WV Children's Health Insurance Program (WVCHIP)

Managed Care Member Handbook

SFY 2023

(July 1, 2022 – June 30, 2023)

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).

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WELCOME

Welcome to The Health Plan's West Virginia Children's Health Insurance Program (WVCHIP) 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. WVCHIP 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.

WHAT IS WVCHIP

In 1997, Congress amended the Social Security Act to create Title XXI "State Children's Health Insurance Program." The West Virginia Legislature established the insurance governance and legal framework in legislation that was enacted in April 1998. Children first began enrolling in the West Virginia Children's Health Insurance Program (WVCHIP) in July 1998.

WVCHIP covers children from birth through the end of the month of their 19th birthday. It pays for a full range of health care services for children, including doctor visits, check-ups, vision and dental visits, immunizations, prescriptions, hospital stays, mental health, and special needs services. Starting July 1, 2019, WVCHIP will cover pregnant women over 19 years of age.

WVCHIP reports to a financial governing board comprised of citizen members, legislators, and state agency members who are responsible for WVCHIP's annual financial plan. The West Virginia Children's Health Insurance Program Board meets at least four times each year, and meetings are open to the public. WVCHIP's administrative office is located at 350 Capitol Street, Room 251, Charleston, West Virginia 25301.

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 WVCHIP. The provider directory can be found on our website at findadoc.healthplan.org. If you want a hard copy of the provider directory, 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 a.m. to 5 p.m.
Address	1110 Main Street, Wheeling WV 26003
Address	141 Summers Street, Charleston WV 25301
Toll-free	1.888.613.8385
TTY	711

Online	healthplan.org/WVCHIP

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. 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/WVCHIP.

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/smartscreen/main.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

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.

Allowed Amounts: The lesser of the actual charge amount or the maximum fee for that service as set by WVCHIP

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.

Benefit Year: A 12-month period beginning January 1 and ending December 31, used to calculate out-of-pocket maximums.

Birth-To-Three (BTT): This statewide system can assess early child development and provide services and support for the families of children three and under who have a delay in their development or may be at risk of having a delay.

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.

Coordination of Benefits: WVCHIP members are otherwise not insured, therefore, this would not apply to WVCHIP members. WVCHIP does not pay claims that indicate payment by any other insurance or source.

Copayment: A set dollar amount a member pays when using certain services, such as office visits, brand name drugs and some dental services.

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

Express Scripts: The third-party administrator that processes and pays claims for prescription drugs, specialty drugs, provides drug information and drug utilization management functions for WVCHIP.

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.

Eligible Expense: A necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by The Health Plan. Eligible expenses by The Health Plan calculated according to WVCHIP fee schedules, rates, and payment policies in effect at the time of service.

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.

Experimental, Investigational, or Unproven Procedures: Medical, surgical, diagnostic, psychiatric, substance use or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by The Health Plan (at the time it makes a determination regarding coverage in a particular case) to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Medical Association Drug Evaluations as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of Phase 1, 2, 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Fee-for-Service: Health care services that WVCHIP pays for. You should use your medical card to get these health care services. These services include pharmacy and birth-to-three.

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 theory, 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.

Help Me Grow: A free program that helps physicians and parents address childhood development issues from birth to age five. The program includes the Ages and Stages Questionnaire (ASQ-3), an expertly staffed hotline, and serves as information and referral service to help connect parents and health care providers with specialized services and therapies as well as support services.

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, physical 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, primary care providers, physician assistants, nurse practitioners or any persons providing direct services to members.

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 Drug Coverage: Health insurance that helps pay for prescription drugs and medications. The Health Plan does not provide prescription drug coverage. Your coverage is provided through Express Scripts, whose logo and information are listed on the back of your member ID card. Express Scripts members services can be reached at 1-855-230-7778

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 member ID card.

Provider Directory: A directory of all the practitioners that you can see with your member 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 Member Services 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.

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

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

Specialist as Primary Care Provider (PCP): Members with a disabling condition, chronic illness or who are SSI eligible, have the option to submit a request for a specialist physician to serve as their PCP. The specialist physician will provide specialty care and PCP services to the member on a routine basis. However, the specialist physician may be required to comply with certain procedures such as obtaining prior authorization for certain services or requesting referrals.

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.

Timely Filing: Claims must be filed within six months for dental, vision, behavioral health, and medical services. Claims not submitted within this period will not be paid, and THP/WVCHIP will not be responsible for payment. It is the obligation of the member or member's guardian to present the THP/WVCHIP member ID card to the provider, i.e., physician's office hospital, etc., at the time of service.

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 19 should have regular, well-child/adolescent visits according to the health check periodicity schedule. This is covered by The Health Plan.

WVCHIP Gold: WVCHIP enrollment group for children in families with incomes at/or below 150% of the Federal Poverty Level (FPL).

WVCHIP Blue: WVCHIP enrollment group for members in families with incomes over 150% up to 211% of the FPL.

WVCHIP Premium: The enrollment group for members in families with incomes over 211% up to 300% of the FPL that requires monthly premium payments.

WVCHIP Exempt: The enrollment group members who are Native American/Alaskan natives who are members of a federally recognized tribe and are exempt from copayments and other cost-sharing.

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 WVCHIP 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 WVCHIP.

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 on available treatment options or alternative courses of care, presented in a manner appropriate to your condition and ability to understand, 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 if 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 doctor as soon as you can to let him or her know
- Follow your PCP's 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 an organ transplant or if you are told you need an organ 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

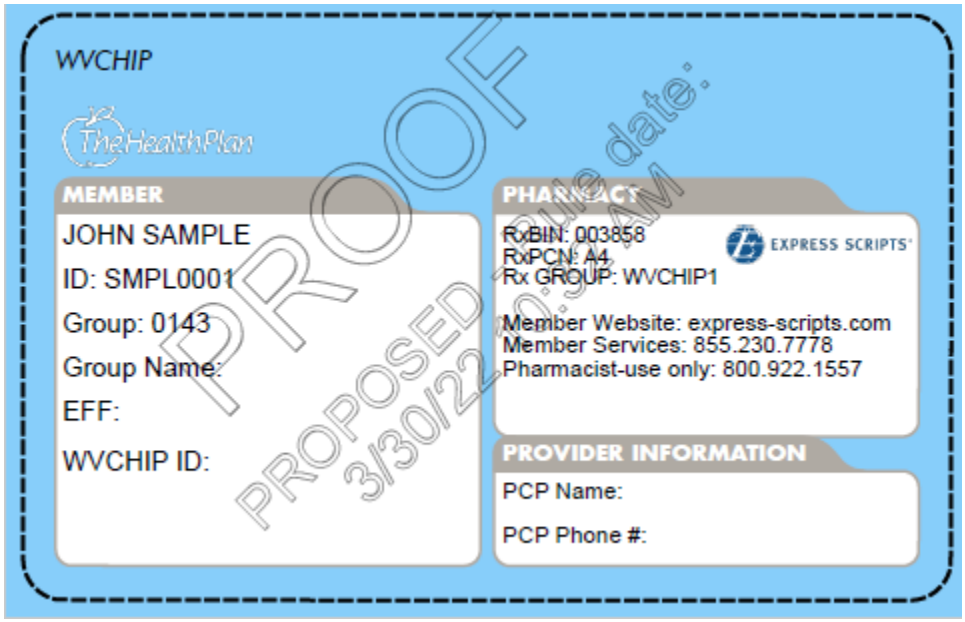
STEPS TO YOUR GETTING CARE

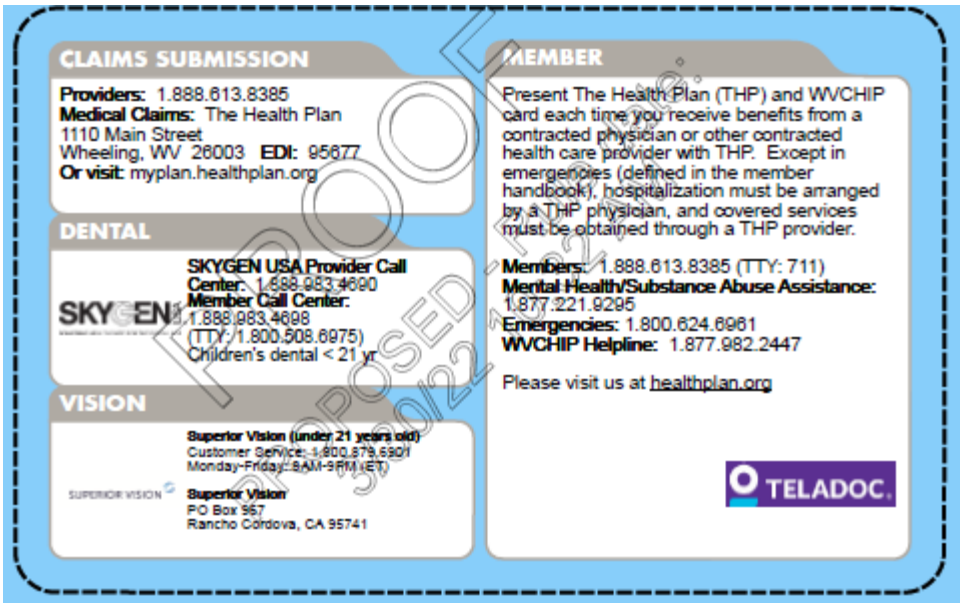
YOUR MEMBER ID CARD

After you join The Health Plan, we will send you your member ID card in the mail within five days. 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 five 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.

Your member ID card should look like this:





You will find some useful information on your card like your WVCHIP 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 available 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) also known as a Patient-Centered Medical Home (PC-MH) from the Provider Directory. A PCP is a specific clinician responsible for coordinating your health care needs. You can find a list of PCPs 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. You will pay a copay if you see a PCP who is not listed on your member ID card or who is in the same office. It is important for you to keep this information up to date.

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 at 1.888.613.8385 to discuss. 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 members 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. 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.

The State of West Virginia and THP guidelines do not allow for WVCHIP members to be 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 PCP's leave our network. If this happens, we will let you know by mail within 15 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 WVCHIP members as they do for members covered by other insurance.

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. No copays apply to well-care visits. 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."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - Covered screening services are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth provided by your primary care physician or dentist. At a minimum, these screenings would include:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development);
2. An unclothed physical exam;
3. Laboratory tests (including blood lead screening appropriate for age and risk factors);
4. Vision testing;
5. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices (ACIP);
6. Hearing testing;
7. Dental services (furnished by direct referral to a dentist for children beginning at six [6] months after the first tooth erupts or by twelve [12] months of age);
8. Behavioral health screening; and
9. Health education (including anticipatory guidance).

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. You can also call our 24/7 nurse line.

TELADOC 24/7 SERVICES

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

You have access to 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
- 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 WVCHIP Benefits table.

YOUR BENEFITS

You can get many services through The Health Plan's WVCHIP managed care program in addition to those that come with fee-for-service WVCHIP. For most benefits, you will need to go through your PCP. There are some services that do not require a referral from your PCP, such as behavioral health or mental health services. 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 the network or we can arrange for someone 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.

WVCHIP 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, behavioral, dental, and vision. You can get the services listed in the WVCHIP Benefits table by using The Health Plan member ID card.

Note: The fact that a physician has recommended a service as medically necessary does not make it a covered expense. The Health Plan reserves the right to make the final determination of medical necessity based on diagnosis and supporting medical data.

Who May Provide Services: The Health Plan will pay for services rendered by a health care professional/facility if the provider is:

- Licensed or certified under the law of the jurisdiction in which the care is rendered
- Enrolled in WVCHIP through MMIS Vendor
- Providing treatment within the scope or limitation of the license or certification

- Not sanctioned by Medicare, Medicaid or both; services of providers under sanction will be denied for the duration of the sanction
- Not excluded by WVCHIP, PEIA, or Medicaid due to adverse audit findings
- Not excluded by other states' Medicaid or CHIP Programs

Covered Services: A comprehensive range of health care services are covered in full unless otherwise noted. Some major categories are listed below. If you have questions about covered services, call Member Services at 1.888.613.8385.

Services with an (*) require prior authorization in some or all circumstances.

WVCHIP	Scope of Benefit
Abortion Services	• Termination of unwanted or endangered pregnancy • Covered only in cases of rape, incest, or endangerment to a mother's life
Allergy Services	• Testing and treatment for allergies • Includes all testing and related treatment services
Applied Behavior Analysis (ABA)	• For members with a primary diagnosis of Autism Spectrum Disorder

WVCHIP	Scope of Benefit
Ambulance Services	• Emergency ground or air ambulance transport to the nearest facility able to provide needed treatment when medically necessary • Facility to facility ground ambulance transportation service that are medically necessary are covered
Behavioral Health Outpatient Counseling	• Counseling for behavioral or mental health care needs by a licensed professional • Limited to 26 visits without prior authorization. • Visit limit is inclusive of outpatient behavioral/mental health services, partial hospitalization, crisis stabilization, intensive outpatient treatment, and other BH/MH services.
Cardiac or Pulmonary Rehabilitation	• A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore enrollees with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department • Limited to 3 sessions per week for 12 weeks or 36 sessions per year for the following conditions: heart attack occurring in the 12 months preceding treatment, heart failure, coronary bypass surgery, or stabilized angina pectoris
Chelation Therapy	• For reduction of lead and other metals
Chiropractic Services	• Services provided by a chiropractor consisting of manual manipulation of the spine • Evaluation and management and diagnostic imaging • For acute treatment of a neuromuscular-skeletal condition, including office visits and x-rays • Limited to 20 visits per calendar year without authorization for members aged 16 and older. Members under age 16 require authorization after initial visit. • Authorization required after 20 visits

WVCHIP	Scope of Benefit
Continuous Glucose Monitor	• For members with diabetes mellitus who often experience unexplained hypoglycemia or impaired awareness of hypoglycemia that puts them at risk or considered otherwise unstable. Covered per FDA age indications • Devices that monitor glucose continuously. Other glucose monitors covered under FFS outpatient pharmacy benefit
Contraceptive Drugs and Devices or Birth Control	• Covered as appropriate per FDA guidelines for age or other restrictions • Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy • Includes, but is not limited to: o IUD and IUCD insertions, or any other invasive contraceptive procedures/devices o Implantable medications o Hormonal contraceptive methods - oral, transdermal, intravaginal, injectable hormonal contraceptives o Barrier contraceptive methods – e.g., diaphragms/cervical caps • Emergency contraceptives – e.g. Plan B and Ella • Over the counter contraceptive medications – e.g., anything with a spermicide, prescription required for coverage under FFS
Cosmetic/ Reconstructive Surgery	• Surgery to repair defects or injuries • When required as the result of accidental injury or disease, or when performed to correct birth defects, such as cleft lip and palate
Dental Services	• Services provided by a dentist, orthodontist, or oral surgeon

WVCHIP	Scope of Benefit
Durable Medical Equipment and Related Supplies	• Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. For the initial purchase and reasonable replacement of standard implant and orthotic/prosthetic devices, and for the rental or purchase (at WVCHIP's discretion) of standard durable medical equipment, when prescribed by a physician • For members who have received covered services from an out-of-state facility and require Durable Medical Equipment (DME)/medical supplies, Orthotics and Prosthetic devices and appliances, and other related services or items that are medically necessary at discharge, a written prescription by the respective out-of-state attending physician must be presented to a West Virginia provider for provision of services requested. This is required to assure the warranty is valid and to ensure that repairs and maintenance are provided in the most efficient and cost-effective means for WVCHIP members. Other DME policies apply
Emergency Outpatient Services and Supplies	• Emergency outpatient services are covered • Includes acute medical or accidental care provided in an outpatient facility, urgent care facility, or a provider's office
Foot Care	• Foot care services • Includes medically necessary foot care performed by a health care provider practicing within the scope of his/her license, including such services as: o Treatment of bunions, neuromas, hammertoe, hallux valgus, calcaneal spurs or exostosis o Removal of nail matrix or root o Treatment of mycotic infections o Diabetic foot care (may include routine foot care) • Surgical procedures other than in office require prior authorization

WVCHIP	Scope of Benefit
Hearing Services	• Hearing exams and hearing aids • Includes annual examinations and medically necessary external hearing aids with prior authorization
HealthCheck	• Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT). • This includes periodic, comprehensive health examinations; developmental delay, vision, dental, and hearing assessments; immunizations; and treatment for follow-up of conditions found through the health examination as covered by WVCHIP • HealthCheck requires standard health screening forms to be completed by providers at well-child exams. See dhhr.wv.gov/healthcheck/Pages/default.aspx for more information

WVCHIP	Scope of Benefit
Hemophilia Program	• WVCHIP has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide quality hemophilia services at a reasonable cost to WVCHIP members. Members who participate in the program will be eligible for the following benefits: • An annual evaluation by specialists in the Hemophilia Disease Management Program which will be paid at 100% with no copay. (This evaluation is not intended to replace, or interrupt care provided by your existing medical home provider or specialists) • Hemophilia expenses, including factor replacement products, incurred at CAMC or WVUH will be paid at 100% with no copay after prior authorization. • Lodging and travel o Lodging expenses for child and 1 or 2 adults/guardians incurred to enable the member to receive services from the Hemophilia Disease Management Program. Lodging must be at an approved travel lodge and will be covered at 100% of charge o Travel expenses incurred between the member's home and the medical facility to receive services in connection with the Hemophilia Disease Management Program. Gas will be reimbursed at the federal rate for one vehicle. Reimbursement of meal expenses up to $30 per day per person. Receipts are required for meal reimbursement o Submit receipts to The Health Plan
Home Health Services	• Intermittent health services of a home health agency when prescribed by a physician • Services must be provided in the home, by or under the supervision of a registered nurse, for care and treatment that would otherwise require confinement in a hospital or skilled nursing facility
Hospice Care	• In-home care provided to a terminally ill individual as an alternative to hospitalization

WVCHIP	Scope of Benefit
Hyperlipidemia (High Cholesterol) Screening	• WVCHIP, along with HealthCheck, has adopted the American Heart Association's (AHA) guidelines regarding blood cholesterol screening for all children and adolescents • Beginning at age 2, WVCHIP recommends, but does not require, that all children and adolescents have a hyperlipidemia risk screening to determine their risk of developing high cholesterol. When one or more risk factors indicate the child is high risk, an initial measurement of total cholesterol can be obtained. • Additional testing and follow-up should be based on total cholesterol levels, following the American Academy of Pediatrics' recommendations for cholesterol management
Immunizations for Children and Adolescents	• Standard immunizations for children and adolescents. • All age-appropriate vaccines through age 18 are covered as recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunizations. WVCHIP covers immunizations as part of an associated office visit to a doctor enrolled in the Vaccines for Children (VFC) program. See "Well Child Care" or the "Immunization Schedules" located at chip.wv.gov for more details. WVCHIP purchases vaccines from the State's VFC program. This program allows physicians to provide free vaccines to children. Members should receive vaccinations from providers that participate in this program • Out-of-State vaccinations are not covered
Immunizations for Pregnant Members 19 and Over	• Immunizations for pregnant women over age 19 • The following immunizations will be covered for members enrolled in the Pregnant Women's Program, unless contraindicated per the immunization guidelines: hepatitis A, hepatitis B, herpes zoster, human papillomavirus, influenza (flu shot), measles, mumps, rubella, meningococcal pneumococcal, tetanus, diphtheria, pertussis, and varicella as recommended by the American Academy of Family Physicians

WVCHIP	Scope of Benefit
Inpatient Hospital and Related Services	• Confinement in a hospital including semi-private room, special care units, and related services and supplies during confinement
Inpatient Medical Rehabilitation Services	• Services related to inpatient facilities that provide rehabilitation services
Iron-Deficiency Anemia Screening	• Anemia screening • WVCHIP, along with HealthCheck, requires that all infants are tested (hemoglobin and/or hematocrit) for iron-deficiency anemia at 12 months of age. Providers are encouraged to screen all infants and children at each well-child exam visit to determine those who are at risk for anemia • Those at high risk or those with known risk factors should be tested at more frequent intervals as recommended by the CDC • This screening will also be covered as needed for pregnant women
Laboratory Services	• Laboratory and x-ray services provided in a facility other than a hospital outpatient department • Including, but not limited to, iron deficiency anemia, lead testing, complete blood count, chemistry panel, glucose, urinalysis, total cholesterol, tuberculosis, etc.
Lead Risk Screen	• A lead risk screen must be completed on all children between the ages of 6 months and 6 years at each initial and periodic visit • A child is considered high risk if there are one or more checked responses on the Lead Risk Screen and low risk if no responses are checked. Serum blood testing is required at 12 and 24 months and up to 72 months if the child has never been screened

WVCHIP	Scope of Benefit
Maternity Services WVCHIP under age 19 WVCHIP pregnant mothers over 19	• Maternal care services including prenatal obstetrical care, midwife services, birthing centers, delivery, and postpartum care service. • WVCHIP pregnant mothers are only eligible for up to 60 days postpartum • If a member is pregnant at the time of turning 19 and aging out of WVCHIP coverage, the member needs to contact DHHR to be evaluated for WVCHIP pregnancy coverage • Maternity services: Coverage includes but is not limited to two ultrasounds during a pregnancy without prior authorization; testing for Downs Syndrome, Associated Protein Plasma-A, etc., with prior authorization; and inpatient stays for vaginal/cesarean delivery, breast pumps and breastfeeding education • Sterilization is covered for members over 21
Mental Health and Substance Use Disorder Services	• Mental health services • Substance use disorder services • This may include evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (including a physician's office)
MRA/ MRI	Magnetic Resonance Angiography (MRA) services • Magnetic Resonance Imaging (MRI) services • Requires prior authorization
Neuromuscular stimulators, bone growth stimulators, vagal nerve stimulators, and brain nerve stimulators	• Stimulators for bone growth, neuromuscular, and vagal and brain nerves

WVCHIP	Scope of Benefit
Nutritional Counseling	• Coverage is limited to 2 visits per year when prescribed by a physician for children with the following conditions: o Diabetes, Type 1 and 2 o Overweight and obesity with documentation of Body Mass Index (BMI) o High cholesterol or other blood lipids o High blood pressure o Gastrointestinal disorders such as GERD or short gut syndrome o Celiac disease o Food allergies o Failure to thrive or poor growth
Nutritional Supplements	• When it is the only means of nutrition and prescribed by your physician or a prescription amino acid elemental formula for the treatment of short bowel or severe allergic condition that is not lactose or soy related
Oral Surgery	• Only covered for extracting impacted teeth, medically necessary orthognathism (straightening of the jaw) and medically necessary ridge reconstruction

WVCHIP	Scope of Benefit
Organ Transplants	• Organ transplants are covered when deemed medically necessary and non-experimental • Fees/Expenses: The Health Plan will pay all covered expenses related to prior transplant, transplant, and follow-up services while the child is enrolled in WVCHIP. Testing for persons other than the chosen donor is not covered • Travel Allowance: Because transplant facilities may be located some distance from the patient's home, benefits include up to $5,000 per transplant for patient travel, lodging, and meals related to visits to the transplant facility or physician. A portion of this benefit is available to cover the travel, lodging and meals for a member of the patient's family or a friend providing support. Receipts are required for payment of this benefit. No alcoholic beverages will be reimbursed. Mileage will be reimbursed at the federal mileage rate for medical expenses. The travel allowance benefit applies only to services pertaining to the transplant • Reimbursement forms are located on THP's website at healthplan.org or you can contact Member Service at 1.888.613.8385 and request one to be emailed or mailed
Orthodontia Services	• Orthodontic services are covered if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development • Treatment is routinely accomplished through fixed appliance therapy and maintenance visits • Comprehensive orthodontic treatment is payable once in the member's lifetime
Outpatient Diagnostic and Therapeutic Services	• Laboratory and diagnostic tests and therapeutic treatments as ordered by your physician
Outpatient Hospital Services	• Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service

WVCHIP	Scope of Benefit
Outpatient Therapy Services: Physical Therapy Occupational Therapy	• Therapy services provided by physical therapists or occupational therapists • Maintenance therapy • 20 visits per calendar year per service type without authorization • Authorization required after 20 visits
Speech Therapy Vision Therapy	• Therapy services provided by speech therapists or vision therapists • Authorization required for all visits
Pap Smear	• Annual pap smear and the associated office visit to screen for cervical abnormalities
PET Scan	• Photo Emission Topography scan • Prior authorization required
Professional Services	• Physician or other licensed provider for treatment of an illness, injury or medical condition • Includes outpatient and inpatient services such as surgery, anesthesia, radiology, office visits, and urgent care visits
Skilled Nursing Facility Services	• Facility based nursing services to those who require 24-hour nursing level of care • Confinement in a skilled nursing facility including a semi-private room, related services and supplies. Confinement must be prescribed by a physician
Sleep Apnea	• Treatment for sleep apnea • All sleep testing, equipment, and supplies are covered
Specialty Drugs (Physician Administered)	• * Specialty drugs for acute and chronic diseases Acute and chronic diseases such as rheumatoid arthritis, anemia, cerebral palsy, hemophilia, osteoporosis, hepatitis, cancer, multiple sclerosis, and growth hormone therapy are examples of conditions that specialty medications are covered
Substance Use Disorder (SUD) Residential Services	• Residential treatment services to treat those with substance abuse. Prior authorization is required. Age 18 and older only.

WVCHIP	Scope of Benefit
Tobacco Cessation	• CHIP members may receive two 12-week treatment cycles per year. There is no limit on tobacco cessation counseling. THP will provide 100% coverage for the tobacco cessation benefit. THP will cover an initial and follow-up visit to the member's physician or nurse practitioner at no cost to the member • Prescription drugs and aides covered under FFS outpatient pharmacy benefit • 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 helping 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.
Urgent Care and After-Hours Clinic Visits	• A visit to an urgent care or after-hours clinic is treated as a physician visit for illness
Vision Services	• Services provided by optometrists, ophthalmologists, surgeons providing medical eye care and opticians. Professional services, lenses including frames, and other aids to vision. Vision therapy • Covered benefits include annual exams and eyewear. Lenses/frames or contacts are limited to a maximum benefit of $125 per year. The year starts on the date of service. The office visit and examination are covered in addition to the $125 eyewear limit

WVCHIP	Scope of Benefit
Well Child Care	• A complete preventive care checkup includes, but is not limited to: o Height and weight measurement o BMI calculation o Blood Pressure Check o Objective vision and hearing screening o Objective developmental/behavioral assessment o Lead risk screen o Physical examination o Age-appropriate immunizations as indicated by physician • Wellness visits are covered at: o 3-5 days after birth o 1 month o 2 months o 4 months o Every 3 months from 6 to 18 months o 24 months o 30 months o 3 years old o 4 years old o Annually after age 4 to 18 years old • Objective– developmental screening tool is to be administered to child at the 9, 18, and 30 months well child visits • Objective– autism screening tool is to be administered to the child at the 18 and 24 months well child visits

WVCHIP FEE-FOR-SERVICE BENEFITS	
Birth-to-Three (BTT)	This statewide system can assess early child development and provide services and support for the families of children three and under who have a delay in their development or may be at risk of having a delay Either a parent or physician may refer a child to BTT program for further assessment by calling 1.866.321.4728 to get an appointment with BTT providers nearest to your location

WVCHIP FEE-FOR-SERVICE BENEFITS	
Outpatient Prescription Benefit Services	Mandatory generic substitution, including oral contraceptives

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. Copays 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.**
- **Pap Smear: $25 gift card for completion of a Pap smear.**
- **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**
- **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.

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.

Dental Services

Dental care is important to your overall health. The Health Plan uses a dental benefit manager, Skygen USA, to provide dental services to WVCHIP members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Members 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 12 months of age. Flouride varnish treatments can be done twice a year by either your PCP or dental provider. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Comprehensive orthodontic treatment is payable only once in the member's lifetime.

If you need to speak with Skygen USA, please call 1.888.983.4698.
Hours of Operation: Monday – Friday, 8 a.m. to 5 p.m.

Member portal: https://thehealthplanwvmwp.sciondental.com

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 use emergency, please call 911 right away.

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

Some services require prior 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 Department at 1.877.221.9295.
Hours of Operation: Monday – Friday, 8 a.m. to 5 p.m.

Behavioral Health Services Not Covered:

- Services provided to individuals under the age of 19 performed in a children's residential treatment facility
- Any services that are covered by fee-for-service
- School-based services
- IMD services
- Peer Recovery Support Services

Court Ordered Services

Medically necessary court ordered treatment services are covered by The Health Plan.

SERVICES NOT COVERED

Some services are not available through The Health Plan or WVCHIP. 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:

- Acupuncture
- All expenses incurred at a facility when a patient leaves against medical advice
- Ancillary services and/or services resulting from an office visit not covered by The Health Plan
- Aqua therapy
- Autopsy and other services performed after death, including transportation of the body or repatriation of remains
- Behavioral or functional type skills training except for applied behavior analysis (ABA) treatment
- Biofeedback
- Coma stimulation
- Cosmetic or reconstructive surgery when not required as a result of accidental injury or disease, or not performed to correct birth defects; services resulting from or related to these excluded services also are not covered
- Court-ordered services that are not covered benefits and not medically necessary
- Custodial care, intermediate care, domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of Autism Spectrum Disorder
- Daily living skills training
- Dental services other than those listed as covered
- Duplicate testing, interpretation or handling fees
- Education, training and/or cognitive services, unless specifically listed as covered services
- Elective abortions
- Electroconvulsive therapy
- Electronically controlled thermal therapy
- Emergency evacuation from foreign country, even if medically necessary
- Expenses for which you are not responsible, such as patient discounts and contractual discounts

- Expenses incurred as a result of illegal action while incarcerated or while under the control of the court system
- Experimental, investigational or unproven services
- Fertility drugs and services
- Foot care (routine, except for diabetic patients) including:
    - Removal in whole or in part: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin)
    - Cutting, trimming, or partial removal of toenails
    - Treatment of flat feet, fallen arches, or weak feet
    - Strapping or taping of the feet
- Genetic testing for screening purposes – except those tests covered under the maternity benefit are not covered; however, a prior authorization may be submitted for review and exceptions may be approved
- Glucose monitoring devices, except Accu-Check models covered under the prescription drug benefit
- Hearing aids implanted; external hearing aids are covered when prior authorized as medically necessary
- Homeopathic medicine
- Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
- Hypnosis
- Routine childhood immunizations from non-VFC providers
- Incidental surgery performed during medically necessary surgery
- Infertility services including in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen, semen storage, any other method of artificial insemination, and any other related services, including workup for infertility treatment
- Maintenance outpatient therapy services, including, but not limited to:
    - Chiropractic treatment
    - Mental health services
    - Occupational therapy
    - Osteopathic manipulations
    - Physical therapy
    - Speech therapy

    - Vision therapy
    - Massage therapy
- Medical equipment, appliances or supplies of the following types:
    - Augmentative communication devices
    - Bariatric beds and chairs
    - Bathroom scales
    - Educational equipment
    - Environmental control equipment, such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors
    - Equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats, massage devices, elevators, stair lifts, escalators, hydraulic van or car lifts, orthopedic mattresses, walking canes with seats, trapeze bars, child strollers, lift chairs, recliners, contour chairs, and adjustable beds or tilt stands
    - Equipment and supplies which are widely available over the counter, such as wrist stabilizers and knee supports
    - Exercise equipment, such as exercycles, parallel bars, walking, climbing or skiing machines
    - Hygienic equipment, such as bed baths, commodes, and toilet seats
    - Motorized scooters
    - Nutritional supplements (unless it is the only means of nutrition or a prescription amino acid elemental formula for the treatment of short bowel or severe allergic condition that is not lactose or soy related), over-the-counter formula, food liquidizers or food processors
    - Professional medical equipment, such as blood pressure kits or stethoscopes
    - Replacement of lost or stolen items
    - Standing/tilt wheelchairs
    - Supplies, such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
    - Traction devices
    - Vibrators
    - Whirlpool pumps or equipment
    - Wigs or wig styling
- Medical rehabilitation and any other services which are primarily educational or cognitive in nature

- Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning
- Non-listed brand name drugs determined not medically necessary
- Non-enrolled providers
- Optical services: Any services not listed as covered benefits under Vision Services, including low-vision devices, magnifiers, telescopic lenses and closed-circuit television systems
- Oral appliances, including but not limited to those treating sleep apnea
- Orientation therapy
- Orthotripsy
- Personal comfort and convenience items or services (whether on an inpatient or outpatient basis), such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician
- Physical conditioning: Expenses related to physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation
- Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered by WVCHIP, when such services are:
    - Related to employment
    - To obtain or maintain insurance
    - Needed for marriage or adoption proceedings
    - Related to judicial or administrative proceedings or orders
    - Conducted for purposes of medical research
    - To obtain or maintain a license or official document of any type
    - For participation in athletics
- Prostate screening, unless medically indicated
- Radial keratotomy, Lasik procedure and other surgery to correct vision
- Safety devices used specifically for safety or to affect performance, primarily in sports-related activities
- Screenings, except those specifically listed as covered benefits
- Service/therapy animals and the associated services and expenses, including training

- Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family, including spouse, brother, sister, parent, or child
- Services rendered outside the scope of a provider's license
- Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit
- Sensory Stimulation therapy (SS)
- Take-home drugs provided at discharge from a hospital
- Treatment of temporomandibular joint (TMJ) disorders, including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma
- The difference between private and semiprivate room charges
- Therapy and related services for a patient showing no progress
- Therapies rendered outside the United States that are not medically recognized within the United States
- Transportation that is not emergent or medically unnecessary facility to facility transports, including
    - Transportation to any service not covered by The Health Plan
    - Transportation of members who do not meet the medical necessity requirements for level of service billed
    - Transportation provided when the member refuses the appropriate mode of transportation
    - Transportation to a service that requires prior authorization but has not been prior authorized
    - Reimbursement for ground or air ambulance mileage beyond the nearest appropriate facility
    - Transportation to the emergency room for routine medical care
- Weight loss, health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, bariatric surgery, and services of a similar nature
- Work-related injury or illness

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 (PRIOR 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. The amount of the copayment will change depending on the service, family composition, and your family income related in relation to the federal poverty level. Please see the table below for more details.

WVCHIP members participate in some level of cost sharing (copayments and premiums), except for those children registered under the federal exception for Native Americans or Alaskan Natives. **There are no copayments for maternity services or pregnant women over 19 years of age.**

WVCHIP has three enrollment groups in the plan. Each enrollment group has a different level of cost sharing.

Medical Services and Prescription Benefits	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
Generic Prescriptions	No copay	No copay	No copay
Listed Brand Prescriptions	$5	$10	$15
Non-listed Brand Prescriptions	Full retail cost	Full retail cost	Full retail cost
Multisource Prescriptions	No copay	$10	$15
Primary Care Physician Medical Home Physician Visit	No copay	No copay	No copay
Physician Visit (non-medical home)	$5	$15	$20

Preventive Services	No copay	No copay	No copay
Immunizations	No copay	No copay	No copay
Inpatient Hospital Admissions	No copay	$25	$25
Outpatient Surgical Services	No copay	$25	$25
Emergency Department (waived if admitted)	No copay	$35	$35
Vision Services	No copay	No copay	No copay
Dental Benefit	No copay	No copay	$25 copay for some non-preventive services

Note: Copayments are waived for all office visits to member's medical home. To save money on copayments for office visits, please choose and use a medical home provider for your child.

Out-of-Pocket Maximums: The maximum copayment amounts applied during a benefit year are as follows:

# Of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
1 Child Medical Maximum	$150	$150	$200
1 Child Prescription Maximum	$100	$100	$150
2 Children Medical Maximum	$300	$300	$400
2 Children Prescription Maximum	$200	$200	$250
3 or more Children Medical Maximum	$450	$450	$600
3 or more Children	$300	$300	$350

Prescription Maximum			
Dental Services	Does not apply	Does not apply	$150 per family

Note: Diabetic supplies, such as lancets and test strips, will count towards out-of-pocket maximums.

Federal regulations exempt Native Americans and Alaskan Natives from cost sharing. This exemption can be claimed by calling 1.877.982.2447 to declare your tribal designation and confirm that it is listed as a federally recognized tribe.

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 13 calendar days. You can file an appeal by calling Member Services at 1.888.613.8385 or you can do so in writing. Keep this for your records. Our appeals coordinator will send you the notice of receipt of your appeal. 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 (psychiatry, obstetrics and gynecology, dentist, pediatrics, and general surgery) 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: Mountain Health Trust Appeals Coordinator
141 Summers Street
Charleston, WV 25301

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.

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

Bureau for Medical Services
Attention: WV Children's Health Insurance Program
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 call, email, or 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.

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 a legal document with your wishes regarding medical treatment if there comes a time when you are too sick to make your decisions known. An advanced directive allows you to plan and participate in decision-making around your health. It is a way to let your providers 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 PCP 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 PCP and/or 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 WVCHIP managed care
- You move outside of our service area
- 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 WVCHIP at 1.877.982.2447.

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 member's parent or representative to facilitate care or treatment decisions when the member is unable to do so. We will provide for the member 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 present 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 WVCHIP, please call Member Services to let us know. Please call and let us know if another insurance company has been involved with your:

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 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.

MEMBER PORTAL

THP's member portal allows online access for members to:

- View claims

- View explanation of benefits (EOB)
- View authorization
- View eligibility
- Print a temporary member ID card
- Find a provider

Go to myplan.healthplan.org to access our secure member portal.

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 OR 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 CHIP Help Line	1.877.982.2447 chip.wv.gov	PO Box 40237 Charleston, WV 25364
Pharmacy- Benefit is through Express Scripts	1-855-230-7778 express-scripts.com	
Medical Management	Toll-Free: 1.888.613.8385	
Enrollment Broker	1.800.449.8466	
Emergency	911; 24-hour nurse line 1.866.687.7347	
Dental benefit through Skygen Dental	1.888.983.4698	
Vision benefit through Superior Vision	1.800.879.6901	
inComm (Gift Cards)	inComm issues gift cards to members on behalf of THP. Members may access their gift card information at OTCnetwork.com	
Mom's Meals	Provides food kits to new moms after delivery. www.momsmeals.com	

mPulse (Text Campaigns)	mPulse sends texts to members about healthy activities on behalf of THP.	
Elevate	Assists with evaluating members for Supplemental Security Income (SSI); Elevate will contact you directly to assist with applying for coverage.	
Behavioral Health	1.877.221.9295	
Teladoc	1.800.TELADOC (1.800.835.2362)	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- WVCHIP Office of Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301
Fraud, Waste, and Abuse	1.877.296.7283	
Suicide and Crisis Lifeline	988	The 988 Suicide & Crisis Lifeline is a United States-based suicide prevention network of over 200+ crisis centers that provides 24/7 service via a toll-free hotline with the number 9-8-8. It is available to anyone in suicidal crisis or emotional distress.

Nondiscrimination Notice

Discrimination is Against the Law

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

Centralized Case Management Operations
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.

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.877.847.7907 (TTY: 711).

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.847.7907 (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.847.7907（TTY：711）。

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.847.7907 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.877.847.7907 (ATS : 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.847.7907 (TTY: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.847.7907 (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.847.7907 (TTY: 711)번으로 전화해 주십시오.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.847.7907 (телетайп: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Hindi:
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।

Italian:
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).

Portugues:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.877.847.7907 (TTY: 711).

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.847.7907 (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.847.7907 (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.877.847.7907（TTY: 711）まで、お電話にてご連絡ください。

Dutch:
MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1.877.847.7907 (TTY: 711).

Pennsylvania Dutch:
Wann du (Deitsch (Pennsylvania German / Dutch)) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.847.7907 (TTY: 711).

Ukranian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (1.877.847.7907) (TTY: 711).

Romanian:
ATENŢIE: Dacă vorbiţi limba română, vă stau la dispoziţie servicii de asistenţă lingvistică, gratuit. Sunaţi la (1.877.847.7907) (TTY: 711).

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (1.877.847.7907) (TTY: 711).