September 2024

Member Handbook

STAR+PLUS Nursing Facility

Jefferson, Lubbock, Medicaid Rural West, and Nueces Service Areas

Wellpoint

833-731-2160 (TTY 711)
wellpoint.com/tx/medicaid

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1031658TXMENWLP 01/24

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Welcome to Wellpoint. We're glad you're our member.

Here are some things you should do to get started:

Look for your Wellpoint ID card in the mail. Keep the card with you. You'll use it to get all your services, like doctor visits, prescriptions, and more. If you have Medicare or private insurance, you'll also have another health plan card to show when you visit a provider.

If you don't receive your member ID card by your first day as a new member, call us at **833-731-2160 (TTY 711)** Monday through Friday, 7 a.m. to 5 p.m. Central time.

Stay connected with your health. Download the free Sydney Health mobile app today to access your ID card, search for a doctor, and more.

Register for our secure website. Visit **wellpoint.com/tx/medicaid** and register for secure access. When you create an account, you'll get helpful tools at your fingertip:

- Choose or change your primary care provider
- Update your address or phone number
- Send us a secure message
- Request a callback
- And more

Want to change your primary care provider? Choose from a large group of doctors who work with our plan. To change your primary care provider online:

- Go to **wellpoint.com/tx/medicaid**.
- Use our **Find Care** tool to search for plan providers who are close to home, speak your language, and can meet your needs.
- **Log In** to your account.
- Click on **My Account**.
- Click on **Change Your Primary Care Provider**.

You can also find doctors in our plan using the provider directory on the *Search providers* page at **wellpoint.com/tx/medicaid**. To get a no-cost paper copy of the provider directory or for help changing your primary care provider, call Member Services at **833-731-2160 (TTY 711)**. If you have both Medicare and Medicaid, contact your Medicare plan to change your primary care provider.

You should have regular checkups with your doctor at any age. Learn more about checkups and wellness visits in the **When should adults get checkups?** section of this member handbook.

We're here for you when you need us. If you have questions about your benefits or health care, you can call Member Services at **833-731-2160 (TTY 711)** Monday through Friday, 7 a.m. to 5 p.m. You can call the same number for 24-hour Nurse HelpLine to talk to a nurse anytime, day or night.

WELLPOINT
STAR+PLUS PROGRAM FOR NURSING FACILITY RESIDENTS
MEMBER HANDBOOK

2505 N. Highway 360
Suite 300
Grand Prairie, TX 75050

833-731-2160 (TTY 711)
wellpoint.com/tx/medicaid

Welcome to Wellpoint
This member handbook will tell you how we can help you get the care you need.

Table of Contents

INFORMATION ABOUT YOUR NEW HEALTH PLAN

Welcome. As a Wellpoint STAR+PLUS nursing facility member, you and your primary care provider (or main doctor) will work together to help keep you healthy. Wellpoint members in the Medicaid Rural Service Area and the STAR Kids program are served by Wellpoint Insurance Company; all other Wellpoint members in Texas are served by Wellpoint Texas, Inc. To find out about doctors and hospitals in your area, visit **wellpoint.com/tx/medicaid** or contact Member Services at **833-731-2160 (TTY 711)**.

Your Wellpoint member handbook

This handbook will help you understand your Wellpoint health plan. If you have questions or need help understanding or reading your member handbook, call Member Services. You can also ask for this handbook in large print, audio, braille, or another language.

IMPORTANT PHONE NUMBERS

Wellpoint toll-free Member Services line

If you have any questions about your Wellpoint health plan, you can call our Member Services department toll free at **833-731-2160 (TTY 711)**. You can call us Monday through Friday, 7 a.m. to 5 p.m. Central time, except for state-approved holidays. If you call after 5 p.m. or on a weekend or holiday, you can leave a voice mail message. A Member Services representative will call you back the next business day.

These are some of the things Member Services can help you with:

- This member handbook
- Member ID cards
- Service coordination and accessing services
- Your doctors
- Doctor appointments including 3-way calls with you and your doctor's office
- Transportation
- Health care benefits
- What to do in an emergency or crisis
- Well care
- Special kinds of health care
- Healthy living
- Complaints and medical appeals
- Rights and responsibilities

You can also call **866-696-0710 (TTY 711)** to learn more about service coordination.

If you have an emergency, your nursing facility will help you get emergency transportation and services if you need them.

For members who don't speak English, we can help you in many different languages and dialects, including Spanish. You may also get an interpreter for visits with your doctor at no cost to you. Please let us know if you need an interpreter at least 24 hours before your appointment. Call Member Services to learn more.

For members who are deaf or hard of hearing, call 711. If you need someone who knows sign language to help you at your doctor visits, we will set up and pay for a sign language interpreter. Please let us know if you need an interpreter at least 24 hours before your appointment.

If you ask for an interpreter less than 24 hours before your appointment, we will still do our best to have an interpreter available for you.

Wellpoint 24-hour Nurse HelpLine

You can call 24-Hour Nurse HelpLine 24 hours a day, seven days a week at **833-731-2160 (TTY 711)**. The call is free, and you can talk to someone in English or Spanish. For other languages, interpreter services are available. Call toll free at **833-731-2160 (TTY 711)** if you need advice on:

- How soon you need care for an illness.
- What kind of health care you need.
- What to do to take care of yourself before you see the doctor.
- How you can get the care you need.

We want you to get the best care you can. Please call us if you have any problems with your services. We want to help you correct any problems you may have with your care.

Behavioral Health and Substance Use Disorder Services line

The Behavioral Health and Substance Use Disorder Services line is available to members, 24 hours a day, seven days a week at **833-731-2160 (TTY 711)**. The call is free, and you can talk to someone in English or Spanish. For other languages, interpreter services are available. You can call the Behavioral Health and Substance Use Disorder Services line for help in getting services. If you have an emergency, your nursing facility will help you get emergency transportation and services if you need them.

Other important phone numbers

STAR+PLUS Program Help Line	**877-782-6440**
Ombudsman Managed Care Assistance Team	**866-566-8989**
Medicaid Hotline	**800-252-8263**
Texas Client Notification Line	**800-414-3406**
Eye Care through Superior Vision of Texas	**800-428-8789**
Pharmacy Member Services	**833-235-2022**

YOUR WELLPOINT ID CARD

What does my Wellpoint ID card look like? How do I use it?

If you don't have your Wellpoint ID card yet, you'll get it soon. Please carry it with you at all times. Show it to any doctor or hospital you visit. You don't need to show your ID card before you get emergency care. The card tells doctors and hospitals you're a Wellpoint member. It also tells them Wellpoint will pay for your medically-needed benefits listed in the **My Benefits** section.

Your Wellpoint ID card lists many of the important phone numbers you need to know, like our Member Services department and 24-hour Nurse HelpLine. If you don't have Medicare, your ID card will show the name and phone number of your primary care provider.

Below are sample ID cards for: 1) members who have Medicaid only and 2) members who have both Medicaid and Medicare.

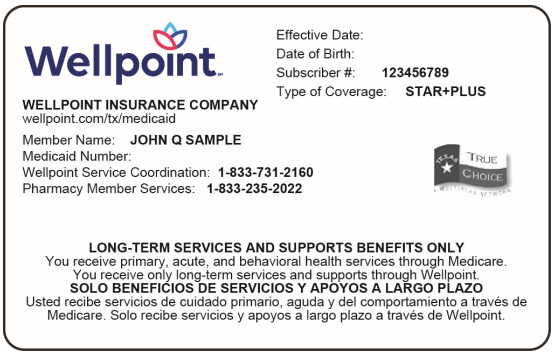
1.

2.

Sample ID cards for Wellpoint members in the Medicaid Rural Service Area for: 1) members who have Medicaid only and 2) members who have both Medicaid and Medicare.

1.

2.



How do I replace my Wellpoint ID card if it is lost or stolen?
If your ID card is lost or stolen, call us right away at **833-731-2160 (TTY 711)**. We will send you a new one. You may also print your ID card from our website at **wellpoint.com/tx/medicaid**. You will need to register and log in to the website to access your ID card information.

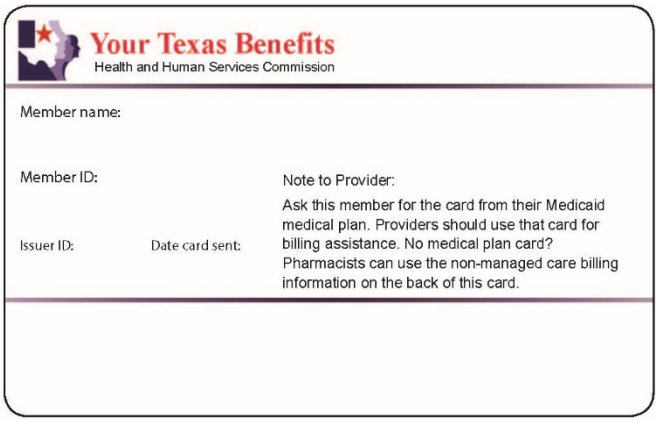
Your Texas Benefits (YTB) Medicaid Card

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

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

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

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



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

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

The back of the YTB Medicaid card has a website you can visit (YourTexasBenefits.com) and a

phone number you can call toll free (**800-252-8263**) if you have questions about the new card.

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

The YourTexasBenefits.com Medicaid Client Portal

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

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

To access the portal, go to YourTexasBenefits.com.

- Click **Log In**.
- Enter your Username and Password. If you don't have an account, click **Create a new account**.
- Click **Manage**.
- Go to the *Quick links* section.
- Click **Medicaid & CHIP Services**.
- Click **View services and available health information**.

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

What if I need a temporary ID verification form?

If you've lost or don't have access to Your Texas Benefits Medicaid card and need a temporary Medicaid ID card, you need to fill out a temporary ID verification form (Form 1027-A). You can get this form by calling your local HHSC benefits office. To find your local HHSC benefits office, call 2-1-1, pick a language, and then pick option 2. Show this form to your provider the same way you would present the Your Texas Benefits Medicaid card. Your provider will accept this form as proof of Medicaid eligibility. You can also go online at YourTexasBenefits.com and print a temporary ID card after logging into your account.

PRIMARY CARE PROVIDERS

What is a primary care provider?

A primary care provider is the main doctor you see for most of your regular health care. Your

primary care provider must be in the Wellpoint plan. Your primary care provider will give you a medical home. A medical home means that he or she will get to know you and your health history and help you get the best possible care. He or she will also send you to other doctors, specialists, or hospitals when you need special care or services. When you enrolled in Wellpoint, you should have picked a primary care provider. If you didn't, we assigned you one. We picked one who should be located close to you.

Will I be assigned a primary care provider if I have Medicare?

Your primary care provider and your acute care coverage is through your Medicare plan. Refer to your Medicare Evidence of Coverage to understand:

- What a primary care provider is.
- Who can be a primary care provider.
- How to change your primary care provider.
- How to get care.

If you have Medicare, some of the information in this handbook about primary care providers and specialists won't apply to you.

How do I see my primary care provider if he/she does not visit my nursing home?

If you don't need ambulance transportation, your nursing facility should provide you with rides to your medical appointments.

How can I change my primary care provider?

Call Member Services if you need to change your primary care provider. You can look in the Wellpoint provider directory you got with your STAR+PLUS enrollment package or go to **wellpoint.com/tx/medicaid** to find a primary care provider.

When will my primary care provider change become effective?

We can change your doctor on the same day you ask for the change. The change will be effective immediately. Call the doctor's office if you want to make an appointment. If you need help making an appointment, call Member Services. We'll help you make the appointment.

How do I get medical care after my primary care provider's office is closed?

If you need to talk to your primary care provider after the office closed, call the provider's office. Someone should call you back within 30 minutes to tell you what to do. You may also call 24-hour Nurse HelpLine at **833-731-2160 (TTY 711)** seven days a week for help.

If you have an emergency, your nursing facility will help you get emergency transportation and services if you need them.

What is the Medicaid Lock-in program?

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

To avoid being placed in the Medicaid Lock-in program:

- Pick one drugstore at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.

- Do not get the same type of medicine from different doctors.

To learn more, call Member Services at **833-731-2160 (TTY 711)**.

You may be approved to get medication from another pharmacy in some cases, such as:
- You move out of the geographical area (more than 15 miles from the lock-in pharmacy).
- The lock-in pharmacy does not have the prescribed medication and it will not be available for more than 2–3 days.
- The lock-in pharmacy is closed for the day and you need the medication urgently.

You should call Member Services at **833-731-2160 (TTY 711)** if you need approval to fill a medication at a pharmacy other than the lock-in pharmacy.

PHYSICIAN INCENTIVE PLANS

Wellpoint rewards doctors for treatments that are cost-effective for people covered by Medicaid. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call **833-731-2160 (TTY 711)** to learn more about this.

CHANGING HEALTH PLANS

What if I want to change health plans?

You can change your health plan by calling the STAR+PLUS Program Helpline at **877-782-6440**. You can change health plans as often as you want, but not more than once a month.

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

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:
- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

If you aren't happy with us, please call Member Services. We'll work with you to try to fix the problem. If you're still not happy, you can change to another health plan.

Who do I call?

You can change your health plan by calling the STAR+PLUS Program Helpline at **877-782-6440**.

How many times can I change health plans?

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

When will my health plan change become effective?

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:
- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Can Wellpoint ask that I get dropped from their health plan for noncompliance?

There are several reasons you could be disenrolled or dropped from Wellpoint. These reasons are listed below. If you have done something that may lead to disenrollment, we'll contact you. We'll ask you to tell us what happened.

You could be disenrolled from Wellpoint if:

- You're no longer eligible for Medicaid.
- You let someone else use your Wellpoint ID card.
- You try to hurt a provider, a staff person, or a Wellpoint associate.
- You steal or destroy provider or Wellpoint property.
- You go to the emergency room over and over again when you don't have an emergency.
- You go to doctors or medical facilities outside the Wellpoint plan over and over again unless you are covered by Medicare.
- You try to hurt other patients or make it hard for other patients to get the care they need.

If you have any questions about your enrollment, call Member Services at **833-731-2160 (TTY 711)**.

MY BENEFITS

What are my health care benefits?

The nursing facility provides your daily care services and add-on services benefits. Wellpoint also provides you with acute care benefits like doctor visits, hospitalizations, prescriptions, and behavioral health services. If you have both Medicare and Medicaid, your acute care benefits will be covered by the traditional Medicare plan you chose.

How do I get these services?

Your nursing facility will provide or help you get nursing facility benefits. Your nursing facility and primary care provider will help you get acute care. Your service coordinator will help make sure you get all the health care services you need.

What if Wellpoint doesn't have a provider for one of my covered benefits?

If you can't get a covered benefit from a provider in our plan, we'll arrange for you to get the services from a provider outside of our plan. We'll reimburse the provider outside of our plan according to state rules. Call Member Services at **833-731-2160 (TTY 711)** to arrange services with a provider outside of our plan. You don't have to call us to get services outside of our plan when you have an emergency.

How much do I have to pay for my health care?

There are no costs for your benefits except the monthly applied income amount you pay the nursing facility. You will not pay deductibles or copays. To learn more about your applied income payment, see the section in this handbook, **What is applied income? What are my responsibilities?**

What are long-term services and supports?

Long-term services and supports are benefits to help you perform everyday tasks to care for yourself such as fixing meals, eating, personal care, light housekeeping, and skilled nursing care. The types and amounts of long-term services and supports benefits you can get will

depend on your needs.

What are my nursing facility long-term services and supports benefits?
A nursing facility provides long-term care to members whose doctor has certified that the member has a medical condition that requires medically necessary daily skilled nursing care. Wellpoint covers daily care nursing facility services, nursing facility add-on services, and Medicare coinsurance for daily care services. Daily care services include:

- Room and board
- Medical supplies and equipment
- Social services programs provided by the nursing facility to help you
- Personal needs items
- Over-the-counter drugs
- Medicare Part A coinsurance

Wellpoint will also pay for any applicable nursing facility staff rate enhancements and applicable professional and general liability insurance.

Add-on services is care provided at the nursing facility that is not part of daily care services and includes, but is not limited to:

- Emergency dental services
- Physician-ordered rehabilitative services (physical, occupational, speech therapies)
- Customized power wheelchairs
- Augmentative communication devices
- Tracheostomy care for members age 21
- Ventilator care

If you have both Medicaid and Medicare, Wellpoint will pay the coinsurance for a Medicare covered stay as part of your nursing facility daily care services. Your Medicare plan or fee-for-service Medicaid will pay the coinsurance for nursing facility add-on services.

How would my benefits change if I moved into the community?
You would be able to get community-based long-term services and supports benefits instead of nursing facility benefits. The kind of benefits you would be able to get is based on your Medicaid eligibility category. Medicaid eligibility is based on your needs, and there are three eligibility categories:

- Other Community Care (OCC) — basic benefits
- Community First Choice (CFC) — mid-level benefits
- Home and Community Based Services (HCBS) STAR+PLUS Waiver (SPW) — high level benefits for members with complex needs

The higher your level of eligibility based on your needs, the more benefits you may be able to get. Below is a list of some of the community-based long-term services and supports benefits you could get based on your needs:

- Primary home care/personal assistance services
- Day activity and health services
- Nursing services (in home)
- Emergency response services (emergency call button)
- Dental services
- Home-delivered meals
- Minor home modifications
- Adaptive aids
- Durable medical equipment
- Medical supplies
- Physical, occupational and speech therapy
- Adult foster care/personal home care
- Assisted living

- Transition assistance services for members leaving a nursing facility — $2,500 maximum
- Respite care
- Dietitian/nutritional service
- Transportation assistance
- Cognitive rehabilitation therapy
- Financial management services
- Support consultation
- Employment assistance
- Supported employment

What are my acute care benefits?

Your primary care provider will give you the care you need or refer you to a doctor. Some Wellpoint benefits are only for members who are a certain age or have a certain kind of health problem. If you have a question or aren't sure if we offer a certain benefit, call Member Services at **833-731-2160 (TTY 711)**.

If you have both Medicare and Medicaid, your acute care benefits will be covered by Medicare or the Medicare plan you have picked.

STAR+PLUS covered services include but are not limited to medically necessary:

- Emergency and nonemergency ambulance services
- Audiology services including hearing aids
- Behavioral health services, including:
  - Inpatient mental health services
  - Outpatient mental health services
  - Psychiatry services
  - Mental health rehabilitative services
  - Counseling services
  - Outpatient substance use disorder treatment services, including:
    - Assessment
    - Detoxification
    - Counseling
    - Medication-assisted therapy
  - Residential substance use disorder treatment (including detoxification services)
  - Psychological and neuropsychological testing
- Birthing services provided by a doctor or certified nurse-midwife in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnosis, and treatment
- Chiropractic services
- Dialysis
- Emergency services
- Family planning
- Federally qualified health center services and other ambulatory services covered by federally qualified health centers
- Hospital services, including inpatient and outpatient
- Laboratory services
- Mastectomy, breast reconstruction and related follow-up procedures, including:
  - Inpatient services; outpatient services provided at an outpatient hospital or ambulatory health- care center, as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:

    - All stages of reconstruction on the breast(s) on which medically-necessary mastectomy procedure(s) have been performed
    - Surgery and reconstruction on the other breast to produce symmetrical appearance
    - Treatment of physical complications from the mastectomy and treatment of lymphedemas
    - Prophylactic mastectomy to prevent the development of breast cancer
  - External breast prosthesis for the breast(s) on which medically-necessary mastectomy procedure(s) have been performed
- Mental health targeted case management
- Outpatient drugs and biologicals, including those dispensed by a pharmacy or administered by a provider
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Preventive services, including an annual adult well-checkup
- Primary care
- Radiology, imaging, and X-rays
- Specialty physician services
- Telehealth
- Telemedicine
- Telemonitoring
- Transplantation of organs and tissues
- Vision (includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses)

How do I get these services? What number do I call to find out about these services?
Your primary care provider will help you get these types of services. You can also call Member Services at **833-731-2160 (TTY 711)**. You can also talk to your service coordinator to learn more.

Are there any limits to any covered services?
There may be some limits to care based on Medicaid covered benefits. You can call Member Services at **833-731-2160 (TTY 711)** or talk to your service coordinator to learn more about benefits and limitations.

What is preapproval?

Some treatment, care, or services may need our approval before your doctor can provide them. This is called preapproval. Your doctor will work directly with us to get the approval. The following require preapproval:

- Most surgeries, including some outpatient surgeries
- All elective and nonurgent inpatient services and admissions
- Chiropractic services
- Most behavioral health and substance abuse services (except routine outpatient and emergency services)
- Certain prescriptions
- Certain durable medical equipment, including prosthetics and orthotics
- Certain gastroenterology procedures
- Home health services

- Hospice services
- Rehabilitation therapy (physical, occupational, respiratory, and speech therapies)
- Sleep studies
- Out-of-area or out-of-network care except in an emergency
- Advanced imaging (things like MRAs, MRIs, CT scans, and CTA scans)
- Certain pain management testing and procedures

This list is subject to change without notice and isn't a complete list of covered plan benefits. Please call Member Services with questions about specific services.

What services are not covered by Wellpoint?

Wellpoint doesn't offer the benefits and services below. These services aren't covered by fee-for-service Medicaid either.

- Anything that isn't medically necessary
- Anything experimental, such as new treatment being tested or hasn't been shown to work
- Cosmetic surgery that isn't medically necessary
- Routine foot care except for members with diabetes or poor circulation
- Fertility treatment services
- Treatment for disabilities connected to military service
- Weight loss program services
- Reversal of voluntary sterilization
- Private room and personal comfort items when hospitalized
- Sex reassignment surgery

To learn more about services not covered by Wellpoint, please call Member Services at **833-731-2160 (TTY 711)**.

What is service coordination?

Service coordination is a specialized services/care process that includes, but is not limited to:

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

How can I talk with a service coordinator?

You will have your own Wellpoint service coordinator. We will send you a letter telling you the name and contact information for your service coordinator. You can also call **866-696-0710 (TTY 711)** to learn more about service coordination.

What will a service coordinator do for me?

When you first become a Wellpoint member, the state sends us information about your health and the services you get from Medicaid. Your service coordinator will read this information to find out more about you. He or she will learn which providers to call to be sure you keep

getting needed care. He or she will ask you how helpful your Medicaid services have been. We'll talk to your Medicaid providers about the care you have been getting. And, if you agree, we'll talk to your doctors about your health care needs.

Your service coordinator will help you get the care you need by:

- Visiting you in your nursing facility to learn more about your health needs and goals.
- Working with you to create a service plan that meets your needs.
- Helping you see your providers when you need to and get needed services including preventive health services.
- Making sure all of your long-term support covered services, your acute care services, and other social services you get outside of Wellpoint are coordinated.
- Helping you get authorizations for medically needed services.
- Encouraging you to take part in your care.

How do I know who my service coordinator is?
When we assign you a service coordinator, we'll send you a letter with his or her name and phone number. We'll send this information each year and anytime your service coordinator changes. You can also find the name and phone number of your personal service coordinator on our website at **wellpoint.com/tx/medicaid**. You will need to select the **Log In** button and register in order to see your personal information. You can also call Member Services to get your service coordinator's name and contact information.

What are my prescription drug benefits?

Medicaid pays for most medicine your doctor prescribes. Your doctor will write a prescription and send it to your nursing facility. Your nursing facility will order and give you the medicine as prescribed by your doctor. If you have Medicare prescription drug benefits, your Medicare plan will provide your prescription drugs. If Medicare doesn't cover your medicine, Medicaid pays for most medicine your doctor says you need.

What extra benefits do I get as a member of Wellpoint?

Wellpoint gives you extra health care benefits just for being our STAR+PLUS nursing facility member. These extra benefits are also called value-added benefits. We give you these benefits to help keep you healthy and to thank you for choosing Wellpoint as your health care plan. Call Member Services to learn more about these extra benefits or visit our website at **wellpoint.com/tx/medicaid**.

Value-added benefit	**How to get it**
Healthy Rewards gift card for completing these healthy activities (for members who do not have Medicare): • $20 every 6 months for a member with diabetes who has a blood sugar test (HbA1c) • $20 every 6 months for a member with diabetes who	To receive a reward: • Join the Healthy Rewards program within 30 days after you complete an eligible healthy activity while you are a Wellpoint member. • Your provider will report healthy activities by submitting a claim within 95 days of your visit. • If you have not received a reward, you must request it within 6 months after the date of your activity. To join the Healthy Rewards program or find

Value-added benefit	How to get it
has a blood sugar test (HbA1c) with a result less than 8	information about the program and rewards: • Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or • Call the Healthy Rewards Customer Service Line at **888-990-8681 (TTY 711)** Monday through Friday from 8 a.m. to 7 p.m. Central time.
$100 gift card to purchase over-the-counter products either online or in store (one card per lifetime)	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.
Health and fitness benefits – WeightWatchers® 13-week membership, $150 Healthy Grocery gift card, on-demand fitness and exercise resources plus choose either a personal exercise kit or 3-month gym membership (one of each benefit type per year) For members with a diagnosis of obesity, hypertension, or diabetes	To request WeightWatchers program, call **833-731-2160 (TTY 711)** or your service coordinator. To access on-demand fitness and exercise resources, visit choosehealthy.com/WPTX. For personal exercise kit, Healthy Grocery gift card, or gym membership, log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.
Online emotional health — secure web and mobile tools you can use 24/7 to help improve your emotional health	Access the Learn to Live Emotional Well-being Resources by visiting **learntolive.com/welcome/txwellpoint**. Type TXWellpoint into the code field and select "Start Now". Then, enter your member ID.
Meditation app subscription for members diagnosed with a behavioral health condition (one per year)	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.
$75 gift card to purchase sensory products (one per year) For members with a developmental disability (DD), intellectual or developmental disability (IDD), or diagnosed with ADHD, depression, autism spectrum disorder, anxiety, PTSD, dementia, or Alzheimer's disease	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.

Value-added benefit	How to get it
Lifestyle aids – choose up to two items (per year) For members with a diagnosis of hypertension, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), or obesity	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.
Enhanced vision benefits — • $150 allowance added to Medicaid benefits for eyeglass frames and lenses or contact lenses every two years • Plastic/polycarbonate lenses — every 36 months For members who don't have Medicare	Call **833-731-2160 (TTY 711)** or go to **wellpoint.com/tx/medicaid** to find vision providers on the *Search Providers* page.
Fresh food options (choose one each year): • Three farm-fresh produce boxes • Annual Sam's Club membership • Annual Costco membership • $150 Healthy Grocery gift card For members with a behavioral health diagnosis, developmental disability (DD), intellectual or developmental disability (IDD), and pregnant members through 60 days after delivery	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.
Up to $200 of asthma relief products selected by member (per household each year) For members diagnosed with	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.

Value-added benefit	How to get it
asthma or chronic obstructive pulmonary disease (COPD)	
Emergency preparedness kit and up to $75 in disaster relief funds (one each per household per lifetime)	To receive the emergency preparedness kit, log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**. For disaster relief funds, call **833-731-2160 (TTY 711)** or your service coordinator.
Routine dental services: one exam, two cleanings, and one set of X-rays each year For members who don't have Medicare	Call DentaQuest at 855-418-1621. This benefit is not available for HCBS STAR+PLUS Waiver program members.
Dental hygiene kit — one kit per year Member must have completed a dental visit within the past six months	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.
E-reader (one per lifetime) and digital library card (one per year). E-reader with screen reader function available for members who are visually impaired or developmentally challenged For members with a behavioral health diagnosis, developmental disability (DD), intellectual or developmental disability (IDD), dementia, or Alzheimer's disease	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.
Memory aids kit with memory care remembrance book, iron-on and decorative labels, permanent markers, and a mp3 player with a $10 music gift card (one kit per lifetime) For members diagnosed with dementia or Alzheimer's disease	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.

Value-added benefit	How to get it
Ex Program: A tobacco cessation program with online activities, education materials, and products. This program can help members as they try to quit using tobacco or chew, smoking cigarettes, or vaping.	Access the program at Go.TheEXProgram.com/WellpointTX.
Substance use disorder recovery support program through a mobile platform to support ongoing recovery. Provides daily motivation, peer support, recovery content, and other critical support For members referred by a service coordinator	Call **833-731-2160 (TTY 711)** or your service coordinator.
Identification documents – receive a $35 gift card to help with the cost of getting a driver's license, birth certificate, social security or state identification card For members with a behavioral health diagnosis, developmental disability (DD), or intellectual or developmental disability (IDD)	Log in to your account at **wellpoint.com/tx/medicaid** to access the Benefit Reward Hub from the *Benefits* page or call **833-731-2160 (TTY 711)**.

How do I get these extra benefits?
Call Member Services or your service coordinator to find out how to get these services. Once we learn about your needs, we'll help you get the right extra benefits.

What health education classes does Wellpoint offer or help you find?

Most health education for our STAR+PLUS nursing facility members is conducted personally by

service coordinators and our case management program. You can also access health and wellness information on the member website at **wellpoint.com/tx/medicaid** or call Member Services or 24-hour Nurse HelpLine at **833-731-2160 (TTY 711)** for help.

What is Complex Case Management? How do I get these services?

In our Complex Case Management program, case managers help manage your health care if you have special needs. A case manager may be able to help you if you have experienced a critical event or have been diagnosed with a serious health condition such as diabetes. We also have special case managers for members who are pregnant.

You don't need a referral from your doctor to get these services. You can contact the Complex Case Management program by calling Member Services at **833-731-2160 (TTY 711)** and asking to speak to a complex case manager. Our case managers are licensed nurses and social workers, available Monday through Friday, 8 a.m. to 5 p.m. Central time. Case managers also have confidential voicemail available 24 hours a day.

What is a Member with Special Health Care Needs?

A Member with Special Health Care Needs (MSHCN) is a member who both:

- Has a serious ongoing illness, a chronic or complex condition, or a disability that will likely last for a long period of time.
- Requires regular, ongoing treatment and evaluation for the condition by appropriate health care personnel.

All STAR+PLUS members qualify as MSHCN. A service coordinator will work with you to make sure your care plan meets your specific needs.

As an MSHCN, you may have a specialist serve as your primary care provider and be treated by a team of doctors and specialists when needed.

Call us at **833-731-2160 (TTY 711)** if you need help getting these services.

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

We can help you with services covered by fee-for-service Medicaid instead of Wellpoint. You don't need a referral from your primary care provider to get these services. Fee-for-service Medicaid benefits include:

- Department of Health and Human Services (HHSC) hospice services
- Preadmission Screening and Resident Review (PASRR) — This is an assessment you will have to see if living in a nursing facility is right for you

MY HEALTH CARE AND OTHER SERVICES

What does medically necessary mean?

Your primary care provider will help you get the services you need that are medically necessary as defined below:

Medically necessary means:

1. For members ages 21 and over, nonbehavioral health-related health care services that are:

a) Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life.
b) Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions.
c) Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies.
d) Consistent with the diagnoses of the conditions.
e) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
f) Not experimental or investigative, and
g) Not primarily for the convenience of the member or provider.

2. For members ages 21 and over, behavioral health services that:
   a. Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder.
   b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
   c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
   d. Are the most appropriate level or supply of service that can safely be provided.
   e. Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
   f. Are not experimental or investigative, and
   g. Are not primarily for the convenience of the member or provider.

Wellpoint will determine medical necessity for nursing facility add-on services. Wellpoint or your Medicare plan will determine medical necessity for acute care, behavioral health services and prescription drugs. Nursing facility add-on services include, but are not limited to emergency dental services, physician-ordered rehabilitative services, customized power wheelchairs, and audio communication devices.

If you have questions regarding an authorization, a request for services, or a utilization management question, you can call Member Services at **833-731-2160 (TTY 711)**.

How is new technology evaluated?

The Wellpoint medical director and our providers look at advances in medical technology and new ways to use existing medical technology. We look at advances in:

- Medical procedures
- Behavioral health procedures
- Medicines
- Devices

We review scientific information and government approvals to find out if the treatment works and is safe. We will consider covering new technology only if the technology provides equal or better outcomes than the existing covered treatment or therapy.

What is routine medical care?

Routine care includes regular checkups, preventive care, and appointments for minor injuries

and illnesses. Your primary care provider sees you when you're not feeling well, but that is only part of his or her job. He or she also takes care of you before you get sick. This is called well care. See the section in this handbook, **When should adults get checkups?**

How soon can I expect to be seen?
You should be able to see your primary care provider within two weeks for routine care.

Are nonemergency dental services covered?
Wellpoint is **not responsible** for paying for routine dental services provided to Medicaid members. Wellpoint **is responsible**, however, for paying for treatment and devices for craniofacial anomalies.

What is emergency medical care?

Another type of care is emergency care. If you have an emergency, your nursing facility will help you get the services you need.

Emergency medical care
Emergency medical care is provided for emergency medical conditions and emergency behavioral health conditions.

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

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

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

- Requires immediate intervention or medical attention without which the member would present an immediate danger to themselves or others, or
- Which renders the member incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency services and emergency care mean:
Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition, including post-stabilization care services.

How soon can I expect to be seen?
You should be able to see your doctor immediately for emergency care.

Do I need a prior authorization?
You don't need a prior authorization for emergency care.

Are emergency dental services covered?
Wellpoint covers limited emergency dental services for the following:

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

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

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

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

How soon can I see my doctor?
We know how important it is for you to see your doctor. We work with the providers in our plan to make sure you can see them when you need to. Our providers must follow the access standards listed below.

Standard name	Wellpoint
Emergency services	As soon as you arrive at the provider for care
Urgent care	Within 24 hours of request
After-hours care	Primary care providers are available 24/7 directly or through an answering service. Refer to the **How do I get medical care after my primary care provider's office is closed?** section of this handbook.
Routine primary care	Within 14 days of request
Routine specialty care	Within 3 weeks of request
Preventive health	Within 90 days of request
Primary care follow-up visit after emergency room visit or hospital stay	Within 14 days of visit or discharge
Prenatal care	
Initial visit	Within 14 days of request
Initial visit for high risk or 3rd trimester	Within 5 days of request or immediately, if an emergency exists

Standard name	Wellpoint
After initial visit	Based on the provider's treatment plan
Behavioral Health	
Non-life-threatening emergency	Within 6 hours of request
Urgent care	Within 24 hours of request
Initial visit for routine care	The earlier of 10 business days or 14 calendar days from request
Follow-up visit for routine care	Within 3 weeks of request
Follow-up visit after hospital stay	Within 7 days of discharge

What is post-stabilization?

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

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

If you need medical care when traveling, call us toll free at **833-731-2160 (TTY 711)** and we will help you find a doctor.

If you need emergency services while travelling, go to a nearby hospital, then call us toll free at **833-731-2160 (TTY 711)**.

What if I am out of the state?

If you are outside of Texas and need medical care, please call us toll free at **833-731-2160 (TTY 711)**. If you need emergency care, go to the nearest hospital emergency room or call 911.

What if I am out of the country?

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

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

Your primary care provider can take care of most of your health care needs, but you may also need care from other kinds of doctors. These doctors are called specialists because they have training in a special area of medicine. Examples of specialists are:

- Allergists (allergy doctors)
- Dermatologists (skin doctors)
- Cardiologists (heart doctors)
- Podiatrists (foot doctors)
- Oncologists (cancer doctors)

We cover services from many different kinds of doctors who provide specialist care. If your primary care provider can't give you needed care, he or she can refer you to a specialist in the Wellpoint plan.

You can choose a specialist to serve as your primary care provider if the specialist agrees to provide your primary care services. Please call Member Services so we can arrange this for you.

What is a referral? What services do not need a referral?

A referral is when your primary care provider sends you to another doctor or service for care. If your primary care provider can't give you the care you need, he or she must refer you to a specialist in the Wellpoint plan. You can see a specialist without a referral from your primary

care provider. It's always best to talk to your primary care provider first about any additional care you need. Your primary care provider can give you information about other doctors in the Wellpoint plan and help coordinate all the care you receive.

If you have Medicare, follow your Medicare plan's referral rules for Medicare covered services.

How soon can I expect to be seen by a specialist?
You'll be able to see the specialist within three weeks from when you call the specialist's office.

How can I ask for a second opinion?

You have the right to ask for a second opinion about the health care services you need. This doesn't cost you anything. You can get a second opinion from another doctor in our plan. Or, if a doctor in our plan isn't available for a second opinion, your primary care provider can submit a request to us to approve for you to see a doctor who isn't in our plan. If you have Medicare, contact your Medicare plan and ask how to get a second opinion.

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

Sometimes, the stress of life can lead to depression, anxiety, marriage and family problems, parenting problems, or alcohol and drug abuse. If you or a family member is having these kinds of problems, we have doctors who can help. Call Member Services at **833-731-2160 (TTY 711)** for help finding a doctor who will help you. All services and treatment are strictly confidential. If you have Medicare, contact your Medicare plan for help in finding a doctor.

Do I need a referral for this?
You don't need a referral from your doctor to get help for behavioral health, alcohol, or drug problems.

What are Mental Health Rehabilitative Services and Mental Health Targeted Case Management?
These services are available to you if you need them based on an appropriate standardized assessment by a mental health professional.

Mental Health Rehabilitative Services are services to help you become able to live in your home or the community such as:

- Medication training and support
- Psychosocial rehabilitative services
- Skills training and development
- Crisis intervention
- Day program for acute needs

Mental Health Targeted Case Management helps you access medical, social, educational, and other services and supports that can help improve your health and your ability to function.

How do I get Mental Health Rehabilitation Services or Mental Health Targeted Care Management?
Call Member Services at **833-731-2160 (TTY 711)** to learn more about available resources. If you have Medicare, contact your Medicare plan to find out if you can get these services.

How do I get my medications?

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

What if I also have Medicare?

You should use your Medicare Part D coverage first to get your medicine. If Medicare does not cover your medicine, Medicaid pays for most medicine your doctor says you need.

How do I find a network drugstore?

Your nursing facility will find you a drugstore in the Wellpoint plan. You can also call Member Services for help at **833-731-2160 (TTY 711)**.

What if I go to a drugstore not in the network?

The pharmacist will explain that they do not accept Wellpoint. You will need to have your prescription filled at a pharmacy that accepts Wellpoint.

What do I bring with me to the drugstore?

If you go to the drugstore, you should bring:

- Your prescription(s) or medicine bottles.
- Your Wellpoint ID card or your Medicare plan ID card.
- Your Texas Benefits Medicaid card.

What if I need my medications delivered to me?

Many pharmacies provide delivery services. Your nursing facility will work with a pharmacy to get your medications delivered for you.

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

If you have problems getting your Wellpoint covered medications, please call us at **833-235-2022 (TTY 711)**. We can work with you, the nursing facility, and the pharmacy to make sure you get the medicine you need.

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

Some medications require our preapproval. If your doctor can't be reached to approve a prescription, you may be able to get a 3-day emergency supply of your medication. Call Wellpoint at **833-235-2022 (TTY 711)** for help with your medications and refills. Ask your pharmacist to dispense a 3-day supply.

What if I lose my medication(s)?

If your medicine is lost or stolen, have your nursing facility call us at **833-731-2162**.

How do I find out what drugs are covered?

Your doctor can choose drugs from the Vendor Drug Program (VDP) list of drugs. It includes all medicines covered by Medicaid.

To view the list, go to the Texas Vendor Drug Formulary page at txvendordrug.com/formulary.

Your medication may be available as a generic drug. A generic drug has the same Food and Drug Administration (FDA) indication as the corresponding brand-name drug and is approved by the FDA. This means both drugs are approved for treatment of the same conditions. Your pharmacy will usually give you the generic drug if it's on the Vendor Drug Program (VDP)

formulary. If your prescription says you need the brand-name drug, we will cover the brand name drug instead of giving you a generic.

Will I have a copay?
Medicaid members don't have copays.

How do I get my medicine if I am traveling?
If you need a refill while traveling, call your doctor for a new prescription to take with you. If you get medication from a pharmacy that's not in the Wellpoint plan, then you'll have to pay for that medication. If you pay for medication, you may submit a request for reimbursement. Call us at **833-235-2022 (TTY 711)** to get information on how to get a reimbursement form and submit a claim.

What if I paid out of pocket for a medicine and want to be reimbursed?
If you had to pay for a medicine, you may submit a request for reimbursement. Call us at **833-235-2022 (TTY 711)** to get a reimbursement form and submit a claim. The reimbursement form is also available online at **wellpoint.com/tx/medicaid** under *Medicaid Benefits* for Pharmacy.

How do I get family planning services?

Wellpoint will arrange for counseling and education about planning a pregnancy or preventing pregnancy. You can call your primary care provider for help or go to any Medicaid family planning provider.

Do I need a referral for this?
You do not need a referral from your doctor.

Where do I find a family planning services provider?
You can find the locations of family planning providers near you online at healthytexaswomen.org/family-planning-program, or you can call Wellpoint at **833-731-2160 (TTY 711)** for help in finding a family planning provider.

When should adults get checkups?
Staying healthy means seeing your doctor for regular checkups. Use the chart below to make sure you are up-to-date with your yearly well-care exams.

Wellness visits schedule for adult members		
EXAM TYPE	**WHO NEEDS IT?**	**HOW OFTEN?**
Well-care visit	Ages 21 and older	Every year
Pelvic exam	Women ages 18 and over	Every year
Pap smear	Women ages 21–29	Pap smear only — every 3 years
	Women ages 30–65	Pap smear only — every 3 years Pap smear/human papillomavirus (HPV) co-testing every 5 years
Clinical breast exam	Women ages 20–39	Every 3 years

	Women ages 40 and over	Every year
Breast self-exam	Women ages 20 and over	Once a month
Mammograms (breast X-ray)	Women ages 40 and over	Every year or as recommended by your doctor
Fecal blood occult test	Ages 50 and over	Every year
Sigmoidoscopy and DRE/PSA or colonoscopy and DRE/PSA	Ages 50 and over	Every 5 years

Wellpoint transportation services for nursing facility residents

What transportation services are offered?
The nursing facility is responsible for providing routine nonemergency transportation services except for dialysis services. If medically necessary, Wellpoint provides nonemergency ambulance transportation for members that require this service.

How do I get this service?
To get nonemergency ambulance transportation, your doctor must contact Wellpoint to ask for authorization for these services. Your doctor can submit a request by fax to **844-206-3445** or by phone at **866-696-0710**.

If you have an emergency and need transportation, your nursing facility will help you get the services you need.

Who do I call for a ride to a medical appointment?
If you don't need ambulance transportation, your nursing facility should provide you with rides to your medical appointments except for dialysis services. You or your nursing facility should call Access2Care at **844-867-2837 (TTY 711)** at least two business days in advance for rides to dialysis services.

How do I get eye care services?

You get eye care benefits. You don't need a referral from your doctor for these benefits. Please call Superior Vision of Texas at **800-428-8789** for help finding a network eye doctor (optometrist) in your area.

Members get coverage for a vision exam, medically necessary frames, and certain plastic lenses every 24 months.

If you have both Medicare and Medicaid, your vision benefits will be provided by Medicare or the Medicare plan you have picked.

Can someone interpret for me when I talk to my doctor? Who do I call for an interpreter?

Call Member Services at **833-731-2160 (TTY 711)** to let us know if you need an interpreter at least 24 hours before your appointment. This service is available for visits with your doctor at no cost to you.

How far in advance do I need to call?
Please let us know at least 24 hours before your appointment if you need an interpreter.

How can I get a face-to-face interpreter in the provider's office?
Call Member Services if you need an interpreter when you talk to your provider at his or her office.

What if I need OB-GYN care?

ATTENTION FEMALE MEMBERS:
Wellpoint allows you to pick any OB-GYN, whether that doctor is in the same network as your primary care provider or not. The OB-GYN you pick must be in the Wellpoint plan.

You have the right to pick an OB-GYN without a referral from your primary care provider. An OB-GYN can give you:

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

How do I choose an OB-GYN?
You do not have to pick an OB-GYN. However, if you are pregnant, you should pick one to take care of you. You can pick any OB-GYN listed in the Wellpoint provider directory. If you need help choosing one, call Member Services at **833-731-2160 (TTY 711)**. If you have Medicare, you will pick an OB-GYN that is in your Medicare plan's network.

If I do not choose an OB-GYN, do I have direct access?
If you don't want to go to an OB-GYN, your primary care provider may be able to treat you for female health care needs. Ask your primary care provider if he or she can give you OB-GYN care. If not, you will need to see an OB-GYN. You will find a list of OB-GYNs in the Wellpoint provider directory. You can also search for one on our website at **wellpoint.com/tx/medicaid** under the **Find Care** tool.

Will I need a referral?
You will not need a referral. You can see only one OB-GYN in a month, but you can visit the same one more than once during that month, if needed.

How soon can I be seen after contacting my OB-GYN for an appointment?
Your OB-GYN should see you within two weeks. We can help you find an OB-GYN in our plan, if needed.

Can I stay with my OB-GYN if he or she is not with Wellpoint?
In some cases, you may be able to keep seeing an OB-GYN who isn't in our plan. Please call Member Services to learn more.

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

If you think you're pregnant, call your primary care provider or OB-GYN right away. You don't need a referral from your primary care provider.

How do I report suspected abuse, neglect, or exploitation?

You have the right to respect and dignity, including freedom from abuse, neglect, and exploitation.

What are abuse, neglect, and exploitation?

- **Abuse** is mental, emotional, physical, or sexual injury, or failure to prevent such injury.
- **Neglect** results in starvation, dehydration, overmedicating or under-medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care, and personal hygiene.
- **Exploitation** is misusing the resources of another person for personal or monetary gain. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Reporting abuse, neglect, and exploitation

The law requires that you report suspected abuse, neglect, or exploitation, including unapproved use of restraints or isolation that is committed by a provider.

Call 911 for life-threatening or emergency situations.

Report by phone (nonemergency) — 24 hours a day, seven days a week, toll free

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

- Nursing facility
- Assisted living facility
- Adult day care center
- Licensed adult foster care provider, or
- Home and Community Support Services Agency (HCSSA) or Home Health Agency

Suspected abuse, neglect, or exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

Report all other suspected abuse, neglect, or exploitation to DFPS by calling **800-252-5400**.

Report electronically (nonemergency)

Go to txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

Helpful information for filing a report

When reporting abuse, neglect, or exploitation, it is helpful to have the names, ages, addresses, and phone numbers of everyone involved.

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

You can have someone make decisions on your behalf if you're too sick to make decisions for yourself. Please call Member Services at **833-731-2160 (TTY 711)** if you would like more information about the forms you need.

What are advance directives?

Emancipated minors and members ages 18 and older have rights under advance directive laws. An advance directive talks about making a living will. A living will says you may not want medical care if you have a serious illness or injury and may not get better. To make sure you get the kind of care you want if you're too sick to decide for yourself, you can sign a living will. This is a type of advance directive. It is a paper that tells your doctor and your family what kinds of care you don't want if you're seriously ill or injured.

How do I get an advance directive?

You can get an advance directive form from your doctor or by calling Member Services. Wellpoint associates cannot offer legal advice or serve as a witness. According to Texas law, you must either have two witnesses or have your form notarized. After you fill out the form, take it or mail it to your doctor. Your doctor will then know what kind of care you want to get.

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

You can sign a paper called a durable power of attorney, too. This paper will let you name a person to make decisions for you when you cannot make them yourself. Ask your doctor about these forms.

What happens if I lose my Medicaid coverage?

If you lose Medicaid coverage but get it back again within six months, you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same primary care provider you had before.

What if I get a bill from my nursing facility? Who do I call?

If you do get a bill, write a letter to a member advocate in your service area and include the bill. For the Wellpoint address, look at the beginning of this book. Keep a copy of the bill for your records. Your letter needs to include the information listed in the next section: **What information will they need?**

You can also call Member Services at **833-731-2160 (TTY 711)** for help.

What information will they need?

In the letter to a member advocate about a bill from your nursing facility, include:

- Your name.
- Your phone number.
- Your Wellpoint ID number.
- The bill you received.

If you can't send the bill, include in the letter:

- The name of the nursing facility.
- The dates of service.

- The nursing facility's phone number.
- The amount charged.
- The account number, if known.

What is applied income? What are my responsibilities?

Applied Income is the member's personal income that the member must provide to the nursing facility as part of their cost-sharing obligation as a Medicaid beneficiary.

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

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and the Wellpoint Member Services department at **833-731-2160 (TTY 711)**. Before you get Medicaid services in your new area, you must call Wellpoint, unless you need emergency services. You will continue to get care through Wellpoint until HHSC changes your address.

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

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

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

Medicaid and Private Insurance

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

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

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

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

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

What are my rights and responsibilities?

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.

   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid and get a timely response to complaints, appeals, external medical reviews, and state fair hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for an external medical review and state fair hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a state fair hearing without an external medical review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, seven days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office; this includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan; interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot

prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have a right to make recommendations to your health plan's member rights and responsibilities.

MEMBER RESPONSIBILITIES:

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

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

HOW WE MAKE DECISIONS ABOUT YOUR CARE

Sometimes, we need to make decisions about how we cover care and services. This is called Utilization Management (UM). All UM decisions are based on your medical needs and current benefits.

We don't encourage doctors to underuse services. And we don't create barriers to getting health care. Providers and others involved in UM decisions don't get rewarded for limiting or denying care. When we hire, promote, or fire providers or staff, it isn't based on their likelihood

to deny benefits. Doctors in our plan use clinical practice guidelines, medical policies, and the benefits of your plan to determine necessary treatments and services.

When you or your doctor asks for certain care that needs a preapproval, our Utilization Review team decides if the service is medically necessary and one of your benefits. If you disagree with our decision, you or your doctor can ask for an appeal.

To speak with someone on our UM team, call Member Services at **833-731-2160 (TTY 711)** Monday through Friday, 7 a.m. to 5 p.m. Central time.

QUALITY MANAGEMENT

What does quality management do for you?

The Wellpoint Quality Management program is here to make sure you're being cared for. We look at services you've received to see if you're getting the best preventive health care. If you have a chronic disease, we check if you're getting help managing your condition.

The Quality Management department develops programs to help you learn more about your health care. We have member outreach teams to help you schedule appointments and arrange transportation if you need it. These services are free because we want to help you get and stay healthy.

We work with our plan providers to teach them and help them care for you. You may get mailings from us about taking preventive health steps or managing an illness. We want you to help us improve by telling us what we can do better. To learn more about our Quality Management program, please call Member Services at **833-731-2160 (TTY 711)**.

What are clinical practice guidelines?

Wellpoint uses national clinical practice guidelines for your care. Clinical practice guidelines are nationally recognized, scientific, proven standards of care. These guidelines are recommendations for physicians and other health care providers to diagnose and manage your specific condition. If you would like a copy of these guidelines, please call Member Services at **833-731-2160 (TTY 711)**.

COMPLAINTS PROCESS

What should I do if I have a complaint about my health care, my provider, my service coordinator, or my health plan? Who do I call?

We want to help. If you have a complaint, please call us toll free at **833-731-2160 (TTY 711)** to tell us about your problem. A Wellpoint Member Services representative or a member advocate can help you file a complaint. Just call **833-731-2160 (TTY 711)**. Most of the time, we can help you right away or at the most within a few days.

Can someone from Wellpoint help me file a complaint?

Yes, a member advocate or Member Services representative can help you file a complaint with us or the appropriate state program. If you have Medicare, a member advocate can also help you file a complaint with your Medicare plan or directly with Medicare. Please call Member Services at **833-731-2160 (TTY 711)**.

How long will it take to process my complaint?
Wellpoint will answer your complaint within 30 days from the date we get it.

What are the requirements and time frames for filing a complaint?
You can tell us about your complaint by calling us or writing us. We will send you a letter within five business days of getting your complaint. This means we have your complaint and have started to look at it. We will include a complaint form with our letter if your complaint was made by phone. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

We will send you a letter within 30 days of when we get your complaint. This letter will tell you what we have done to address your complaint.

If your complaint is about an ongoing emergency or hospital stay, it will be resolved as quickly as needed for the urgency of your case and no later than one business day from when we receive your complaint.

How do I file a complaint with the Health and Human Services Commission once I have gone through the Wellpoint complaint process?
Once you have gone through the Wellpoint complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll free 866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
PO Box 13247
Austin, TX 78711-3247

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

If you file a complaint, Wellpoint will not hold it against you. We will still be here to help you get quality health care.

Do I have the right to meet with a complaint appeal panel?
Yes. If you're not happy with the answer to your complaint, you can ask us to look at it again. You must ask for a complaint appeal panel in writing. Write to us at:

Member Advocates
Wellpoint
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

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

When we get your request, we'll send you a letter within five business days. This means that we have your request and started to work on it. You can also call us at **833-731-2160 (TTY 711)** to ask for a complaint appeal panel request form. You must complete the form and return it to us.

We'll have a meeting with Wellpoint staff, providers in the health plan, and other Wellpoint members to look at your complaint. We'll try to find a day and time for the meeting so you can be there. You can bring someone to the meeting if you want to. You don't have to come to the meeting. We'll send you a letter at least five business days before the complaint appeal panel meeting. The letter will have the date, time, and place of the meeting. We'll send you all of the information the panel will look at during the meeting.

We'll send you a letter within 30 days of getting your written request. The letter will tell you the complaint appeal panel's final decision. This letter will also give you the information the panel used to make its decision.

APPEALS PROCESS

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

There may be times when we say we will not pay for all or part of the care that has been recommended. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Wellpoint to look again at the care your doctor asked for and we said we will not pay for. A designated representative can be a family member, your provider, an attorney, a friend, or any person you choose.

If you ask someone (a designated representative) to file an appeal for you, you must also send a letter to Wellpoint to let us know you have chosen a person to represent you. Wellpoint must have this written letter to be able to consider this person as your representative. We do this for your privacy and security.

You can appeal our decision orally or in writing:

- You can call Member Services at **833-731-2160 (TTY 711)**.
- You can send us a letter or the request form included with our decision letter to:
  Wellpoint Appeals
  PO Box 62429
  Virginia Beach, VA 23466-2429

How will I find out if services are denied?

If we deny services, we will send you a letter at the time the denial is made.

What are the time frames for the appeals process?

You or a designated representative can file an appeal. You must do this within 60 days of the date of the first letter from Wellpoint saying we won't pay for or cover all or part of the recommended care.

When we receive your letter or call, we will send you a letter within five business days. This letter will let you know we received your appeal. We will also let you know if we need any other information to process your appeal. Wellpoint will contact your doctor if we need medical information about the service.

A doctor who has not seen the case before will look at your appeal. They will decide how we should handle the appeal.

We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we receive your appeal unless we need more information from you or the person you asked to file the appeal for you. If we need more information, we may extend the appeals process for 14 days if the delay is in your best interest. If we extend the appeals process, we will let you know in writing the reason for the delay. You may also ask us to extend the process if you know more information we should consider.

How can I continue receiving services that were already approved?

You have 60 days to file an appeal from the date of our decision letter. To continue receiving services that have already been approved by Wellpoint but which may be part of the reason for your appeal, you must file a request for continuation of benefits on or before the later of:

- Ten days after we mail the notice to you to let you know we will not pay for or cover all or part of the care.
- The date the notice says the service will end.

If the decision on your appeal upholds our first decision, you may be asked to pay for the services you received during the appeals process.

If the decision on your appeal reverses our first decision, Wellpoint will pay for the services you received while your appeal was pending.

Can someone from Wellpoint help me file an appeal?

Yes, a member advocate or Member Services representative can help you file an appeal with Wellpoint or with the appropriate state program. Please call Member Services toll free at **833-731-2160 (TTY 711)**.

Can I request an external medical review and state fair hearing?

Yes, you can ask for an external medical review and state fair hearing after the Wellpoint internal appeal process is complete. Your request must be made within 120 days of the date of our appeal decision letter. An external medical review cannot be requested without a state fair hearing but you can withdraw your request for the hearing after you get the external medical review decision.

Can I request a state fair hearing only?

Yes. You can ask for a state fair hearing without an external medical review after the Wellpoint internal appeal process is complete. Your request must be made within 120 days of the date of our appeal decision letter.

See the next sections, **Emergency Appeals, State Fair Hearings**, and **External Medical Review Information** to learn more.

EMERGENCY APPEALS

What is an emergency appeal?

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

How do I ask for an emergency appeal? Does my request have to be in writing?

You or the person you ask to file an appeal for you (a designated representative) can request an emergency appeal. You can request an emergency appeal orally or in writing, either:

- Call Member Services at **833-731-2160 (TTY 711)**.
- Send a letter or the request form included with our decision letter to:
  Wellpoint Appeals
  PO Box 62429
  Virginia Beach, VA 23466-2429

What are the time frames for an emergency appeal?

After we receive your letter or call and agree your request for an appeal should be expedited, we will send you a letter with the answer to your appeal. We will do this within 72 hours from receipt of your appeal request.

If your appeal is about an ongoing emergency or hospital stay, we will call you with an answer within one business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal within 72 hours.

What happens if Wellpoint denies the request for an emergency appeal?

If we do not agree your request for an appeal should be expedited, we will call you right away. We will send you a letter within two calendar days to let you know how the decision was made and your appeal will be reviewed through the standard review process.

Who can help me file an emergency appeal?

A member advocate or Member Services representative can help you file an emergency appeal. Please call Member Services at **833-731-2160 (TTY 711)**.

STATE FAIR HEARINGS

Can I ask for a state fair hearing?

If you, as a member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a state fair hearing. You may name someone to represent you by contacting the health plan in writing to name the person you want to represent you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the state fair hearing within 120 days of the date on the health plan's internal appeal decision letter with the decision being challenged. If you do not ask for the state fair hearing within 120 days, you may lose your right to a state fair hearing. To ask for a state fair hearing, you or your representative should either send a letter to Wellpoint at:

State Fair Hearing/EMR Coordinator
Wellpoint
PO Box 62429
Virginia Beach, VA 23466-2429

Or you can call Member Services at **833-731-2160 (TTY 711)**.

You have the right to keep getting any service the health plan denied or reduced, at least until the final state fair hearing decision is made if you ask for a state fair hearing by 10 days

following the date the health plan mailed the appeal decision letter. If you do not request a state fair hearing by this date, the service the health plan denied will be stopped.

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

Health and Human Services Commission (HHSC) will give you a final decision within 90 days from the date you asked for the state fair hearing.

Can I ask for an emergency state fair hearing?
If you believe that waiting for a state fair hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency state fair hearing by writing or calling Wellpoint. To qualify for an emergency state fair hearing through HHSC, you must first complete the Wellpoint internal appeals process.

EXTERNAL MEDICAL REVIEW INFORMATION

Can I ask for an external medical review?

If you, as a member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for an external medical review with state fair hearing. An external medical review is an optional, extra step you can take to get your case reviewed for free before your state fair hearing. You, your parent, your authorized representative, or your legally authorized representative (LAR) must ask for the external medical review within 120 days of the date the health plan mails the letter with the internal appeal decision. If you do not ask for the external medical review within 120 days, you may lose your right to an external medical review. To ask for an external medical review, you, your parent, your representative, or your legally authorized representative may either:

- Fill out the *State fair hearing and external medical review request form* that came with the member notice of MCO internal appeal decision letter and mail or fax it to Wellpoint by using the address or fax number at the top of the form; or
- Call Wellpoint at **833-731-2160 (TTY 711)**.

You have the right to keep getting any service the health plan denied or reduced, at least until the external medical review and final state fair hearing decision is made if you ask for an external medical review with state fair hearing within 10 days following the date the health plan mailed the internal appeal decision letter. If you do not request continued benefits by this date, the service the health plan denied will be stopped.

You may withdraw your request for an external medical review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing your external medical review request. An external medical review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the external medical review decision is received, you have the right to withdraw the state fair hearing request. You may withdraw your state fair hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the member continues with a state fair hearing and the state fair hearing decision is different from the Independent Review Organization decision, it is the state fair hearing decision that is final. The state fair hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can I ask for an emergency external medical review?
If you believe that waiting for a standard external medical review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent, or your legally authorized representative may ask for an emergency external medical review and emergency state fair hearing by writing or calling Wellpoint. To qualify for an emergency external medical review and emergency state fair hearing review through HHSC, the member must first complete the Wellpoint internal appeals process.

FRAUD AND ABUSE INFORMATION

Do you want to report waste, abuse, or fraud?

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

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

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

- Call the OIG Hotline at **800-436-6184**.
- Visit oig.hhs.texas.gov and click on "Report Fraud" to complete the online form.
- You can report directly to your health plan:

  Compliance Officer
  Wellpoint
  2505 N. Highway 360, Suite 300
  Grand Prairie, TX 75050
  800-839-6275

Other reporting options include:

- Special Investigations Fraud Hotline: **866-847-8247** (reporting can be anonymous)
- Wellpoint Member Services: **833-731-2160**

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

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events

  - Summary of what happened
- When reporting someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud

INFORMATION THAT MUST BE AVAILABLE ON AN ANNUAL BASIS

As a member of Wellpoint, you can ask for and get the following information each year:

- Information about network providers — at a minimum primary care doctors, specialists, and hospitals in our service area; this information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients; and, when applicable, professional qualifications, specialty, medical school attended, residency completion, and board certification status
- Any limits on your freedom of choice among network providers
- Your rights and responsibilities
- Information on complaint, appeal, external medical review, and state fair hearing procedures
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits; this is designed to make sure you understand the benefits to which you are entitled
- How you get benefits, including authorization requirements
- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits
- How you get emergency coverage and limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services, and post-stabilization services
  - The fact that you do not need prior authorization from your primary care provider for emergency care services
  - In case of emergency, follow instructions provided by your nursing facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid
  - A statement saying you have a right to use any hospital or other settings for emergency care
  - Post-stabilization rules
- Policy on referrals for specialty care and for other benefits you cannot get through your primary care provider
- The Wellpoint practice guidelines

Member Guide to Managed Care Terms

Term	Definition
Appeal	A request for your managed care organization to review a denial or a grievance again.
Complaint	A grievance that you communicate to your health insurer or plan.
Copayment	A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Durable Medical Equipment (DME)	Equipment ordered by a health care provider for everyday or extended use. Coverage for DME may include but is not limited to: oxygen equipment, wheelchairs, crutches, or diabetic supplies.
Emergency Medical Condition	An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.
Emergency Medical Transportation	Ground or air ambulance services for an emergency medical condition.
Emergency Room Care	Emergency services you get in an emergency room.
Emergency Services	Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
Excluded Services	Health care services that your health insurance or plan doesn't pay for or cover.
Grievance	A complaint to your health insurer or plan.
Habilitation Services and Devices	Health care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.
Health Insurance	A contract that requires your health insurer to pay your covered health care costs in exchange for a premium.
Home Health Care	Health care services a person receives in a home.
Hospice Services	Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
Hospital Outpatient Care	Care in a hospital that usually doesn't require an overnight stay.
Medically Necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.
Network	The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.
Non-participating Provider	A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating

	provider.
Participating Provider	A provider who has a contract with your health insurer or plan to provide covered services to you.
Physician Services	Health care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.
Plan	A benefit, like Medicaid, which provides and pays for your health care services.
Pre-authorization	A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision or approval, sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.
Premium	The amount that must be paid for your health insurance or plan.
Prescription Drug Coverage	Health insurance or plan that helps pay for prescription drugs and medications.
Prescription Drugs	Drugs and medications that by law require a prescription.
Primary Care Physician	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.
Primary Care Provider	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.
Provider	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional, or health care facility licensed, certified, or accredited as required by state law.
Rehabilitation Services and Devices	Health care services such as physical or occupational therapy that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.
Skilled Nursing Care	Services from licensed nurses in your own home or in a nursing home.
Specialist	A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
Urgent Care	Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.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