Amerigroup RealSolutions® in healthcare





STAR+PLUS Nursing Facility

Member Handbook

Bexar, El Paso, Harris, Jefferson, Lubbock, Medicaid Rural West, Tarrant, and Travis Service Areas

1-800-600-4441

www.myamerigroup.com/TX

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

TX-MHB-0087-14 03.15

Amerigroup RealSolutions in healthcare

www.myamerigroup.com

Dear Member:

Welcome to Amerigroup. We are pleased that you chose us to arrange for your Amerigroup benefits.

The member handbook tells you how Amerigroup works and how we can help you take good care of your health. It tells you how to get health care when you need it, too.

You will get your Amerigroup ID card and more information from us in a few days. Your ID card will tell you when your Amerigroup membership starts and it has important contact information.

We want to hear from you. Call **1-800-600-4441**. You can talk to a Member Services representative about your benefits. You can also talk to a nurse on our Nurse HelpLine by calling **1-866-864-2544**.

Thank you for picking us as your health plan.

Sincerely,

LeAnn Behrens
President
Amerigroup
Medicaid Health Plans - Texas

AMERIGROUP
STAR+PLUS PROGRAM FOR NURSING FACILITY RESIDENTS
MEMBER HANDBOOK

Bexar Service Area
12500 San Pedro Ave.
Suite 400
San Antonio, TX 78216

El Paso Service Area
7430 Remcon Circle
Building C, Suite 120
El Paso, TX 79912

Harris and Jefferson Service Areas
3800 Buffalo Speedway
Suite 400
Houston, TX 77098

Lubbock Service Area
3223 S. Loop 289
Suite 110
Lubbock, TX 79423

West Medicaid Rural Service Area
2505 N. Highway 360
Suite 300
Grand Prairie, TX 75050

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

Travis Service Area
823 Congress Ave.
Suite 400
Austin, TX 78701

1-800-600-4441
www.myamerigroup.com/TX

Welcome to Amerigroup!
This member handbook will tell you how to use Amerigroup to get the care you need.

Table of Contents

INFORMATION ABOUT YOUR NEW HEALTH PLAN

Welcome to Amerigroup! Amerigroup is a managed care organization committed to helping you get the right care for your needs. As a member of the Amerigroup STAR+PLUS program, you and your primary care provider or doctor will work together to help keep you healthy and care for your health problems. Amerigroup helps you get quality health care. Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company. All other Amerigroup members in Texas are served by Amerigroup Texas, Inc. To find out about doctors and hospitals in your area, visit www.myamerigroup.com/TX or contact Member Services at **1-800-600-4441**.

Your Amerigroup member handbook

This handbook will help you understand your Amerigroup health plan. If you have questions or need help understanding or reading your member handbook, call Member Services. Amerigroup also has the member handbook in a large print version, an audio-taped version, and a Braille version. The other side of this handbook is in Spanish.

IMPORTANT PHONE NUMBERS

Amerigroup toll-free Member Services line

If you have any questions about your Amerigroup health plan, you can call our Member Services department toll-free at **1-800-600-4441**. You can call us Monday through Friday from 7 a.m. to 6 p.m. Central time, except for state-approved holidays. If you call after 6 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
- 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 1-866-696-0710 to get information about service coordination.

In case of emergency, follow instructions provided by your nursing facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.

For members who do not speak English, we are able to help in many different languages and dialects, including Spanish. This service is also available 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 for more information.

For members who are deaf or hard of hearing, call the AT&T Relay Service toll-free at 711. Amerigroup will set up and pay for you to have a person who knows sign language help you during your doctor visits. Please let us know if you need an interpreter at least 24 hours before your appointment.

Amerigroup 24-hour Nurse HelpLine

The Nurse HelpLine is available to all members 24 hours a day, 7 days a week. It is a free service which you can hear in English or Spanish. For other languages, interpreter services are available. You can call the Nurse HelpLine toll-free 7 days a week at **1-866-864-2544** if you need advice on:

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

We want you to be happy with the services you get through Amerigroup. Please call Member Services if you have any problems. We want to help you correct any problems you may have with your care.

Behavioral Health and Substance Abuse Services line

The Behavioral Health and Substance Abuse services line is available to members 24 hours a day, 7 days a week at **1-800-600-4441**. It is a free service which you can hear in English or Spanish. For other languages, interpreter services are available. You can call the Behavioral Health and Substance Abuse services line for help in getting 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.

Other important phone numbers

STAR+PLUS Program Help Line	1-800-964-2777
Medicaid Managed Care Helpline	1-866-566-8989 (TDD 1-866-222-4306)
Block Vision for Eye Care	1-800-428-8789
Texas Client Notification Line	1-800-414-3406
Amerigroup on Call/Nurse HelpLine 24 hours a day, 7 days a week	1-866-864-2544
Member Services For behavioral health and substance abuse care For service coordination For information about our disease management programs For information about prescription drugs	1-800-600-4441

YOUR AMERIGROUP ID CARD

What does my Amerigroup ID card look like?

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

Your Amerigroup ID card lists many of the important phone numbers you need to know, like our Member Services department and the Nurse HelpLine/Amerigroup on Call. It also has the phone number for you to call to get eye care.

If your ID card is lost or stolen, call Amerigroup right away. We will send you a new one. You may also print your ID card from our website at www.myamerigroup.com/TX. You will need to register and log in to the website to access your ID card information. 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 Amerigroup members in the Medicaid Rural Service Area:

1. 

2. 

What information is on my Amerigroup ID card?

The card tells providers and hospitals you are a member of Amerigroup. It lets them know that Amerigroup will pay for the medically needed benefits listed in the **My Benefits** section.

Your Amerigroup ID card lists many of the important phone numbers you need to know like our Member Services department and Nurse HelpLine.

How do I replace my Amerigroup ID card if it is lost or stolen?

If your ID card is lost or stolen, call us right away at 1-800-600-4441. We will send you a new one. You may also print your ID card from our website at www.myamerigroup.com/TX. You will need to register and log in to the website to access your ID card information.

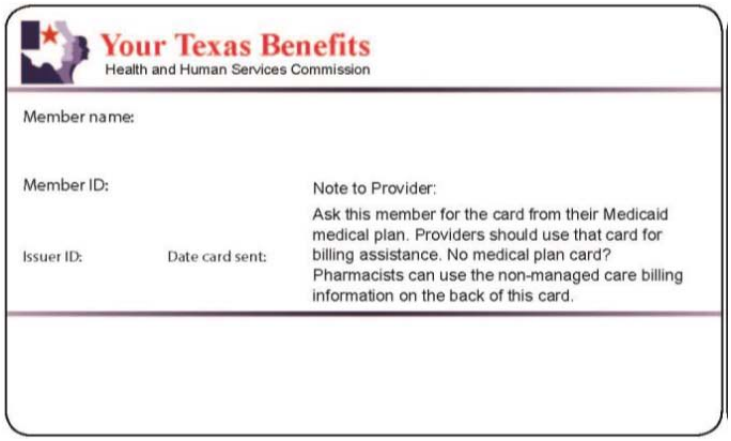
Your Texas Benefits Medicaid card

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

You will be issued one card, and will only receive a new card in the event your card is lost or stolen. If your Medicaid ID card is lost or stolen, you can get a new one by calling toll-free at 1-855-827-3748, or by going online to print a temporary card at www.yourtexasbenefits.com.

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

Your health history 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 health history through the secure online network, call toll-free at 1-800-252-8263.



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

- Your name and Medicaid ID number
- The date the card was sent to you
- The name of the program you're in if you get:
  - Medicare (QMB, MQMB)
  - Texas Women's Health Program (TWHP)
  - Hospice
  - STAR Health
  - Emergency Medicaid, or
  - Presumptive Eligibility for Pregnant Women (PE)
- Facts your 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 Your Texas Benefits Medicaid card has a website you can visit (www.yourtexasbenefits.com) and a phone number you can call toll-free (1-800-252-8263) if you have questions about the new card.

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

What if I need a temporary ID verification form?

If you have lost or do not have access to Your Texas Benefits Medicaid card and need a temporary Medicaid ID card, you can get a temporary verification form (Form 1027-A) by calling your local HHSC benefits office. To find your local HHSC benefits office, call 2-1-1, pick a language and then select option 1. Present this form as proof of your eligibility for Medicaid in the same way you would present the Your Texas Benefits Medicaid card as described above. Your provider will accept this form as proof of Medicaid eligibility. You can also go online at www.yourtexasbenefits.com and print a temporary ID card after logging into your account.

PRIMARY CARE PROVIDERS

What is a primary care provider?

Amerigroup members must have a family doctor, also called a primary care provider. Your doctor must be in the Amerigroup network. Your doctor will give you a medical home. That means that he or she will get to know you and your health history and be able to help you get the best possible care. He or she will also send you to other doctors or hospitals when you need special care. When you enrolled in Amerigroup, you should have picked a primary care provider. If you did not, we assigned one to you. We picked one who should be close to you.

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

If you also have Medicare coverage, your acute care coverage is through your Medicare plan. You pick a primary care provider through your Medicare coverage. Please look at the Evidence of Coverage for your Medicare plan to understand the role of a primary care provider, who can be a primary care provider, how to change your primary care provider, and how to get care. If you have Medicare, some of the information in this handbook about primary care providers and specialists will not apply to you.

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

If you do not need ambulance transportation, your nursing facility should provide you with transportation to your medical appointments. If your nursing facility cannot provide transportation to one of your appointments, call Member Services at 1-800-600-4441 and we will help you get transportation.

How can I change my primary care provider?

Call Member Services if you need to make a primary care provider change. You can look in the Amerigroup provider directory you got with your STAR+PLUS enrollment package or go to www.myamerigroup.com/TX to see the primary care providers Amerigroup offers.

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, call Member Services. We will help you make the appointment.

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

If you have a medical concern that you need to discuss with the 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 our Nurse HelpLine 24 hours a day, 7 days a week for help.

In case of emergency, follow instructions provided by your nursing facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.

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 1-800-600-4441.

If you are in the Medicaid Lock-in Program, you can be approved to receive a medication at a pharmacy other than the lock-in pharmacy in some circumstances, such as when:

- 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 1-800-600-4441 if you need approval to receive a medication at a pharmacy other than the lock-in pharmacy.

PHYSICIAN INCENTIVE PLAN

Amerigroup rewards doctors for treatments that are cost-effective for people covered by Medicaid. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call Member Services at 1-800-600-4441 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 1-800-964-2777. You can change health plans as often as you want, but not more than once a month.

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

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

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

If you do not like something about Amerigroup, please call Member Services. We will work with you to try to fix the problem. If you are still not happy, you may change to another health plan.

Who do I call?

You can change your health plan by calling the STAR+PLUS Program Helpline at 1-800-964-2777.

How many times can I change health plans?

You can change plans as many times 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 cannot change your plan until you are discharged.

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

There are several reasons you could be disenrolled from Amerigroup without asking to be disenrolled. These are listed below. If you have done something that may lead to disenrollment, we will contact you. We will ask you to tell us what happened.

You could be disenrolled from Amerigroup if:

- You are no longer eligible for Medicaid
- You let someone else use your Amerigroup ID card
- You try to hurt a provider, a staff person, or an Amerigroup associate
- You steal or destroy property of a provider or Amerigroup
- You go to the emergency room over and over again when you do not have an emergency
- You go to doctors or medical facilities outside the Amerigroup 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 1-800-600-4441.

MY BENEFITS

What are my health-care benefits?

As a nursing facility resident, you get benefits for daily care services provided by the nursing facility and for nursing facility add-on services. You also get benefits from Amerigroup for acute care such as doctor visits, hospitalizations, prescriptions and behavioral health services. If you have both Medicare and Medicaid, your acute care benefits will be covered by Medicare or the Medicare plan you have picked.

How do I get these services?

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

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

If a covered benefit is not available to you through a network provider, Amerigroup will arrange services with an out-of-network provider and will reimburse the out-of-network provider according to state rules. You must contact Member Services at 1-800-600-4441 to arrange out-of-network services except in case of emergency.

What are long-term services and supports (LTSS)?

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 LTSS benefits that a person can get depend on individual needs.

What are my nursing facility LTSS 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. Amerigroup 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, personal needs items, social services programs provided by the nursing facility to benefit residents, over-the-counter drugs, and Medicare Part A coinsurance; Amerigroup 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), customized power wheelchairs, and augmentative communication devices.
- For members who have both Medicaid and Medicare, Amerigroup will pay the coinsurance for a Medicare covered stay as part of your nursing facility daily care services; your Medicare plan or Texas 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 eligible for community-based LTSS benefits instead of your nursing facility benefits. You would qualify for benefits according to your needs for services. The kinds and amounts of benefits you could get would be based on your category of Medicaid eligibility which is based on your needs. The basic category of coverage is called Other Community Care (OCC). The next higher level is Community First Choice (CFC). The third category for members with more complex medical needs is called HCBS STAR+PLUS Waiver (SPW). The higher your level of eligibility based on your needs, the more benefits are available. Below is a listing of some of the different types of community-based LTSS benefits:

- 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?

The following list shows acute care benefits that Amerigroup covers for STAR+PLUS members who are nursing facility residents. Your primary care provider will give you the care you need or refer you to a doctor who can give you the care you need. If you have a question or are not sure whether Amerigroup offers a certain benefit, you can call Member Services for help at 1-800-600-4441 for more information.

- Ambulance services
- Birthing services provided by a physician or advanced practice registered nurse in a licensed birthing center
- Chiropractic care
- Dialysis
- Emergency room services
- Family planning services and supplies
- Federally qualified health center services and other ambulatory services covered by federally qualified health centers
- Health education
- Hearing tests
- Hearing aids
- Hospital services
- Inpatient behavioral health services
- Interpreter services (available through Member Services)
- Laboratory
- Mental health and substance abuse services (limited to certain kinds of providers)
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prescription drugs
- Prenatal care
- Preventive services, including an annual adult well-checkup for patients 21 years of age and over
- Primary care services
- Private-duty nursing (limited to members who need more individual and continual care than they can get from a home health agency, nursing facility, or hospital)
- Radiology, imaging, and X-rays
- Specialty physician services
- Transplants (if medically necessary, like liver, heart, lung, bone marrow, and kidney)
- Vision

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

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 1-800-600-4441 or your service coordinator if you need more information.

Are there any limits to any covered services?

There may be some limits to care such as for chiropractic services or number of inpatient or outpatient mental health visits. You can call Member Services at 1-800-600-4441 or your service coordinator for more information on benefit limitations.

What services are not covered by Amerigroup?

These are benefits and services that Amerigroup does not offer. These services are not covered by fee-for-service Medicaid either:

- Services that are not medically necessary
- Experimental services such as new treatment that is being tested or has not been shown to work
- Cosmetic surgery that is not 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 transformation or transsexual surgery

For more information about services not covered by Amerigroup, please call Member Services at 1-800-600-4441.

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 an Amerigroup personal service coordinator. We will send you a letter to let you know the name and contact information for your service coordinator. You can also call 1-866-696-0710 to get information about service coordination. If you are deaf or hard of hearing, please call 711.

What will a service coordinator do for me?

The state sends us information about your health and the services you have been getting from Medicaid. Your service coordinator will read this information to find out more about you. It will tell your service coordinator which providers he or she needs to call to be sure you keep getting the right care. We will ask you how helpful your Medicaid services have been. We will talk to your Medicaid providers about the care you have been getting. And, if you agree, we will 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 assess your unique physical, behavioral, functional, environmental, and long-term care needs
- Collecting complete and accurate information about you to help you get the right kind of care
- Working with you to create a service plan that meets your needs
- Helping you get timely and coordinated access to your providers and the covered services you need (including the correct preventive health services)
- Coordinating your nursing facility covered services and your acute care with social and other services that you get outside Amerigroup
- Giving authorizations for services that are medically needed
- Encouraging you to take part in your care

How do I know who my service coordinator is?

When we assign a personal service coordinator to you, we will send you a letter with his or her name and telephone number. We will also send you a letter with this information each year and anytime your service coordinator changes. You can also find the name and telephone number of your personal service coordinator on our website at www.myamerigroup.com/TX. You will need to click the Register button and register for Member Self Service in order to see your personal information. Another way to get your personal service coordinator name and contact information is to call Member Services.

What are my prescription drug benefits?

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. If you have Medicare benefits, your Medicare plan will provide your prescription drug benefits. If Medicare does not cover your medicine, Medicaid pays for most medicine your doctor says you need.

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

Amerigroup covers extra health-care benefits for our STAR+PLUS nursing facility members. 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 Amerigroup as your health-care plan. Call Member Services for more information on the extra benefits you can get or visit our website at www.myamerigroup.com/TX.

Value-Added Benefit	How to Get It
Enhanced vision benefits (for members who do not have Medicare)	Call 1-800-600-4441 or go to www.myamerigroup.com/TX for more information

Free cellphone and up to 250 minutes of services each month if you qualify, plus: • 200 extra one-time bonus minutes when you choose to receive free health text messages from Amerigroup • Unlimited inbound text messages plus free health and wellness and renewal reminder texts from Amerigroup • Unlimited minutes when calling our Member Services line • Minutes include international calling if available	Call 1-800-600-4441 or go to www.myamerigroup.com/TX for more information
Smoking/tobacco cessation help – telephone support with your own personal coach and a full range of nicotine replacement therapy as needed	Call 1-800-600-4441 or go to www.myamerigroup.com/TX for more information
Healthy lifestyle coaching for eligible members ages 18 to 64 diagnosed and taking medication for hypertension or type 2 diabetes mellitus – Gift card rewards for reaching health goals	Call 1-877-868-2004 or go to www.myamerigroup.com/HealthyRewards for more information
Healthy Rewards gift cards for getting cholesterol screening for members with cardiac disease, and diabetic screenings for members with diabetes mellitus	Call 1-877-868-2004 or go to www.myamerigroup.com/HealthyRewards for more information
Disaster Kits – first aid kit after completion of personal disaster plan online	Call 1-800-600-4441 or go to www.myamerigroup.com/TX for more information
Personal exercise kit (for members who do not have Medicare)	Call 1-800-600-4441 or go to www.myamerigroup.com/TX for more information
Fall prevention kit (for members who do not have Medicare)	Call 1-800-600-4441 or go to www.myamerigroup.com/TX for more information

How do I get these extra benefits?

Call Member Services or your service coordinator to find out how to get these services. We will find out about your needs and which services you can get.

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

We work to help keep you healthy with information about health education programs or events held in your community. We can help you find classes or events near your home. You can call Member Services to find out where and when these classes or events are held. Some of the programs may include:

- Amerigroup services and how to get them
- Quitting cigarette smoking
- Protecting yourself from violence
- Other health topics

We will also mail a member newsletter to you once each year. This newsletter gives your health information about wellness, taking care of illnesses, benefits information, and many other topics.

Amerigroup has disease management programs to help you better manage your chronic health problems. Your primary care doctor and the Amerigroup Disease Management team will assist you with your health-care needs. Some programs available are for asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, major depressive disorder, substance use disorder, diabetes, HIV/AIDS, and schizophrenia. Licensed nurses and social workers support you over the phone. They help arrange other services like smoking cessation, nutrition classes, or other community support activities. If you have a chronic health condition and want to know more about our disease management program, please call Member Services at 1-800-600-4441. Ask to speak to a Disease Management case manager.

What is Complex Case Management?

Complex Case Management is a program that we have in addition to our disease management program. We have case managers available to 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 have special case managers for members with a high risk pregnancy, multiple pregnancy, history of preterm delivery with a past pregnancy, or current preterm labor.

How do I get these services?

You do not need a referral from your doctor. You can contact the Complex Case Management Program by calling Member Services at **1-800-600-4441** and asking to speak to a complex case manager. Our case managers are licensed nurses and social workers, available Monday through Friday from 8 a.m. to 5 p.m. Central time. Case managers also have confidential voice mail available 24 hours a day.

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

We can help you get some services covered by fee-for-service Medicaid instead of Amerigroup. You do not need a referral from your primary care provider to get these services. Fee-for-service Medicaid benefits include:

- Department of Aging and Disability Services (DADS) hospice services
- Preadmission Screening and Resident Review (PASRR) – PASRR is a federal requirement to help determine whether an individual is not inappropriately placed in a nursing home for long-term care

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

Amerigroup will determine medical necessity for nursing facility add-on services. Amerigroup 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 1-800-600-4441 (TTY 711).

How is new technology evaluated?

The Amerigroup Medical Director and participating providers review and evaluate new medical advances in technology (or the new application of existing technology) in medical procedures, behavioral health procedures, pharmaceuticals, and devices to determine their appropriateness for covered benefits. Scientific literature and government approval are reviewed for determining if the treatment is safe and effective. The new medical advance or treatment (or new application of existing technology) must provide equal or better outcomes than the existing covered benefit treatment or therapy for it to be considered for coverage by Amerigroup.

What is routine medical care?

In most cases when you need medical care, you call your doctor to make an appointment. Then you go to see the doctor or the doctor comes to see you. This will cover most minor illnesses and injuries, as well as regular checkups. This type of care is known as **routine care**. Your primary care provider is someone you see when you are not feeling well, but that is only part of your primary care provider's job. Your primary care provider 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 2 weeks for routine care.

Are nonemergency dental services covered?

Amerigroup is **not responsible** for paying for routine dental services provided to Medicaid members.

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

What is emergency medical care?

Another type of care is **emergency care**. In case of emergency, follow instructions provided by your nursing facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.

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 women, serious jeopardy to the health of a woman or her unborn child

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

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

How soon can I expect to be seen?

You should be able to see your doctor immediately for emergency care.

Do I need a prior authorization?

You do not need a prior authorization for emergency care.

Are emergency dental services covered?

Amerigroup 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

Amerigroup 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?

Amerigroup is dedicated to arranging access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. Providers are required to follow access standards listed below. Standards are measured from the date of presentation or request, whichever occurs first.

Standard Name	Amerigroup
Emergency Services	Immediately upon member presentation at the service delivery site
Urgent Care	Within 24 hours
Routine Primary Care	Within 14 days
Routine Specialty Care	Within 3 weeks
Preventive Health: Adult	Within 90 days
Prenatal Care	Within 14 days
Pregnancy High Risk/3rd trimester	Within 5 days or immediately, if an emergency exists
Behavioral Health Nonlife-threatening Emergency	Within 6 hours (NCQA)
Behavioral Health-Urgent Care	Within 24 hours
Behavioral Health-Routine Care	The earlier of 10 business days or 14 calendar days
After-Hours Care	For primary care providers Practitioners accessible 24/7 directly or through answering service - Answering service or recording assistance in English and Spanish and member reaches on call physician or medical staff within 30 minutes
Office Wait Time	Within 30 minutes

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 1-800-600-4441 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 1-800-600-4441.

What if I am out of the state?

If you are outside of Texas and need medical care, please call us toll-free at 1-800-600-4441. 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)

Amerigroup offers services from many different kinds of doctors that provide other medically needed care. In most cases, you need to have a referral from your primary care provider to see another doctor. The referral may be a phone call or a paper from your primary care provider telling the specialist what kind of health care you need.

Members with disabilities, special health-care needs, or chronic complex conditions have a right to direct access to a specialist. This specialist may serve as your primary care provider. Please call Member Services so this can be arranged.

What is a referral?

A referral is when your primary care provider sends you to another doctor or service for care. Your primary care provider may refer you to a specialist in the Amerigroup network if your primary care provider cannot give you the care you need.

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

Once you talk to your doctor and set up an appointment, you will be able to see the doctor within 3 weeks. In a few cases a referral is not needed. Read the "**What services do not need a referral?"** section below for more information.

What services do not need a referral?

You can get the following services without a referral from your doctor:

- Emergency care

- Behavioral health services (mental health and/or substance abuse) from an Amerigroup behavioral health services provider
- Family planning from any Amerigroup network or state-approved Medicaid family planning provider
- Prenatal care from an Amerigroup network obstetrician or certified nurse-midwife
- Eye care from an Amerigroup network eye care provider (optometrist)
- Screening or testing for sexually transmitted diseases, including HIV, from an Amerigroup network doctor

If you have Medicare, you will need to follow your Medicare plan's rules about referrals for Medicare covered services.

How can I ask for a second opinion?

Amerigroup members have the right to ask for a second opinion about the use of any health care. This does not cost you anything. You can get a second opinion from a network provider or a non-network provider (if a network provider is not available). You should talk to your primary care doctor to get a referral for a second opinion. If a network provider is not available for a second opinion, your primary care doctor can submit a request to Amerigroup to authorize a visit to a non-network provider. If you have Medicare, contact your Medicare plan and ask how to get a second opinion.

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

Sometimes the stress of handling the many responsibilities of a home and family can lead to depression, anxiety, marriage and family problems, parenting problems, and alcohol and drug abuse. If you or a family member is having these kinds of problems, Amerigroup contracts with doctors who can help. Call Member Services at 1-800-600-4441 for help in getting the name of a doctor who will see you if you need one. 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 do not need a referral from your doctor to get these services from Amerigroup.

What are Mental Health Rehabilitative Services and Mental Health Targeted Case Management?

These are services available to you as STAR+PLUS benefits if you are not covered by Medicare and:

- You are an adult age 18 or over that has a severe mental, behavioral, or emotional disorder that can be diagnosed and that substantially interferes with or limits your ability to function in one or more major life activities
- You are a child aged 3-17 that has currently or at any time in the past year has had a mental, behavioral, or emotional disorder that can be diagnosed and that substantially interferes with or limits your ability to function in family, school, or community activities

Mental Health Rehabilitative Services includes training and services to help you maintain independence in your home and 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 these services?

If you or a family member has been diagnosed with or has shown signs of this type of condition, Amerigroup contracts with doctors who can help. Call Member Services at **1-800-600-4441** to get the name of a doctor near you. 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 in getting 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 be able to find a drugstore that is in the Amerigroup network. You can also call Member Services for help at 1-800-600-4441.

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

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

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 Amerigroup ID card or your Medicare plan ID card, and
- 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 medications, please call Amerigroup Member Services at 1-800-600-4441. 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?

If your doctor cannot be reached to approve a prescription, you may be able to get a 3-day emergency supply of your medication. Call Amerigroup at 1-800-600-4441 for help with your medications and refills.

What if I lose my medication(s)?

If your medicine is lost or stolen, have your nursing facility contact Amerigroup at 1-800-454-3730.

How do I find out what drugs are covered?

Amerigroup uses the state Vendor Drug Program (VDP) list of drugs that your doctor can choose from. It includes all medicines covered by Medicaid.

To view the Texas Formulary Drug Search, go to www.txvendordrug.com/formulary/formulary-search.asp.

When there is a generic drug available, it will be covered if it is on the VDP formulary. Generic drugs are equal to brand-name drugs as approved by the Food and Drug Administration (FDA).

Will I have a copay?

Medicaid members do not have a copay.

How do I get my medicine if I am traveling?

Amerigroup has network pharmacies in all 50 states. If you need a refill while traveling, call your doctor for a new prescription to take with you.

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 Member Services at 1-800-600-4441 to get information on how to get a reimbursement form and submit a claim.

How do I get family planning services?

Amerigroup will arrange for counseling and education about planning a pregnancy or preventing pregnancy. You can call your doctor and make an appointment for a visit. You can also 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 www.dshs.state.tx.us/famplan/locator.shtm, or you can call Amerigroup at 1-800-600-4441 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	Age 21 and older	Every year
Pap smear and pelvic exam	Age 18 and over	Every year
Clinical breast exam	Women age 20-39	Every 3 years
	Age 40 and over	Every year
Breast self-exam	Women age 20 and over	Once a month
Mammograms (breast X-ray)	Women age 40 and over	Every year
Fecal blood occult test	Age 50 and over	Every year

Wellness Visits Schedule for Adult Members		
EXAM TYPE	**WHO NEEDS IT?**	**HOW OFTEN?**
Sigmoidoscopy and DRE/PSA or colonoscopy and DRE/PSA	Age 50 and over	Every 5 years

Amerigroup Transportation Services for Nursing Facility Residents

What transportation services are offered?

The nursing facility is responsible for providing routine non-emergency transportation services. If medically necessary, Amerigroup provides non-emergency ambulance transportation for members that require this service.

How do I get this service?

To get non-emergency ambulance transportation, your provider must contact Amerigroup to request authorization for these services. Your doctor can submit a request by fax to 1-844-206-3445 or by telephone at 1-866-696-0710.

In case of emergency, follow instructions provided by your nursing facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.

Who do I call for a ride to a medical appointment?

If you do not need ambulance transportation, your nursing facility should provide you with transportation to your medical appointments. If your nursing facility cannot provide transportation to one of your appointments, call Member Services at 1-800-600-4441 and we will help you get transportation.

How do I get eye care services?

Amerigroup members get eye care benefits. You do not need a referral from your doctor for these benefits. Please call Block Vision at 1-800-428-8789 for help finding a network eye doctor (optometrist) in your area.

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

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

Call Member Services at 1-800-600-4441 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 if you need an interpreter at least 24 hours before your appointment.

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

Call Member Services if you need to have an interpreter with you when you talk to your provider.

What if I need OB/GYN care?

ATTENTION FEMALE MEMBERS:
Amerigroup allows you to pick any OB/GYN, whether that doctor is in the same network as your primary care provider or not.

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 are not required to pick an OB/GYN doctor. However, if you are pregnant, you should pick an OB/GYN to take care of you. You can pick any OB/GYN doctor listed in the Amerigroup provider directory. If you need help picking an OB/GYN, call Member Services at 1-800-600-4441. 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 do not want to go to an OB/GYN, your primary care provider may be able to treat you for your OB/GYN health 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 network OB/GYNs in the Amerigroup provider directory you got with your STAR+PLUS enrollment package.

Will I need a referral?

You will not need a referral; however, you can only have 1 OB/GYN visit in a month. You can only see 1 OB/GYN in a month, but you can have more than 1 visit during that month with the same OB/GYN, if needed.

While you are pregnant, your OB/GYN can be your primary care provider. The nurses on our 24-hour Nurse HelpLine can help you decide if you should see your primary care provider or an OB/GYN.

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

Your OB/GYN should see you within 2 weeks. We can help you find an Amerigroup OB/GYN, if needed.

Can I stay with my OB/GYN if he or she is not with Amerigroup?

You may have been seeing a doctor who is not in our network for OB/GYN care. In some cases, you may be able to keep seeing this OB/GYN. Please call Member Services to find out more about this.

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

If you think you are pregnant, call your primary care provider or OB/GYN doctor right away. You do not need a referral from your doctor to see an OB/GYN doctor.

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

Members with disabilities, special health-care needs, or chronic complex conditions have a right to direct access to a specialist. This specialist may serve as your primary care provider. Please call your service coordinator or Member Services at 1-800-600-4441 so this can be arranged.

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 are too sick to make decisions for yourself. Please call Member Services at 1-800-600-4441 if you would like more information about the forms you need.

What are advance directives?

Emancipated minors and members 18 years of age or 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 are 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 do not want if you are seriously ill or injured.

How do I get an advance directive?

You can get a living will form from your doctor or by calling Member Services. You can fill it out by yourself or call Member Services for help; however, Amerigroup 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 a living will. Call your doctor to remove the living will from your medical record. You can also make changes in the living will 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 6 months, you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same primary care provider you had before.

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

If you do get a bill, send the bill along with a letter saying that you have been sent a bill to the member advocate in your service area at the Amerigroup location nearest you listed in the front of this book. In the letter, include your name, the telephone number you can be reached at, and your Amerigroup ID number. If you are unable to send the bill, be sure to include in the letter the name of the nursing facility, the dates of service, the nursing facility's phone number, the amount charged, and the account number, if known. You can also call Member Services at 1-800-600-4441 for help.

What information will they need?

In the letter, include your name, the telephone number you can be reached at, and your Amerigroup ID number. If you are unable to send a copy of the bill, be sure to include in the letter the name of the nursing facility, the dates of service, the nursing facility's phone number, the amount charged, and 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 Amerigroup Member Services department at 1-800-600-4441. Before you get Medicaid services in your new area, you must call Amerigroup, unless you need emergency services. You will continue to get care through Amerigroup 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 1-800-846-7307.

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

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

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

MEMBER RESPONSIBILITIES:

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

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

QUALITY MANAGEMENT

What does quality management do for you?

The goal of the Amerigroup Quality Management Program is to improve the health and well-being of our members. We look at services you have received to be sure you are getting the best preventive health care. If you have a chronic disease, we look to make sure you are getting any needed help with managing your condition.

The Quality Management department develops programs to help improve your knowledge about your health care. We have member outreach teams that may call to encourage you to schedule appointments for needed care. A team member will offer to help you schedule your medical appointments and arrange transportation if you need it. These services are provided free of charge because we want you to enjoy the best possible health.

We work with our contracted providers to give them education and information to help them provide the best care for you. You may receive mailings from us about taking preventive health steps or managing an illness. We encourage members and providers to make suggestions to help us improve quality of care for our members. If you would like more information about Quality Management Program goals, our steps to reach those goals, and results, please call Member Services at 1-800-600-4441.

What are clinical practice guidelines?

Amerigroup uses national clinical practice guidelines for the care of members. 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. They guide decisions on diagnosis, management, and treatment of patients. If you would like a copy of these guidelines, contact Member Services at 1-800-600-4441.

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 1-800-600-4441 to tell us about your problem. An Amerigroup Member Services representative or a member advocate can help you file a complaint. Just call 1-800-600-4441. Most of the time, we can help you right away or at the most within a few days.

Can someone from Amerigroup help me file a complaint?

Yes, a member advocate or Member Services representative can help you file a complaint with Amerigroup or with 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 1-800-600-4441. Interpreter services are available at no cost to you.

How long will it take to process my complaint?

Amerigroup 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 5 business days of getting your complaint. This means that we have your complaint and have started to look at it. We may call you to get more information.

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. The letter will also tell you about an option to have a second level review with a different reviewer. If you choose to have a second review, we will send you a letter with a response within 30 days of when you tell us that you want the second review.

How do I file a complaint with the Health and Human Services Commission once I have gone through the Amerigroup complaint process?

Once you have gone through the Amerigroup complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Resolution Services
Texas Health and Human Services Commission
Health Plan Operations - H-320
PO Box 85200
Austin, TX 78708-5200

If you can get on the Internet, you can send your complaint in an email to hpm_complaints@hhsc.state.tx.us.

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

APPEALS PROCESS

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

There may be times when Amerigroup says it will not pay for or cover all or part of the care that has been recommended. For example, if you ask for a service that is not covered such as cosmetic surgery, Amerigroup is not allowed to pay for it. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Amerigroup to look again at the care your doctor asked for and we said we will not pay for.

You can appeal our decision in 2 ways:

- You can call Member Services
  - If you call us, **you must still send us your appeal in writing,** except for an expedited appeal
  - We will send you an appeal form in the mail after your call
  - Fill out and sign the appeal form and send it to us within 30 days of when you received the letter telling you we were denying your request, at Amerigroup Appeals, 2505 N. Highway 360, Suite 300, Grand Prairie, TX 75050
  - If you need help filling out the appeal form, please call Member Services
- You can send us a letter to Amerigroup Appeals, 2505 N. Highway 360, Suite 300, Grand Prairie, TX 75050

How will I find out if services are denied?

If we deny services, we will send you a letter.

What are the time frames for the appeals process?

You or a designated representative can file an appeal. You must do this within 30 days of when you get the first letter from Amerigroup that says we will not pay for or cover all or part of the care that has been recommended.

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

When we get your letter or call, we will send you a letter within 5 business days. This letter will let you know we got your appeal. We will also let you know if we need any other information to process your appeal. Amerigroup will contact your doctor if we need medical information about the service.

A doctor who has not seen your case before will look at your appeal. He or she will decide how we should handle your appeal.

We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get 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 that we should consider.

How can I continue receiving my services that were already approved?

To continue receiving services that have already been approved by Amerigroup but may be part of the reason for your appeal, you must file the appeal on or before the later of:

- 10 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 that has already been approved
- The date the notice says your service will end

If you request that services continue while your appeal is pending, you need to know that you may have to pay for these services.

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

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

Can someone from Amerigroup help me file an appeal?

Yes, a member advocate or Member Services representative can help you file an appeal with Amerigroup or with the appropriate state program. If you have Medicare, a member advocate can also help you file an appeal with your Medicare plan or directly with Medicare. Please call Member Services toll-free at 1-800-600-4441. Interpreter services are available at no cost to you.

Can I request a state fair hearing?

Yes, you can ask for a fair hearing at any time during or after the Amerigroup appeal process unless you have asked for an expedited appeal. See the **State Fair Hearing** and the **Expedited Appeals** sections below for more information.

EXPEDITED APPEALS

What is an expedited appeal?

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

How do I ask for an expedited appeal? 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 expedited appeal. You can request an expedited appeal in 2 ways, orally or in writing:

- You can call Member Services at 1-800-600-4441
- You can send us a letter to Amerigroup Appeals, 2505 N. Highway 360, Suite 300, Grand Prairie, TX 75050

What are the time frames for an expedited appeal?

When we get your letter or call, we will send you a letter with the answer to your appeal. We will do this within 3 business days.

If your appeal relates to an ongoing emergency or hospital stay we said we would not pay for, we will call you with an answer within 1 business day. We will also send you a letter with the answer to your appeal within 3 business days.

What happens if Amerigroup denies the request for an expedited appeal?

If we do not agree that your request for an appeal should be expedited, we will call you right away. We will send you a letter within 3 calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

If the decision on your expedited appeal upholds our first decision and Amerigroup will not pay for the care your doctor asked for, we will call you and send you a letter to let you know how the decision was made. We will also tell you your rights to request an expedited state fair hearing.

Who can help me file an expedited appeal?

A member advocate or Member Services representative can help you file an expedited appeal. Please call Member Services at 1-800-600-4441. Interpreter services are available at no cost to you.

STATE FAIR HEARING

Can I ask for a state fair hearing?

If you, as a member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 90 days of the date on the health plan's letter with the decision. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should either send a letter to the health plan at:

Fair Hearing Coordinator
Amerigroup
3800 Buffalo Speedway, Suite 400
Houston, TX 77098

Or you can call Member Services at 1-800-600-4441. We can help you with this request.

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

- 10 calendar days following the MCO's mailing of the notice of the action or

- The day the health plan's letter says your service will be reduced or end

If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

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

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

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 1-800-436-6184
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled "I WANT TO," click "Report fraud, waste, or abuse" to complete the online form or
- You can report directly to your health plan:
  Compliance Officer
  Amerigroup
  2505 N. Highway 360, Suite 300
  Grand Prairie, TX 75050
  1-800-839-6275

Other reporting options include:

- External Anonymous Compliance Hotline: 1-877-660-7890 or amerigroup.silentwhistle.com
- Email: corpinvest@amerigroup.com
  obe@amerigroup.com

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 Amerigroup, 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
- Any limits on your freedom of choice among network providers
- Your rights and responsibilities
- Information on complaint, appeal, and fair hearing procedures
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits; this is designed to make sure you understand the benefits to which you are entitled
- How you get benefits, including authorization requirements
- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits
- How you get 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 Amerigroup practice guidelines

We hope this book has answered most of your questions about Amerigroup. For more information, you can call the Amerigroup Member Services department.

NOTICE OF PRIVACY PRACTICES

The original effective date of this notice was April 14, 2003.

Please read this carefully.

This tells you who can see your Protected Health Information (PHI) with and without your OK. It also tells what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called Protected Health Information (PHI), safe for our members. That means if you're a member right now or if you used to be.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get PHI from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI? We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment**
  - To share information with the doctors, clinics and others who bill us for your care

- When we say we'll pay for health care or services before you get them

- **For health care business reasons**

- To help with audits, fraud and abuse programs, planning, and everyday work

- To find ways to make our programs better

- **For public health reasons**

- To help public health officials keep people from getting sick or hurt

- **With others who help with or pay for your care if you can't speak for yourself and it's best for you**

We must get your OK in writing before we use or share your PHI for anything but your care, payment, everyday business, research or other things not in this notice. Other things could be selling it or using it to sell things to you. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to Worker's Compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**

- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in another way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to another address or to send it in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI hasn't been kept private.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at **1-800-600-4441.** If you're deaf or hard of hearing, call the AT&T Relay Service at **711.**

What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

We reserve the right to change this notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the Web at **www.myamerigroup.com**.

As we told you in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws if they say we need to do more than the Federal HIPAA Privacy Rule. This notice tells you about your rights and what the state laws say we have to do.

Your Personal Information

We may ask for, use and share Personal Information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:

– Health

– Habits

– Hobbies

- We may get PI about you from other people or groups like:

– Doctors

– Hospitals

– Other insurance companies

- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.