a disability according to the Americans with Disabilities Act, you can contact the State ADA Coordinator at:

WV Department of Administration
Building 1, Room E-119
1900 Kanawha Blvd. East,
Charleston, WV 25305
1.304.558.4331

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- On the web: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail:

U.S. Department of Health and Human Services
200 Independence Ave SW
Room 509F HHH Building
Washington, DC 20201

- By phone: 1.800.368.1019 (TTY/TDD 1.800.537.7697)

For a complaint form, visit hhs.gov/ocr/office/file/index.html



Discrimination is Against the Law

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

- 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 The Health Plan Customer Service Department.

If you believe that The Plan 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: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department 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, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

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 1-877-847-7907 (TTY: 711)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالعمان. اتصل برقم 1-877-847-7907 (رقم هاتف الصم والبكم: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-847-7907 (TTY: 711) पर कॉल करें।

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-847-7907 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-847-7907 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-847-7907 (TTY: 711).

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。1-877-847-7907 (TTY: 711)まで、お電話にてご連絡ください。

Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).

DEFINITIONS

There are special words and phrases that we use to describe how we arrange medical care. The list below explains some of these words and phrases. This list will help you understand the rest of this handbook. The Health Plan will provide a summary of our accreditation report, if applicable, upon request by the member.

The Health Plan must ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Appeal: A way for you to request the review of The Health Plan's decision if you think we made a mistake. For example, you might not agree with a decision that denies a benefit or payment.

Case Management: A patient-specific process of coordinating resources and creating flexible, quality, cost-effective health care options. It should result in a quality efficient delivery of health care services. This is done by registered nurses that focus on members with a complex illness and/or injury. Members can self-refer for case management services by calling The Health Plan.

Community Resources: The Health Plan Clinical Services Department keeps a list of community resources that may assist you with some services. These are agencies in your local community that help you with social services. They can also help with physical health, behavioral health, and disability needs. The social worker and/or care/case nurse navigators can help you access these services.

Co-payment: A fixed amount you pay each time you get a covered service or supply. For example, if you use the emergency room when it is not an emergency, you might pay \$8.

Covered Services: Health care services that The Health Plan pays for. Use The Health Plan ID card to get these services.

Customer Services: People who work at The Health Plan who help you. They can help you find a practitioner or dentist. They can listen to a complaint. They can answer your questions. They can help you understand how The Health Plan works.

Durable Medical Equipment (DME): Certain items your provider orders for everyday or extended use. Examples of these items are wheelchairs, crutches, diabetic supplies, hospital beds, oxygen equipment and supplies, nebulizers, and walkers.

Emergency Medical Condition: A sudden problem that you may think needs immediate care. Emergency care is given in or by a hospital emergency room. It is to evaluate and treat a medical problem caused by sudden, unexpected symptoms that require immediate medical attention. An emergency is usually a sudden and unexpected illness or injury that needs care to prevent (1) serious harm to the health of the person (or unborn child); (2) serious harm to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you receive in an emergency room.

Emergency Services: Covered inpatient and outpatient services that are (1) given by a qualified practitioner and; (2) needed to evaluate or stabilize an emergency medical condition. This includes emergency services within or outside of the plan.

Excluded Services: Health care services that The Health Plan does not pay for or cover.

Fee-for-Service: Health care services that the Medicaid program pays for. The Health Plan does not cover these services. These services include nursing home, pharmacy, transplants and non-emergency transportation.

Grievance: A complaint you make, either in writing or orally, about any aspect of service delivery provided or paid for by The Health Plan or our providers. For example, you might complain about the quality of your care.

Habilitation Services and Devices: Health care services and devices that help you keep, learn, or improve skills and functioning for daily living. Examples include occupational therapy, speech therapy, and other services for people with disabilities in inpatient and/ or outpatient settings.

Health Insurance: A contract that requires The Health Plan to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home, including limited part-time or intermittent skilled nursing care, home health aide services, occupational therapy, speech therapy, medical social services, DME, medical supplies, and other services.

Hospice Services: Services to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. A specially trained team of

professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Medically Necessary: Health care services or supplies needed to diagnose or treat an illness or injury, to improve the functioning of a malformed body member, to attain, maintain or regain functional capacity, for the prevention of illness, or to achieve age-appropriate growth and development.

Member Services: People who work at The Health Plan who help you. They can help you find a practitioner or dentist. They can listen to a complaint. They can answer your questions. They can help you understand how The Health Plan works.

Network: A group of providers who has contracted with The Health Plan to give care to members. The list of The Health Plan providers can be found in your Provider Directory. It will be updated whenever there are changes.

Non-participating Provider: A doctor, hospital, facility, or other licensed health care professional who has not signed a contract agreeing to provide services to The Health Plan members.

Participating Provider: A doctor, hospital, facility, or other licensed health care professional who has signed a contract agreeing to provide services to The Health Plan members. They are listed in your Provider Directory.

Physician Services: Health care services that a licensed medical physician provides or coordinates.

Plan: An entity that provides, offers, or arranges coverage of certain health care services needed by plan members. You are a member of our health plan, The Health Plan.

Practitioner: All doctors, PCPs, physician assistants, or any persons providing direct services to enrollees.

Premium: The amount you pay for your health insurance every month based on your income. In addition to the premium, you may have to pay a co-payment.

Prescription Drugs: Drugs and medication that, by law, require a prescription.

Prescription Drug Coverage: Health insurance that helps pay for prescription drugs and medications. The Health Plan does not provide prescription drug coverage, but the State of West Virginia does.

Primary Care Physician: Your regular practitioner who will help you arrange your medical care. It is also called a “PCP.” The name and phone number of your PCP will be on your ID card.

Primary Care Provider (PCP): A physician, nurse practitioner, physician assistant, or other participating provider you have chosen to be your personal doctor. Your PCP works with you to coordinate your healthcare, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed, or admitting you to the hospital.

Provider Directory: A directory of all the practitioners that you can see with your ID card. You may need to get a referral from your PCP to see some specialty practitioners. Annually, we will remind you that you can ask for an updated practitioner directory at any time by calling the Customer Service Department or view the list on the website.

Provider: Hospitals, clinics, or facilities that give you medical care.

Referral: Permission from your PCP to see certain kinds of practitioners or get certain kinds of health care services.

Rehabilitation Services and Devices: Health care services and devices that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. Examples include occupational therapy, speech therapy, and psychiatric rehabilitation services in inpatient and/ or outpatient settings.

Secondary Care Practitioner (SCP): A plan sub-specialty practitioner who provides specialty care to a member on a routine basis. The SCP is listed separately in the practitioner list.

Service Area: The parts of West Virginia where you can use your ID card.

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

Specialist: A doctor who focuses on a specific kind of health care such as a surgeon or a cardiologist (heart doctor).

Specialty Practitioner: A plan practitioner who provides specialty care to members. He/She coordinates with a member’s primary or secondary care practitioner on specialty plans of treatment. A referral and approval may be required.

Tertiary Facility: A facility that The Health Plan has contracted with to provide specialty medical and hospital services that are not normally available through local plan providers.

Urgent Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgent care from out-of-network providers when network providers are unavailable or you cannot get to them. Examples of when to get urgent are a sprained ankle, a bad splinter, or the flu.

Well-care: Children ages birth up to age 21 should have regular, well-child/adolescent visits according to the health check periodicity schedule. This is covered by The Health Plan.

Adults should also have an annual well-care visit. This is covered by The Health Plan.

YOUR RIGHTS

As a member of The Health Plan, you have rights around your health care and to receive information according to contract standards. Each year, The Health Plan submits its annual report to the Bureau for Medical Services (BMS) by April 1. This report includes a description of the services, personnel and the financial standing of The Health Plan.

The annual report is available to members by request only. To get a copy of the report, you can call Member Services at 1.888.613.8385. You can also get a copy of the report from BMS.

You have the right to:

- Ask for and obtain all included information
- Be told about your rights and responsibilities
- Get information about The Health Plan, our services, our providers, and your rights
- Be treated with respect and dignity
- Not be discriminated against by The Health Plan
- Access all services that The Health Plan must provide
- Choose a provider in our network
- Take part in decisions about your health care
- Refuse treatment and choose a different provider
- Get information according to the member's ability to understand on treatment options and different courses of care regardless of cost or benefit coverage
- Have your privacy respected
- Ask for and to get your medical records within 30 days of request

- Ask that your medical records be changed or corrected if needed within 60 days of request
- Be sure your medical records will be kept private
- Recommend changes in policies and procedures including, but not limited to, member rights and responsibilities
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation
- Get covered services, no matter what cultural or ethnic background or how well you understand English
- Get covered services regardless of if you have a physical or mental disability, or if you are homeless
- Refer yourself to in-network and out-of-network family planning providers
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services
- Get emergency post-stabilization services
- Get emergency health care services at any hospital or other setting
- Accept or refuse medical or surgical treatment under State law and to make an advance directive
- Have your parent or a representative make treatment decisions when you can't
- Make complaints and appeals
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services
- Ask for a state fair hearing after a decision has been made about your appeal
- Request and get a copy of this member handbook annually after initial enrollment
- Disenroll from your health plan
- To exercise your rights. Exercising these rights does not adversely affect our treatment of you
- Ask us about our quality improvement program and tell us how you would like to see changes made
- Ask us about our utilization review process and tell us how you would like to see changes made
- Know the date you joined our health plan
- Know that we only cover health care services that are part of your plan
- Know that we can make changes to your health plan benefits as long as we tell you about those changes in writing
- Get news on how providers are paid
- Find out how we decide if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost to you
- Use interpreters who are not your family members or friends

- Know you will not be held liable if your health plan becomes bankrupt (insolvent)
- Know your provider can challenge the denial of service with your permission

YOUR RESPONSIBILITIES

As a member of The Health Plan, you also have some responsibilities:

- Read through and follow the instructions in this handbook
- Work with your PCP to manage and improve your health
- Ask your PCP any questions you may have
- Call your PCP at any time when you need health care
- Give information about your health to The Health Plan and your PCP
- Always remember to carry your member ID card
- Only use the emergency room for real emergencies
- Keep your appointments
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know
- Follow your PCPs recommendations about appointments and medicine
- Go back to your PCP or ask for a second opinion if you do not get better
- Call Member Services at 1.888.613.8385 whenever anything is unclear to you or you have questions
- Treat health care staff and others with respect
- Tell us right away if you get a bill that you should not have gotten or if you have a complaint
- Tell us and your DHHR caseworker right away if you have had a transplant or if you are told you need a transplant
- Tell us and DHHR when you change your address, family status or other health care coverage
- Know that we do not take the place of workers' compensation insurance

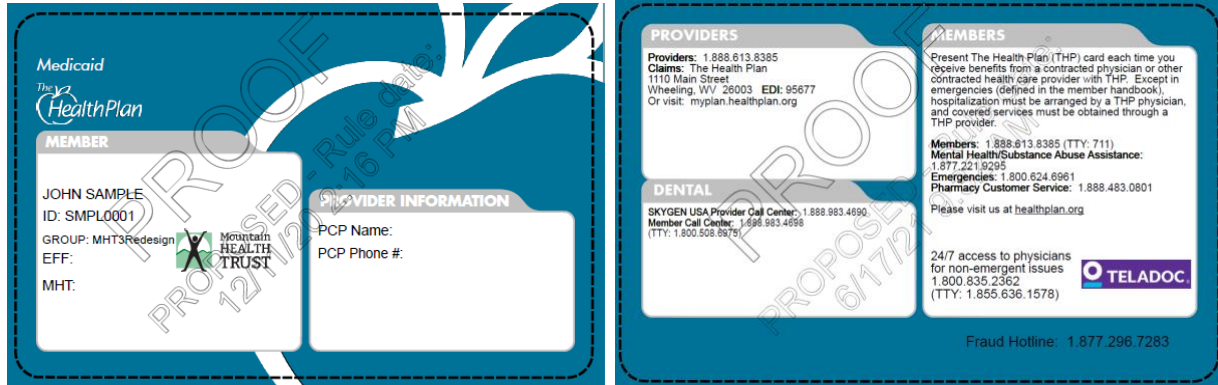
STEPS TO YOUR GETTING CARE

YOUR MEMBER ID CARD

After you join The Health Plan, we will send you your member ID card in the mail. Each member of your family who has joined The Health Plan will receive his or her own card. If you have not received your member ID card after 14 days, please call Member Services at 1.888.613.8385.

It is important to always keep your member ID card with you. You will need it any time you get care. Your card is your proof that you are a member of The Health Plan.

Mountain Health Trust Medicaid members, your card should look like this:



You will find some useful information on your card like your Medicaid ID number, your PCP's name and office phone number, the start date of your health coverage, and other important phone numbers. Having your card out when you call Member Services can help us serve you faster.

Please call Member Services immediately at 1.888.613.8385 if:

- You lose your card
- Your card is stolen
- You have not received your card(s)
- Any of the information on the card(s) is wrong
- You have a baby or add a new member to your family
- You move
- Someone in your family dies

Please call your county DHHR immediately if you move to another state or to another country.

CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

Each member of The Health Plan chooses a primary care provider (PCP) from the Provider Directory. A PCP is a specific clinician responsible for coordinating your health care needs. You can find a list of PCP's online at findadoc.healthplan.org. Member Services can help you select a PCP to best fit your needs. If you do not pick a PCP from the directory, we will choose one for you.

If you have a chronic illness, then you may be able to select a specialist as your PCP. As a member with special healthcare needs, you have the right to direct access to a specialist. This means that The Health Plan cannot require you to get a referral or prior authorization to see a specialist that is in our network. Please call Member Services to discuss (1.888.613.8385). Women can also receive women's health care services from an obstetrical/ gynecological practitioner (OB/GYN) without a referral from your PCP.

Upon request, a description of the method of physician compensation is available to The Health Plan members.

HOW TO SCHEDULE AN APPOINTMENT

You will visit your PCP for all of your routine health care needs. All new members should try to schedule an appointment within 90 days. You can schedule your appointments by calling the PCP's office phone number. Your PCP's name and office phone number will be listed on your member ID card. You can call 24 hours a day, seven days a week. On the day of your visit, remember to bring your member ID card. Please show up on time, and call to cancel an appointment if you cannot make it.

Your first appointment:

All new member should set up an initial health assessment or a first exam with your PCP as soon as you can. This first visit with your PCP is important. It is a time to get to know each other, review any health history and needs and come up with a plan to keep you healthy that works for you. If you are an adult, your first health review should be within 90 days of joining The Health Plan. A child should be seen by a PCP within 60 days of joining. If you are an SSI member, you should visit your PCP or specialist who handles your care within 45 days of joining The Health Plan. During the first exam, the PCP can learn about your health care needs and teach you ways to stay healthy.

WHAT IF I RECEIVE A BILL OR HAVE TO PAY FOR CARE?

You should contact Member Services if you receive a bill from a provider. We will check to be sure that it is not for a charge the provider should have billed to The Health Plan.

Federal regulations do not allow for Medicaid members to be reimbursed for services or balanced billed for services. Please contact Member Services before paying for any medical bills.

CHANGING YOUR PCP

If you need to, you can change your PCP for any reason. Let us know right away by calling Member Services at 1.888.613.8385. You can change your PCP at any time. We will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so he or she can get to you know you and your medical history.

Sometimes PCPs leave our network. If this happens, we will let you know by mail within 14 calendar days for a PCP and within 30 days for a hospital. We can assign you a new PCP or you can pick a new one yourself within 30 days of the notice. If we need to assign you a new PCP for another reason, we will let you know.

WHERE TO GET MEDICAL CARE

Please read below to understand what type of care to get in different situations. Our providers should offer the same hours of operations for Medicaid members as they do for commercial members.

ROUTINE CARE

You should see your PCP for all routine health care visits. Routine visits are when a delay in medical care would not cause a serious problem with your health. Some reasons to get a routine health care visit include checkups, screenings, physicals, and care for diabetes and asthma. You can call your PCP to schedule these visits at any time. You and your PCP should work together to get you the care you need.

- **Well-Care Visits** – A well care visit is when you or your child sees your PCP for a preventive visit. These visits are not for treating conditions or diseases, so you should schedule a well care visit even if you do not feel sick. During the appointment, your PCP will review your medical history and health. Your PCP may suggest ways to improve your health, too. You can learn

more about well-care visits under the section titled “More Information About Your Coverage.”

- After Hours Care – You can reach your PCP even if it is after normal business hours. Just leave a voicemail with your name and phone number. Your PCP or another PCP from the same office will call you back as soon as possible or during office hours.

TELADOC 24/7 SERVICES

You can call or video chat with Teladoc 24/7 365 days a week.

Access medical, behavioral health and dermatology services from your home, work or when traveling.

Doctors can diagnose, treat and prescribe medication for your non-emergency situation. This includes treatments for flu, sore throat, eye infections, bronchitis and more.

URGENT CARE

You can visit an urgent care center when you have an injury or illness that needs prompt care but is not an emergency. Some examples of when to get urgent care are:

- A sprained ankle
- A bad splinter
- The flu

You can also get urgent care if you are traveling and are too far from your PCP's office. You can schedule an urgent care appointment by calling your PCP. You should explain the medical problem so that your PCP can make your appointment or help you decide what to do.

EMERGENCY CARE

You should get emergency care when you have a very serious and sudden medical problem. An emergency would make someone think he or she needs to be treated right away. Some examples of an emergency are:

- Vaginal bleeding
- A heart attack
- Severe chest pain
- Seizures
- Rape

You should not go to the emergency room (ER) for things like:

- Colds
- Minor cuts and bruises
- Sprained muscles.

If you believe you have a medical emergency, call 911 immediately or go to the nearest ER. When you get there, show your member ID card. You do not need approval from your PCP or The Health Plan. If you are traveling and away from home when you have a medical emergency, go to the nearest ER. You have the right to go to the nearest hospital, even if it is not in our network. If you're not sure what to do, call your PCP or The Health Plan at 1.888.613.8385. Remember to use the ER only if you have an emergency. You are always covered for emergencies.

If you need to stay in the hospital after an emergency, please make sure The Health Plan is called within 24 hours. If you are told that you need other medical care to treat the problem that caused the emergency, the provider must call The Health Plan. If you are able, call your PCP to let him or her know that you have a medical emergency. You will need to schedule follow-up (called post-stabilization) services with your PCP.

For more information about emergency transportation and post-stabilization services, please see the Mountain Health Trust (WV Medicaid) Covered Benefits Table.

YOUR BENEFITS

You can get many services through The Health Plan's Medicaid managed care program in addition to those that come with regular Medicaid. For most benefits, you will need to go through your PCP. There are some services that do not require a referral from your PCP. This means that you do not need approval from your PCP. To get these services, look in your Provider Directory for the list of providers who offer these services. You can schedule the appointment yourself. You have the right to a second opinion from a qualified health care professional within or outside the network, at no cost to you. This second opinion could be in addition to that of a specialist referred by the PCP. If you have any questions, The Health Plan can help. Just call Member Services at 1.888.613.8385. Member Services can explain how to access your services.

COVERED SERVICES

Your covered services must be medically necessary. You should get these services from providers in The Health Plan network. Your PCP should provide covered services or refer you to another provider to do so. The services included

fall under medical (maternity and sexually transmitted disease services), behavioral, dental, and vision.

Mountain Health Trust (WV Medicaid) Covered Benefits

Medical

- **Primary Care/Specialist Office Visits/FQHC/RHC**—Includes physician, physician assistant, nurse practitioner and nurse midwife services.
- **Physician Services** – Certain services may require prior authorization or have service limits. May be delivered through telehealth.
- **Laboratory and X-ray Services**—Includes lab services related to substance abuse treatment. Services must be ordered by a physician and certain procedures have service limits. Genetic testing requires pre-authorization.
- **Clinics**—Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.
- **Private Duty Nursing**—For children ages 0-21. Requires prior authorization limits apply.

Hospital

- **Inpatient** – Includes all inpatient services (including bariatric, long-term acute care (LTAC) and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. Requires pre-authorization.
- **Organ and Tissue Transplants**—Corneal transplants only.
- **Outpatient** – Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.

Ambulatory Surgical Care

- Includes services and equipment for surgical procedures.

Emergency

- **Post-stabilization**—Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.
- **Emergency Transportation**—Includes ambulance and air ambulance. Out-of-state requires pre-authorization.

Rehabilitation

- **Pulmonary Rehabilitation** – Includes procedures to increase strength of respiratory muscle and functions. Must meet plan guidelines. Maximum of 12 weeks or 36 visits per calendar year.
- **Cardiac Rehabilitation** - Includes supervised exercise sessions with EKG monitoring. Limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery.
- **Inpatient Rehabilitation** – Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals (in a rehabilitation facility; limited to 60 days per calendar year). Requires pre-authorization.

Specialty

- **Podiatry** – Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered. Surgical procedures other than in-office require pre-authorization.
- **Physical and Occupational Therapy** - Combined 20 visits per year for habilitative and rehabilitative services.
- **Speech Therapy** – For children (ages 0-21): Pre-authorization required. The benefit limit is 20 visits per calendar year. For adults (21 and older): Limited to specific medical/surgical conditions and pre-authorization is required.
- **Chiropractor** – Limited to manual manipulation of the spine and X-ray exam related to service. Limited to a maximum of 20 visits per calendar year.
- **Handicapped Children's Services/Children with Special Health Care Needs Services** - Includes coordinated services and limited medical services, equipment and suppliers (for children only).
- **Nutritionist**—Medical nutritionist visits are limited to six visits per calendar year. Medical nutritionist visits for weight loss only if part of evaluation for bariatric surgery requires pre-authorization.

Preventive Care and Disease Management

- **EPSDT**—(ages 0-21) Includes health care services for any medical or psychological condition discovered during screening (for children only). Needs that are identified that are over the allowable or not included in the covered services require a pre-authorization.
- **Tobacco Cessation**—Includes therapy, counseling, and services. Guidance and risk-reduction counseling covered for children. **The Health Plan has certified American Lung Association Freedom from Smoking counselors to help you quit smoking. Most people already know that smoking is bad for their health. Our program focuses on how to *quit*, not *why*. Freedom From Smoking is designed to help tobacco users get control of and break their addiction. No one method works for all tobacco users. The Health Plan's program is 90 days. A counselor will call you and help you get any prescriptions approved. They will help you build better habits and break current ones. People who finish the program are six times more likely to be tobacco free one year later than those that quit on their own. If you would like to quit give our counselors a call at 1.888.450.6023.**
- **Sexually Transmitted Disease Services**—Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.

- **Preventive Screenings**—Annual pap smear for cervical cancer screening beginning at age 18, earlier if medical necessary. Mammography screening: Ages 35-39 at least once, 40-49 every two years unless medically determined that member is at risk, one every year and 50+ one every year. Prostate cancer screening: Beginning at age 50. Colorectal screening: Age 50 and older without symptoms or under age 50 with symptoms.

Maternity

- **Right From The Start**—Includes prenatal care and care coordination. Services covered through 60-day post-partum and infants less than one year old.
- **Family Planning**—Services to aid recipients of child bearing age to voluntarily control family size or to avoid or delay an initial pregnancy. Pregnancy terminations and infertility treatments are not covered.
- **Maternity Care**—Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Durable Medical Equipment, Orthotics and Prosthetics

- Requires pre-authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

- Requires pre-authorization for all visits. If you revoke three times, you are no longer eligible for hospice. For adults, rights are waived to other Medicaid services related to the terminal illness.

Home Health Care

- Covered for nursing, physical therapy, occupational therapy, and speech therapy. Includes services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Pre-authorization required prior to 2nd certification period.

Dental

For children (ages 0-21)

- Must use participating practitioners (see provider directory or call Skygen Dental).
- Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires pre-authorization.

For adults (21 and older)

- Must use participating practitioners (see provider directory or call Skygen Dental).
- Accident or injury, tumor removal, or emergency extraction.
- \$1,000 for preventive and restorative care, such as cleanings and crowns.
- TMJ is not covered for adults.

Vision

For children (ages 0–21)

- Must use participating vision services practitioners. See provider directory or call Superior Vision.
- Vision screening and therapy.
- One eye exam covered once every 12 months.
- Limited one frame per year.
- Contact lenses covered for certain diagnosis.
- Repairs.

For adults (21 and older)

- Adults limited to medical treatment only.
- Medical contact lenses for adults and children covered for certain diagnosis.
- One pair glasses up to 60 days after cataract surgery.

Diabetes Management—Members diagnosed with diabetes have the right to access vision services without a PCP referral for an annual examination. If annual exam reveals abnormal conditions, any follow-up appointment with a specialist will require pre-authorization from the member's PCP.

Hearing

For children (ages 0–21)

- Requires pre-authorization.
- Audiology screening (only if referred by a PCP or ENT practitioner).
- One hearing aid every five years.
- Hearing aid evaluations, hearing aid supplies, batteries, and repairs. Certain procedures may have service limits, or require prior authorization. Augmentation communication devices limited to children under 21 years of age and require prior approval.

For adults (21 and older)

- Requires pre-authorization.
- Covered for specific medical conditions.

Behavioral Health

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility** – Includes services for children (up to age 21) with mental illness and substance abuse. Limits frequency and amount of services. Certain services require pre-authorization.
- **Inpatient Psychiatric Services under age 21** – Includes behavioral health and substance abuse hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires pre-authorization.
- **Inpatient Psychiatric Services for ages 21-64** – Includes treatment through an individual plan of care at an institution for mental diseases (IMD). Pre-admission and continued authorization is required. Certification required.

- **Outpatient** – Includes services for individuals with mental illness and substance abuse. Limits frequency and amount of services. Providers must be ACT certified. Children’s residential treatment is not covered. Certain services require pre-authorization.
- **Psychological Services** – May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. Certain services require pre-authorization.
- **Drug Screening** – Laboratory services to screen for presence of one of more drugs of use. Limits apply and pre-authorization is required for some testing.
- **Substance Abuse Disorder (SUD) Services** – Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance abuse. Prior authorization is required.

Benefits Under Fee-for-Service Medicaid

Abortion – Includes drugs, devices, and procedures for termination of ectopic pregnancy. Physician certification required.

Early Intervention Services for Children Three and Under

Tubal Ligation - Includes doctor and hospital charges.

Nursing Facility Services – Includes nursing, social services, and therapy.

Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.

Personal Care for Aged/Disabled – Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited on per unit per month basis. Requires physician order and nursing plan of care.

ICF/MR Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for the mentally retarded. Requires physician or psychiatrist certification.

Prescription Drugs – Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Not covered: Drugs for weight gain/loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Hemophilia blood factors and hepatitis C virus related drugs are covered by Medicaid FFS. Call the Molina HelpDesk at 1.888.483.0797 to help you find a pharmacy or to find out if your pharmacy is in network. *You can also find this information at wvmmis.com.

The Health Plan will still cover some drugs. We cover medicines that you get during a hospital stay and in the emergency room. We also cover those you get in the doctor's office, such as injectable medicines like vaccines.

Organ Transplant Services – Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/ research nature or for end-stage diseases. Must be used to manage disease.

School-based Services – Service limitations are listed in the fee for service Medicaid provider manual.

Transportation – Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, call: 1.844.549.8353.

Opioid Treatment Program - Services under the SUD 1115 Waiver Comprehensive opioid MAT program including medication, treatment services and laboratory services.

In addition to your benefits, The Health Plan offers value-added services. When eligible members complete the healthy behaviors in the table below, they will receive a reward. We offer these services to encourage health education and to promote health. Copayments may not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services.

Value-Added Services and Rewards

- **Annual well visits:** Ages 3-21 - Receive a \$25 gift card.
- **Maternity:** \$100 gift card for six prenatal visits and \$50 for post-partum visit between 7-84 days of delivery.
- **Diabetes:** \$25 gift card for completion of an HbA1c blood test and \$25 gift card for a diabetic eye exam for ages 18-75.
- **Dental:** \$25 gift card for dental exams for children up to age 21.
- **Mammogram:** \$50 gift card for completion of a mammogram, ages 40+.
- **Pap Smear:** \$25 gift card for completion of a Pap smear.
- **Free Cell Phone:** Free cell phone with free minutes for text and voice, unlimited calls to Member Services and free wellness and appointment reminder texts.
- **Boy and Girl Scouts** annual membership fee for ages 5-18.
- **Participation in Member Advisory Committee:** Assist THP with better understanding how to meet your needs

- **Jobs and Hope West Virginia Assistance:** Assist members in referral program.
- **Teladoc:** 24/7/365 access to providers for non-emergent treatment.
- **Meals for Moms:** New moms may receive a week's worth of meals following discharge from hospital after newborn delivery.
- **COVID Vaccine:** \$25 gift card for completing COVID vaccine (limited to 1 gift card)
- **Life Coach:** Available to assist with resume development, interview skills and job searches.
- **Smoking Cession:** \$25 gift card for completing THP smoking cessation course (effective 1/1/2022)
- **Health Risk Assessment:** \$25 gift card for members up to age 21 for completing a Health Risk Assessment (effective 1/1/2022)

These incentives are subject to change January 1 and July 1 each year. Please contact Member Services to verify most current value adds. Please allow up to six (6) months to receive gift card funds.

Smoking Cessation Program Guidelines:

To Graduate from Program and Qualify for \$25: Members will have two requirements to graduate from the program:

- Minimally, the member must engage in 2 calls with the tobacco cessation counselor. The minimum engagement will require the enrollment and education call, and a follow up call with the counselor at the end of the program. The counselor will have a conversation with each member to determine the member's desired engagement level during the enrollment and education call.
- If the member gets a prescription, they must fill all prescriptions on time. If the member does not get a prescription, they will need to engage in an additional 2 calls to track the member through the program.

How to opt in: Members may self-refer to the program by calling into The Health Plan's tobacco cessation line or enrolling online. They may also be referred to the program through providers or nurse navigators.

MORE INFORMATION ABOUT YOUR COVERAGE

Please read below for more details about your coverage. If you have any questions, please call Member Services at 1.888.613.8385.

WELL-CHILD VISITS

Well-child visits, also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, are important to make sure children are healthy and stay healthy. The EPSDT benefit covers all medically necessary and preventive health care services for members up to age 21. Both sick and well care services are provided by your PCP at no cost.

Some screenings that children can get include:

- Physical exams
- Laboratory tests
- Vision testing
- Immunizations
- Hearing test
- Dental services
- Behavioral health screenings
- Health education
- Health and development history

Checkups and screenings are needed to detect health problems. Your PCP can diagnose and treat any health issues early, before they become more serious. Call your PCP or Member Services to schedule a well-child visit. Transportation and scheduling help is also available upon request at no cost.

DENTAL SERVICES

Dental care is important to your overall health. The Health Plan uses a dental benefit manager, Skygen USA, formerly known as Scion Dental, to provide dental services for both children and adult Mountain Health Trust members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Members under 21 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by twelve months of age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Members up to 21 can also access the Fluoride Varnish Program, offered by providers certified from the WVU School of Dentistry. For more information about the fluoride varnish application, ask your provider. Children are covered for non-emergency and emergency dental services.

For adults 21 years and older, THP, in partnership with Skygen, will cover up to \$1,000 in preventive and restorative dental care. This includes services such as cleanings, x-rays, crowns and other preventive and restorative services. Any cost above \$1,000 will be your responsibility to pay the dentist.

Emergency dental services are also covered. These services may be provided by a dentist, orthodontist, or oral surgeon. Some examples of a dental emergency include:

- Severe pain
- Hemorrhage
- Traumatic injury to the teeth and surrounding tissue
- Unusual swelling of the face or gums

If you need to speak with Skygen USA, please call 1.888.983.4698.

Hours of Operation: Monday – Friday, 8:00 a.m. to 5:00 p.m.

BEHAVIORAL HEALTH SERVICES

You do not need a referral for behavioral health services. Your PCP or Member Services can help you get these services from behavioral health providers. You can also call 1.877.221.9295.

If there is a mental health or substance abuse emergency, please call 911 right away.

The Health Plan provides inpatient and outpatient services to members. This benefit includes mental health services, substance abuse (alcohol and drugs) services, case management, rehabilitation and clinic services, and psychiatric residential treatment services.

Some services require pre-authorization. Your PCP or Member Services can help you get these services from behavioral health providers. You can also call The Health Plan Behavioral Health Services at 1.877.221.9295. Hours of Operation: Monday – Friday, 8:00 a.m. to 5:00 p.m.

Behavioral Health Services Not Covered:

- Services provided to individuals under the age of 21 performed in a children's residential treatment facility
- Any services that are covered by fee-for-service
- School-based services

If there is a mental health or substance abuse emergency, please call 911 right away.

COURT ORDERED SERVICES

Medically necessary court ordered treatment services are covered by The Health Plan. Court ordered services are subject to BMS reviews and determination.

SERVICES NOT COVERED

Some services are not available through The Health Plan or Medicaid. If you choose to get these services, you may have to pay the entire cost of the service. The Health Plan is not responsible for paying for these services and others:

- All non-medically necessary services.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition.
- Cosmetic/plastic surgery will be covered only to correct conditions from accidents/injuries like a car accident and birth defects like a cleft lip. Breast implants are covered only for mastectomy due to breast cancer or fibrocystic breast disease. You may have to get a second opinion before getting these services.
- Removal/replacement of breast implants must be proven medically necessary. Implants must have been inserted for reconstructive purposes due to mastectomy for breast cancer or fibrocystic breast disease. You may have to get a second opinion before getting these services.
- These conditions must have happened while you were a member of The Health Plan. If not, The Health Plan must determine an ongoing history of medically necessary cosmetic/plastic surgery to correct these conditions. The Health Plan may do so by looking at your past medical records.
- Removal of breast implants that were inserted for cosmetic reasons only will not be covered.
- Oral surgery for adults will be covered to correct conditions from accidents/injuries, like a car accident. The accident/injury must have happened *while* you were a member of The Health Plan. An oral surgeon *must* be needed to correct these conditions. These services must start within six months of the accident/injury.
- Custodial or home care, rest and respite care, or other services primarily to assist in the activities of daily living and personal comfort items (to include cleansing and luxury items). This includes personal services and residential services.

- Health care that is for research, investigation, or experimental as determined by The Health Plan. The Health Plan will look at standards of the AMA, FDA, NIH, Medicare, or reports of consultants to decide if a health care treatment is experimental or investigational.
- Private rooms are not paid for, except when medically needed and approved by The Health Plan. Personal or comfort items and services like guest meals, lodging, radio, television, and telephone.
- Hospital or medical care for problems that state or local law requires treatment in a public facility.
- Any injury or sickness when any benefits, settlements, awards, or damages will be received or paid. This also includes workers' comp, employer's liability or similar law or act. This applies even if you waived your rights to workers' comp, employer's liability, or similar laws or acts. Be sure to tell The Health Plan if you will get any benefits, settlements, awards, damages, or workers' comp.
- Reversal of voluntary sterilization and associated services and/or expenses.
- Sterilization for members under age 21.
- Sex transformation procedures and hormone therapy associated with sex transformation procedures
- Special services not approved by The Health Plan.
- Provider and medical services outside the service area will not be paid for if you knew you would need these services before you left the service area. If you know you will need services and you may be traveling soon, tell your PCP or The Health Plan.
- Hearing aid evaluations, bone-anchored hearing aids, cochlear implants, hearing aids, hearing aid supplies, batteries and repairs will only be covered for members under the age of 21. Coverage depends on hearing loss and The Health Plan guidelines.
- Exams for insurance, sports physicals, camp physicals, or daycare physicals will not be paid for unless it is part of your yearly physical exam given by your PCP.
- Medical and surgical treatment for *all* infertility services.
- Abortions are covered by FFS Medicaid.
- Long-term cardiac and pulmonary, physical, respiratory, occupational or speech therapy will only be paid for in certain situations, such as for children.

- Services for acupressure, hypnosis, electrolysis, Christian Science treatment and autopsy. Any education or training classes including Lamaze and to quit smoking (unless under RFTS). Estrogen and androgen pellet implants, arch supports, massage, and paternity testing are not covered.
- Liposuction, panniculectomies or abdominoplasty, such as surgery to remove fatty tissue ("tummy tucks").
- Work hardening programs, including functional capacity evaluations.
- Services at non-medical weight loss clinics and diet centers, mini-gastric bypass surgery, and gastric balloon for treatment of obesity. Consideration for bariatric surgery and related services require prior authorization. Also included are wiring of the jaw, weight control programs, screening for weight control programs, and similar services.
- Organ transplants and related expenses are covered under FFS.
- Vision services for members over age 21 are limited to medical treatment only and require an approved referral to a participating ophthalmologist.
- Practitioner and medical services that are not medically necessary or appropriate as determined by The Health Plan will not be paid for.
- Other limitations specifically stated in the provider and medical benefits list in this handbook.
- Services not provided, arranged, or authorized by your practitioner, except in an emergency or when allowed in this policy. Elective pre-surgery testing on an inpatient basis without the authorization of The Health Plan's medical director.
- Sports-related devices.
- Acupuncture, unless it is for anesthesia used with a covered procedure.
- Services by a practitioner with the same legal address or who is a member of the covered person's family. This includes spouse, brothers, sisters, parents or children.
- Unlicensed services by a practitioner.
- War-related injuries or treatment in a state or federal provider for military or service-related injuries or disabilities
- Non-medical services related to the treatment of temporomandibular joint dysfunction (TMJ) or craniomandibular joint dysfunction (CMD). WV Medicaid covers TMJ for children up to age 21.
- If a member decides to get hospice services instead of medical treatment, he/she gives up the right to other Mountain Health Trust (WV Medicaid) services for the terminal illness. Coverage continues for other medical conditions not related to the terminal illness.

- Sterilization of a mentally incompetent or institutionalized person.
- Inpatient tests not ordered by the attending practitioner or other licensed practitioner, except in cases of emergency.
- Therapy and related services for a patient showing no progress. Speech therapy for members ages 0-21 must meet criteria and be pre-authorized. Speech therapy for adults is not a covered benefit except when medically needed as a result of specific medical/surgical conditions such as ALS, cerebral palsy, stroke, or physical trauma.
- Non-emergency transportation is covered by FFS Medicaid.
- Services that, in the judgment of your practitioner, are not medically appropriate or not required by accepted standards of medical practice or the plan rules governing services
- Megavitamin therapy.
- Services performed after your physician has advised the member that further services are not medically appropriate or not covered services.
- Homeopathic treatments.
- Treatment for flat foot and subluxation of the foot are not covered.

This is not a complete list of the services that are not covered by The Health Plan. If a service is not covered, not authorized, or is provided by an out-of-network provider, you may have to pay. If you have a question about whether a service is covered, please call Member Services at 1.888.613.8385.

GETTING YOUR BENEFITS

REFERRALS AND SPECIALTY CARE

Referrals are not needed when you go to see your PCP. For women, referrals are not needed for appointments with your OB/GYN. If you need health care that your PCP cannot give, your PCP can refer you to another provider who can. Usually, you will be referred to a specialist in our network. When your PCP refers you, the care you get from a specialist will be covered. To see our list of specialists, please call us at 1.888.613.8385 or visit findadoc.healthplan.org. Member Services can also help you if you believe you are not getting the care you need.

SERVICE AUTHORIZATIONS

If you need to see a provider who is not on our list, your PCP must ask The Health Plan for approval. Asking for an out-of-network referral is called a service authorization request. If the service is available within The Health Plan's network, there is no guarantee you will be approved to see the out of network providers.

It is important to remember that your PCP must ask us for approval before seeing an out-of-network provider. Your PCP can call Member Services at 1.888.613.8385. If you are approved to see a provider who is outside of our plan, your visits will be covered. If we do not approve a service authorization, you can appeal the decision.

PRIOR AUTHORIZATIONS

Sometimes you may need certain services or treatments that require approval. Before you get this type of care, your provider must ask Member Services. If the care is best for your needs, then it will be covered. If we do not approve a prior authorization, you can appeal the decision.

OUT-OF-NETWORK SERVICES

If we are unable to provide certain covered services, you may get out-of-network services. The cost will be no greater than it would be if you received the services within our network. Services will be provided in an acceptable and timely manner.

NEW TECHNOLOGY

To make sure you have access to the newest medical treatments, The Health Plan looks for new medical advances, procedures and treatments. The Health Plan uses scientific evidence, medical effectiveness and decisions from government agencies to decide if it will pay for new kinds of treatment.

COST SHARING

Cost sharing, or a copayment, is the money you need to pay at the time of service. Whenever you see your PCP or a provider you were referred to in our network, you are not responsible for any costs except the copayment. The amount of the copayment will change depending on the service and the federal poverty level. Please see the table below for more details.

Copayments will be collected for:

- Inpatient and outpatient services
- Physician office visits, including nurse practitioner visits
- Non-emergency use of an emergency room
- Caretaker relatives age 21 and up
- Transitional Medicaid members age 21 and up
- Any other members that are not specifically exempt

Service	Up to 50.00% FPL	50.01 – 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	\$0	\$35	\$75
Office Visits (Physicians and Nurse Practitioners)	\$0	\$2	\$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding emergency rooms)	\$0	\$2	\$4

Non-Emergency Use of Emergency Room	\$8	\$8	\$8
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Copayments will not be collected for:

1. Family planning services
2. Emergency services
3. Behavioral health services
4. Members under age 21
5. Pregnant women (including 60 days after pregnancy)
6. American Indians and Alaska Natives
7. Members getting hospice care
8. Members in nursing homes
9. Other members or services not under the State Plan authority
10. Members who have met their household maximum limit for cost-sharing per calendar quarter
11. Members with primary insurance other than Medicaid

You have to pay the copays listed above until you and all family members in your household enrolled in the plan get to the household copay maximum. Your household copay maximum is based on your household income. You're assigned to a tier based on your household size and income for the quarter.

Tier	Gross quarterly income range for a household of 2	Copay maximum
Tier 1	\$0 - \$1,1966	\$8
Tier 2	\$1,967 - \$3,932	\$71
Tier 3	\$3,933 - and above	\$143

You'll have no copays for the rest of the quarter once your household meets its copay maximum. You will start each quarter with \$0 in copays and build towards your copay maximum.

For more information on copayment amounts, please call Member Services at 1.888.613.8385.

ACCESS AND AVAILABILITY GUIDE

The Health Plan offers services in every county of West Virginia. The table below lists how long it should take for you to be seen by a provider in different situations.

The Health Plan wants to make sure your waiting times at practitioner offices are short. All members of The Health Plan should have the same access to medical

care. If you feel your waiting time was not the same as other patients, call The Health Plan Member Services Department.

Type of Visit:	When You Should be Seen:
Routine Care	Within 21 Days
Urgent Care	Within 48 Hours
Initial Prenatal Care	Within 14 Days of Known Pregnancy
Emergency Care	Immediately

The following table shows what your travel time should be for your appointments.

Traveling to Your:	Should Take No Longer Than:
PCP	30 Minutes
Specialist You See Often	30 Minutes
Hospital	45 Minutes
Tertiary Services	60 Minutes

LETTING US KNOW WHEN YOU'RE UNHAPPY

When you have a problem, try speaking with Member Services or your PCP to resolve it. If you are still unhappy or do not agree with a decision we have made about your health care, there are different types of complaints you can make. These are known as grievances and appeals. Information on the number of grievances and appeals and their disposition is available upon request. You can also request a state fair hearing once you have gone through the process for grievances and appeals.

APPEALS

As a member of The Health Plan, you have the right to appeal a decision. You can file an appeal if you do not agree with our decision about your service authorization or prior authorization request. Our decision to reduce, suspend, or stop services will be sent to you in a Notice of Action letter. You will have 60 calendar days from the date of the Notice of Action to file an appeal with The Health Plan. If you would like your benefits to continue while the appeal is pending, you or your provider must file a request within 10 calendar days. You can file an appeal by calling Member Services at 1.888.613.8385 or you can do so in writing. Our appeals coordinator will send you the notice of receipt of your appeal. Keep this for your records. If you choose to write to us, you will need to

include your address. With written consent, you can also have someone else, like your PCP, file an appeal on your behalf.

To file a written appeal, please mail it to:

The Health Plan
Attn: Mountain Health Trust Appeals Coordinator
1110 Main Street
Wheeling, WV 26003

The Health Plan will respond to your appeal within 30 calendar days from the day your appeal is received. If it is in your interest, you can ask for a delay in our decision for up to 14 days. If we need to delay our decision for another reason, we will give you written notice within two days. For appeals that need to be resolved more quickly, we will give you our decision within 72 hours after receiving your appeal. You may have to pay the cost of services, depending on the outcome. If we do not meet these timelines, you have the right to file a state fair hearing.

You have the right to see and get copies of:

- Any records that have to do with your appeal
- Your benefits
- Documents explaining how we made our decision

The Health Plan has qualified staff participating in your appeal decision review.

- Medical Directors – Board certified practitioners (radiology, behavioral health, obstetrics and gynecology, and general surgeon) with current state licensures
- Nurse Navigators - Registered nurses with current state licensures

As our member, you have the right to an independent, external review of any internal THP decision about a denied service or other appeal.

If you need help with an appeal, you can call Member Services toll-free at 1.888.613.8385. We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

GRIEVANCES

As a member of The Health Plan, you have the right to file a grievance at any time. You can file a grievance if you are unhappy with something about The Health Plan or one of our providers. You can also file a grievance if you disagree with our decision about your appeal. To file an informal grievance, call us at 1.888.613.8385 to let us know that you are unhappy with The Health Plan or your health care services. You can also take steps to file a formal grievance, or allow

someone like your PCP to do so on your behalf. If you choose to write to us, you will need to include your address.

To file a written grievance, please mail it to:

The Health Plan
Attn: Medicaid Appeals Coordinator
1110 Main Street
Wheeling, WV 26003

We will usually get our answer to you within 45 days and no later than 90 days from the date your grievance is received.

You have the right to see and get copies of:

- Any records that have to do with your grievance
- Your benefits
- Documents explaining how we made our decision

If you need help with a grievance, you can call Member Services toll-free at 1.888.613.8385. We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

KEEPING YOUR APPEALS AND GRIEVANCES

The Health Plan will keep copies of your appeal and grievance documents, records and information about your appeal and grievance for your review for 10 years.

FAIR HEARINGS

As a member of The Health Plan, you have the right to request a state fair hearing. You can only request a state fair hearing after you have received notice that The Health Plan is upholding the decision to reduce, suspend, or stop your benefits. You must request the state fair hearing no later than 120 calendar days from the date of our decision notice. It is our job to mail you the form and give you the information you need.

Once you get the form, please mail it back to:

WV Bureau for Medical Services
Office of Managed Care
Room 251, 350 Capitol Street
Charleston, West Virginia 25301

If you would like your benefits to continue while the hearing is going on, you or your provider must file a request in writing to our office within 13 calendar days. You may have to pay the cost of services, depending on the outcome. Parties

to the state fair hearing can include the State, The Health Plan, your representative, or the representative of a deceased member. The State will hear your case and decide within 90 days of your request for a state fair hearing.

Please call Member Services at 1.888.613.8385 if you have questions about requesting a state fair hearing. You can also call the Department of Health and Human Resources at 1.304.558.1700.

COMPLAINTS

At any time, you can file a complaint. You may fax it to The Health Plan at 1.888.450.6025

You will need to send us a letter that has:

- Your name
- Your mailing address
- The reason why you are filing the complaint and what you want The Health Plan to do
- Your doctor or authorized representative can also file a complaint or grievance for you

REPORTING FRAUD

If you suspect fraud, waste, or abuse by a member or provider of The Health Plan, please report it to our special investigative unit (SIU). You do not need to give us your name or information when you call or fill out the form. To report fraud, waste, or abuse, please call 1.877.296.7283. You may also complete the Fraud, Waste, and Abuse Reporting form on our website or by mailing it to us:

healthplan.org

The Health Plan
1110 Main Street
Wheeling, WV 26003

OUR POLICIES

ADVANCE DIRECTIVES

Under Federal and State law, you have the right to make decisions about your medical care, including an advance directive. An advance directive is legal document with your wishes regarding medical treatment if there comes a time when you are too sick to make your decisions known. An advance directive allows you to plan in advance and participate in decision-making around your health. It is a way to let your doctors know what kind of treatment you do or do not want. You can also allow someone you trust to make treatment decisions for

you. This would allow that person to make choices about your care and treatment. Many people choose a relative or someone they know well.

You should speak with your doctor about making an advance directive. You do not have to fill one out, but you may want to. If you decide to let someone you trust make treatment decisions for you, be sure to speak with that person. Making an advance directive requires filling out forms and stating your wishes in writing. It will become a part of your medical records. Remember, you can change your advance directive at any time.

Your doctor and Member Services can help you to fill out or answer questions about advance directives.

ENDING YOUR MEMBERSHIP

If you do not wish to be a member of The Health Plan, you have the right to disenroll at any time. You may re-enroll in another health plan if you choose. The enrollment broker can help you. Just call 1.800.449.8466.

Sometimes members are disenrolled from The Health Plan involuntarily. This can happen if:

- You are no longer eligible for Medicaid managed care
- You move outside of our service area
- You are placed in a nursing facility, state institution, or intermediate care facility for the mentally retarded for more than 30 calendar days
- You were incorrectly enrolled in The Health Plan
- You die

If this happens, your services may stop suddenly. The enrollment broker and Member Services can answer any questions you may have about disenrollment. If you move out of the country or out of state, call the West Virginia Bureau for Medical Services as 1.304.558.1700.

APPROPRIATE TREATMENT OF MINORS

The law says that persons under age 18 cannot give valid consent for medical care. The parent or guardian must give consent for medical care for the minor (child). We will permit the enrollee's parent or representative to facilitate care or treatment decisions when the enrollee is unable to do so. We will provide for the enrollee or representative involvement in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment, and comply with requirements of federal and state law with respect to advance directives.

A person over age 16 but under age 18 may ask a court to declare him or her "emancipated." If the court agrees, the person can approve his or her own medical care. Anyone over age 16 who is married is considered emancipated.

The parents of an emancipated child have no right to control, nor a duty to give care and money support to the child. Any child who is emancipated can give valid consent to medical care. This person then becomes financially responsible for the costs of the medical treatment.

Mature minors can give medical consent. A person is considered mature based on age, intelligence, experience, living situation, education, and degree of maturity.

Any licensed physician can examine, diagnose, treat, and counsel any minor at his or her request for an addiction or dependency of alcohol or drugs. This can be without the knowledge or consent of the minor's parent or guardian. This is also the same for any venereal disease.

Minors can consent to family planning services. The services must be kept confidential from the parents if the minor asks.

If a minor presents with a medical problem needing immediate care or which could cause immediate danger to the child's health, and no parent or guardian can be found to approve care, then the minor can consent to medical care.

Oral interpreters for minors are available in the case of an emergency.

THIRD PARTY LIABILITY

If you have insurance other than Medicaid, please call Member Services to let us know. Please call and let us know if another insurance company has been involved with your:

- Workers' compensation claim
- Personal injury
- Medical malpractice law suit
- Car accident

You must use any other health insurance you have first before using Medicaid.

RECOMMENDING CHANGES IN POLICIES OR SERVICES

If you have recommendations or ideas, please tell us about them. You can help us make changes to improve our policies and services. To let us know, please call Member Services at 1.888.613.8385.

CHANGES TO YOUR HEALTH PLAN

If there are any changes to your benefits or other information in this handbook, we will let you know at least 30 days before the effective date of the change and no later than the actual effective date. Please let us know if you have any questions about program changes.

Quality Improvement

At The Health Plan, we want to make your health better. To do this, we have a Quality Improvement (QI) program. Through this program we:

- Evaluate our health plan in order to improve it
- Track how happy you are with your PCP
- Track how happy you are with us
- Use the information we get to make a plan to improve our services
- Carry out our plan to help make your health care better

You may ask us to send you information about our QI program. This will include a description of the program and a report on our progress in meeting our improvement goals. Call Member Services at 1.888.613.8385.

ACCREDITATION REPORT

The Health Plan is accredited by the National Committee for Quality Assurance (NCQA). You can request a summary of our accreditation report by calling Member Services.

Workforce West Virginia

Workforce WV offered tools to help with job searches, unemployment, and training. Workforce WV has the largest database of job seekers and openings in the state. The education and training opportunities provide residents work skills needed by businesses. Visit their website at <http://workforcwv.org>. If you don't have a job due to a health issue, please contact us at 1.888.348.2922 (TTY: 711).

Health Home

The Health Home Program coordinates physical and behavioral health (both mental and substance disorder), long-term and social services, and support for members with chronic health conditions. If you would like assistance with enrolling in a health home, please contact us at 1.888.613.8385 (TTY: 711).

IMPORTANT CONTACT INFORMATION

Entity	Phone Number	Street Address
The Health Plan Member Services	Toll-Free: 1.888.613.8385	1110 Main Street Wheeling, WV 26003 <u>OR</u> 141 Summers Street Charleston, WV 25301
County DHHR	304.558.0684	Office of the Secretary One David Square, Suite 100 East Charleston, WV 25301
West Virginia Bureau for Medical Services	304.558.1700	350 Capitol Street Charleston, WV 25301
Pharmacy – Benefit is through BMS Fiscal Agent	1.888.483.0797 Call this number if you need information about your pharmacy or your pharmacy benefit. wvmmis.com	
Medical Management	Toll-Free: 1.888.613.8385	
Enrollment Broker	1.800.449.8466	
Emergency	911; 24-hour nurse line 1.800.624.6961	
Dental (Skygen)	1.888.983.4698	
Vision under 21 years old	1.800.879.6901	
Behavioral Health	1.877.221.9295	
Teladoc	1.800.TELADOC (835.2362)	24/7/365 access to physicians for non-emergency situations
Grievances/ Appeals	1.888.613.8385	
State Fair Hearing	304.558.1700	Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301
Fraud, Waste, and Abuse	1.877.296.7283	
Non-Emergency Transportation	1.844.549.8353	