Member Handbook

Amerigroup Community Care

Georgia Families 360°SM

Georgia Families 360°SM Member Intake Line
855-661-2021
myamerigroup.com/GA

1031024GAMESAGP 06/24

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This member handbook has important information about your Amerigroup Community Care benefits. Call the Georgia Families 360°SM Member Intake Line at **855-661-2021** for a verbal translation.

Dear Member:

Welcome to Amerigroup! We're about more than doctor's visits. With special services like health education and events, we offer you many ways to get and stay healthy. Some of our special benefits:

- Round-trip rides to doctor visits
- Dental exams twice a year without any copay
- Feminine hygiene products with a prescription at no cost
- Free membership for your child at participating Boys & Girls Clubs (excludes summer camp)

Member handbook

Your member handbook tells you how we work and how to get healthcare and keep your family healthy. Georgia Families 360°SM Adoption Assistance members can also find information about the program starting on page 63 of this handbook. If you have questions about your member handbook, you can call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** to talk to a representative. You can also call this number to talk to a nurse on 24-hour Nurse HelpLine.

Member website

You can visit our member website at myamerigroup.com/GA to:

- Choose, change, or find a PCP who works with your plan.
- Request an ID card.
- Find medications covered by your plan.
- View your member handbook or find a provider.

What to expect next

Your Amerigroup ID card is available by contacting the legal guardian DFCS/DJJ Case Manager. It's also available to print from our website and app. The name of member's primary care provider (PCP) is on the card, too. Please check the PCP's name on your ID card. If it's not right, please call Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**. For Adoption Assistance members, your child's ID card will arrive in a few days.

Thank you for choosing us to help you get quality healthcare benefits for you and your family.

Sincerely,

Melvin W. Lindsey
Plan President
Amerigroup Community Care

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Amerigroup Community Care

Foster Care, Adoption Assistance, and Select Members in Department of Juvenile Justice

740 W. Peachtree Street, Atlanta, GA 30308

855-661-2021 (TTY 711) • myamerigroup.com/GA

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WELCOME TO AMERIGROUP COMMUNITY CARE

About your new health plan

Amerigroup is a Georgia care management organization (CMO). We work with the Georgia Department of Community Health to help your child get Georgia Families 360°℠ program benefits.

How to get help

Georgia Families 360°℠ Member Intake Line

If you have any questions about the Amerigroup health plan, call our Georgia Families 360°℠ Member Intake Line team at **855-661-2021 (TTY 711)**. You can call 24 hours a day, seven days a week.

The Georgia Families 360°℠ Member Intake Line can help you with:

- Amerigroup benefits
- The member handbook
- Member ID cards
- Getting care
- Choosing your PCP
- Changing your PCP
- Doctor appointments
- Choosing a dentist
- Dentist appointments
- Finding a network pharmacy
- Urgent care
- Out of town care
- Transportation
- Special needs
- Healthy living
- Gift card programs
- Health education classes

Please also call the Georgia Families 360°℠ Member Intake Line if the member:

- Wants us to send a copy of our Notice of Privacy Practices. This is at no cost to the member. The notice tells the member:
  - How medical information about the member may be used.
  - How medical information may be disclosed.
  - How to get access to this information.
  - Has any problems with their care or isn't happy with the services they got from the doctors and hospitals we work with.

For members who do not speak English, we offer translation over the phone in many languages and dialects. We also provide translation over the phone for doctor visits. Please call the Georgia Families 360°℠ Member Intake Line at **855-661-2021 (TTY 711)** at least 24 hours before the member's visit if the member wants these services. These services are at no cost to the member.

The Georgia Families 360°℠ Member Intake Line

Call your care coordinator or the Georgia Families 360°℠ Member Intake Line at **855-661-2021 (TTY 711)** to be connected to your care coordinator for advice on:

- How soon members need care when they are sick.
- What kind of healthcare members need.
- What to do to take care of the member until they see a doctor.
- How the member can get the care he or she needs.

We want the member to be happy with his or her services through the Amerigroup network of doctors and hospitals. Please call the Georgia Families 360°℠ Member Intake Line at **855-661-2021 (TTY 711)** if there are problems with the member's care.

Other important phone numbers

- Enrollment questions: Call the Georgia Families 360°℠ Member Intake Line at **855-661-2021 (TTY 711)**.
- Routine eye care: Call Avesis Vision at **866-522-5923**.
- Dental care: Call DentaQuest at **800-895-2218 (TTY 711)**.
- Questions about your medications: Call Pharmacy Member Services at **833-205-6006**.

Amerigroup member handbook

This handbook will help the member understand their Amerigroup health plan. If the member has questions or needs help understanding or reading it, call the Georgia Families 360°℠ Member Intake Line at **855-661-2021 (TTY 711)**. We can answer your questions over the phone, or we can send you a hard copy in one of these formats, at no cost to you:

- A large print version
- An audio taped version
- A Braille version

The other side of this handbook is in Spanish. Call Member Services to get a hard copy in a language other than English or Spanish, at no cost to you.

Identification cards

The member should have a Medicaid ID card from the Georgia Department of Community Health (DCH). This card is also called the Medical Assistance Certification.

Our members also get an Amerigroup ID card. It can be requested by having legal guardian DFCS/DJJ Case Manager call the Georgia Families 360°℠ Member Intake Line at **855-661-2021 (TTY 711)**, or you may go online at **myamerigroup.com/GA**. Always keep it with the member and show it to any provider that the member visits. The member does not need to show the ID card for emergency care. The member can get covered services through an Amerigroup network provider in the state of Georgia. Any requests to see a non-network provider must have prior approval.

The card tells doctors and hospitals:

- Who is a member of Amerigroup.
- Who the member's Amerigroup primary care provider (PCP) is.
- Who the member's Amerigroup primary care dentist (PCD) is.
- Amerigroup will pay for the medically needed benefits listed in the section **Amerigroup healthcare benefits**.

The Amerigroup ID card has the name and phone number of the member's PCP and PCD on it. The date he or she became an Amerigroup member is also shown. The ID card has important phone numbers needed like:

- Our Georgia Families 360°℠ Member Intake Line
- 24-hour Nurse HelpLine
- Eye care
- Dental care
- Our Pharmacy Member Services department

Always carry the Amerigroup ID card and the Medicaid card. If the Amerigroup ID card is lost or stolen, call the Georgia Families 360°℠ Member Intake Line at **855-661-2021 (TTY 711)** right away. We will send you a new one, or you can visit **myamerigroup.com/GA** to download a copy.

Service regions

Service region	Counties		
Atlanta	**You live in the Atlanta service region if you live in one of these counties:**		
	Barrow	DeKalb	Jasper
	Bartow	Douglas	Newton
	Butts	Fayette	Paulding
	Carroll	Forsyth	Pickens
	Cherokee	Fulton	Rockdale
	Clayton	Gwinnett	Spalding
	Cobb	Haralson	Walton
	Coweta	Henry	
East	**You live in the East service region if you live in one of these counties:**		
	Burke	Jefferson	Taliaferro
	Columbia	Jenkins	Warren
	Emanuel	Lincoln	Washington
	Glascock	McDuffie	Wilkes
	Greene	Putnam	
	Hancock	Richmond	
North	**You live in the North service region if you live in one of these counties:**		
	Banks	Gilmer	Oconee
	Catoosa	Gordon	Oglethorpe
	Chattooga	Habersham	Polk
	Clarke	Hall	Rabun
	Dade	Hart	Stephens
	Dawson	Jackson	Towns
	Elbert	Lumpkin	Union
	Fannin	Madison	Walker
	Floyd	Morgan	White
	Franklin	Murray	Whitfield

Service Region	Counties		
Southeast	**You live in the Southeast service region if you live in one of these counties:**		
	Appling	Chatham	Montgomery
	Bacon	Effingham	Pierce
	Brantley	Evans	Screven
	Bryan	Glynn	Tattnall
	Bulloch	Jeff Davis	Toombs
	Camden	Liberty	Ware
	Candler	Long	Wayne
	Charlton	McIntosh	
Central	**You live in the Central service region if you live in one of these counties:**		
	Baldwin	Johnson	Pulaski
	Bibb	Jones	Talbot
	Bleckley	Lamar	Taylor
	Chattahoochee	Laurens	Telfair
	Crawford	Macon	Treutlen
	Crisp	Marion	Troup
	Dodge	Meriwether	Twiggs
	Dooly	Monroe	Upson
	Harris	Muscogee	Wheeler
	Heard	Peach	Wilcox
	Houston	Pike	Wilkinson
Southwest	**You live in the Southwest service region if you live in one of these counties:**		
	Atkinson	Dougherty	Schley
	Baker	Early	Seminole
	Ben Hill	Echols	Stewart
	Berrien	Grady	Sumter
	Brooks	Irwin	Terrell
	Calhoun	Lanier	Thomas
	Clay	Lee	Tift
	Clinch	Lowndes	Turner
	Coffee	Miller	Webster
	Colquitt	Mitchell	Worth
	Cook	Quitman	
	Decatur	Randolph	

DOCTORS

Primary care provider and primary care dentist

All Amerigroup members must have a primary care provider (PCP) and primary care dentist (PCD). The PCP and PCD must work with our plan.

What is a PCP?

The PCP will give the member a medical home, which means they will:

- Get to know the member's health history.
- Give the member all of the basic health services they need.

- Send the member to other doctors or hospitals when they need special care.

What is a PCD?

The PCD will give the member a dental home. A dental home is where the member gets dental care. The dental home will give the member needed oral health services. The dental home may refer the member to medical and behavioral health providers the same way a PCP does. They do this to integrate care and help improve the member's health.

Choosing a PCP or PCD

When the member became an Amerigroup member, they were assigned a PCP and PCD. We chose one who should be close by the member if the member or authorized representative did not choose a PCP or PCD. The PCP and PCD's name and phone number are on the Amerigroup ID card.

The member can choose a new PCP and PCD. Just look in the provider directory online, or we can help choose a new PCP or PCD. Call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** for help.

If the member is seeing a doctor or dentist now, look in the provider directory. You can find out if that doctor is in our network. If so, you can tell us the member wants to keep that doctor as his or her PCP or PCD.

If the member had a different doctor before he or she joined Amerigroup

When the member joined, they may have been seeing a doctor who isn't in our network. The member may be able to keep seeing this doctor while he or she finds a network PCP. Call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** to find out more. We will make a plan for the member and the doctors, so we all know when the member needs to start seeing the new network PCP.

How to change a member's primary care provider

The member can change their PCP at any time. If the member needs to change a PCP, the member will need to pick a new PCP who works with our plan. There are two ways to change a PCP:

- **Online:** Visit **myamerigroup.com/GA** and select **Find a Doctor** to search our online provider directory. Then, log in to change the PCP right from the website.
- **By phone:** Call the Georgia Families 360°SM Member Intake if the member needs help choosing a new PCP. If the member calls to change a PCP, the change will be made on the next business day.

If the primary care provider's office moves, closes or stops working with our plan

The PCP's office may move, close, or stop working with our plan. If this happens, we will call to let you know. In some cases, the member may be able to keep seeing this PCP for care. Please call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** for more information. In some cases, the member may be able to keep seeing the PCP for care while a new PCP is chosen. We will keep in touch with you and the member's PCP so we all know when the member needs to start seeing the new network PCP.

We can also help the member pick a new PCP. Call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** for help. Once they have picked a new PCP, we will send the member a new ID card within 10 calendar days.

If the primary care provider asks for a member to be changed to a new primary care provider

The PCP may ask for the member to be changed to a new PCP. The PCP may do this if:

- The member does not follow their medical advice over and over again.
- The PCP agrees that a change is best for the member.
- The PCP does not have the right experience to treat the member.
- The assignment to the PCP was made in error (like an adult assigned to a child's doctor).

If the PCP asks you to change to a new PCP, call the Member Intake Line at **855-661-2021 (TTY 711)** for help finding a new PCP. You can also call to let us know the member does not want to change his or her PCP.

If a member wants to go to a doctor who is not their primary care provider

If the member needs care from a specialist or another doctor who isn't the member's PCP, please talk to the member's PCP first. If the specialist or other doctor doesn't work with our plan, the PCP will need to refer the member first. They may help set up the visit with the specialist for the member. If the member goes to a doctor that the PCP has not referred the member to, the care the member gets may not be covered, and we may not pay for it. Behavioral health providers do not require a referral.

There are some times where the member doesn't need a referral from the PCP:

- If the member wants to see a behavioral health provider for mental health, alcohol, or substance abuse services.
- If the member wants to see an OB-GYN.
- If the member has disabilities, special healthcare needs or chronic complex conditions. In this case, the member has a right to direct access to a specialist. This specialist may serve as the member's PCP. Please call the Georgia Families 360°SM Member Intake Line so this can be arranged.

For a list of services that don't require a referral, see the section called **Services that do not need a referral**.

Specialists

The member's PCP can take care of most of the member's healthcare needs. But the member may need care from other kinds of doctors who give care for a certain illnesses or parts of the body. These doctors are called specialists. We have many kinds of specialists who work with our plan. Here are some examples:

- Allergists (allergy doctors)
- Dermatologists (skin doctors)
- Cardiologists (heart doctors)
- Obstetricians-gynecologists, or OB-GYNs (for women's health – see **Choosing an OB-GYN**)
- Behavioral Health (mental health/substance use disorder doctors)

Remember, the member may need a referral from the PCP to get services from some specialists. Talk with the PCP first.

Choosing an OB-GYN

Female members can see an obstetrician and/or gynecologist (OB-GYN) who works with our plan for women's health needs. These services include:

- Well-woman visits where the doctor will talk about things like breast and reproductive health, birth control, and vaccines the member may need
- Prenatal care
- Family planning
- Referrals to a specialist who works with our plan
- Care for any female medical condition

Members don't need a referral from their PCP to see their OB-GYN. If the member doesn't want to go to an OB-GYN, their PCP may be able to treat her for OB-GYN health needs. Ask the member's PCP if he or she can give the member OB-GYN care. If not, the member will need to see an OB-GYN. To find an OB-GYN who works with us, use our **Find a Doctor** tool online at **myamerigroup.com/GA**. For help choosing an OB-GYN, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**.

If the member has a baby, call the Georgia Families 360°SM Member Intake Line within 24 hours. Also, call Georgia Gateway at **877-423-4746**. This will help us make sure the new baby gets health services.

Second opinion

Members have the right to ask for a second opinion for any healthcare service. The member can get a second opinion from a provider who works with us. The member can also get a second opinion from a non-network provider if there is not a network provider in his or her area. The member may ask for a second opinion from Amerigroup. This is at no cost to the member. Once approved, the member's PCP will send copies of all related records to the doctor who will give the second opinion. The PCP completing the second opinion will let the member and Amerigroup know the outcome of the second opinion.

If the member had a different doctor before he or she joined Amerigroup

When the member joined, they may have been seeing a doctor who isn't in our network. The member may be able to keep seeing this doctor while they find a network PCP. Call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** to find out more. We will make a plan for the member and the doctors, so we all know when the member needs to start seeing the new network PCP.

Coordination of services

We can help the member access services offered by:

- Children's Intervention services
- Community Care services
- Independent Care Waiver Program — services that help a limited number of adult members with physical disabilities live in their own homes
- Mental Retardation (MR) waiver services
- Individuals with Disabilities Education Act (IDEA) services

TELEHEALTH

Live in a rural area and have to travel a long way to see doctors? Amerigroup and the Georgia Partnership for Telehealth (GPT) have made it easier to get specialty and behavioral healthcare. With GPT services, members can use face-to-face video conferencing for visits with specialists, behavioral health providers and others whose offices are hard to get to. To learn more about telehealth providers and services in your area:

- Go to gpth.org
- Call the Georgia Partnership for TeleHealth at 866-754-4325
- Call the member's doctor
- Call Georgia Families 360°℠ Member Intake Line at **855-661-2021 (TTY 711)**

Scheduling a Telehealth (GPT) visit

To schedule a specialist visit:

1. The referring doctor contacts GPT to plan the visit.
2. GPT fills out a patient intake form and sends it to the specialist's scheduler.
3. The scheduler gets needed member information.
4. The scheduler contacts GPT to confirm the visit.

To learn more about telehealth services, call GPT toll free at 866-754-4325. Or visit gpth.org to find out where you can get telehealth services. You can also call the member's doctor or the Member Intake Line at **855-661-2021 (TTY 711)**.

CARE COORDINATION

Role of care coordination/care coordinator

We will assign the member a care coordinator to help the member get the healthcare they need. Care coordinators will help by:

- Serving as the main contact between the member, Amerigroup, state agencies, foster parents, other caregivers, and the member's doctors.
- Keeping all doctors and authorized caregivers up to date on the member's care and services.
- Create and monitor member's care plan goals.

The care coordinator is the main contact between the member, Amerigroup, state agencies, foster parents, other caregivers, and the member's doctors.

Our interdisciplinary care coordination teams:

- Are responsible for coordinating all services identified in the member's care plan.
- Include care coordinators who provide information to and help providers, members, foster parents, caregivers, and Division of Family and Children Services (DFCS) or Department of Juvenile Justice (DJJ) staff with access to care and coordination of services.
- Ensure access to primary, dental, and specialty care and support services, including helping members, caregivers, foster parents, and DFCS and DJJ staff with locating providers and scheduling and getting appointments as necessary.
- Help with coordinating nonemergency transportation for members, as needed, for provider appointments and other healthcare services.
- Document efforts to obtain provider appointments, arrange transportation, and establish meaningful contact with the member's primary care provider (PCP). A PCP shall include general/family practitioners, pediatricians, internist, physician's assistants, CNM or NP-Cs.
- Establish meaningful contact with the member's primary care provider, physicians, dentists, specialists, and other providers
- Arrange for referrals to community-based resources based on provider availability and specialty and keep track of problems with getting appointments, arranging transportation, establishing meaningful contact with providers, or arranging referrals to community-based resources.
- Ensure providers, DFCS, DJJ, and Department of Behavioral Health and Developmental Disabilities (DBHDD) staff, caregivers, foster parents, and foster care and Juvenile Justice members have access to information about the Amerigroup preauthorization process.
- Define program requirements and processes, including the member appeals process and how we help providers and members with the process.
- Educate other Amerigroup staff about when medical information is required by DFCS and DJJ for court hearings.
- Offer application help for members who may qualify for Supplemental Security Income (SSI) benefits.

How to access the Care Coordination team

Call **855-661-2021 (TTY 711)** or email GF360@amerigroup.com to reach the member's care coordinator or someone else from the team.

CONTINUITY OF CARE AND TRANSITION OF CARE ISSUES

If the member needs help with keeping services they have or need a different service or doctor, the care coordination team can help the member. This is called continuity of care or transition of care.

Continuity of care

So members continue to get the care they need, we'll allow them to see the same doctors and cover services they were getting as a part of their treatment plans under their previous health plan or

through Fee-for-Service Medicaid. This includes issuing an out-of-network authorization to ensure the member's condition remains stable and services are consistent to meet the member's needs as appropriate. After the continuity period has ended or the member is considered medically or psychologically stable, we will work with the member and/or caregiver to note additional changes in services or a movement to a network provider where needed.

All allowances will continue for a period of at least 30 days or until the Amerigroup authorized healthcare service plan is completed.

Transition of members

We will coordinate with all Georgia state agency offices and departments as needed when a member transitions in or out of enrollment with Amerigroup.

If a member transitions from another care management organization (CMO) or from private insurance, we will contact the member's prior CMO or other insurer. We will ask for:

- Information about the member's needs.
- Current medical necessity determinations.
- Authorized care and treatment plans.

Members will get a one-time 30-day supply of their current non-preferred or non-formulary medicines to allow time for their provider to find another preferred medicine on our formulary or submit a prior authorization request.

If foster care members or members in Department of Juvenile Justice transition from Fee-for-Service Medicaid, we will coordinate with the Department of Community Health (DCH) staff assigned to coordinate administrative services. We will contact the member's prior service providers, including PCPs, specialists, and dental providers.

We will ask for:

- Information about the member's needs.
- Current medical necessity determinations.
- Authorized care and treatment plans.

For foster care and Department of Juvenile Justice members turning age 18 and exiting foster care and the Juvenile Justice system, we:

- Support DFCS and DJJ in transition planning for members returning to their homes.
- Assess the member's community support needs so the member can stay in the community and remain stable through the transition out of foster care or residential placement with DJJ. This includes, but is not limited to:
    - Pointing out and facilitating connections to the range of medical services needed and providers of these services.
    - Assessing needs and giving advice for access to specialized medical or social supports, including:
        - Positive behavioral supports.
        - Medication support.

- Durable medical equipment.
- Communication devices, vehicles, or home adaptations.

For all members, we will:

- Review health status and other data to decide whether the member meets the general eligibility criteria for entering a Home- or Community-Based Services (HCBS) waiver program.
- Provide guidance on the waiver application process and, if necessary, place the member on waiver waiting list(s).
- Teach members about options for services and supports available after eligibility ends in partnership with DFCS and DJJ, including:
    - Independence Plus
    - Individuals with Disabilities Education Act participation and application for postsecondary options (housing and vocational opportunities)

Members will be given facts about getting disability services from colleges, universities, and employers where appropriate.

GOING TO THE DOCTOR

The first doctor's appointment

Call the member's doctor to set up his or her first visit. Newly enrolling foster care members should see their PCP within the first 10 calendar days of enrollment with Amerigroup. New DJJ and Adoption Assistance Members should see their PCP within the first 90 calendar days of enrollment with Amerigroup. By finding out more about his or her health now, their PCP can take better care of the member if he or she gets sick. If you want our help setting up the member's first appointment, call **855-661-2021 (TTY 711)**.

How to make an appointment

It's easy to set up a visit with the member's PCP. Just call the PCP's office. The phone number is on the Amerigroup ID card. If you need help, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**. We will help you set up a visit. When you call, let us know what the member needs (like a checkup or a follow-up visit). Also, tell the PCP's office if the member does not feel well. This will let the PCP's office know how soon the member needs to be seen. It may shorten the wait before the member sees the PCP.

Wait times in the office

You should be told what the waiting time is when you get to the member's appointment. You can reschedule their appointment if you can't wait. Your wait time at the provider's office should not be more than the following:

Type of appointment	Wait time
Scheduled appointment	No more than 30 minutes
Unscheduled or walk-in appointment	No more than 45 minutes

If you call after hours and leave a message, the PCP will call back. Your wait time for a response should not be more than the following:

Type of call	Wait time
Urgent call	No more than 20 minutes
Other call	No more than one hour

Wait times for appointments

We want the member to get care when he or she needs it. When you call to set up an appointment with a provider who works with us, they should give you an appointment within the time frames listed below:

Type of appointment	Time frame
Dental provider	No more than 21 calendar days
Urgent dental care	No more than 48 hours
PCP (routine visit)	No more than 14 calendar days
PCP (adult sick visit)	No more than 24 hours
PCP (pediatric sick visit)	No more than 24 hours
Specialists	No more than 30 calendar days
Pregnant women (initial visit)	No more than 14 calendar days
Nonemergency hospital stays	No more than 30 calendar days
Mental health providers	No more than 14 calendar days
Urgent care providers	No more than 24 hours
Emergency providers	Immediately (24 hours a day, seven days a week) and without prior authorization

What to bring when you go for a doctor visit

When you go to a doctor visit, bring the member's:

- Amerigroup ID card.
- Current Medicaid ID card.
- Medicines the member is taking now.
- List of questions for the member's doctor.

How to cancel a doctor visit

If you set up a visit with the member's doctor and then can't go, call the doctor's office. Tell the office to cancel the visit. You can set up a new visit when you call. Try to call at least 24 hours before the visit. This will let someone else see the doctor at that time.

If you want us to cancel the visit for the member, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**. If you do not call to cancel the member's doctor visits over and over again, the PCP may ask for the member to be changed to a new doctor.

How to get healthcare when the primary care provider's office is closed

Except in the case of an emergency or when the member needs care that does not need a referral (see the section **Services that do not need a referral**), you should always call the PCP first before the member gets medical care. Help from the PCP is available 24 hours a day.

If you call the PCP's office when it's closed, leave a message with your name and a phone number where you can be reached. Someone should call you back soon to tell you what to do. You may also call the Georgia Families 360°SM Member Intake Line for help at **855-661-2021 (TTY 711)**.

If you think the member needs emergency care, call 911 or go to the nearest emergency room right away.

How to get healthcare when the member is out of town

If the member needs emergency care when he or she is out of town or outside of Georgia, go to the nearest hospital emergency room or call 911. If the member needs urgent care, call their PCP. See the section **Urgent care** for more information. If the PCP's office is closed, leave a phone number where you can be reached. The PCP or someone else should call you back. Follow the doctor's instructions. You may be told to get the member care where you are if the member needs it very quickly. You can also call 24-hour Nurse HelpLine at **800-600-4441 (TTY 711)** for help. If the member needs routine care like a checkup or prescription refill when they are out of town, call the PCP or 24-hour Nurse HelpLine.

Please note: If you're outside of the U.S. and the member gets healthcare services, they will not be covered by Amerigroup or Medicaid.

HOW TO GET TO A DOCTOR APPOINTMENT OR TO THE HOSPITAL

If the member needs transportation for nonemergency medical care, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**. Be sure to call at least three days before the visit. Tell them the time of the member's visit and where to pick them up. The transportation vendor for the region will call you back to give you a pickup time.

Transportation for Medicaid members

Medicaid members can also call the Georgia NET (Non-Emergency Transportation) service directly. Call the phone number found next to the county where the member lives below. Be sure to call at least three days before a scheduled visit. You can call Monday through Friday from 7 a.m. to 6 p.m. Some Georgia NET service providers also offer mileage reimbursement to and from medical appointments. Please inquire about this program when you call to make your transportation appointment.

The following chart lists the region, phone number, and counties by service based on where you live.

Region	Broker/ Phone number	Counties served
North	**Verida**	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth,

Region	Broker/ Phone number	Counties served
	Toll free **866-388-9844** **Local** **678-510-4555**	Franklin, Gilmer, Gordon, Greene, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee, Paulding, Pickens, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White, Whitfield
Atlanta	**Verida** **404-209-4000**	DeKalb, Fulton, Gwinnett
Central	**Modivcare** **Toll free** **888-224-7981** **Local** **404-305-3535**	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox, Wilkinson
East	**Modivcare** **Toll free** **888-224-7988**	Appling, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne, Wilkes
Southwest	**Modivcare** **Toll free** **888-224-7985**	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster, Worth

If you have an emergency and need transportation, call **911** for an ambulance.

To learn more about Medicaid Non-Emergency Medical Transportation (NEMT) program, visit **medicaid.georgia.gov/programs/all-programs/non-emergency-medical-transportation**

Doctor’s office and hospital access for members with disabilities

The doctors and hospitals who work with our plan should help members with disabilities get the care they need. Members who use wheelchairs, walkers, or other aids may need help to get into an office. If the member needs a ramp or other help, make sure the doctor’s office knows this before they go there. This way, they will be all set for the visit. If you want help talking to the doctor about the member’s special needs, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**.

WHAT MEDICALLY NECESSARY MEANS

The primary care provider (PCP) will help the member get the medically necessary health services they need. Medically necessary means the services are:

a) Needed to prevent, test for and/or treat conditions that could cause:
   - Suffering or pain.
   - Physical deformities or limited function.
   - A handicap, or make a handicap worse.
   - Illness or death.

b) Given at the right places and at the right levels of care for the treatment of members' health conditions.

c) In line with healthcare practice guidelines and standards that professional healthcare or government agencies agree to.

d) In line with the diagnosis of the conditions.

e) No more unpleasant or limiting than needed to give a good balance of safety, effectiveness, and efficiency.

f) Not mainly for the ease of the doctor or member.

Our medical directors decide if care is medically needed based on the right coverage and level of care and service. We don't offer extra payment to providers based on what they decide is medically needed or not.

Be sure the member follows the treatment plan prescribed by their provider. This can help make sure the member gets well faster. If the member doesn't, it could take the member longer to get well or his or her condition could get worse.

MEDICAL ADVANCES AND NEW TECHNOLOGY

Our medical directors and the doctors who work with our plan look at new medical advances (or changes to existing technology) in:

- Medical procedures
- Behavioral health procedures
- Pharmaceuticals
- Medical devices

They review new advances and technologies to decide if:

- These advances or technologies should be covered benefits.
- The government has agreed the treatment is safe and effective.
- The results of the advances or technologies are as good as or better than treatments covered by your current benefits.

They also look at scientific literature to find out if:

- The government thinks these new procedures or treatments are safe and effective.

- They have the same or better outcomes than the treatments we use now.

They do this to decide if we should include these procedures and treatments in our plan.

AMERIGROUP HEALTHCARE BENEFITS

Amerigroup covered services

The following list shows the healthcare services and benefits that the member can get from Amerigroup. The member's primary care provider (PCP) will give the care the member needs or refer the member to a doctor who can give the member the care they need.

For a few special Amerigroup benefits, members have to be a certain age or have a certain kind of health problem. Some healthcare services and benefits need prior authorization from Amerigroup. Amerigroup will only pay for services which we have approved. If you have a question or are not sure whether we offer a certain benefit, you can call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** for help.

These are covered services Amerigroup members in the Georgia Families 360°SM program get:

- Ambulatory surgical services
- Audiology services
- Ancillary medical services
- Basic behavioral health services (assessments and therapy)
- Clinical services (other than hospitals)
- Clinical lab services, diagnostic testing, and radiology services
- Dental services
- Disease services
- Diagnostic services
- Durable Medical Equipment (DME)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Emergency dental services
- Emergency medical services
- End-stage renal disease services
- Eye care and vision services
- Family planning services
- Home health extended services
- Home health services
- Immunizations (children and adults)
- Inpatient hospital services
- Lab and X-ray services
- Medical and surgical dental services
- Medical transportation services
- Medicines
- Nurse-midwife services

Copayments

A copayment or copay is the amount the member may need to pay for a covered service. **There are no copays** for members in foster care, adoption assistance and Department of Juvenile Justice in the Georgia Families 360°SM program.

EXTRA AMERIGROUP BENEFITS

We offer members extra benefits called value-added services, including:

- Free memberships to participating Boys & Girls Clubs for members ages 6 to 18 (excluding summer camp)
- A free coupon booklet full of discounts to local retailers
- Free Girl Scouts membership for girls K–12th grade
- Free flu shots at participating pharmacies and a Flu Pandemic Prevention Kit for ages 16–21
- GED assistance
- Taking Care of Baby and Me®, our program for all pregnant members with up to $75 in gift cards for completing the program. To enroll in the Healthy Rewards program or to learn more, please call Healthy Rewards at **888-990-8681**) (see the section **Special care for pregnant members** for details).
- Pregnant members and new parents can get free diapers, potty-training seats, a mom-to-be catalog, a Sam's Club membership, and much more
- Healthy Adults, Healthy Results program that includes on-demand fitness videos, access to a live health coach, WW® vouchers (formerly called Weight Watchers), a gym membership, and exercise kit for members ages 18 and older
- Healthy Rewards program offers a gift card with a value up to $75 a year to spend at local retailers to eligible members who complete preventive care services
- Summer Fresh Food Connect where eligible members can select between HelloFresh, a fresh produce box, or membership for free only grocery delivery
- Up to $200 for dorm room essentials for graduating high schoolers
- Annual subscription to a meditation and sleep app for eligible members ages 12 and older
- Certain approved over-the-counter (OTC) medicines and feminine hygiene products when prescribed by the member's doctor and gotten from pharmacies that work with our plan without any copays

We give you these extra benefits to help keep the member healthy and to thank you for being our member. To learn more, visit extra benefits section at **myamerigroup.com/GA** or email us at GF360@amerigroup.com.

Prior authorization

Some of our services and benefits need prior authorization or approval. This means the doctor must ask us to approve them. Emergency services, services related to an emergency medical condition, and urgent care do not need approval.

We have a Utilization Review team which looks at approval requests. The team will:

- Decide if the service is needed.
- Decide if it's a benefit in your plan.

The doctor can ask for an appeal if we say we won't pay for the care that wasn't approved. We'll let the member and their doctor know what we decide within 14 calendar days after we get the appeal request. The request can be for:

- Services that are not approved.
- Services that have been changed in the amount, length or scope that is less than asked for.

Time frames for prior authorization requests

- *Standard care authorizations:* This means we'll decide on a regular time frame. We will decide on nonurgent care services within 3 business days after we get the request. We will tell the doctor of services that have been approved within 3 business days after we get the request. You or the doctor can ask to extend the time frame up to 14 calendar days. All decisions and notifications will occur within 14 calendar days if the time frame is extended.

- *Expedited care authorizations:* This means we'll make a fast decision. The doctor can ask for an expedited review if he or she thinks a delay will cause grave harm to the member's health. We'll decide on expedited requests within 24 hours (one workday) from when we get the request. We will let the doctor know of services that have been approved by phone or fax within 24 hours (one workday) after we get the request. We can ask to extend the time frame up to five work days if we can give good reasons to the Department of Community Health (DCH) for our need for more information and how the extension is in the member's best interest. We'll make all decisions and let the doctor know within five workdays if the time frame is extended.

- *Extensions:* An extension may be granted for 14 more calendar days if you or the doctor asks for an extension. Or we show DCH a need for more information and/or the extension is in your best interest. All decisions and notifications must occur by the end of the 14-day extension.

All pharmacy prior authorization requests are completed within 24 hours after we get the request unless additional information is needed from the doctor. If additional information is needed, then the time frame can be extended up to 72 hours (3 days) after receiving the request. We will send the doctor a fax at the time the prior authorization decision is made. If it's not approved, we will send you and the doctor a letter telling you this. You can also access your prior authorization decisions on the member secure portal at **member.amerigroup.com/public/login**. Your doctor may prescribe another medicine or give us more information on why you need that medicine. If necessary, you can ask for a 72-hour supply of medication from the retail pharmacy while you wait for a decision on your prior authorization request.

If you have questions about prior authorization, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** or email at GF360@amerigroup.com.

SERVICES THAT DON'T NEED A REFERRAL

It is always best to ask the member's primary care provider (PCP) for a referral for any Amerigroup service. But the member can get the following services without a referral from their PCP:

- Care from a specialist who works with our plan
- Emergency care
- Care provided by the member's Amerigroup PCP or their nurse or doctor assistant
- Yearly exams from an Amerigroup network OB-GYN
- Dental care from an Amerigroup dentist
- Eye care from an Amerigroup eye care provider (optometrist)
- Screening or testing for sexually transmitted diseases, including HIV, from an Amerigroup doctor
- EPSDT services provided by the member's PCP for Medicaid members under 21 years old

BENEFITS AND SERVICES THAT AREN'T COVERED

There are some services not covered by Amerigroup and Medicaid:

- Erectile dysfunction medications
- Orthodontia (braces)*
- Disposables (such as diapers, cotton, or bandages)*
- Services given by a relative or member of your household
- Cosmetic surgery
- Experimental items
- Partial dentures*

* Disposables, partial dentures, and orthodontia (braces) are only covered for children under EPSDT when medically necessary.

For more information about services that aren't part of your benefits, please call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**.

PROGRAM FOR YOUTH IN FOSTER CARE

Transition-age Youth (TAY)

Georgia Families 360°SM recognizes the unique needs of youth in foster care and transitioning into adulthood. Through the TAY program, Amerigroup offers education and resources for youth transitioning from foster care. Please call **855-661-2021 (TTY 711)** for more information.

DIFFERENT TYPES OF HEALTHCARE

Routine care

In most cases when medical care is needed, you call the primary care provider (PCP) to make an appointment. Then take the member to go to see the PCP. This will cover most minor illnesses and injuries, as well as regular checkups. This type of care is known as routine care.

The PCP is someone the member would see when they are not feeling well, but that is only part of the PCP's job. The PCP also takes care of the member before they get sick. This is called well care. See the section **Well care for children and adults**.

The member should be able to see their PCP within 21 days for routine care. The medical benefit plan does not cover non-emergent services performed by an out-of-network provider when those services are offered by an in-network provider.

Urgent care

The second type of care is urgent care. There are some injuries and illnesses that are not emergencies but can turn into an emergency if they are not treated within 24 hours. Some examples are:

- Throwing up
- Minor burns or cuts
- Earaches
- Headaches
- Sore throat
- Muscle sprains/strains

For urgent care, call the PCP. The PCP will tell you what to do. The PCP may tell the member to go to his or her office right away. The member may be told to go to some other office to get immediate care. You should follow the PCP's instructions. In some cases, the PCP may tell the member to go to the emergency room at a hospital for care. See the next section about emergency care for more information.

You can also call 24-hour Nurse HelpLine for advice about urgent care. The member should be able to see the PCP within 24 hours for an urgent care appointment.

Emergency care

After routine and urgent care, the third type of care is emergency care. If there is an emergency, you should call **911** or go to the nearest hospital emergency room right away. You do not have to use a hospital in the Amerigroup network. The member does not need prior authorization or a referral to get emergency care.

If you want advice, call the member's PCP or 24-hour Nurse HelpLine. The most important thing is to get medical care as soon as possible. The member should be able to see a doctor immediately for

emergency care. Members with emergency medical conditions don't have to pay for follow-up screenings and treatments needed to diagnose specific conditions or to stabilize them.

What's an emergency?

An emergency is when not seeing a doctor to get care right away could result in death or very serious harm to the member's body. The problem is so severe that someone with an average knowledge of health and medicine can tell the problem.

These problems:

- May be life-threatening or cause serious damage to your body or mental health (or, with respect to a pregnant woman, the health of the woman, or her unborn child).
- May cause serious harm to a bodily function, organ, or body part.
- May cause serious harm to self or others because of an alcohol or drug abuse emergency.
- May cause injury to self or bodily harm to others.

Here are some examples of problems that are most likely emergencies:

- Trouble breathing
- Loss of consciousness
- Chest pains
- Very bad bleeding that does not stop
- Very bad burns
- Shakes called convulsions or seizures

What is post-stabilization?

Post-stabilization care services are services the member gets after emergency medical care. The member may get these services to help keep his or her condition stable. We normally pay for these services.

Be sure to call the member's PCP within 24 hours after visiting the emergency room. The PCP will give or arrange any follow-up care the member needs.

PREVENTIVE CARE FOR CHILDREN AND ADULTS

All Amerigroup members need to have regular preventive care visits with their primary care provider (PCP). During a preventive care visit, the PCP can see if the member has a problem before it is a bad problem. When the member joins Amerigroup, call their PCP and make the first appointment within 90 calendar days.

Preventive care for children — the EPSDT program

Children need more well-care visits than adults. These well-care visits for children are part of Georgia's Early and Periodic Screening, Diagnostic and Testing (EPSDT) program. The EPSDT program helps to make sure all children who are eligible for Medicaid get regular well-care visits. The EPSDT program in Georgia provides:

- Health and development history
- Immunizations (shots)

- Dental referrals
- Health education and counseling
- Anticipatory guidance
- Measurement
- TB risk review and skin tests
- Vision and hearing screening
- Physical exam
- Development review assessment
- Lead risk assessment
- Behavioral assessment
- Nutrition review
- Lab tests (for blood lead screening)

Who can get EPSDT visits?
All people under 21 years old who get Medicaid benefits should get EPSDT visits.

Babies need to see their PCP at least eight times by the time they are 12 months old and more times if they get sick. Our care coordinators can help children with special needs or illnesses get the checkups, tests, and shots they need.

At these EPSDT visits, the child's PCP will:
- Make sure the baby is growing well.
- Talk to you about what to feed the baby and how to help the baby go to sleep.
- Answer questions you have about the baby.
- See if the baby has any problems that may need more healthcare.
- Talk to you about shots your baby will get to protect him or her from illnesses.

When the member should go to EPSDT visits
Georgia Families 360°$_{SM}$ members must follow the initial EPSDT, Dental, and Trauma assessment timeline:

Appointment type	Days to complete the appointment
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Exam	**10** calendar days of being active with Amerigroup
Dental Exam (starting at age 1)	**10** calendar days of being active with Amerigroup
Trauma Assessment (for members ages 5–17)	**15** calendar days of being active with Amerigroup

Medical records must be submitted within 24–72 business hours of service delivery via fax at **888-375-5064**.

Outside of the initial EPSDT, Dental and Trauma assessment, child must be taken to their PCP's office when:

- 3–5 days old
- By 1 month old
- 2 months old
- 6 months old
- 9 months old
- 12 months
- 18 months
- 24 months
- 30 months

• 4 months old • 15 months • Each year from 3–21 years

The member should go his or her PCP every year for a checkup from age 3 until age 21. Your child will have their teeth and gums checked by his or her PCP as a part of their regular EPSDT visits starting at 6 months old. By 12 months, your child should have established a dental home and had their first dental exam. Be sure to make these appointments. Take the member to their PCP when scheduled.

Autism screening
The PCP will screen the member for autism at 18 and 24 months.

Developmental screening
The PCP will look for developmental delays at each EPSDT visit when screened at 9, 18, and 30 months.

Developmental surveillance
The PCP will look for developmental delays at each EPSDT visit except when screened at 9, 18, and 30 months.

Behavioral assessment
The PCP will assess for any psychosocial or behavioral risk to include mental health and substance abuse at each EPSDT visit.

Alcohol, depression screening, and drug use assessment
The PCP will assess for any risk of alcohol or drug use each year from 11–21 years of age.

Hematocrit/hemoglobin risk assessment
The member's PCP will conduct a lab blood test at 12 months and assess the member for any risks at the ages below:

- 4 months
- 15 months
- 18 months
- 24 months
- 30 months
- Each year from 3–21 years of age

Blood lead screening
The PCP will screen and assess for lead poisoning during EPSDT visits. The child will be screened at:

- 6 months
- 9 months
- 18 months
- 24 months
- 3–6 years

The PCP will also give the child a blood test at 12 months and 24 months. This test will tell if the child has lead in their blood. The PCP will take a blood sample by pricking the child's finger or taking blood from their vein.

Tuberculin risk assessments

The member's PCP will assess them for any risk of tuberculosis by 1 month and at:

- 6 months
- 12 months
- 24 months
- Each year from 3–21 years of age

Dyslipidemia (cholesterol) risk assessment

The member's PCP will assess the member for any risk at:

- 24 months
- 4 years
- 6 years
- 8 years
- 12–17 years
- Once between 9–11 years
- Once between 18–20 years old

Cervical dysplasia/Pap test screening

A girl's PCP will assess her for any risk at each visit from 21 years of age.

Eye screening

The member's PCP will screen their vision during EPSDT visits. The child will be screened each year at:

- 3–6 years
- 8 years
- 10 years
- 12 years
- 15 years

The member's PCP will also assess their vision for any risks right after the child is born and at:

- 3–5 days old
- By 1 month old
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 7 years
- 9 years
- 11 years
- 13 years
- 14 years
- Each year from 16–21

Please see the section **Eye care** under the heading **Special kinds of healthcare** for more information.

Hearing screening

The child's PCP will screen the child's hearing during EPSDT visits. The child's PCP will screen the child's hearing right after the child is born and at:

- 4 years

- 5 years
- 6 years
- 8 years
- 10 years

The child's PCP will also assess the child's hearing for any risks at:

- 3–5 days old
- By 1 month old
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 7 years
- 9 years
- Each year from 11–21

Dental care

The child will have their teeth and gums checked by their PCP as a part of their regular EPSDT visits starting at 6 months old. At age 1, the child should begin seeing a dentist every six months. Please see the section **Dental care** under the heading **Special kinds of healthcare** for more information.

Fluoride varnish

A fluoride varnish will be put on your child's teeth in the primary care setting through age 5. Once your child's teeth have come in, fluoride varnish may be applied every 3 to 6 months in the primary care or dental office.

Immunizations

It's important for the child to get their immunizations (shots) on time. Take the child to the doctor when their PCP says a shot is needed. Use the charts listed next to help you keep track of the shots the child needs. (Source: Centers for Disease Control and Prevention website: *Immunization Schedules* (2022): cdc.gov.)

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Hepatitis B (HepB)	1st dose	←— 2nd dose —→			←— 3rd dose —→												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			←— 4th dose —→				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		← 3rd or 4th dose, See Notes →										
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		←— 4th dose —→										
Inactivated poliovirus (IPV <18 yrs)			1st dose	2nd dose	←— 3rd dose —→							4th dose					
Influenza (IIV4)					Annual vaccination 1 or 2 doses								Annual vaccination 1 dose only				
or																	
Influenza (LAIV4)											Annual vaccination 1 or 2 doses		Annual vaccination 1 dose only				
Measles, mumps, rubella (MMR)					See Notes		←— 1st dose —→					2nd dose					
Varicella (VAR)							←— 1st dose —→					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series, See Notes										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														1 dose			
Human papillomavirus (HPV)														See Notes			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes											1st dose		2nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)														See Notes			
Pneumococcal polysaccharide (PPSV23)											See Notes						
Dengue (DEN4CYD; 9-16 yrs)													Seropositive in endemic areas only (See Notes)				

Range of recommended ages for all children
Range of recommended ages for catch-up vaccination
Range of recommended ages for certain high-risk groups
Recommended vaccination can begin in this age group
Recommended vaccination based on shared clinical decision-making
No recommendation/ not applicable

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES 2022

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
Dengue vaccine	DEN4CYD	Dengvaxia®
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	DT	No trade name
Haemophilus influenzae type b vaccine	Hib (PRP-T)	ActHIB® Hiberix®
	Hib (PRP-OMP)	PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV4	Multiple
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D	Menactra®
	MenACWY-CRM	Menveo®
	MenACWY-TT	MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C	Bexsero®
	MenB-FHbp	Trumenba®
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax 23®
Poliovirus vaccine (inactivated)	IPV	IPOL®
Rotavirus vaccine	RV1 RV5	Rotarix® RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Tetanus and diphtheria vaccine	Td	Tenivac® Tdvax™
Varicella vaccine	VAR	Varivax®
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	DTaP-IPV/Hib	Pentacel®
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix® Quadracel®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	MMRV	ProQuad®

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child and adolescent immunization schedule

1. Determine recommended vaccine by age (**Table 1**)
2. Determine recommended interval for catch-up vaccination (**Table 2**)
3. Assess need for additional recommended vaccines by medical condition or other indication (**Table 3**)
4. Review vaccine types, frequencies, intervals, and considerations for special situations (**Notes**)
5. Review contraindications and precautions for vaccine types (**Appendix**)

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual
- ACIP Shared Clinical Decision-Making Recommendations www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Scan QR code for access to online schedule

CS310020-A

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2022

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib®, Pentacel®, Hiberix®), Vaxelis® or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; OR if both doses were PedvaxHIB® and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months and previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

American Academy of Pediatrics
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Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures.

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the Bright Futures Guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

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	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9] ⟶	⟶	⟶	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	⟵	⟵	●[10]	⟶	⟵	●	⟶	⟵	⟵	●	⟶
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening				●	●	●	●																									
Developmental Screening								●			●		●																			
Autism Spectrum Disorder Screening											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES																																
Newborn Blood		●	● ⟶	⟶	⟶																											
Newborn Bilirubin		●																														
Critical Congenital Heart Defect		●																														
Immunization		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead							★	★	● or ★		★	● or ★		★	★	★	★															
Tuberculosis				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia												★			★		★		★	⟵	●	⟶	★	★	★	★	★	⟵	⟵	⟵	●	⟶
Sexually Transmitted Infections																						★	★	★	★	★	★	★	★	★	★	★
HIV																						★	★	★	★	⟵	⟵	●	⟶	★	★	★
Hepatitis B Virus Infection		★ ⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶
Hepatitis C Virus Infection																													● ⟶	⟶	⟶	⟶
Sudden Cardiac Arrest/Death																						★ ⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶	⟶
Cervical Dysplasia																																●
ORAL HEALTH							●	●	★		★	★	★	★	★	★	★															
Fluoride Varnish							⟵	⟵	⟵	⟵	●	⟶	⟶	⟶	⟶	⟶																
Fluoride Supplementation							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ⟵ ★ or ● ⟶ = range during which a service may be provided

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(continued)

14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2014-3716), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (https://pubmed.ncbi.nlm.nih.gov/32439401), and "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (https://pubmed.ncbi.nlm.nih.gov/32510990). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See "Poverty and Child Health in the United States" (https://doi.org/10.1542/peds.2016-0339), "The Impact of Racism on Child and Adolescent Health" (https://doi.org/10.1542/peds.2019-1765), and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (https://doi.org/10.1542/peds.2021-052582).
15. A recommended assessment tool is available at http://crafft.org.
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (https://doi.org/10.1542/peds.2017-4081), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Suicide and Suicide Attempts in Adolescents" (https://doi.org/10.1542/peds.2016-1420), and "The 21st Century Cures Act & Adolescent Confidentiality" (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (https://doi.org/10.1542/peds.2011-0322).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (https://doi.org/10.1542/peds.2009-0329).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (https://doi.org/10.1542/peds.2011-3211).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://publications.aap.org/redbook/pages/immunization-schedules. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (https://doi.org/10.1542/peds.2016-1493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://www.cdc.gov/nceh/lead/docs/final_document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the US Preventive Services Task Force (USPSTF) recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per "Sudden Death in the Young: Information for the Primary Care Provider" (https://doi.org/10.1542/peds.2021-052044).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (https://doi.org/10.1542/peds.2010-1564).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
36. Perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/). See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in November 2021 and published in July 2022. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN NOVEMBER 2021

HEPATITIS B VIRUS INFECTION

Assessing risk for HBV infection has been added to occur from newborn to 21 years (to account for the range in which the risk assessment can take place) to be consistent with recommendations of the USPSTF and the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.

- Footnote 31 has been added to read as follows: "Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient."

SUDDEN CARDIAC ARREST AND SUDDEN CARDIAC DEATH

Assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the risk assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider").

- Footnote 33 has been added to read as follows: "Perform a risk assessment, as appropriate, per 'Sudden Death in the Young: Information for the Primary Care Provider' (https://doi.org/10.1542/peds.2021-052044)."

DEPRESSION AND SUICIDE RISK

Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP policy.

- Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See 'Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management' (https://doi.org/10.1542/peds.2017-4081), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Suicide and Suicide Attempts in Adolescents' (https://doi.org/10.1542/peds.2016-1420), and 'The 21st Century Cures Act & Adolescent Confidentiality' (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx)."

BEHAVIORAL/SOCIAL/EMOTIONAL

The Psychosocial/Behavioral Assessment recommendation has been updated to Behavioral/Social/Emotional Screening (annually from newborn to 21 years) to align with AAP policy, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines.

- Footnote 14 has been updated to read as follows: "Screen for behavioral and social-emotional problems per 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (https://doi.org/10.1542/peds.2014-3716), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders' (https://pubmed.ncbi.nlm.nih.gov/32439401), and 'Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative' (https://pubmed.ncbi.nlm.nih.gov/32510990). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See 'Poverty and Child Health in the United States' (https://doi.org/10.1542/peds.2016-0339), 'The Impact of Racism on Child and Adolescent Health' (https://doi.org/10.1542/peds.2019-1765), and 'Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health' (https://doi.org/10.1542/peds.2021-052582)."

FLUORIDE VARNISH

- Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

FLUORIDE SUPPLEMENTATION

- Footnote 38 has been updated to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

CHANGES MADE IN NOVEMBER 2020

DEVELOPMENTAL

- Footnote 12 has been updated to read as follows: "Screening should occur per 'Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening' (https://doi.org/10.1542/peds.2019-3449)."

AUTISM SPECTRUM DISORDER

- Footnote 13 has been updated to read as follows: "Screening should occur per 'Identification, Evaluation, and Management of Children With Autism Spectrum Disorder' (https://doi.org/10.1542/peds.2019-3447)."

HEPATITIS C VIRUS INFECTION

- Screening for HCV infection has been added to occur at least once between the ages of 18 and 79 years (to be consistent with recommendations of the USPSTF and CDC).
- Footnote 32 has been added to read as follows: "All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually."

HRSA

Preventive care for adults

Staying healthy includes going to see the PCP for regular checkups. Use the chart below to make sure the member is up-to-date with his or her yearly preventive care exams.

Preventive care visits schedule for adult members

Exam type	Who needs it?	How often?
Preventive Well-visit	Age 21 and over	Every year
Cervical Cancer Screening and Pelvic Exam Pap tests are given every 3 years. Precancer checks are given every 1–3 years. They are part of the pelvic exam for women who are sexually active or over 21.	Women: Age 21 and over	Every year
Clinical Breast Exam	Women: Age 20 and over	Every year

When the member misses one of the preventive care visits

If the member does not get a preventive care visit on time, make an appointment with the appropriate PCP as soon as you can. If you need help setting up the appointment, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**. If the member has not visited their PCP on time, Amerigroup will call you to remind you to make the EPSDT appointment.

SPECIAL KINDS OF HEALTHCARE

Eye care

Our members don't need a referral from their primary care provider (PCP) for eye care benefits. Medicaid members under age 21 can have the following covered every 12 months:

- Routine refractions
- Routine eye exams
- Medically needed eyeglasses or contact lenses

Call Avesis Vision at **866-522-5923** for help finding an eye doctor (optometrist) in who works with our plan.

Dental care

Our members don't need referrals from their PCPs for dental care benefits and don't pay copays for dental care visits. Medicaid members under age 21 and pregnant women have covered benefits as part of Medicaid EPSDT services.
These benefits include:

- Exam and cleaning every six months
- X-rays every six months
- Fillings, extractions, and other treatments as medically needed

Benefits that are not covered for pregnant members over the age of 21 are:

- Root canals
- Dentures
- Partial dentures
- Implants
- Orthodontia (braces)

To find a dentist in who works with your plan, call DentaQuest toll free at **800-895-2218 (TTY 711)** or visit DentaQuest.com.

To learn more about dental benefits, go to DentaQuest.com and select:

1. Members
2. Georgia
3. Find a dentist

Call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** if you:

- Need help making a dental appointment.
- Need help getting to a dental appointment.

How often should you get a dental checkup?

Dentists have a chart that suggests how often the member should get checkups. The chart also tells the dentist what is important to look at during each dental visit. Everybody is different, and every mouth is different. Talk with the member's dentist to figure out what is best for them. The best plan is to:

- Find a dentist that the member will like and trust.
- Have him or her see the dentist every six months.
- Stay with that dentist so they can watch the member's oral health as the member grows and changes.

The member's PCP will provide oral health screenings, preventive counseling, and make recommendations to see a dentist for ongoing dental care. The member's PCP will also complete an oral health risk assessment at:

- 6 months
- 9 months
- 12 months
- 18 months
- 24 months
- 30 months

Family planning services

Amerigroup will arrange for counseling and education about planning a pregnancy or preventing pregnancy. You can call the PCP or OB-GYN and make an appointment for a visit for the member. A referral from the PCP is not required.

Special care for pregnant members

Taking Care of Baby and Me® is the Amerigroup program for all pregnant members. It is very important to see your primary care provider (PCP) or obstetrician or gynecologist (OB-GYN) for care when you are pregnant. This kind of care is called prenatal care. It can help you to have a healthy baby. Prenatal care is always important, even if you have already had a baby. With our program, members

receive health information and rewards for getting prenatal and postpartum care. Amerigroup wants to reward you with a baby gift for getting prenatal care. To find out more about this program, call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)**.

When you become pregnant

If you think you are pregnant, call your PCP or OB-GYN doctor right away. You do not need a referral from your PCP to see an OB-GYN doctor. Your OB-GYN should see you within 14 days. Visiting your PCP or OB-GYN as soon as you think you are pregnant is important. This can help you have a healthy baby.

Call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)** as soon as you know you are pregnant. We will help you find an Amerigroup OB-GYN. We will also help you choose a PCP for your baby before they are born.

Your PCP or OB-GYN may want you to visit more than this based on your needs.

Visit our Pregnancy and Wellness page at **myamerigroup.com/ga/your-health /pregnancy-womens-health.html** for information and resources on how to keep you and your baby healthy. If you would like to receive pregnancy information by mail, please call Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)**.

Resource Mother program

As part of your postpartum benefits, you are eligible for a Resource Mother for 12 months after having a baby. The Resource mother provides peer services in coordination with your case manager and can provide assistance in dealing with personal and social issues as well as supportive counseling. To learn more about the Resource Mother program, call Member Services at **800-600-4441 (TTY 711)**.

Medicines

We work with our providers and pharmacists to choose the right medicine from our formulary (list of approved drugs). These are the drugs we cover as part of your plan. The formulary includes medicine that is:

- Safe to use.
- Effective to treat medical conditions.
- Approved by the Food and Drug Administration.

We cover:

- Certain prescription medicines.
- Certain over-the-counter (OTC) medicines and feminine hygiene products with a prescription required.
- Certain childhood vaccines (age 3 to 18) when administered at a network pharmacy that is enrolled in the Vaccine for Children program.
- Certain adult vaccines (age 19 and older) when administered at a network pharmacy.

We don’t cover some medicines, including:

- Alternative medicines, like echinacea and gingko biloba.
- Antiseptics and disinfectants, like hydrogen peroxide.
- Various bulk chemicals.
- Dietary management products.
- Mouth, throat, and dental agents, like throat lozenges.
- Pharmaceutical adjuvants (vaccine additives, like mineral oil).

All the doctors who work with our plan have access to this drug list. The doctor should use this list when they write a prescription. Certain medicines on the preferred drug list (PDL) and all medicines that are not listed on the Amerigroup PDL need prior authorization. It takes about 24 hours to complete a prior authorization review once we receive it from your doctor. You can view the PDL for your plan at **myamerigroup.com/GA** under *Pharmacy Benefits* and select **Go to Pharmacy** to see the list of medicines your PCP can choose from. If you have any questions about your medicine, call Pharmacy Member Services at **833-205-6006**. You can also call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** to ask for a copy of the PDL. We’ll send it to you at no cost.

The member can get prescriptions filled at pharmacies in their plan (called network pharmacies) or by home delivery. You can find a pharmacy in the provider directory online at **myamerigroup.com/GA**. Select **Find a Doctor** and look for the *Pharmacy* link. If you don’t know if a pharmacy works with our plan, ask the pharmacist. Call the Georgia Families 360°SM Member Intake Line number on your Amerigroup ID card at **855-661-2021 (TTY 711)** for information about medicines we cover as part of your plan.

Getting prescriptions filled

We work with CarelonRx to manage your prescription drug benefit. Take the written prescription from the doctor to your pharmacy. Or the doctor can call in the prescription to your pharmacy. Your pharmacy will refill your prescription for up to a 30-day supply, as indicated. If you are on medication for asthma, depression, or diabetes, you can receive up to a 60-day supply at your pharmacy after two previous 30-day fills of the same dose. You will need to show your Amerigroup ID card at the pharmacy. You can also use the mail order (also referred to as home delivery) option and receive up to a 60-day supply for certain medications after two previous 30-day fills of the same dose at your pharmacy. If you are in Foster Care or DJJ, you can receive up to a 30-day supply by mail order. If you have questions or would like to start using CarelonRx Home Delivery, please call **833-205-6006** anytime. CarelonRx will take care of everything, including calling your provider for a prescription refill.

It’s good to use the same pharmacy each time. This way, the pharmacist will know about problems that may occur when taking more than one prescription. If a new pharmacy is used, you should tell the pharmacist about all of the prescription and OTC medicines you are taking.

Emergency prescription medicine supply

Members may ask for a three-day supply of their prescription from the pharmacy while waiting for approval. This is for certain medicines that need prior authorization. This cannot be done for medicines that are not in the Amerigroup pharmacy benefit or not covered by Medicaid.

How to get care when the member cannot leave the home

Amerigroup will find a way to help take care of the member. Call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** right away if the member cannot leave their place of residence. We will put you in touch with their care coordinator who will help the member get the medical care they need.

SPECIAL AMERIGROUP SERVICES FOR HEALTHY LIVING

Health information

Learning more about health and healthy living can help you stay healthy. One way to get health information is to ask the primary care provider (PCP). Another way is to call us. 24-hour Nurse HelpLine is available 24 hours a day, seven days a week to answer your health questions. We can tell you if the member needs to see the doctor. We can also tell you how you can help take care of some health problems the member may have.

Health education classes

To help keep members healthy, we have health education programs. We can also help you find health classes nearby. You can call the Georgia Families 360°SM Member Intake Line at **855-661-2021** to find out where and when these classes are held. Some of the classes include:

- Amerigroup services and how to get them
- Childbirth
- Infant care
- Parenting
- Pregnancy
- Quitting cigarette smoking
- Protecting yourself from violence
- Other classes about health topics

Some of the larger medical offices that work with us (like clinics) show health videos that talk about immunizations (shots), prenatal care, and other important health topics. We hope the member will learn more about staying healthy by watching these videos.

Community events

We sponsor and participate in special community events and family fun days where everyone can receive health information and have a good time. The member can learn about topics like healthy eating, asthma, and stress. The member can play games and win prizes. Our team will be there to answer questions about benefits, too. To find out when and where these events will be, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**, visit us on Facebook at facebook.com/AmerigroupCorporation or *Your Community* section at **myamerigroup.com/GA**.

Durable medical equipment

We help arrange the member's durable medical equipment (DME). The member's PCP must get prior authorization for these benefits. Please call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** for questions about DME equipment.

Quality management

Amerigroup has a quality management program that checks the quality of care and services given to our members. We want to know what you like and do not like. Your ideas will help us make our plan better. You can call Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)** to learn more about our programs.

We also offer members a way to be aware of healthcare safety. You can get information on all of our network hospitals at hhs.gov/programs/social-services/health-care-facilities/index.html. This website will help you compare the care these hospitals offer.

GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE ACT

Making a living will (advance directive)

Emancipated minors and members over 18 years old have rights under the Georgia Advance Directive for Health Care Act.

The member has the right to:
- Control all aspects of your care and treatment.
- Refuse treatment you don't want.
- Get the care you want.
- Ask for medical treatment to be withdrawn.

There are three parts to the Georgia Advance Directive for Health Care Act:
- Part one lets you choose a person to make decisions for you when you cannot make them yourself; this person is called a healthcare agent.
- Part two lets you make choices about getting the care you want if you are too sick to decide for yourself.
- Part three lets you choose someone you appointed as your guardian if a court says this is necessary.

If you wish to sign an Advance Directive for Health Care form, you can:
- Ask the primary care provider (PCP) for the form.
- Call our Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)** for the form.

Take or mail the completed form to the PCP or specialist who will then know what kind of care the member would want to have. The member can change their mind at any time. If the member does, call the PCP to remove the form from their medical record. Fill out and sign a new form if they wish to make changes.

Remember to:

- Give a copy of the completed form to the healthcare agency, guardian, and the physician.
- Keep a copy at home in a place where it can be easily found if needed.
- Look at the form regularly to make sure it says what the member wants.

You can get a copy of the Georgia Advance Directive for Health Care Act online at **aging.dhs.georgia.gov**.

You can ask for a copy of this form and its instructions at no cost by writing to the Georgia DHS Division of Aging Services at:

Georgia DHS Division of Aging Services
47 Trinity Avenue
Atlanta, GA 30334

If you have questions or need more information, call the Division's Information and Referral Specialist at **404-657-5258**. If you signed an advance directive and believe that a doctor or hospital has not followed the instructions in it, you can file a complaint. You can call the Healthcare Facility Regulation Division Complaint Intake at **800-878-6442**.

You can also write to:

Department of Community Health
Healthcare Facility Regulation Division
2 Martin Luther King Jr. Drive
East Tower, 17th Floor
Atlanta, GA 30334

OMBUDSMAN LIAISON

What is the Office of the Ombudsman?

The Amerigroup Managed Care Office of the Ombudsman helps solve problems from a neutral view to ensure our members get all medically necessary covered services. The Ombudsman provides a voice to speak and act on behalf of members in foster care. They make sure the member's voice is heard.

An Ombudsman acts as an independent forum to review and resolve complaints made by or on behalf of children in foster care regarding their care. Any concerned adult may also call to express his or her concerns and complaints through the Amerigroup Ombudsman.

What does the Amerigroup Office of the Ombudsman do?

- Listens to the member's concerns
- Serves as an objective resource to resolve healthcare issues
- Gathers additional information related to the member's concern
- Helps members with urgent enrollment and disenrollment problems
- Offers information and referrals
- Identifies ways to improve the effectiveness of healthcare services
- Educates members on how to effectively use the healthcare system

- Helps make a plan to address concerns and makes suggestions

The Ombudsman will not take sides in a complaint. They will consider all sides in a fair way. It is our job to help develop fair solutions to healthcare access problems.

The member can reach the Ombudsman by calling the toll-free help line at **855-558-1436** or email at helpOMB@amerigroup.com.

COMPLAINTS, GRIEVANCES AND APPEALS

Complaints and Grievances

A complaint or grievance is an oral or written expression of dissatisfaction about services or care the member received. Possible subjects for grievances include:

- Quality of care or services provided
- Rudeness of a provider or employee
- Failure to respect your rights

All levels of grievances must be completed within 90 calendar days. Please call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** if you have questions or concerns about services or network providers.

Level 1 Grievance

We will try to solve your complaint on the phone. If we cannot take care of the problem during your call, you can file a Level 1 grievance. A Georgia Families 360°SM Member Intake Line representative can provide:

- Help writing and filing a grievance letter.
- Verbal translation of other languages.
- Help for those who are blind or have low vision.
- TDD/TTY lines for the deaf or hard of hearing through 711.

The member's legal guardian or your authorized representative can file a grievance. The member's doctor cannot file a grievance for the member unless the doctor has been named as the member's personal representative. The member or responsible party must send written approval to have a representative file a grievance on his or her behalf.

To file a grievance, you or your representative can call, fax or send us a letter. You may call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** for help with writing a letter.

Send your letter to:

Appeals and Grievances Department
Amerigroup Community Care
740 W. Peachtree Street
Atlanta, GA 30308
Fax: 877-842-7183

We will send you a letter within 10 working days to let you know we got your grievance. If you need a verbal translation, please call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)** toll free.

We will look into the member's grievance when we get it. We will send you a letter within 90 calendar days of when you told us about your grievance or sooner if your health condition calls for it. This letter will tell you the decision Amerigroup makes and the reasons for our decision. We will include information on how to file a Level 2 grievance.

Level 2 Grievance

If you're not happy with the answer to your Level 1 grievance, you can ask for a grievance committee hearing. You must write or call us with this request within 10 working days from the date of the letter with the first grievance answer. Send your letter to:

Appeals and Grievances Department
Amerigroup Community Care
740 W. Peachtree Street
Atlanta, GA 30308
Toll free: **855-661-2021 (TTY 711)**

The Grievance Committee is made up of Amerigroup staff and healthcare providers who were not involved in the first decision. A person who was involved in the first decision may present information to the committee or answer questions. Amerigroup will send the member a letter within 10 working days to let the member know we received the grievance. If the member needs a verbal translation, please call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)** toll free.

We will try to find a day and time for the meeting so the member can be there. We will tell the member the date, time, and place of the meeting at least seven calendar days ahead of time. The member can bring someone to the meeting if the member wants to. The member does not have to come to the meeting.

We will send the member a letter within 30 calendar days — or sooner if the member's health condition calls for it — of the meeting request to tell the member what the committee decides about the member's grievance and the reasons for the decision. The total time for Amerigroup to complete the total grievance process with written notification will be completed within 90 calendar days from the filing date. This is our final decision.

If the member or an authorized representative files or makes a complaint or grievance, we will not hold it against the member. We will still be here to help the member get quality healthcare.

Appeal process

A member can make an appeal when he or she doesn't agree with a decision we made about his or her care. There may be times when we say we will not pay for care that has been recommended by the

member’s doctor. The member or the member’s parent, legal guardian, or authorized representative can ask for an appeal if we:

- Deny or limit a service the member or the member’s doctor asked us to approve.
- Reduce, suspend, or stop services the member has been getting that we already approved.
- Fail to give services in the required time frame.
- Fail to give the member a decision on an appeal they already filed in the required time frame.
- Do not let you exercise your right to get services from providers who do not work with our health plan. This is when you live in an area with only one health plan.
- Deny your request to dispute a financial charge. This includes your percentage of the costs, copayments, monthly payments, deductibles, and other member financial charges.

The member will get a letter from us when any of these actions happen. This letter is called an adverse benefit determination. The adverse benefit determination will tell the member how and why we made our decision. The member can file an appeal if they don’t agree with our decision.

The member must file an appeal within 60 calendar days from the date on his or her adverse benefit determination letter. There are three ways to file an appeal:
1. The member may call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**. Have the member’s doctor send us his or her medical information about this service.
2. The member can fax a letter to Quality Management at **877-842-7183**.
3. The member can send us a letter to the address below. The member may call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** for help with writing a letter. Include information such as the care the member is looking for and the people involved. Have the member’s doctor send us their medical information about this service. The address is:

Appeals
Amerigroup Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

We’ll send the member a letter within 10 working days of getting the member’s appeal request. It will let the member know we got the appeal.

If the member doesn’t send us the appeal request within 60 days of the date on the adverse benefit determination letter, the member’s request will be denied. We’ll send the member a letter if this happens.

We’ll answer the member’s appeal request based on the type of appeal the member files. For life-threatening or urgent services also known as expedited appeals, we’ll answer within 72 hours of the appeal request. For nonemergency services also known as standard appeals, we’ll answer within 30 calendar days of the appeal request.

A doctor who hasn’t seen the member’s case before will look at the member’s appeal request. This doctor will:

- Make the decision on the member's appeal.
- Report to a doctor who has not looked at the member's case in the past.
- Have experience treating the same or similar conditions, if the appeal is about the best type of care for your condition.

At any time during the appeal process, the member or the member's representative may:

- Have the right to access copies of all documents related to the member's appeal.
- Have the right to copies of all documents related to the member's appeal free of charge.
- Provide additional information or facts to Amerigroup in person or in writing.
- Get a copy, free of charge, of the benefit guide, guidelines, criteria, or protocol we used to decide the member appeal.

If the member needs to give us more information, the member can ask us for up to 14 more calendar days. If needed, we may also ask for 14 more calendar days to make a decision on a standard appeal. If we need more time, we'll send the member a letter telling them why. We'll do this if we feel more information is needed, and it's in the member's best interest.

If the member needs a verbal translation, please call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)** toll free. One of our representatives can:

- Help write a request for an appeal.
- Help file an appeal.
- Set up verbal translation into other languages.
- Arrange help for those who are blind or have low vision.

A toll-free TTY line for people who are deaf or hard of hearing is available by calling 711.

Expedited Appeals

An expedited appeal is an appeal that gets the member a decision fast. There may be times when the member or the member's provider will want us to make a faster appeal decision. This could be because the member or the member's doctor feel taking the time for the standard appeal process could seriously harm the member's life or health.

We will answer the member's expedited appeal request within 72 hours after we get the member's request. If the member's health condition calls for it, it will be sooner. The member, the member's authorized representative, or the member's doctor can ask for an expedited appeal in two ways:

1. The member can call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)**.
2. The member can fax a letter to Quality Management at **877-842-7183**.

The member has the right to submit written comments, documents, or other information, like medical records or provider letters that might help the member's appeal. The member must do so within 72 hours of the request for expedited appeal.

If the member asks for an expedited appeal and we don't agree the member's request for an appeal should be expedited, we'll call the member right away. We'll send the member a letter within two calendar days to let the member know how the decision was made. We'll also let the member know

the appeal request will be reviewed through the standard review process. See the **Appeals** section for help. The member may file a grievance if the member doesn't agree with this decision by calling the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)**

ADMINISTRATIVE LAW HEARING

Medicaid eligible members

If the member doesn't agree with our appeal decision, the member can ask for a hearing with an administrative law judge. The member can ask for a hearing only after the member has gotten the appeal resolution letter. The member must ask for a hearing within 30 days from the date on the appeal resolution letter. The member's provider cannot ask for a hearing for the member unless the member names him or her as his or her personal representative.

To ask for a hearing, send a letter to:

Amerigroup Community Care
Quality Management Department
Administrative Law Hearings
740 W. Peachtree Street
Atlanta, GA 30308

At any time during the Administrative Law Hearing process, the member or the member's representative may:

- Obtain and examine a copy of the documents that will be used for review.
- Provide additional information or facts to Amerigroup in person or in writing.

The member can ask for a continuation of benefits during the Administrative Law Hearing process. See the section **Continuation of Benefits** for help.

The decision reached by an Administrative Law Hearing will be final.

The member can request an administrative law hearing by sending a letter to:

Amerigroup Community Care
Quality Management Department
Administrative Law Hearings
740 W. Peachtree Street
Atlanta, GA 30308

The member may also submit the complaint to the Department of Insurance. The address is:

Department of Insurance
2 Martin Luther King, Jr. Drive
West Tower, Suite 704
Atlanta, GA 30334

The Department of Insurance telephone and fax information is:
Local phone: **404-656-2070**
Toll free: **800-656-2298**
Fax: **404-657-8542**

The Office of State Administrative Hearings will tell the member of the time, place, and date of the hearing. An administrative law judge will hold the hearing. The member may speak for themselves or let a friend or family member speak for them. The member may get help from a lawyer. The member may also be able to get free legal help. If the member wants a lawyer, please call one of these telephone numbers:

- Georgia Legal Services: **404-206-5175**
- Georgia Advocacy Office: **800-537-2329**
- Atlanta Legal Aid:
    - **404-377-0701** (DeKalb-Gwinnett Counties)
    - **770-528-2565** (Cobb County)
    - **404-524-5811** (Fulton County)
    - **404-669-0233** (South Fulton-Clayton Counties)
    - **678-376-4545** (Gwinnett County)
    - State Ombudsman Office: **888-454-5826**

You may also ask for free mediation services after you have filed a request for hearing. Please call **404-657-2800**.

We will comply with the administrative law hearing decision.

CONTINUATION OF BENEFITS

You may ask Amerigroup to continue to cover the member's benefits during the appeal and administrative law hearing process. If coverage of a service they are receiving is denied or reduced and you want to continue that service during the appeal or administrative law hearing committee review, you can call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)** to request it.

You must call to ask us to continue the member's benefits within 10 calendar days of when we mailed you the notice that said we wouldn't cover or pay for a service.

We must continue coverage of the benefits until:
- You withdraw the appeal or administrative law hearing request.
- Ten calendar days from the date of the appeal resolution letter have passed, and you have not made a request to continue benefits until an administrative law hearing decision is reached.
- An appeal or administrative law hearing decision is reached and is not in the member's favor.
- Authorization expires or the member's service limits are met.

The member may have to pay for the cost of any continued benefit if the final decision is not in their favor. If a decision is made in the member's favor as a result of your appeal or appeal, Amerigroup will authorize and pay for the services we said we would not cover before.

MAINTAINING MEDICAID BENEFITS BEYOND AGE 18

Medicaid provides two options for youth who age out of foster care or who opt out of foster care.

Option 1: Transition age youth who remain in foster care to age 21 should work with his or her Division of Family and Children Services (DFCS) case manager to enroll in Chafee Independence Program Medicaid. Eligible members may also apply for Chafee Independence Program Medicaid online at **gateway.ga.gov/access**.

Option 2: Former foster care Medicaid is for youth that opt out of foster care at age 18 or upon aging out of the Independent Living program. Former foster care Medicaid is available until the member turns 26.

The Division of Family and Children Services can assist with continuation of coverage. You may visit your local Division of Family and Children Services county office or visit gateway.ga.gov/access.

The Affordable Care Act allows for Adoption Assistance Members to receive extended Medicaid benefits to age 21.

OTHER INFORMATION

Enrollment

All eligible members in foster care and select members in Juvenile Justice must be enrolled in the Georgia Families 360°SM program with Amerigroup as their health plan.

Nonmandatory enrollment

Members enrolled in the following programs are not required to be enrolled in Amerigroup:

- Children less than 21 years of age who are in foster care under Title IV-E of the Social Security Act and are enrolled in the Georgia Pediatric program
- Children who live or have been assigned out of the state of Georgia
- Children in CMS

Reasons why the member can be disenrolled from Amerigroup

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

The member could be disenrolled immediately from Amerigroup if he or she is:

- No longer eligible for Medicaid
- Disenrolled by the Georgia Department of Community Health (DCH)
- Let someone else use his or her Amerigroup ID card
- Moves out of state
- Sent to jail or prison
- Placed in a long-term nursing facility, state institution or intermediate care facility for the mentally disabled

If you have any questions about your enrollment, call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**.

If the member gets a bill

Always show the member's Amerigroup ID card and current Medicaid ID card when they see a doctor, goes to the hospital or goes for tests. Even if your doctor told you to go, you must show the Amerigroup ID to make sure you are not sent a bill for services covered by Amerigroup.

The member does not have to show their Amerigroup ID card before getting emergency care.

If the member does get a bill, send it to us with a letter saying that they have been sent a bill. Send the letter to the address below:

Amerigroup Community Care
Quality Management Department
740 W. Peachtree Street
Atlanta, GA 30308

The member who has an emergency medical condition is not liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member. If you need help understanding this or other information in this handbook, call our Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**.

Changes in Amerigroup coverage

Sometimes, we may have to make changes in the way your plan works, our covered services, or the doctors and hospitals that work with us. The care coordinator will call when we make changes to the benefits or services in your plan or the information will be available on our website at **myamerigroup.com/GA**.

The member's PCP office may move, close, or stop working with us. If this happens, we'll call. We can also help pick a new PCP. You can call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)** if you have any questions. We can also send you a current list of our network doctors upon request.

How to tell us about changes you think we should make

We want to know what you like and do not like about Amerigroup. Your ideas will help us make us better. Please call us with your ideas. The Georgia Families 360°$_{SM}$ Member Intake Line is available 24/7 at **855-661-2021 (TTY 711)**.

You can also send a letter to:
Amerigroup Community Care
740 W. Peachtree Street
Atlanta, GA 30308

We have a group of members, community leaders, and advocates who meet quarterly to give us their ideas and provide feedback. These meetings are called **Health Education Advisory Committee (HEAC).** This is a chance for you to find out more about us, ask questions, and give us suggestions for improvement. If you would like to be part of this group, call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)**.

We also send surveys to some members. The surveys ask questions about what you do and don't like about us. If we send you a survey, please fill it out and send it back. Our staff may also call to ask what you like and don't like about the plan. Please tell them what you think. Your ideas can help us make us better.

How we pay providers

Different providers in our network have agreed to be paid in different ways by us. The provider may be paid each time they treat a patient (fee-for-service). Or the provider may be paid a set fee each month for each member whether or not the member actually gets services (capitation).

These kinds of pay may include ways to earn more money. This kind of pay is based on different things like member satisfaction, quality of care, accessibility, and availability. Contact us to find out more about how:

- We pay our contracted doctors and other providers who work with us.
- Our plan is set up and run.

Call the Georgia Families 360°$_{SM}$ Member Intake Line at **855-661-2021 (TTY 711)**. Or write us at:

Amerigroup Community Care
740 W. Peachtree Street
Atlanta, GA 30308

About the Georgia Health Information Network (GaHIN)

The Georgia Health Information Network (GAHIN) is a health information exchange (HIE). An HIE:

- Brings providers and healthcare settings together to improve patient care.
- Allows approved healthcare providers to share their patients' electronic health records with each other on an as needed basis.

We’re a proud member of the GaHIN.

GaHIN’s vision is to create a healthier Georgia through using and sharing electronic health information. This will help:
- Improve healthcare for all people living in Georgia.
- Providers and health plans, like Amerigroup, better manage your health and wellness.

GaHIN can help you and your family:
- Get preventive care on time — your doctor can easily track your checkups, medicines, and shots.
- Avoid filling out long medical history forms or trying to remember your medicines — in emergencies, your doctors can quickly get medical information for you (or your child).
- Keep your medical records more private — records are sent electronically instead of by fax, telephone, or regular mail.
- Get the best treatment decisions possible — all of your doctors will have a complete picture of your medical history and your condition.
- Keep your health records safe from disasters, like floods — there’s no risk of losing X-rays, MRIs, or other reports in your medical history.

All GaHIN providers will let patients know they’re taking part in an HIE. When you visit a provider who takes part in an HIE, you’ll get a notice about it. The notice may come with the provider's Health Insurance Portability and Accountability Act (HIPAA) privacy notice. You can ask for a copy of your provider’s notice of privacy practices.

Only approved members of GaHIN and the national HIE network have access to patients’ medical records. This is on an as needed basis. All providers in GaHIN have to follow:
- HIPAA laws and rules.
- Rules to make sure your health records stay safe, secure, and private.

You can opt out of having your records shared through the HIE at any time. Just fill out an opt-out form from your doctor. If you opt out, providers can’t use GaHIN to share your health records. If you opt out and want to opt in again, let your provider know.

For more information on the GaHIN, please visit gahin.org/who-we-serve/patients.

THE RIGHTS AND RESPONSIBILITIES OF AN AMERIGROUP MEMBER

The member’s rights

Our members have the right to:
- Get timely and proper notice; you must get notice in writing before we take any action to end your Amerigroup coverage.
- Get a Medicaid Fair Hearing if you disagree with a decision we make about your healthcare coverage.
- Get a copy of the member handbook and other materials in your own language.

- Get a copy of the Notice of Privacy Practices that tells you your rights on protected health information (PHI) and our responsibility to protect your PHI. This includes the right to know how we handle, use, and share your PHI.
- PHI is defined by HIPAA Privacy Regulations as information that:
  - Identifies you or can be used to identify you.
  - Either comes from you or has been created or received by a healthcare provider, a health plan, your employer, or a healthcare clearinghouse.
  - Has to do with your physical or mental health condition, providing healthcare to you or paying for providing healthcare to you.
- Information about medical and pharmacy benefits.
- Have access to providers who work with our plan.
- Know how to get a current directory of doctors who work with our plan.
- Know how to change their PCP.
- Get information about your health plan and its services, your Amerigroup doctors and other providers who work with our plan; call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**.
- Get information about your rights and responsibilities.
- Choose any of our Amerigroup network specialists.
- Be referred to specialists who are experienced in treating disabilities if you have any chronic disabilities.
- Have access to a PCP or a backup PCP 24 hours a day, 365 days a year, for urgent care; this information is on your member ID card.
- Call 911 without getting our permission if you have an emergency situation.
- Direct access to women's routine and preventive healthcare (OB-GYN).
- Have a doctor make the decision to deny or limit your coverage.
- Have no gag rules, which means doctors are free to discuss all medical treatment options, even if they are not covered services.
- Know how we pay doctors, so you know if there are rewards or fines tied to medical decisions.
- Know how to make a complaint to Amerigroup.
- Know how to ask us for an appeal of a decision to not pay for a service or limit coverage.
- Know you or your doctor cannot be penalized for filing a complaint or appeal.
- Be treated with respect and dignity by healthcare providers, their staff, and all individuals employed by our company.
- In accordance with federal law (42 CFR 438.10), you have the right to get information in a way and format that is easily understood, such as:
  - Materials in your prevalent non-English language.
  - Member handbook.
  - Plan benefit information (medical and pharmacy).
  - Oral interpretation services free of charge.
  - Disenrollment information.
  - Applicable cost-sharing information (excludes DJJ and FC).
  - Access to network providers and how to change your PCP and obtain a provider directory.
  - Access to physician incentive plans upon request.

- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.
- Have information about Amerigroup, our services, policies and procedures, providers, member rights and responsibilities, and any changes made.
- Talk about your medical record with your PCP; you can ask for a summary of that record.
- Refuse treatment to the extent of the law and be aware of the results; this includes the right to refuse to be part of research.
- Decide ahead of time the kind of care you want if you become sick, injured or seriously ill by making a living will.
- Decide ahead of time the person you want to make decisions about your care if you are not able to by making a durable power of attorney.
- Expect that your records and communications will be treated confidentially and not released without your permission.
- If you are over 18, expect that you will be able to participate in and make decisions about your own and the member's healthcare.
    - If you are under 18, expect that you will be able to participate in and make decisions about your own and the member's healthcare if you are married or declared emancipated by a court order.
- Choose a PCP, choose a new PCP, and have privacy during a visit with a doctor.
- Have your medical information given to a person you choose to coordinate care when you are unable to or have it given to a person who is legally authorized when concern for your health makes it inadvisable to give such information to you.
- As required by federal law (42 CFR 438.206 through 438.210), have medical services available to you, including coordination of care, access to specialists, and authorization of services.
- Be free from liability and receiving bills from providers for medically needed or covered services that we authorized or covered but for which the provider was not paid.
- Information about cost sharing.
- Only be responsible for copays as described in this member handbook.
- Be free from any Amerigroup debts in the event of insolvency and liability for covered services in which the state does not pay to Amerigroup.
- Be free from payment for covered services in which the payment exceeds the amount you would be responsible for if Amerigroup provided the service.
- Continue as a member of Amerigroup despite your health status or need for care.
- Call our Georgia Families 360°SM Member Intake Line toll free at **855-661-2021 (TTY 711)** 24 hours a day, seven days a week.
- Get help from someone who speaks your primary language or get help through a TTY/TDD line if you are deaf or hard of hearing at **711** at no cost to you.
- Expect doctor offices to have wheelchair access.
- Receive information on available treatment options and alternatives, regardless of cost or benefit coverage.
- Ask for and receive a copy of your medical records.
- Ask to amend or correct the record.
- Take part in making decisions about your healthcare with your doctor.
- Make suggestions about the Amerigroup member rights and responsibilities policy.

- Discuss questions you may have about your medical care or services with Amerigroup; call the Georgia Families 360°SM Member Intake Line at **855-661-2021**.
- Facts about how to disenroll.
- Amerigroup does not prohibit, or otherwise restrict healthcare professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, the risks, benefits, and consequences of treatment or non-treatment.

Responsibilities

Our members have the responsibility to:

- Notify your PCP as soon as possible after you get emergency treatment.
- Go to the emergency room when you have an emergency.
- Call Amerigroup if you have a problem and need help.
- Tell your PCP about symptoms or problems and ask questions.
- Read this member handbook to understand how Amerigroup works.
- Notify Amerigroup if a family member who is in Amerigroup has died; someone must also notify Amerigroup if you die.
- Give Amerigroup proper identification when you enroll.
- Treat your doctors, their staff and Amerigroup employees with respect and dignity.
- Not be disruptive in your doctor's office.
- Respect the rights and property of all providers.
- Cooperate with people providing your healthcare.
- Get information about treatment and consider this treatment before it is done.
- Discuss any problems in following your doctor's directions.
- Consider the results of refusing treatment recommended by a doctor.
- Help your PCP get your medical records from the doctor you had before; you should also help your PCP fill out new medical records.
- Respect the privacy of other people waiting in the doctors' offices.
- Get permission from your PCP or the PCP's associates before seeing a consultant or specialist; you should also get permission from your PCP before going to the emergency room unless you have an emergency medical condition.
- Call Amerigroup and change your PCP before seeing a new PCP.
- Learn and follow the Amerigroup policies and procedures outlined in this handbook until you are disenrolled.
- Make and keep appointments and be on time. Always call the doctor's office if you need to cancel an appointment, change your appointment time, or will be late.
- Discuss complaints, concerns, and opinions in an appropriate and courteous way.
- Tell your doctor who you want to be told about your health.
- Get medical services from your PCP.

- Know and get involved in your healthcare. You should talk with your doctor about recommended treatment. You should then follow the plans and instructions for care agreed upon with your provider.
- Follow physicians' orders on medications prescribed.
- Carry your Amerigroup and/or Medicaid card(s) at all times. You should report any lost or stolen cards to Amerigroup quickly. You should also contact Amerigroup if information on your ID card is wrong or if you have changes in name, address, or marital status.
- Show your ID cards to each provider.
- Tell Amerigroup about any doctors you are currently seeing.
- Provide true and complete information about your circumstances.
- Report a change in your circumstances.
- Give Amerigroup and your doctor the information they need to take care of your medical needs.

Nondiscrimination Notice

Amerigroup is a Health Plan licensed as a Care Management Organization in the state of Georgia who administers the Medicaid, and Children's Health Insurance Programs in Georgia. Amerigroup doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Amerigroup directly or through a contractor or any other entity with which Amerigroup arranges to carry out its programs and activities.

Fraud or other Misrepresentation Notice

Amerigroup will not intentionally misrepresent information or furnish false statements to a member, potential member, or healthcare provider.

HOW TO REPORT MISUSE OF THE MEDICAID PROGRAM

If you know someone who is misusing the Medicaid program, you can report him or her. To report doctors, clinics, hospitals, nursing homes or Medicaid program enrollees, write or call Amerigroup at:

Amerigroup Community Care
740 W. Peachtree Street
Atlanta, GA 30308
855-661-2021 (TTY 711)

To report doctors, clinics, hospitals, nursing homes or Medicaid program enrollees, you can also write or call the Department of Community Health's Office of Inspector General:

Office of Inspector General
Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower, 19th Floor
Atlanta, Georgia 30334
Toll Free: **800-533-0686**
Local: **404-463-7590**
oiganonymous@dch.ga.gov
Submit Online Form: **dch.georgia.gov/report-medicaidpeachcare-kids-fraud**

If you are deaf or hard of hearing, call **711**.

KENNY A. CONSENT DECREE

In June 2002, Children's Rights filed a class-action lawsuit against state and county officials responsible for the foster care system in metropolitan Atlanta on behalf of the approximately 3,000 children in foster care in Atlanta (specifically foster care children in Fulton and DeKalb counties).

In July 2005, the state of Georgia required an infrastructure change, began service guarantees and improved oversight for child safety. The decree required the state to meet specific benchmarks and reform the child welfare system. These reforms, specific to foster care, include providing physical, dental, mental, and developmental health screenings within specified periods of time.

DEFINITIONS

Department of Juvenile Justice (DJJ): The Georgia state agency that serves juvenile offenders up to the age of 21. While holding the offenders accountable for their actions through probation supervision and secure detention centers, this agency provides youth with medical and psychological treatment, as well as specialized programs designed to prepare the youth with the social, intellectual, and emotional tools they will need as adults. When DJJ has placement and care responsibility provided through the court, DJJ may place youth in out of the home residential care, such as group homes, emergency shelters, residential facilities, and childcare institutions. The member, who is in out-of-home care, receives medical and behavioral health treatment by providers in the communities where they are placed.

Foster Care (FC): A 24-hour substitute care for children placed away from their parents or guardians and for whom the title IV-E agency (Department of Human Services) has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes.

Roles of the Division of Family and Children Services

A Division of Family and Children Services (DFCS) case manager is a team member who provides assistance to children and families by helping them address behavioral health and social problems related to child abuse and neglect or adoption assistance. DFCS case managers provide help and perform duties related to various social services program areas, such as Child Protective Services (CPS), foster care, resource development, and adoption assistance.

Division of Family and Children Services Revenue Maximization Specialist

A Revenue Maximization Specialist (RMS) is a regional eligibility specialist trained in Title IV-E foster care and adoption assistance programs and Medicaid eligibility for child welfare funding determinations and Medicaid eligibility.

Division of Family and Children Services Clinical Program Specialist

DFCS region-specific team members whose responsibilities include, but are not limited to, the following:

- Oversight of DFCS children getting behavioral health services and working with the Department of Behavioral Health and Developmental Disabilities (DBHDD) program specialists serving specific regions across the state
    - Reviews the status of a child receiving inpatient treatment at a psychiatric residential treatment facility or psychiatric hospital at least monthly
    - Participates in discharge goals and planning
- Monitors all foster care children getting behavioral health medication
- Maintains a regional listing of available behavioral health providers
- Guides or assists DFCS case managers for foster care members getting behavioral health services, developmental disability services or special medical services transition from non-foster care Medicaid to foster care Medicaid and vice versa to ensure continuity of services

Members of these teams will work directly with the member's assigned care coordination team.

Role of Department of Juvenile Justice

The Department of Juvenile Justice (DJJ) serves youth who are involved in the juvenile justice system. DJJ provides probation supervision services, secure detention, medical care, and behavioral health treatment to the member in the department's care. When appropriate, the member committed to DJJ is placed in out-of-home care, such as group homes, emergency shelters, residential facilities, and childcare institutions. The member who is in out-of-home care receives medical and behavioral health treatment by providers in the communities where they are placed.

There is a DJJ staff who may be involved with coordinating care for the member placed out of the home. This staff may include the following:

- Office of Federal Programs — The office that manages the Georgia Families 360°SM program for DJJ. Specifically, the Office of Federal Programs contains Revenue Maximization Eligibility Staff who determine Medicaid eligibility for DJJ members in residential placement, an Operations Analyst

who is solely responsible for completing and submitting **all** DJJ e-forms to Amerigroup, and a Program Coordinator who manages all Georgia Families 360°$_{SM}$ DJJ operations.

- DJJ Juvenile Probation and Parole Specialist (JPPS) — A DJJ staff responsible for providing intake, informal adjustment, and probation services to the member for the Juvenile Court and aftercare and commitment services to the member under DJJ supervision. At a minimum, JPPS will be responsible for supervision while in residential care and the development of service plans that may consist of healthcare, mental health, and educational needs identified during the member's initial assessment that may not be limited to referrals to collaborative agencies or resource providers.
- Human Service Professional — The designated residential program employee, with case management responsibilities for the member, who shares joint service planning responsibilities with the JPPS.
- DJJ Residential Placement Specialist (RPS) — DJJ staff responsible for identifying, coordinating, and overseeing out-of-home care for committed child/young adult.
- DJJ Residential Treatment Services Specialist (RTSS) — DJJ staff responsible for coordinating and chairing utilization reviews of members in residential care, as well as service compliance of RBWO vendors.
- DJJ Case Expeditor — DJJ staff responsible for identifying and coordinating out-of-home care as an alternative to detention for the member as approved by the court.

Members of this team will work directly with the member's assigned care coordination team.

OTHER DEFINITIONS

- **Appeal:** An appeal is a request you make when you don't agree with a decision we made about your care.
- **Copayment:** A copayment or copay is the amount the member may need to pay for a covered service.
- **Durable Medical Equipment (DME):** Medical equipment that is ordered by a doctor for use in the home. For example, wheelchairs, ventilators, or crutches are types of DME.
- **Emergency:** An emergency is when not seeing a doctor to get care right away could result in death or very serious harm to your body.
- **Emergency Medical Transportation:** Ambulance services for an emergency medical condition.
- **Emergency Room Care:** Emergency services you receive in an emergency room.
- **Excluded Services:** Healthcare services that your Amerigroup plan doesn't pay for or cover.
- **Grievance**: A complaint or grievance is an oral or written expression of dissatisfaction about services or care you received.
- **Habilitation Services:** Healthcare services that help you keep, learn, or improve skills and functioning for daily living.
- **Health Insurance:** A type of insurance coverage that pays for medical expenses.
- **Home Health Care:** Medical care provided in a patient's home.
- **Hospice Services:** Supportive care to people in the final phase of a terminal illness and their families.

- **Hospital Outpatient Care:** Medical care or treatment that does not require an overnight stay in a hospital.
- **Hospitalization:** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
- **Medically Necessary:** Healthcare services needed to correct or make better a defect, physical or mental illness, or condition in line with accepted medical practices.
- **Network:** The providers and facilities your health plan has contracted with to provide healthcare services.
- **Non-participating Provider:** A provider who doesn't have a contract with your health plan to provide services to you.
- **Participating Provider:** A healthcare provider in your Amerigroup network. Also called an in-network provider.
- **Physician Services:** Healthcare services a doctor provides or coordinates.
- **Plan:** Amerigroup is your health plan, or Plan, which pays for and coordinates your healthcare services.
- **Preauthorization:** A decision by Amerigroup that a service or prescription drug is medically necessary for you. Sometimes called prior authorization. Emergency services, services related to an emergency medical condition, and urgent care do not need approval.
- **Premium:** An amount you pay for your health insurance.
- **Prescription Drug Coverage:** When the health plan helps pay for prescription and OTC medications.
- **Prescription Drugs:** Medications that by law require a prescription.
- **Primary Care Physician or Primary Care Provider:** Your primary care provider is the doctor or other healthcare provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. They also may talk with other doctors and providers about your care and refer you to them. Usually, you must see your primary care provider before you see any other healthcare provider.
- **Provider:** Any doctor, hospital, agency, or other person who has a license or is approved to deliver healthcare services. A provider may also be a clinic, pharmacy, or facility.
- **Rehabilitation Services:** Healthcare services that help you recover from an illness, accident, or major operation. These services may include physical therapy, occupational therapy, speech-language pathology, and psychiatric rehabilitation services.
- **Skilled Nursing Care:** Certain skilled services that can only be performed by licensed nurses in your home or in a nursing home.
- **Specialist:** A physician who provides healthcare for a specific disease or part of the body. You may need a referral from your PCP to get services from some specialists.
- **Urgent Care:** There are some injuries and illnesses that are not emergencies, but can turn into an emergency if they are not treated within 24 hours.

WE HOPE THIS HANDBOOK HAS ANSWERED MOST OF YOUR QUESTIONS ABOUT AMERIGROUP. FOR MORE INFORMATION, YOU CAN CALL THE GEORGIA FAMILIES 360°SM MEMBER INTAKE LINE AT 855-661-2021 (TTY 711).

HIPAA notice of privacy practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in March 2021.

Please read this notice carefully. This tells you:
- **Who can see your protected health information (PHI).**
- **When we have to ask for your OK before we share your PHI.**
- **When we can share your PHI without your OK.**
- **What rights you have to see and change your PHI.**

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

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 it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that is 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 cannot 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 it is 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 healthcare if you tell us it is 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, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care
  - When we say we will pay for healthcare or services before you get them (called prior authorization or preapproval)
  - To find ways to make our programs better, as well as support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you do not want this, please visit **amerigroup.com/amerigroup/privacy-policy.html** for more information.
- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention 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**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it is OK
  - With someone who helps with or pays for your healthcare, if you cannot speak for yourself and it is best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research, or other things listed below. 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 cannot 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 are asked
- To answer legal documents
- To give information to health oversight agencies for things such as audits or exams
- To help coroners, medical examiners, or funeral directors find out your name and cause of death
- To help when you 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

Your rights

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We do not 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. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we do not 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 some other 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 shared your PHI with someone else. This will not list the times we shared it because of healthcare, payment, everyday healthcare business, or some other reasons we did not list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- 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 we have to do

- The law says we must keep your PHI private except as we 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 will do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, such as if you are in danger.
- We must tell you if we have to share your PHI after you asked us not to.
- If state laws say we have to do more than what we said here, we will follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and vendors, may call or text you using an automatic telephone dialing system or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we will not contact you in this way anymore. Or you may call **844-203-3796 (TTY 711)** toll free to add your phone number to our Do Not Call list.

What to do if you have questions

If you have questions about our privacy rules or want to use your rights, please call Member Services toll free at **800-600-4441 (TTY 711)** Monday through Friday, 7 a.m. to 7 p.m. Eastern time.

What to do if you have a complaint

We are here to help. If you feel your PHI has not 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.

You may write to or call the Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70

61 Forsyth St. SW
Atlanta, GA 30303-8909
Phone: **800-368-1019**
TDD: **800-537-7697**
Fax: **404-562-7881**

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we will tell you about the changes in a letter. We also will post them on the web at **amerigroup.com/amerigroup/privacy-policy.html**.

Race, ethnicity, and language

We get race, ethnicity, and language information about you from state agencies for Medicaid and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:

- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

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 is 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 such as:
  - Doctors.
  - Hospitals.
  - Other insurance companies.
- We may share PI with people or groups outside of our company without your OK in some cases.
- We will let you know before we do anything where we have to give you a chance to say no.
- We will tell you how to let us know if you do not 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.

Revised March 2021.

Amerigroup Community Care follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- National origin
- Disability
- Color
- Age
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

Communicating with you is important

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic, and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at **800-600-4441 (TTY 711)** if you're a Georgia Families member, or at **855-661-2021 (TTY 711)** if you're a Georgia Families 360°SM member.

Your rights

Do you feel you didn't get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail, email, fax, or phone:

Grievance Coordinator
740 W. Peachtree Street
Atlanta, GA 30308

Phone: **800-600-4441 (TTY 711)**
Fax: **877-842-7183**

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the web:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **By mail:** U.S. Department of Health and Human Services
  200 Independence Ave. SW, Room 509F, HHH Building
  Washington, DC 20201
- **By phone:** **800-368-1019 (TTY/TDD 800-537-7697)**

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

We can translate this at no cost.
Call the customer service number on your member ID card.

Podemos traducir esto gratuitamente. Llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación (ID Card).	*Spanish*
نستطيع ترجمة هذه المواد مجاناً. اتصل بخدمات الاعضاء، بأستخدام رقم الهاتف المدون على بطاقة الاعضاء لديك.	*Arabic*
Մենք կարող ենք անվճար թարգմանել սա: Զանգահարեք հաճախորդների սպասարկման բաժին ձեր անդամաքարտում (ID card) նշված հեռախոսահամարով:	*Armenian*
ဤအရာကို ကျွန်ုပ်တို့ အခမဲ့ ဘာသာပြန်ပေးနိုင်ပါသည်။ သင့် ID ကတ်ပါ ဝယ်ယူသုံးစွဲသူ ဝန်ဆောင်မှုနံပါတ်ကို ဖုန်းဆက်ပါ။	*Burmese*
我們可以免費為您提供翻譯版本。請撥打您 ID 卡上所列的電話號碼洽詢客戶服務中心。	*Chinese*
ما می توانیم این را به رایگان برایتان ترجمه کنیم. به شماره خدمات مراجعین ما که پشت کارت شناسایی تان (ID) درج شده، تلفن بزنید.	*Farsi*
Nous pouvons traduire ceci gratuitement. Appelez le numéro du service après-vente sur votre carte d'identification.	*French*
Nou ka tradwi sa la pou okenn pri. Pélé nimero sèvis kliyentèl la sou tô kat didantité.	*Fr. Creole*
Wir können das gerne kostenlos übersetzen. Bitte wenden Sie sich an die Kundenservice-Hotline auf Ihrer ID-Karte.	*German*
Μπορούμε να σας μεταφράσουμε το παρακάτω χωρίς χρέωση. Καλέστε τον αριθμό του Τμήματος Εξυπηρέτησης Πελατών που θα βρείτε στην κάρτα ταυτοποίησής σας.	*Greek*
અમે આનું ભાષાંતર કોઈપણ ખર્ચ લીધા વિના કરી શકીએ છીએ. તમારા ID કાર્ડ પર આપેલ ગ્રાહક સેવા નંબર પર ફોન કરો.	*Gujarati*
אנחנו יכולים לתרגם את זה ללא עלות. התקשר למספר של שירות הלקוחות הנמצא על גבי כרטיס הזיהוי שלך.	*Hebrew*
हम इसका अनुवाद निशुल्क कर सकते हैं। अपने ID **कार्ड पर दिए गए ग्राहक सेवा नंबर पर फोन करें।**	*Hindi*
Peb txhais tau qhov ntawm no dawb. Hu rau lub chaw haujlwm pab cov neeg siv peb cov kev pab tus xovtooj uas nyob ntawm koj daim npav ID rau tus tswv cuab.	*Hmong*

Possiamo effettuare la traduzione gratuitamente. Contatti il numero dell’assistenza clienti riportato sulla Sua tessera identificativa.	*Italian*
私たちは、この文章を無料で翻訳することができます。ご自身のIDカードにあるカスタマーサービス番号へお電話ください。	*Japanese*
យើងអាចបកប្រែជូនដោយឥតអស់ថ្លៃអ្វីទេ ។ សូមទូរស័ព្ទទៅផ្នែកសេវាអតិថិជន តាមលេខមាននៅលើប័ណ្ណ ID របស់អ្នក ។	*Khmer*
저희는 이것을 무료로 번역해 드릴 수 있습니다. 가입자 ID 카드에 있는 고객 서비스부 번호로 연락하십시오.	*Korean*
ພວກເຮົາສາມາດແປອັນນີ້ໃຫ້ທ່ານໄດ້ຟຣີ. ໃຫ້ໂທຫາຝ່າຍບໍລິການລູກຄ້າທີ່ມີເບີຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.	*Laotian*
Możemy to przetłumaczyć bez żadnych kosztów. Zadzwoń pod numer obsługi klienta za pomocą karty ID.	*Polish*
Podemos traduzir isto gratuitamente. Ligue para o serviço de atendimento ao cliente que consta no seu cartão de identificação.	*Portuguese*
Мы можем это бесплатно перевести. Позвоните в отдел обслуживания по телефону, приведенному на вашей идентификационной карточке участника плана.	*Russian*
Možemo to prevesti besplatno. Pozovite na broj korisničkog servisa s Vaše identifikacione kartice (ID).	*Serbian*
Maaari namin ito isalin-wika nang walang bayad. Mangyaring tawagan ang numero ng customer service sa inyong ID card na pang miyembro.	*Tagalog*
เราสามารถแปลได้โดยไม่มีค่าใช้จ่ายใดๆ ติดต่อหมายเลขโทรศัพท์ของฝ่ายบริการลูกค้าบนบัตรประจำตัวของคุณ	*Thai*
ہم اس کا ترجمہ مُفت کر سکتے ہیں۔ اپنے ID کارڈ پر دیے گئے کسٹمر سروس کے نمبر پر کال کریں۔	*Urdu*
Chúng tôi có thể phiên dịch tài liệu này miễn phí. Xin gọi dịch vụ khách hàng qua số điện thoại ghi trên thẻ ID hội viên của quý vị.	*Vietnamese*
מיר קענען דאס איבערזעצן פריי פון אפצאל. רופט דעם קאסטומער סערוויס נומער אויף אייער אידענטיטעט קארטל.	*Yiddish*

MEMCOMM-0489-16

The additional section includes supplementary information for members in the Adoption Assistance program.

For all questions, please call 855-661-2021.

myamerigroup.com/GA

This member handbook has important information about Amerigroup Community Care benefits. Call the Georgia Families 360°SM Member Intake Line toll free at **855-661-2021 (TTY 711)** for a verbal translation.

Welcome to Amerigroup. Thank you for choosing us to help you get quality healthcare benefits for your family.

This member handbook tells you how Amerigroup works and how to keep your family healthy. It tells you how to get healthcare, too. You can always ask for the latest handbook calling the Georgia Families 360°SM Member Intake Line toll free at **855-661-2021 (TTY 711)**.

There is also information included about a free membership for your child to participate in the Boys & Girls Clubs (excluding summer camp). This is a special Amerigroup benefit for members ages 6 to 18 who live near a Boys & Girls Club. The clubs provide many fun and educational activities for children. They are a great place to go after school. There is something for everyone.

You will get your Amerigroup ID card and more facts from us in a few days. Your ID card will tell you when your Amerigroup membership starts. The name of your primary care provider (PCP) is on the card, too. Please check the PCP's name on your ID card. If it is not right, please call us.

You can call the Georgia Families 360°SM Member Intake Line toll free at **855-661-2021**. You can talk to a representative about your benefits.

Our Member Intake Line is available 24 hours a day, seven days a week. You can take advantage of these services:

- Choose or find a PCP in the Amerigroup network.
- Change your child's PCP.
- Request an ID card.
- Update your child's address or phone number.
- Request a member handbook or provider directory.

Sincerely,

Melvin W. Lindsey
Plan President
Amerigroup Community Care

Amerigroup Community Care

ADOPTION ASSISTANCE (AA)
MEMBER HANDBOOK SECTION

740 W. Peachtree Street • Atlanta, GA 30308
855-661-2021 • myamerigroup.com/GA

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DEFINITIONS

Adoption Assistance (AA) — A program founded by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) that provides financial and medical benefits to adoptive families who adopt children with special needs up to 18 years of age. There are three categories of adoption assistance:

- Monthly adoption assistance payments
- Medicaid benefits
- Nonrecurring adoption assistance (such as adoption fees, court costs, attorney fees and others)

The Affordable Care Act allows Adoption Assistance members extended Medicaid benefits through age 26.

CARE COORDINATION

Role of care coordination/care coordinator

Amerigroup will assign the member a care coordinator to aid the member in getting the healthcare they need to take care of him or herself. Our Amerigroup care coordination team will support the member's doctor's plan for their health by helping all of the member's doctors talk with each other to ensure they get the best care to get and stay healthy. The care coordination team will also make suggestions on other services the member may need to help them reach treatment plan goals. The care coordinator is the main contact between you, Amerigroup, the state agencies, other caregivers, and the member's doctor.

Our interdisciplinary care coordination teams:

- Connect the member with needed healthcare services.
- Work with all of the providers and other interested parties to coordinate healthcare services.
- Coordinate healthcare services identified in the member's healthcare treatment plan.
- Ensure access to primary, dental, and specialty care and support services, including assisting members, caregivers, and adoptive parents with locating providers and scheduling appointments as necessary.
- Help with coordinating non-emergent transportation for members, as needed, for provider appointments and other healthcare services.
- Establish meaningful contact with the member's primary care physician, dentist, specialists, and other providers.
- Arrange for referrals to community-based resources.
- Ensure providers and adoptive parents have access to information about the Amerigroup prior authorization process.
- Define program requirements and processes, including the member appeals process and how we assist providers and members with the process.
- Offer application assistance to members who may qualify for Supplemental Security Income (SSI) benefits.

How to access care coordination services/call center

Care coordination services are available 24 hours a day, seven days a week. If assistance is needed getting any type of service, please call the care coordination team at the Georgia Families 360°SM Member Intake Line **855-661-2021 (TTY 711)**. This number is also on the Amerigroup member ID card.

CONTINUITY OF CARE AND TRANSITION OF CARE ISSUES

If help is needed with keeping services the member already has or the member needs a different service or doctor, the care coordination team can help. This is called continuity of care.

Continuity of care

To ensure continuity of care, the care coordinator will allow members to continue with their providers and services. These services must have been allowed in the treatment plans from the members:

- Prior care management organization
- Private insurer or Fee-for-Service Medicaid

The time frame for this is usually about 30 days. It may vary based on individual situations. The care coordinator will issue an out-of-network approval to ensure the member's condition remains stable and services are consistent to meet the member's needs. After the continuity period has ended or the member is considered medically or psychologically stable, we will work with the member and/or caregiver to note additional changes in services. This includes movement to an in-network provider where needed.

All allowances will continue for a period of at least 30 days or until the Amerigroup authorized healthcare treatment plan is completed.

Transition of members

We will coordinate with all Georgia state agency offices and departments as needed when a member transitions in or out of enrollment with Amerigroup.

If a member transitions from another care management organization (CMO) or from private insurance, we will contact the member's prior CMO or other insurer. We will ask for:

- Information about the member's needs.
- Current medical necessity determinations.
- Authorized care and treatment plans.

If a member transitions from Fee-for-Service Medicaid, we will work with the Department of Community Health (DCH) to determine the needs of the member. We will contact the member's prior service providers, including primary care physicians, specialists, and dental providers. We will ask for:

- Information about the member's needs.
- Current medical necessity determinations.
- Authorized care and treatment plans.

Members will get a one-time 30-day supply of their current non-preferred or non-formulary medicines to allow time for their provider to find another preferred medicine on our formulary or submit a prior authorization request.

For all members, we will:

- Work with DFCS to teach members about services and supports available after eligibility ends including:
  - Independence Plus
  - Individuals with Disabilities Education Act participation and application for postsecondary options (housing and vocational opportunities)
  - Waivers

Education will include facts on accessing disability services available from educational institutions and employers where appropriate.

DENTAL

You will have a chance to choose your child's dentist or Amerigroup will choose one for your child. The dentist will be your child's primary care dentist (PCD).

How to access a primary care dentist

You may call DentaQuest at **800-895-2218 (TTY 711)**, or you may visit their website at **DentaQuest.com**.

How to change a primary care dentist

The member's PCD may be changed by calling **800-895-2218 (TTY 711)** or by visiting **DentaQuest.com**.

How to seek help with scheduling appointments

Sometimes members need a little help setting up an appointment to go the doctor or other services. The care coordination team can help set up an appointment to get the care needed. Please call the Georgia Families 360°SM Member Intake Line at **855-661-2021 (TTY 711)**, and we will work on a time and date for an appointment that works best.

Once the appointment has been set, we will reach out to the member and let them know what has been organized.

CALL CENTER

Role of the call center

Our call center is called the Georgia Families 360°SM Member Intake Line. The Georgia Families 360°SM Member Intake Line can help with the following:

- Choosing or finding a primary care provider (PCP) in the Amerigroup network
- Changing a PCP
- Requesting an ID card
- Updating an address or phone number
- Requesting a member handbook or provider directory

The Georgia Families 360°SM Member Intake Line can be accessed at any time at **855-661-2021 (TTY 711)**.

How to access Georgia Families 360°SM Member Intake Line

Call the Georgia Families 360°SM Member Intake Line at **855-661-2021** 24 hours a day, seven days a week. If you are deaf or hard of hearing, call **711**.

HEALTHCARE SERVICES

Roles of the Division of Family and Children Services

A Division of the Family and Children Services (DFCS) case manager is a team member who provides assistance to children and families by helping them address behavioral health and social problems related to child abuse and neglect or adoption assistance. DFCS case managers provide help and perform duties related to various social services program areas, such as Child Protective Services (CPS), foster care, resource development, and adoption assistance.

Division of Family and Children Services Revenue Maximization Specialist

A revenue maximization specialist (RMS) is trained in Title IV-E foster care, adoption assistance programs, and Medicaid eligibility. The RMS:

- Takes applications for Medicaid.
- Decides Medicaid eligibility.
- Decides on funding for foster care and adoption assistance.
- Makes Medicaid redeterminations for healthcare benefits.

COPAYMENTS

A copayment or copay is the amount the member may need to pay for a covered service. There are no copays for members in the Adoption Assistance Georgia Families 360°$_{SM}$ program. You should contact your care coordinator or call the Georgia Families 360°$_{SM}$ Intake Line if you are asked to pay for healthcare services.

PHARMACY

Medicines

All the doctors who work with Amerigroup have access to this drug list. Your doctor or your child's doctor should use this list when they write a prescription. Certain medicines on the Preferred Drug List (PDL) and all medicines that are not listed on the Amerigroup PDL need prior authorization. It takes about 24 hours to complete a prior authorization review once we receive it from your doctor. You can view the PDL for your plan at **myamerigroup.com/GA.** Under *Pharmacy Benefits*, select **Go to Pharmacy** to see the list of medicines your PCP can choose from. If you have any questions about your medicine, call Pharmacy Member Services at **833-205-6006**. You can also call Member Services to ask for a copy of the PDL. We'll send it to you at no cost.

We work with CarelonRx to manage your prescription drug benefit. Take the written prescription from your doctor to your pharmacy. Or your doctor can call in the prescription to your pharmacy. Your pharmacy will refill your prescription for up to a 30-day supply, as indicated. If you are on medication for asthma, depression, or diabetes, you can receive up to a 60-day supply at your pharmacy after two previous 30-day fills of the same dose. You will need to show your Amerigroup ID card to the pharmacy. You can also use the mail order (also referred to as home delivery) option and receive up to a 60-day supply for certain medications after two previous 30-day fills of the same dose at your pharmacy. If you have questions or would like to start using CarelonRx Home Delivery, please call **833-205-6006** anytime. CarelonRx will take care of everything, including calling your provider for a prescription refill.

The decision to approve or deny the request for prior authorization is made within 24 hours of receipt of all necessary information. If your doctor has not responded to the Pharmacy department's request to get the information needed to make the decision within 72 hours, the decision time frame will have expired and a letter will be sent to you and the doctor. If necessary, you can ask for a 72-hour supply of medication from the retail pharmacy while you wait for a decision on your prior authorization request.

If you have any questions about your medicine, call Pharmacy Member Services at **833-205-6006**.

ENROLLMENT

Non-mandatory enrollment

Adoption Assistance members enrolled in the following programs are not required to be enrolled in Amerigroup:

- Children less than 21 years of age who are in foster care under Title IV-E of the Social Security Act and are enrolled in the Georgia Pediatric Program (GAPP)
- Children who live or have been assigned out of the state of Georgia
- Member enrolled in CMS
- Adoption Assistance members may disenroll for cause or during their anniversary enrollment period. Members who disenroll will be placed back into Fee-for-Service Medicaid.

DISENROLLMENT FOR ADOPTION ASSISTANCE MEMBERS

How to disenroll from Amerigroup

If you don't like something about Amerigroup, please call the Georgia Families 360°SM Member Intake Line at **855-661-2021**. We will work with you to try and fix the problem. If you're still not happy, you may be able to change back to Medicaid Fee-for-Service (FFS). You can opt out of the Georgia Families 360°SM program without cause and return to Medicaid FFS during your first 90 days of enrollment. After that, you can change to Medicaid FFS without cause every 12 months. You may return to FFS Medicaid delivery system for cause at any time. The Department of Community Health decides if the cause is valid and allows for disenrollment.

The following are causes for disenrollment by Adoption Assistance (AA) members:

- Amerigroup does not, because of moral or religious objections, provide the covered service the AA member seeks.
- The AA member needs related services to be performed at the same time and not all related services are available within the network; the AA's provider or another provider has determined that receiving services separately would subject the AA member to unnecessary risk.
- Other reasons include, but are not limited to, poor quality of care, lack of access to services or lack of providers experienced in dealing with AA members' healthcare needs.

Please call the Georgia Families 360°SM Member Intake Line at **855-661-2021** for help with disenrollment or send an email to the Department of Community Health at GF360@dch.ga.gov. Include the member's:

- Name
- Medicaid number
- Date of birth

- Reason for wanting to opt out

How to enroll back into Amerigroup

At any time after you disenroll from Amerigroup, you are able to enroll back into the health plan. Please email the Department of Community Health at GF360@dch.ga.gov to enroll back into Amerigroup.

OFFICE OF THE OMBUDSMAN LIAISON

What is the Office of the Ombudsman?

The Amerigroup Managed Care Office of the Ombudsman helps solve problems from a neutral view to ensure our members get all medically necessary covered services. The Ombudsman provides a voice to speak and acts on behalf of children, youth, and young adults in foster care and receiving adoption assistance. They make sure your voice is heard.

The Ombudsman Liaison reviews and resolves complaints made by or on behalf of children in foster care and those receiving adoption assistance regarding their care. Any concerned adult may also call to express their concerns and complaints through the Amerigroup Ombudsman.

What does the Amerigroup Office of the Ombudsman do?

- Listens to your concerns
- Serves as an objective resource to resolve healthcare issues
- Gathers additional information related to your concern
- Helps members with urgent enrollment and disenrollment problems
- Offers information and referrals
- Identifies ways to improve the effectiveness of healthcare services
- Educates members on how to effectively use the healthcare system
- Helps make a plan to address concerns and makes suggestions

The Amerigroup Ombudsman can be reached at:

- Phone – **855-558-1436**
- Email – helpOMB@amerigroup.com
- Fax – **888-375-5067**