Amerigroup

STAR

Member Handbook

Bexar, Dallas, Harris, Jefferson, Lubbock, Medicaid Rural Central, Medicaid Rural Northeast, Medicaid Rural West, and Tarrant Service Areas

September 2022

800-600-4441 (TTY 711) | myamerigroup.com/TX

TEXAS STAR Your Health Plan ★ Your Choice

TEXAS Health and Human Services

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September 2022

Welcome to Amerigroup! We're glad you're our member!

Here are some things you should do to get started:

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

If you don't receive your member ID card by your first day as a new member, call us at **800-600-4441 (TTY 711)** Monday through Friday from 7 a.m. to 6 p.m.

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

Register for our secure website. Visit **myamerigroup.com/TX** and register for secure access. When you create an account, you'll get helpful tools at your fingertips:

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

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

1. Go to **myamerigroup.com/TX**.
2. Use our **Find a Doctor** tool to search for plan providers who are close to home, speak your language, and can meet your needs.
3. Log in to your account.
4. Select **Your Account**.
5. Select **Change Your Primary Care Provider**.

You can also find doctors in our plan using the STAR provider directory for your location on the **Find a Doctor** page at **myamerigroup.com/TX**. To get a no-cost paper copy of the provider directory, or for help changing your primary care provider, call Member Services at **800-600-4441 (TTY 711)**.

You should have regular checkups with your doctor at any age. Learn more about checkups and wellness visits in the **What services are offered by Texas Health Steps?** and **When should adults get checkups?** sections of this member handbook.

We're here for you when you need us. If you have questions about your benefits or health care, you can call Member Services at **800-600-4441 (TTY 711)** Monday through Friday from 7 a.m. to 6 p.m. Central time. You can call the same number for 24-hour Nurse HelpLine to talk to a nurse anytime, day or night.

HEALTH TIPS THAT MAKE HEALTH HAPPEN

You need to go to your doctor now!

When is it time for a well-care visit?
All Amerigroup members need regular Texas Health Steps checkups or adult well-care visits. This way your primary care provider or doctor can see if you have a problem before it is a bad problem. When you become an Amerigroup member, call your doctor and make the first appointments for you and your child within 90 days.

Well care for children: The Texas Health Steps Program
Children need more wellness checkups than adults. For children birth through age 20 who have Medicaid, these medical checkups are called Texas Health Steps. When your child becomes an Amerigroup member, we may contact you to remind you to take your child for a medical checkup. Your child should get Texas Health Steps medical checkups at the times listed below:

Texas Health Steps medical checkups schedule for your child	
Birth	9 months old
3-5 days old	12 months old
2 weeks old	15 months old
2 months old	18 months old
4 months old	2 years old
6 months old	2 1/2 years old
After age 2 1/2, your child should visit the doctor every year. Amerigroup encourages and covers annual checkups for children ages 3 through 20.	

Be sure to make these appointments and take your child to their doctor when scheduled. Find health problems before they get worse and harder to treat. Prevent health problems that make it hard for your child to learn and grow. If your child's doctor or dentist finds a health problem during a checkup, your child can get the care they need such as eye exams and glasses, hearing tests and hearing aids, or dental care.

Are you a migrant farmworker? We will help you find doctors and clinics and help you set up appointments for your children. Your child can receive their checkup or service sooner if you are leaving the area.

What if I become pregnant?
If you think you are pregnant, call your doctor or OB/GYN right away. You don't need a referral to see an OB/GYN. This can help you have a healthy baby.

If you have any questions or need help making an appointment with your doctor or OB/GYN, please call Member Services at **800-600-4441 (TTY 711).**

ALERT! DO NOT LOSE YOUR HEALTH-CARE BENEFITS — RENEW YOUR ELIGIBILITY FOR MEDICAID BENEFITS ON TIME.

AMERIGROUP MEMBER HANDBOOK

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

800-600-4441 (TTY 711)
myamerigroup.com/TX

Welcome to Amerigroup!

You will get most of your health care through Amerigroup. This member handbook will tell you how we can help you get the health care you need.

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INFORMATION ABOUT YOUR NEW HEALTH PLAN

Welcome! As an Amerigroup STAR program member, you and your primary care provider will work together to get and keep you healthy. Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company. All other Amerigroup members in Texas are served by Amerigroup Texas, Inc. To find doctors and hospitals in your area, visit **myamerigroup.com/TX** or contact Member Services at **800-600-4441 (TTY 711)**.

Your Amerigroup member handbook

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

IMPORTANT PHONE NUMBERS

Amerigroup toll-free Member Services line

If you have any questions about your Amerigroup health plan, you can call our Member Services department toll-free at **800-600-4441 (TTY 711)**. You can call us Monday through Friday from 7 a.m. to 6 p.m. Central time, except for state-approved holidays. If you call after 6 p.m. or on a weekend or holiday, you can leave a voice mail message. A Member Services representative will call you back the next business day.

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

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

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

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

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

If you have an emergency, you should call 911 or go to the nearest hospital emergency room right away. If you need advice, call your primary care provider or 24-hour Nurse HelpLine 7 days a week at **800-600-4441 (TTY 711)**.

For urgent care (see the **What is urgent medical care?** section of this handbook), you should call your primary care provider, even on nights and weekends. Your primary care provider will tell you what to do. Call us to find an urgent care clinic near you. Or call 24-hour Nurse HelpLine at **800-600-4441 (TTY 711)** for advice anytime, day or night.

Amerigroup 24-hour Nurse HelpLine

You can call 24-hour Nurse HelpLine 24 hours a day, 7 days a week. Call toll-free at **800-600-4441 (TTY 711)** if you need advice on:

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

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

Behavioral Health and Substance Use Disorder services line

The Behavioral Health and Substance Use Disorder services line is available to members 24 hours a day, 7 days a week at **800-600-4441 (TTY 711)**. The call is free, and you can talk to someone in English or Spanish. For other languages, interpreter services are available. You can call the Behavioral Health and Substance Use Disorder services line for help in getting services.

If you have an emergency, you should call 911 or go to the nearest hospital emergency room right away.

Nonemergency Medical Transportation (NEMT) services and Where's My Ride? line

Call our NEMT Services line toll-free if you do not have transportation to covered health-care services. These services include rides to the doctor, dentist, pharmacy, hospital, and other places you receive Medicaid services. NEMT services do not include ambulance trips.

Amerigroup will use our transportation vendor, Access2Care, to arrange all travel. To schedule a trip, call **833-721-8184**. You can call Monday through Friday from 8 a.m. to 5 p.m. local time, except for state-approved holidays. If you do not speak English, we can help you in many other languages, including Spanish. For members who are deaf or hard of hearing, please call **711**.

You should request NEMT services as early as possible. Call at least two business days before you need the NEMT service. For a long-distance trip outside your service area, you should request the NEMT service at least five business days before you need it. See the **"How to get a ride?"** section for a list of situations when you can receive transportation with less than 48 hours' notice.

When you are waiting on transportation from us, whether going or returning on a scheduled trip, you can call the NEMT Services line. Pick the **"Where's My Ride?"** option to find out the status of your ride. You can call between 5 a.m. to 7 p.m. local time Monday through Saturday or any time you are waiting for a scheduled ride.

Other important phone numbers

If you have an emergency, you should call 911 or go to the nearest hospital emergency room right away.

STAR Program Help Line	800-964-2777
Ombudsman Managed Care Assistance Team	866-566-8989
Medicaid Hotline	800-252-8263
Texas Early Childhood Intervention Program	800-628-5115
Texas Health Steps	877-847-8377
Eye care through Superior Vision of Texas	800-428-8789
Pharmacy Member Services	833-235-2022
Dental care for members 20 years and younger through:	
DentaQuest	800-516-0165
MCNA Dental	800-494-6262
UnitedHealthcare	877-901-7321

YOUR AMERIGROUP ID CARD

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

If you don't have your Amerigroup ID card yet, you'll get it soon. Always carry it with you. Show it to any doctor or hospital you visit. You don't need to show your ID card before you get emergency care. The card tells doctors and hospitals you're an Amerigroup member and who your doctor is. It also tells them Amerigroup will pay for the medically needed services listed in the **Benefits** section.

You may also print your ID card from our website at **myamerigroup.com/TX**. You'll need to register and log in to the website to access your ID card information.

Sample Amerigroup ID card for STAR members

Sample Amerigroup ID card for STAR members in the Medicaid Rural Service Area

How do I read my Amerigroup ID card?
Your Amerigroup ID card has the name and phone number of your doctor on it. Your ID card lists many of the important phone numbers you need to know, like our Member Services department and 24-hour Nurse HelpLine. It also lists the numbers for vision care and Pharmacy Member Services.

How do I replace my Amerigroup ID card if it is lost or stolen?
If your ID card is lost or stolen, call us right away at **800-600-4441 (TTY 711)**. We'll send you a new one. You may also print your ID card from our website at **myamerigroup.com/TX**. You'll need to register and log in to the website to access your ID card information.

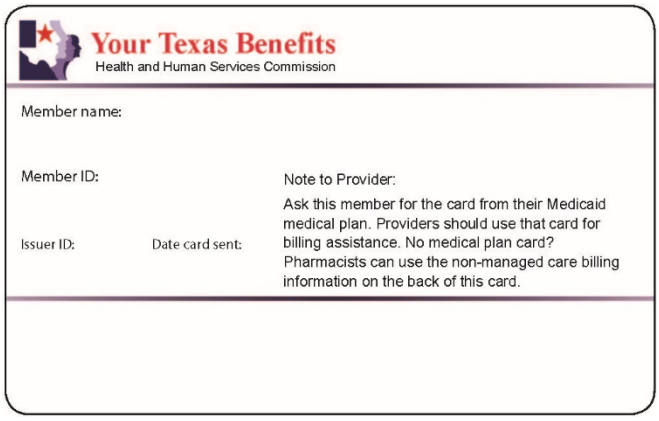
Your Texas Benefits (YTB) Medicaid Card

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

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

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

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



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

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

The back of the YTB Medicaid card has a website you can visit (YourTexasBenefits.com) and a phone number you can call toll-free (**800-252-8263**) if you have questions about the new card.

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

The YourTexasBenefits.com Medicaid Client Portal

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

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

To access the portal:

1. Go to **YourTexasBenefits.com**.
2. Click **Log In.**
3. Enter your Username and Password. If you don't have an account, click **Create a new account.**
4. Click **Manage.**
5. Go to the *Quick links* section.
6. Click **Medicaid & CHIP Services.**
7. Click **View services and available health information**.

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

What if I need a temporary ID verification form?

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

PRIMARY CARE PROVIDERS

What is a primary care provider?

A primary care provider, also called a family doctor, is the main doctor you see for most of your regular health care. Your primary care provider must be in the Amerigroup plan. Your primary care provider will give you a medical home. A medical home means that they will get to know you and your health history and help you get the best possible care.

When you enrolled in Amerigroup, you should have picked a primary care provider in our plan. If you didn't, we assigned you one who should be located close to you. Your primary care provider's name and phone number are printed on your Amerigroup ID card.

If you or your child have been getting care from a doctor who treats children and need to change to a doctor who provides care to adults, you can switch your primary care provider. We can help you choose a doctor for adults and transfer your medical records. Call Member Services toll-free at **800-600-4441 (TTY 711)**.

Your primary care provider will also send you to specialists, other doctors, or hospitals when you need special care or services they can't provide.

Can a specialist ever be considered a primary care provider?

If you need regular specialist care, we may approve a specialist to serve as your primary care provider. A specialist can serve as a primary care provider if you have a disability, special health-care needs, or a chronic, life-threatening illness or condition where:

- You may need to be hospitalized many times for your condition.
- You need to get most of your care from a specialist.
- Your primary care provider isn't able to arrange the care you need.

What do I need to bring with me to my doctor's appointment?

When you go to your doctor's appointment, bring:

- Your Amerigroup ID card.
- Your Texas Benefits Medicaid card.
- Any medicines you're taking and your shot records.
- Any questions you want to ask your doctor.

If the appointment is for your child, bring the same items listed above.

How can I change my primary care provider?

Call Member Services if you need to change your primary care provider. You can go to **myamerigroup.com/TX** to find a new one. You can also change your primary care provider online when you set up a secure account.

Can a clinic be my primary care provider?

Yes, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) in our plan can serve as your primary care provider.

How many times can I change my/my child's primary care provider?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us toll-free at **800-600-4441 (TTY 711)** or writing to us at one of our offices near you. Office locations are listed in the front of this handbook. Please address your written request to the member advocate. You can also make the change online when you set up a secure account.

When will my primary care provider change become effective?

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

Are there any reasons why a request to change a primary care provider may be denied?

You won't be able to change your doctor if:

- The doctor you picked doesn't take new patients.
- The new doctor isn't in our plan.

Can my primary care provider move me to another primary care provider for noncompliance?

Your primary care provider may ask for you to change to another primary care provider if:

- You don't follow their medical advice over and over again.
- Your doctor agrees a change is best for you.
- Your doctor doesn't have the right experience to treat you.
- You were assigned to the doctor by mistake (like an adult assigned to a child's doctor).

What if I choose to go to another doctor who is not my primary care provider?

Talk to your primary care provider first about any care you need from other doctors. They can refer you to other doctors in our plan and help coordinate all the care you need.

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

If you need to talk to your primary care provider after the office is closed, call their phone number on your ID card. Someone should call you back within 30 minutes to tell you what to do. You may also call 24-hour Nurse HelpLine 24 hours a day, 7 days a week for help.

If you think you need emergency care, see the **What is emergency medical care?** section of this handbook, call 911, or go to the nearest emergency room right away.

What is the Medicaid Lock-in Program?

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

To avoid being put in the Medicaid Lock-in Program:

- Pick one drugstore at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more, call Member Services at **800-600-4441 (TTY 711)**.

In some cases, you may be approved to get medication from another pharmacy, such as:

- You move out of the geographical area (more than 15 miles from the lock-in pharmacy).
- The lock-in pharmacy doesn't have the prescribed medication and it won't be available for more than 2-3 days.
- The lock-in pharmacy is closed for the day and you need the medication right away.

You should call Member Services at **800-600-4441 (TTY 711)** if you need approval to receive a medication at a pharmacy other than the lock-in pharmacy.

PHYSICIAN INCENTIVE PLANS

Amerigroup cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit medically necessary covered services to members. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call **800-600-4441 (TTY 711)** to learn more about this.

CHANGING HEALTH PLANS

What if I want to change health plans?

You can change your health plan by calling the Texas STAR Program Help Line at **800-964-2777**. You can change health plans as often as you want.

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

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

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

Who do I call?
You can change your health plan by calling the Texas STAR Program Help Line at **800-964-2777**.

How many times can I change health plans?
You can change health plans as often as you want.

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

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

Can Amerigroup ask that I get dropped from their health plan (for noncompliance, etc.)?
There are several reasons you could be dropped from Amerigroup, including:

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

If you've done something that may lead to being dropped from our plan, we'll contact you. We'll ask you to tell us what happened. If you have any questions about your enrollment, call Member Services at **800-600-4441 (TTY 711)**.

BENEFITS

What are my health-care benefits?
Your primary care provider will give you the care you need or refer you to another doctor. Some Amerigroup benefits are only for members who are a certain age or have a certain kind of health problem. If you have a question or aren't sure if we offer a certain benefit, call Member Services.

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

- Emergency and nonemergency ambulance services.
- Audiology services, including hearing aids, for adults and children.
- Behavioral health services, including:
  - Inpatient mental health services.
  - Outpatient mental health services.
  - Psychiatry services.

- Mental health rehabilitative services.
- Counseling services for adults (21 years of age and older).
- Outpatient substance use disorder treatment services, including:
  - Assessment.
  - Detoxification.
  - Counseling.
  - Medication-assisted therapy.
- Residential substance use disorder treatment (including room and board, and detoxification services).

- Birthing services provided by a doctor or certified nurse-midwife in a licensed birthing center.
- Birthing services provided by a licensed birthing center.
- Cancer screening, diagnosis, and treatment.
- Chiropractic services.
- Dialysis.
- Durable medical equipment and supplies.
- Early childhood intervention.
- Emergency services.
- Family planning.
- Home health care.
- Hospital services, including inpatient and outpatient.
- Laboratory services.
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - Inpatient services; outpatient services provided at an outpatient hospital or ambulatory health-care center, as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
    - Surgery and reconstruction on the other breast to produce symmetrical appearance.
    - Treatment of physical complications from the mastectomy and treatment of lymphedemas.
    - Prophylactic mastectomy to prevent the development of breast cancer.
  - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
- Medical checkups and Comprehensive Care Program services for children (from birth through age 20) through the Texas Health Steps program.
- Mental health targeted case management.
- Nonemergency medical transportation services.
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Outpatient drugs and biologicals, including those dispensed by a pharmacy or administered by a provider.
- Drugs and biologicals provided in an inpatient setting.
- Podiatry.

- Prenatal care.
- Primary care.
- Preventive services, including an annual adult well check for patients 21 years of age and older.
- Radiology, imaging, and X-rays.
- Specialty physician services.
- Telehealth.
- Telemedicine.
- Telemonitoring, to the extent covered by Texas Government Code §531.01276.
- Therapies — physical, occupational, and speech.
- Transplantation of organs and tissues.
- Vision (includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses).

How do I get these services?
Your primary care provider will help you get these types of services or you can call Member Services at **800-600-4441 (TTY 711)**.

What if Amerigroup doesn't have a provider for one of my covered benefits?
If a plan benefit isn't available through a doctor in our plan, we'll arrange for you to see one outside of the plan. We'll reimburse them according to state rules. You must call Member Services at **800-600-4441 (TTY 711)** to arrange services with a doctor outside of our plan except in an emergency.

Are there any limits to any covered services?
There may be some limits to care, such as for chiropractic services, based on Medicaid covered benefits. You can call Member Services at **800-600-4441 (TTY 711)** for a complete list of benefits and limitations.

What is preapproval?

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

- Most surgeries, including some outpatient surgeries
- All elective and nonurgent inpatient services and admissions
- Chiropractic services
- Most behavioral health and substance use disorder services (except routine outpatient and emergency services)
- Certain prescriptions
- Certain durable medical equipment, including prosthetics and orthotics
- Certain gastroenterology procedures
- Digital hearing aids
- Home health services
- Hospice services
- Rehabilitation therapy (physical, occupational, respiratory, and speech therapies)

- Sleep studies
- Out-of-area or out-of-network care, except in an emergency
- Advanced imaging (things like MRAs, MRIs, CT scans, and CTA scans)
- Certain pain management testing and procedures

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

What services are not covered by Amerigroup?

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

- Anything that is not medically necessary
- Anything experimental, such as a new treatment being tested or hasn't been shown to work
- Cosmetic surgery that isn't medically necessary
- Sterilization for members under age 21
- Routine foot care except for members with diabetes or poor circulation
- Fertility treatment services
- Treatment for disabilities connected to military service
- Weight loss program services
- Reversal of voluntary sterilization
- Private room and personal comfort items when hospitalized
- Sex reassignment surgery

To learn more about services not covered by Amerigroup, please call Member Services at **800-600-4441 (TTY 711)**.

What are my prescription drug benefits?

Medicaid pays for most medicine your doctor prescribes. Adults as well as children can get as many prescriptions as are medically necessary for medicines found on the Vendor Drug Program (VDP) list of drugs. Your doctor will use the VDP when writing your prescriptions. You may fill your prescription at any pharmacy in our plan unless you're in the Medicaid Lock-in Program.

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

You don't have to pay for plan health-care benefits. You don't pay any premiums, enrollment fees, deductibles, copays, or cost sharing.

What extra benefits do I get as a member of Amerigroup? How can I get these services?

Amerigroup gives you extra health-care benefits just for being our STAR member. These extra benefits are also called value-added benefits. We give you these benefits to help keep you healthy and to thank you for choosing Amerigroup as your health-care plan. Call Member Services to learn more about these extra benefits and how to get them or visit our website at **myamerigroup.com/TX**.

Value-added benefit	How to get it
Healthy Rewards gift card for completing these healthy activities: • $120 for completing 6 Texas Health Steps checkups per the Texas Health Steps visit schedule, for children ages 0–15 months (refer to the **What is Texas Health Steps?** section of this handbook) • $20 per visit for Texas Health Steps checkups at ages 18, 24, or 30 months • $20 each year for completing Texas Health Steps checkups, for ages 3–20 years • $20 for getting a full series of the rotavirus vaccinations (shots or other type of vaccine) (2–3 visits on different days depending on type of vaccine), for children ages 42 days through 24 months • $25 for a member who has a prenatal checkup in the first trimester of pregnancy or within 42 days of joining the health plan • $50 for a member who has a postpartum checkup within 7 to 84 days after giving birth • $20 every 6 months for getting a blood sugar test (HbA1c) for members ages 18 or older with diabetes • $20 every 6 months for getting a blood sugar test (HbA1c) with a result less than 8, for members ages 18 or older with diabetes • $20 for members newly diagnosed with attention deficit hyperactivity disorder (ADHD) who have a follow-up visit with their prescribing provider within 30 days after starting their medication treatment, for members ages 6 to 12 • $20 for having a follow-up outpatient visit with a behavioral health provider within 7 days of discharge from the hospital for a behavioral health stay, up to 4 times per year • $20 for getting a full series of the HPV (Human papillomavirus) vaccination (2 vaccines at least 146 days apart or 3 vaccines on different days), for members from their 9th through 13th birthday	To receive a reward: • Join the Healthy Rewards program within 30 days after you complete an eligible healthy activity while you are an Amerigroup member. • Your provider will report most healthy activities by submitting a claim within 95 days of your visit. • If you have not received a reward, you must request it within 6 months after the date of your activity. To join the Healthy Rewards program or find information about the program and rewards: • Log in to your account at **myamerigroup.com/TX** to access the Benefit Reward Hub from the Benefits page or • Call the Healthy Rewards Customer Service Line at **888-990-8681 (TTY 711)** Monday through Friday from 8 a.m. to 7 p.m. Central time

Value-added benefit	How to get it
Healthy Rewards gift card allowance for over-the-counter products for completing these healthy activities: • $20 for getting a full series of flu (influenza) vaccinations (2 vaccinations on different days), for children ages 6 months through 24 months • $20 each year for getting a flu vaccination, for members ages 3 or older Excludes any products covered by Medicaid	To receive a reward: • Join the Healthy Rewards program within 30 days after you complete an eligible healthy activity while you are an Amerigroup member. • Your provider will report healthy activities by submitting a claim within 95 days of your visit. • If you have not received a reward, you must request it within 6 months after the date of your activity. To join the Healthy Rewards program or find information about the program and rewards: • Log in to your account at **myamerigroup.com/TX** to access the Benefit Reward Hub from the Benefits page or • Call the Healthy Rewards Customer Service Line at **888-990-8681 (TTY 711)** Monday through Friday from 8 a.m. to 7 p.m. Central time
General Education Diploma (GED) — we'll cover the test fee for your GED test	Call **800-600-4441 (TTY 711)**. For members ages 18 and older.
Online emotional health — secure web and mobile tools you can use 24/7 to help improve your emotional health	Access the Learn to Live Emotional Well-being Resources by visiting **learntolive.com/welcome/TXAmerigroup**. Type TXAmerigroup into the code field and hit "submit." Then, enter your member ID. For members ages 13 and older.
24-hour Nurse HelpLine — nurses are available 24 hours a day, 7 days a week for your health-care questions	Call **800-600-4441 (TTY 711)**.
Help getting rides for: • Family members to go with you to medical services. • Pregnancy, birthing, or newborn classes for pregnant members.	Call **833-721-8184 (TTY 711)**. Rides for additional family members must be preapproved. For rides to WIC offices and Member Advisory

Value-added benefit	How to get it
• Visits to Women, Infants, and Children (WIC) offices. • Member Advisory Group meetings.	Group meetings, every member can get one ride per month, with up to 12 rides each year.
Up to $100 for a Boys & Girls Club basic membership for members ages 6 to 18 where available (paid $50 per semester)	Go to your local Boys & Girls Club.
One sports or school physical every year for members ages 4 to 19	See your primary care provider. A nurse practitioner or physician assistant who is a primary care provider can give the sports or school physical.
First-aid kit and a personal disaster plan (1 kit per member per lifetime)	Log in to your account at **myamerigroup.com/TX** to access the Benefit Reward Hub from the Benefits page or call **800-600-4441 (TTY 711)**.
Dental hygiene kit for members age 21 and older — 1 kit per year	Log in to your account at **myamerigroup.com/TX** to access the **Benefit Reward Hub** from the Benefits page or call **800-600-4441 (TTY 711)**.
Taking Care of Baby and Me® program — helps our pregnant members, new moms, and their babies get and stay healthy Pregnant members will get pregnancy, postpartum, and newborn educational materials to help them learn about pregnancy and postpartum care. This includes the importance of prenatal and ongoing doctor visits.	Call **800-600-4441 (TTY 711)** or go to **myamerigroup.com/TX** for more information.
Free cellphone/smartphone through the Lifeline program with monthly minutes, data, and texts. If you qualify, you also get: • Unlimited calls to Member Services and member advocates for calls placed through Member Services. • 200 bonus minutes when you join. • 100 bonus minutes for your birthday.	Call **800-600-4441 (TTY 711)** or go to **myamerigroup.com/TX** for more information. Birthday bonus minutes start the month after you join. To see if you qualify for the federal Lifeline Assistance program, go to safelinkwireless.com and fill out the application.
Allergy-free pillow cover (1 per year) for members ages 20 and younger who have been diagnosed with asthma and participate in a disease or case management program	Log in to your account at **myamerigroup.com/TX** to access the Benefit Reward Hub from the Benefits page or call **800-600-4441 (TTY 711)**.

Value-added benefit	How to get it
Help with weight management through a program with 24/7 online access to resources, tools, and activities on healthy snacking, portion management, weight goals, extra calories, and exercise tips	Access the CommonGround Library platform by logging into your secure account at **myamerigroup.com/TX**. For members ages 13 and older.
Pregnancy and early parenting program online 24/7 through web or mobile app to support expecting and new parents	Access the CommonGround Library platform by logging into your secure account at **myamerigroup.com/TX**. For members ages 13 and older.
Kick the Habit for Teens: An interactive, text-based program to help teens ages 13–17 quit vaping or using e-cigarettes. The program focuses on web counseling for up to 12 weeks.	Text the keyword VAPEOUTTX to **88709** to enroll.
Kick the Habit: A tobacco cessation program with online activities, education materials, and products. This program can help members as they try to quit using tobacco or chew, smoking cigarettes, or vaping.	Access the program at **go.theexprogram.com/amerigrouptx**.
Social services resource directory online to help locate community supports such as food and nutrition, housing, education, and employment services	To find services near you, visit **myamerigroup.com/TX** and select **Community Support** under *Get Help*.

What health education classes does Amerigroup offer?

We work to help keep you healthy by holding educational events in your area and by helping you find community health education programs close to you. These events and community programs may include:

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

For events in your area, check the *Community Support* page at **myamerigroup.com/TX** under the **Get Help** tab. For help finding a community program, call Member Services or dial **2-1-1**. Please note: some community organizations may charge a fee for their programs.

What is Disease Management?

Disease Management

A Disease Management (DM) program can help you get more out of life. As part of your Amerigroup benefits, we're here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called DM case managers. They'll help you learn how to better manage your condition, or health issue. You can choose to join a DM program at no cost to you.

You can join a Disease Management program to get health-care and support services if you have one of these conditions:

- Asthma
- Bipolar Disorder
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major Depressive Disorder – Adult
- Major Depressive Disorder – Child and Adolescent
- Schizophrenia
- Substance Use Disorder

How it works

When you join one of our DM programs, a DM case manager will:

- Help you create health goals and make a plan to reach them.
- Coach you and support you through one-on-one phone calls.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition and/or treatment plan (ways to help health issues).
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your health-care providers, like helping you with:
  - Making appointments.
  - Getting to health-care provider visits.
  - Referring you to specialists in our health plan, if needed.
  - Getting any medical equipment you may need.
- Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco like quitting smoking).

Our DM team and your primary care provider are here to help you with your health-care needs.

How to join

We'll send you a letter welcoming you to a DM program, if you qualify. Or, call us toll-free at **888-830-4300 (TTY 711)** Monday through Friday from 8:30 a.m. to 5:30 p.m. local time.

When you call, we'll:

- Set you up with a DM case manager to get started.
- Ask you some questions about your or your child's health.
- Start working together to create your or your child's plan.

You can also email us at **dmself-referral@amerigroup.com**. Please be aware that emails sent over the internet are usually safe, but there is some risk third parties may access (or get) these emails without you knowing. By sending your information in an email, you acknowledge (or know, understand) third parties may access these emails without you knowing.

You can choose to opt out (we'll take you out of the program) of the program at any time. Please call us toll-free at **888-830-4300 (TTY 711)** from 8:30 a.m. to 5:30 p.m. local time Monday through Friday to opt out. You may also call this number to leave a private message for your DM case manager 24 hours a day.

Useful phone numbers
In an emergency, call **911**.

Disease Management:
Toll-free: **888-830-4300 (TTY 711)**
Monday through Friday
8:30 a.m. to 5:30 p.m. local time
Leave a private message for your case manager 24 hours a day.

After-hours:
Call 24-hour Nurse HelpLine
24 hours a day, 7 days a week
800-600-4441 (TTY 711)

Disease Management rights and responsibilities
When you join a Disease Management program, you have certain rights and responsibilities. You have the right to:

- Get details about us, such as:
  - Programs and services we offer.
  - Our staff and their qualifications (skills or education).
  - Any contractual relationships (deals we have with other companies).
- Opt out of DM services.
- Know which DM case manager is handling your DM services and how to ask for a change.
- Get support from us to make health-care choices with your health-care providers.
- Ask about all DM-related treatment options (choices of ways to get better) mentioned in clinical guidelines (even if a treatment is not part of your health plan benefits) and talk about options with treating health-care providers.

- Have personal data and medical information kept private.
- Know who has access to your information and how we make sure your information stays secure, private, and confidential.
- Receive polite, respectful treatment from our staff.
- Get information that is clear and easy to understand.
- File complaints to Amerigroup by calling **888-830-4300 (TTY 711)** toll-free, from 8:30 a.m. to 5:30 p.m. Central time Monday through Friday and:
  - Get help on how to use the complaint process.
  - Know how much time Amerigroup has to respond to and resolve issues of quality and complaints.
  - Give us feedback about the Disease Management program.

You also have a responsibility to:
- Follow the care plan that you and your DM case manager agree on.
- Give us information needed to carry out our services.
- Tell us and your health-care providers if you choose to opt out (leave the program).

Disease Management does not market products or services from outside companies to our members. DM does not own or profit from outside companies on the goods and services we offer.

What is a Member with Special Health Care Needs (MSHCN)?

A Member with Special Health Care Needs (MSHCN) is someone who both:
- Has a serious ongoing illness, a chronic or complex condition, or a disability that will likely last for a long period of time.
- Requires regular, ongoing treatment and evaluation for the condition by appropriate health-care personnel.

Examples are:
- Members diagnosed with respiratory illness (such as chronic obstructive pulmonary disease COPD, chronic asthma, or cystic fibrosis), diabetes, heart disease, kidney disease, HIV, or AIDS.
- Child members receiving ongoing therapy services which may include physical therapy, speech therapy, or occupational therapy (such as for longer than 6 months).
- Members receiving Personal Care Services, Private Duty Nursing, or Prescribed Pediatric Extended Care Center services.

MSHCN also include the following:
- Early Childhood Intervention (ECI) program participants.
- Pregnant women who have a high-risk pregnancy, including those who are:
  - Ages 35 and older, or 15 and younger
  - Diagnosed with preeclampsia, high blood pressure, or diabetes

    - Diagnosed with mental health or substance use disorders
    - With a previous preterm birth, as identified on the perinatal risk report
- People who have a mental Illness with a substance use disorder.
- People with behavioral health issues, including substance use disorders or serious emotional disturbance (SED) or serious and persistent mental illness (SPMI), that affect their physical health and ability to follow treatment plans.
- Members with high-cost catastrophic cases or high service utilization, such as high volume of emergency room or hospital visits.

We have a system for identifying and contacting MSHCN. You may also request a screening to find out if you meet the criteria for MSHCN.

What is service coordination for Members with Special Health Care Needs? How can I get service coordination?
Service coordination for MSHCN is when you work with a service coordinator to help you get covered care and services to treat a health condition. A qualified service coordinator will work with you to develop a service plan and make sure all your care and services work together. Your service coordinator will work with you and your doctors to make sure you get the care and services you need. You may also have a specialist serve as your primary care provider.

What will a service coordinator do for me?
They will help you get the services you need by:
- Identifying your health-care needs through an assessment.
- Creating a service plan to meet those needs.
- Discussing the service plan with you, your family, and your representative (if needed) to make sure you understand and agree with it.
- Helping you get needed services.
- Working as a team with you and your doctors.
- Making sure all health-care and other services you can get outside of Amerigroup are coordinated.

How can I talk with a service coordinator?
You don't need a referral from a doctor to talk to a service coordinator. Call Member Services at **800-600-4441 (TTY 711)** and ask to speak to one. Service coordinators are available Monday through Friday from 8 a.m. to 5 p.m. local time. If one isn't available, you can leave a confidential voice mail.

What is Case Management?
If you don't qualify for MSHCN service coordination, we also have a case management program.

Through this program, we have case managers who can help you manage critical events and health issues that may last for a while. A case manager will help you manage your health-care needs. To contact a case manager, call Member Services at **800-600-4441 (TTY 711)** and ask to

speak to one. They're available Monday through Friday from 8 a.m. to 5 p.m. local time. If you need to leave a message, they have confidential voicemail available 24 hours a day.

What other services can Amerigroup help me get?

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

- Texas Health Steps dental (including orthodontia) — Medicaid members ages 20 and younger can get dental benefits through a dental managed care organization.
- Texas Health Steps environmental lead investigation (ELI).
- Texas Health Steps Personal Care Services for members birth through age 20.
- Early Childhood Intervention (ECI) case management/service coordination.
- ECI Specialized Skills Training.
- Texas School Health and Related Services (SHARS).
- Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program.
- Tuberculosis services provided by Department of State Health Services (DSHS)-approved providers (directly observed therapy and contact investigation).
- Community First Choice (CFC) services.

HEALTH-CARE AND OTHER SERVICES

What does medically necessary mean?

Your doctor will help you get the services you need that are medically necessary as defined below.

Medically necessary means:

1) For members from birth through age 20, the following Texas Health Steps services:
   a) Screening, vision, and hearing services.
   b) Other health-care services, including behavioral health services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
      - Must comply with the requirements of the Alberto N., et al. v. Traylor, et al. partial settlement agreements, and
      - May include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b- g) of this definition.
2) For members over age 20, nonbehavioral health-related health-care services that are:
   a) Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life.
   b) Provided at appropriate facilities and at the appropriate levels of care for the

treatment of a member's health conditions.

c) Consistent with health-care practice guidelines and standards that are endorsed by professionally recognized health-care organizations or governmental agencies.
d) Consistent with the diagnoses of the conditions.
e) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
f) Not experimental or investigative, and
g) Not primarily for the convenience of the member or provider.

3) For members over age 20, behavioral health services that:
   a) Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder.
   b) Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
   c) Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
   d) Are the most appropriate level or supply of service that can safely be provided.
   e) Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
   f) Are not experimental or investigative, and
   g) Are not primarily for the convenience of the member or provider.

If you have questions regarding an authorization, a request for services or a utilization management question, you can call us at **800-600-4441 (TTY 711)**.

How is new technology evaluated?

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

- Medical procedures.
- Behavioral health procedures.
- Medicines.
- Devices.

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

What is routine medical care?

Routine care includes regular checkups, preventive care and appointments for minor injuries and illnesses. Your primary care provider sees you when you're not feeling well, but that's only part of their job. They also take care of you before you get sick. This is called well care. See the **What services are offered by Texas Health Steps?** and **When should adults get checkups?** sections of this handbook to learn more.

How soon can I expect to be seen?
You should be able to see your doctor within 2 weeks for routine care.

What is urgent medical care?

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

- Minor burns or cuts.
- Earaches.
- Sore throat.
- Muscle sprains/strains.

What should I do if my child or I need urgent medical care?
For urgent care, you should call your doctor's office, even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Amerigroup Medicaid. For help, call us toll-free at **800-600-4441 (TTY 711)**. You also can call 24-hour Nurse HelpLine at the same number for help with getting the care you need.

How soon can I expect to be seen?
You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Amerigroup Medicaid.

What is emergency medical care?

After routine and urgent care, the third type of care is **emergency care**. If you have an emergency, you should call 911 or go to the nearest hospital emergency room right away. If you want medical advice, call your primary care provider or 24-hour Nurse HelpLine 7 days a week at **800-600-4441 (TTY 711).** Please get medical care as soon as possible.

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

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

1) Placing the patient's health in serious jeopardy.
2) Serious impairment to bodily functions.

3) Serious dysfunction of any bodily organ or part.
4) Serious disfigurement.
5) In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency behavioral health condition means:
Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing average knowledge of medicine and health:
1) Requires immediate intervention and/or medical attention without which the member would present an immediate danger to themselves or others.
2) Which renders the member incapable of controlling, knowing, or understanding the consequences of their actions.

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

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

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

Are emergency dental services covered by the health plan?
Amerigroup covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:
- Treatment for dislocated jaw.
- Treatment for traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Hospital, physician, and related medical services such as drugs for any of the above conditions.

What do I do if my child needs emergency dental care?
During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call us toll-free at **800-600-4441 (TTY 711)** or call 911.

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

the access standards listed below.

Standard name	Amerigroup
Emergency services	As soon as you arrive at the provider for care
Urgent care	Within 24 hours of request
Routine primary care	Within 14 days of request
Routine specialty care	Within 3 weeks of request
Primary care follow-up visit after emergency room visit or hospital discharge	Within 14 days of visit or discharge
After-hours care	Primary care providers are available 24/7 directly or through an answering service. Refer to the **How do I get medical care after my primary care provider's office is closed?** section of this handbook.
Preventive health	
Children (new member)	New members birth through age 20, as soon as possible and no later than 90 days after enrollment
Children less than 6 months old	Within 14 days of request
Members ages 6 months through 20 years	Within 60 days of request
Members ages 21 and older	Within 90 days of request
Prenatal care	
Initial visit	Within 14 days of request
Initial visit for high risk or 3rd trimester	Within 5 days of request or immediately, if an emergency exists
After initial visit	Based on the provider's treatment plan
Behavioral health	
Non-life-threatening emergency	Within 6 hours of request
Urgent care	Within 24 hours of request
Initial visit for routine care	The earlier of 10 business days or 14 calendar days from request
Follow-up visit for routine care	Within 3 weeks of request
Follow-up visit after hospital stay	Within 7 days of discharge

You should call your primary care provider within 24 hours after you visit the emergency room. If you can't call, have someone else call for you. Your doctor will give or arrange any follow-up care you need.

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

Help from your primary care provider is available 24 hours a day. If you call your primary care provider'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 within 30 minutes to tell you what to do. You may also call 24-hour Nurse HelpLine to talk to a nurse anytime.

If you think you need emergency care, call 911 or go to the nearest emergency room right away. Refer to the **What is emergency medical care?** section of this handbook to help you decide if you need emergency care.

What if I get sick when I am out of town or traveling?

If you need medical care when traveling, call us toll-free at **800-600-4441 (TTY 711)** and we will help you find a doctor. If you need emergency services while travelling, go to a nearby hospital, and then call us toll-free at **800-600-4441 (TTY 711**).

What if I am out of the state?

If you are outside of Texas and need medical care, please call us toll-free at **800-600-4441 (TTY 711)**. If you need emergency care, go to the nearest hospital emergency room or call 911.

What if I am out of the country?

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

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

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

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

We cover services from many different kinds of doctors who provide specialist care. If your primary care provider can't give you needed care, they can refer you to a specialist in our plan. If you have disabilities, special health-care needs, or chronic complex conditions, you can have a specialist as your primary care provider if the specialist agrees to provide your primary care services. Please call Member Services so we can arrange this for you.

What is a referral?

A referral is when your primary care provider sends you to another doctor or service for care. Your primary care provider may refer you to a specialist in our plan if they can't give you the care you need.

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

You'll be able to see a specialist within three weeks from when you call the specialist's office.

What services don't need a referral?
You don't need a referral from your primary care provider to get needed care from providers in our plan. It's always best to talk to your primary care provider first about any additional care you need. Your primary care provider can tell you about other doctors in our plan and help coordinate all the care you receive.

How can I ask for a second opinion?
You have the right to ask for a second opinion about the health-care services you need. This doesn't cost you anything. You can get a second opinion from a doctor in our plan. If one isn't available for a second opinion, your primary care provider can submit a request to us to authorize a visit to a non-network provider.

How do I get help if I have behavioral (mental) health, alcohol, or drug problems?
Sometimes the stress of life can lead to depression, anxiety, marriage and family problems, or alcohol and drug abuse. If you or a family member is having these kinds of problems, we have doctors who can help. Call Member Services at **800-600-4441 (TTY 711)** for help finding a doctor who will help you. All services and treatment are strictly confidential.

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

What are Mental Health Rehabilitative Services and Mental Health Targeted Case Management?
Mental Health Rehabilitative Services help you stay independent in your home and the community, such as:

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

Mental Health Targeted Case Management helps you access medical, social, educational, and other services and supports that can help improve your health and your ability to function. These services are available if you need them based on an appropriate standardized assessment by a mental health professional.

How do I get these services?
Call Member Services at **800-600-4441 (TTY 711)** to learn more about available resources.

How do I get my medications?
Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drugstore or may be able to send the prescription for you.

You or your children can get as many prescriptions as medically necessary from the Vendor Drug Program (VDP) list of drugs. You may go to any pharmacy in the Amerigroup plan to have your prescription filled unless you're in the Medicaid Lock-in Program.

You should use the same pharmacy each time you need medicine. This way, your pharmacist will know all the drugs you're taking. They can tell you about drug interactions and side effects. If you use another pharmacy, you should tell the pharmacist about any other medicines you're taking.

How do I find a network drugstore?
To find a pharmacy in our plan, go to our website at **myamerigroup.com/TX** and select **Find a Doctor**. You can search for a pharmacy near you. You can also ask the pharmacist or call Member Services for help.

What if I go to a drugstore that is not in the network?
The pharmacist will explain that they don't accept Amerigroup. You'll need to take your prescription to a pharmacy in our plan.

What do I bring with me to the drugstore?
When you go to the drugstore, you should bring:

- Your prescription(s) or medicine bottle(s).
- Your Amerigroup ID card.
- Your Texas Benefits Medicaid card.

What if I need my medications delivered to me?
Many pharmacies provide delivery services. Ask your pharmacist if they can deliver to your home.

Who do I call if I have problems getting my medications?
If you have problems getting your Amerigroup-covered medications, please call us at **833-235-2022 (TTY 711)**. We can work with you and your pharmacy to make sure you get the medicine you need.

What if I can't get the medication my doctor ordered approved?
Some medicines require our preapproval. If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication. Call us at **833-235-2022 (TTY 711)** for help with your medications and refills. Ask your pharmacist to dispense a 3-day supply.

What if I lose my medications?
If your medicine is lost or stolen, have your pharmacist call Provider Services at **800-454-3730**.

How do I find out what drugs are covered?
Your doctor can choose drugs from the Texas Vendor Drug Program (VDP) list of drugs. It includes all medicines covered by Medicaid.

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

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

How do I transfer my prescriptions to a plan pharmacy?
If you need to transfer your prescriptions, all you need to do is:

- Call the nearest plan pharmacy and give the needed information to the pharmacist, or
- Bring your prescription container to the new pharmacy, and they'll handle the rest.

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

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

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

What if I need durable medical equipment (DME) or other products normally found in a pharmacy?
Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all members, Amerigroup pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), Amerigroup also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call **800-600-4441 (TTY 711)** for more information about these benefits.

How do I get family planning services?

Amerigroup will arrange for counseling and education about planning a pregnancy or preventing pregnancy. You can call your primary care provider for help or go to any Medicaid family planning provider. A doctor can't require parental consent for minors to receive family planning services and must keep family planning use confidential.

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

Where do I find a family planning services provider?
You can find the locations of family planning providers near you online at https://healthytexaswomen.org/family-planning-program, or you can call Amerigroup at **800-600-4441 (TTY 711)** for help in finding a family planning provider.

What is case management for children and pregnant women?

Case management for children and pregnant women
Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?
Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- Have health problems, or
- Are at a high risk for getting health problems.

What do case managers do?
A case manager will visit with you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?
Case managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you get a case manager?
Contact Amerigroup for more information or call Texas Health Steps at **877-847-8377** (toll-free), Monday to Friday, 8 a.m. to 8 p.m.

- Amerigroup Case Management phone: **800-600-4441 (TTY 711)**
- Amerigroup website: **myamerigroup.com/TX**

What is Early Childhood Intervention (ECI)?
ECI is a statewide program for families with children birth to age 3 with disabilities and developmental delays. ECI helps families support their children through developmental services. ECI evaluates and assesses, at no cost to families, to see if they are eligible and what services they'll need. Families and professionals work together to plan services based on the unique needs of the child and family.

The Health and Human Services Commission (HHSC) is the state agency responsible for ECI. A local ECI program will determine if a child can get ECI services, and it will develop a child's individual service plan. Amerigroup is responsible for paying for the services in the plan.

Do I need a referral for this?
You don't need a referral from your child's doctor to get these services.

Where do I find an ECI provider?
To get information about ECI services and other resources, call the HHS Office of the Ombudsman at **877-787-8999**, select a language, then select option 3. You can also search online for an ECI program near you. Go to the ECI Program Search page at https://citysearch.hhsc.state.tx.us.**.**

Participation in an ECI program is voluntary. If you choose not to use a local ECI program, Amerigroup must provide medically necessary services for your child. Call us at **800-600-4441 (TTY 711)** if you need help getting these services.

What is Head Start?
Head Start is a program to help children ages 5 or younger get ready for school. This program can help with:
- Language.
- Literacy.
- Social and emotional development.

To find a Head Start program near you, call toll-free **866-763-6481** or go to http://benefits.gov/benefits/benefit-details/1941.

What is Texas Health Steps?

What services are offered by Texas Health Steps?
Texas Health Steps is the Medicaid health-care program for STAR children, teens, and young adults, birth through age 20.

Texas Health Steps gives your child:

- Free regular medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.
- A case manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:

- Find health problems before they get worse and are harder to treat.
- Prevent health problems that make it hard for children to learn and grow like others their age.
- Help your child have a healthy smile.

When to set up a checkup:

- You will get a letter from Texas Health Steps telling you when it's time for a checkup.
- Call your child's doctor or dentist to set up the checkup.
- Set up the checkup at a time that works best for your family.

If the doctor or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:

- Eye tests and eyeglasses.
- Hearing tests and hearing aids.
- Dental care.
- Other health care.
- Treatment for other medical conditions.

Call Amerigroup Member Services at **800-600-4441 (TTY 711)** or Texas Health Steps at **877-847-8377 (877-THSTEPS)** toll-free if you:

- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps.
- Need help finding and getting other services.

If you can't get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital, or drug store.

How and when do I get Texas Health Steps medical and dental checkups for my child?
The first well-child visit will happen in the hospital right after your baby is born. For the next 6 visits, you must take your baby to their doctor's office. Children need these checkups even when they're healthy. Your child needs to have checkups at these ages.

Texas Health Steps medical checkup schedule for your child	
Birth	9 months old
3–5 days	12 months old

2 weeks old	15 months old
2 months old	18 months old
4 months old	2 years old
6 months old	2 1/2 years old
After age 2 1/2, your child should visit the doctor every year. Amerigroup encourages and covers annual checkups for children ages 3 through 20.	

Be sure to make these appointments. Take your child to their doctor when scheduled.

Does my doctor have to be part of the Amerigroup plan?
Your child can see any Texas Health Steps doctor for these checkups. The Texas Health Steps doctor doesn't have to be in our plan.

Do I have to have a referral?
Your child can get Texas Health Steps care without a referral.

What if I need to cancel an appointment?
If you're unable to keep your appointment, you must call your doctor and cancel. You can make a new appointment when you call.

What to do if you are out of town and your child is due for a Texas Health Steps visit?
If you're out of town and your child is due for a Texas Health Steps visit, call your doctor's office or Member Services for help.

What if I am a migrant farmworker?
Migrant farmworkers move to different places to follow seasonal farm work. They could work on farms, in fields, as a food processor or packer, or with dairy products, poultry, or livestock during certain times of the year. You can get your checkups sooner if you are leaving the area. If you call us and tell us you're a farmworker, we'll:

- Help you find doctors and clinics, and help you set up appointments.
- Let doctors know you need to be seen quickly because you may have to leave the area to go to your next job.

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

Well-care visit schedule for adult members		
EXAM TYPE	**WHO NEEDS IT?**	**HOW OFTEN?**
Well-care visit	Ages 21 and over	Every year
Pelvic exam	Women ages 18 and over	Every year
	Women ages 21–29	Pap smear only — every 3 years

Pap smear	Women ages 30–65	Pap smear only — every 3 years Pap smear/human papillomavirus (HPV) cotesting — every 5 years
Clinical breast exam	Women ages 20–39	Every 3 years
	Ages 40 and over	Every year
Breast self-exam	Women ages 20 and over	Once a month
Mammograms (breast X-ray)	Women ages 40 and over	Every year or as recommended by your doctor
Fecal blood occult test	Ages 50 and over	Every year
Sigmoidoscopy and DRE/PSA or colonoscopy and DRE/PSA	Ages 50 and over	Every 5 years

If I miss my well-care visits or my child's Texas Health Steps checkup, what do I do?
If you or your child doesn't get a well-care visit on time, make an appointment with your doctor as soon as you can. If you need help setting up the appointment, call Member Services. If your child hasn't visited their doctor on time, we'll send you a postcard reminding you to make your child's Texas Health Steps appointment.

NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

What are NEMT services?

NEMT services provide transportation to nonemergency health-care appointments for members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you receive Medicaid services. These trips do NOT include ambulance trips.

What services are part of NEMT services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health-care service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain health-care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health-care services. Lodging services are limited to the

overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services.

If you need an attendant to travel to your appointment with you, NEMT services will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15–17 years old must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adults on file to travel alone. Parental consent is not required if the health-care service is confidential in nature.

How to get a ride?
Your MCO will provide you with information on how to request NEMT services. You should request NEMT services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances, you may request the NEMT service with less notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

You must notify your MCO prior to the approved and scheduled trip if your medical appointment is cancelled.

If you have an emergency and need transportation, call 911 for an ambulance. You can also refer to the **What is emergency medical care?** section of this handbook to learn more.

What if I can't be transported by taxi, van, or other standard vehicles to get to health-care appointments?
If you have a medical condition that causes you to need an ambulance to get to health-care appointments, your doctor can send a request to Amerigroup. Call Member Services at **800-600-4441 (TTY 711)** for information about how your doctor can send a request.

If you need an ambulance for an emergency, your doctor does not need to send a request.

How do I get eye care services?

Amerigroup Medicaid members are eligible for eye care benefits. You do not need a referral from your doctor for these benefits. Please call Superior Vision of Texas at **800-428-8789** for help finding a plan eye doctor (optometrist) in your area.

Children ages 20 and younger get coverage for a vision exam once every 12 months and medically necessary frames and lenses or contact lenses once every 24 months, or when otherwise medically necessary. Adult members ages 21 years and older get coverage for a

vision exam and medically necessary frames and lenses or contact lenses every 24 months.

What dental services does Amerigroup cover for children?

Amerigroup covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

- Treatment of dislocated jaw
- Treatment for traumatic damage to teeth and supporting structures
- Removal of cysts
- Treatment of oral abscess of tooth or gum origin

Amerigroup covers hospital, physician, and related medical services for the above conditions. This includes services the doctor provides and other services your child might need, like anesthesia or other drugs.

Amerigroup is also responsible for paying for treatment and devices for craniofacial anomalies.

Your child's Medicaid dental plan provides all other dental services, including services that help prevent tooth decay and services that fix dental problems. Call your child's Medicaid dental plan to learn more about the dental services they offer.

- DentaQuest **800-516-0165**
- MCNA Dental **800-494-6262**
- UnitedHealthcare **877-901-7321**

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

Call Member Services at **800-600-4441 (TTY 711)** to tell us if you need an interpreter at least 24 hours before your appointment. This service is available for visits with your doctor at no cost to you.

How far in advance do I need to call?

Please let us know at least 24 hours before your appointment if you need an interpreter. If you ask for an interpreter less than 24 hours before your appointment, we will still do our best to have an interpreter available for you.

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

Call Member Services if you need an interpreter when you talk to your provider at his or her office.

What if I need OB/GYN care?

Female members can see any Amerigroup plan obstetrician or gynecologist (OB/GYN) for female health-care needs.

ATTENTION FEMALE MEMBERS:

Amerigroup allows you to pick any OB/GYN, whether that doctor is in the same network as your

primary care provider or not. The OB/GYN you pick must be in the Amerigroup plan.

Do I have the right to choose an OB/GYN?
You have the right to pick an OB/GYN without a referral from your primary care provider. An OB/GYN can give you:

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

How do I choose an OB/GYN?
You're not required to pick an OB/GYN. However, if you're pregnant, you should pick one to care for you. You can pick any OB/GYN listed in the Amerigroup provider directory. If you need help choosing one, call Member Services at **800-600-4441 (TTY 711)**.

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

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

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

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

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

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

What other services/activities/education does Amerigroup offer pregnant women?
It's very important to see your doctor or OB/GYN for care when you're pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if you've already had a baby.

Our Taking Care of Baby and Me® program gives pregnant women health information and rewards for getting prenatal and postpartum care. You may get a care manager to help you get the prenatal care and services you need during your pregnancy and up to your postpartum checkup. Your care manager may call to check on you and answer questions. They can also help you find prenatal resources in your community. To find out more about the Taking Care of Baby and Me program, call Member Services.

Our program also helps pregnant members with complicated health-care needs. Nurse care managers work closely with these members to provide:

- Education.
- Emotional support.
- Help in following their doctor's care plan.
- Information on services and resources in the community, such as transportation, Women, Infants, and Children (WIC) program, breastfeeding, and counseling.

Our nurses work with doctors to help keep you healthy and deliver healthy babies.

My Advocate®

As part of Taking Care of Baby and Me, you are also part of My Advocate which delivers prenatal, postpartum, and well-child health education by phone, web, and smartphone app that is both helpful and fun. You will get to know MaryBeth, the My Advocate automated personality. MaryBeth will respond to your changing needs as your baby grows and develops. You can count on:

- Education you can use.
- Communication with your care manager based on My Advocate messaging should questions or issues arise.
- An easy communication schedule.
- No cost to you.

With My Advocate, your information is kept secure and private. Each time MaryBeth calls, she'll ask you for your year of birth. Please don't hesitate to tell her. She needs the information to be sure she's talking to the right person.

Helping you and your baby stay healthy

My Advocate gives you answers to your questions, plus medical support if you need it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn, and answer a question or two over the phone. If you tell MaryBeth you have a problem, you'll get a call back from a care manager. My Advocate topics include:

- Pregnancy and postpartum care.
- Well-child care.
- Postpartum depression.
- Immunizations.
- Healthy living tips.

To learn more about My Advocate, visit myadvocatehelps.com.

While you're pregnant, it's especially important to take care of your health. You may be able to get healthy food from the Women, Infants, and Children (WIC) program. Member Services can give you the phone number for the WIC program close to you. Just call us.

We will send you an educational book, called the Pregnancy and Beyond Resource Guide. The book includes:

- Self-care information about your pregnancy.
- A section of the book for writing down things that happen during your pregnancy.
- Details on My Advocate that tell you about the program and how to enroll and get health information to your phone by automated voice, web, or smartphone app.
- A Labor, Delivery, and Beyond section with information on what to expect during your third trimester.
- A section of the book on having a healthy baby, postpartum depression, and caring for your newborn with helpful resources.
- Information about Making a Family Life Plan and long-acting reversible contraception (LARC).

When you're pregnant, you must go to your doctor or OB/GYN at least:

- Every four weeks for the first 6 months.
- Every two weeks for the 7th and 8th months.
- Every week during the last month.

Your doctor or OB/GYN may want you to visit more often based on your health needs.

NICU Programs

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program and a NICU Post Traumatic Stress Disorder (NICU PTSD) program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are given an educational resource outlining successful strategies they can use to work with the care team. The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and helping make referral to treatment for PTSD in parents. This program supports mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.

Where can I find a list of birthing centers?

Please call us at **800-600-4441 (TTY 711)** to find out which birthing centers are in our plan.

Can I pick a primary care provider for my baby before the baby is born?

Yes, you can pick a primary care provider for your baby before the baby is born.

When you have a new baby
When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery.
- 96 hours after a cesarean section (C-section).

You may stay in the hospital less time if your doctor and the baby's doctor see that you and your baby are doing well. If you and your baby leave the hospital early, your doctor may ask you to have an office or in-home nurse visit within 48 hours.

How and when can I switch my baby's primary care provider?
To switch your baby's primary care provider, go to the **Find a Doctor** link at **myamerigroup.com/TX**. While there, you can search for a new one in our plan and change your primary care provider. To make the change online, you'll need to register first. Once you register, login and update your primary care provider.

You can also call Member Services if you need help finding a new one. We can change your child's primary care provider on the same day you ask for the change. The change will be effective immediately. Call the primary care provider's office if you want to make an appointment. If you need help making an appointment, call Member Services.

Can I switch my baby's health plan?
For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at **800-964-2777**.

You cannot change health plans while your baby is in the hospital.

How do I sign up my newborn baby?

The hospital where your baby is born should help you start the Medicaid application process for your baby. Check with the hospital social worker before you go home to make sure the application is complete. You should also call 2-1-1 to find your local Health and Human Services Commission (HHSC) office to make sure your baby's application has been received. If you're an Amerigroup member when you have your baby, your baby will be enrolled with Amerigroup on their date of birth.

How and when do I tell Amerigroup?
Remember to call Amerigroup Member Services as soon as you can to let your case manager know you had your baby. We will also need to get information about your baby. You may have already picked a primary care provider for your baby before they were born. If not, we can help you pick a primary care provider.

How can I receive health care after my baby is born (and I am no longer covered by

Medicaid)?
After your baby is born, you may lose Medicaid coverage. You may be able to get some health-care services through the Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

Healthy Texas Women Program
The Healthy Texas Women Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.

To learn more about services available through the Healthy Texas Women Program, write, call, or visit the program's website:
Healthy Texas Women Program
PO Box 14000
Midland, TX 79711-9902
Phone: **800-335-8957**
Website: https://healthytexaswomen.org
Fax: (toll-free) **866-993-9971**

DSHS Primary Health-Care Program
The DSHS Primary Health-Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a copayment, but no one is turned down for services because of a lack of money.

Primary Health Care focuses on prevention of disease, early detection, and early intervention of health problems. The main services provided are:
- Diagnosis and treatment.
- Emergency services.
- Family planning.
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, X-ray, nuclear medicine, or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

You will be able to apply for Primary Health-Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com.

To learn more about services you can get through the Primary Health-Care program, email, call, or visit the program's website:

Website: dshs.state.tx.us/phc
Phone: **512-776-7796**
Email: PPCU@dshs.state.tx.us

DSHS Expanded Primary Health-Care Program
The Expanded Primary Health-Care Program provides primary, preventive, and screening services to women ages 18 and above whose income is at or below the program's income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breastfeeding.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com.

To learn more about services you can get through the DSHS Expanded Primary Health Care program, visit the program's website, call, or email:

Website: dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx
Phone: **512-776-7796**
Fax: **512-776-7203**
Email: PPCU@dshs.state.tx.us

DSHS Family Planning Program
The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men.

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com.

To learn more about services you can get through the Family Planning program, visit the program's website, call, or email:

Website: https://healthytexaswomen.org/family-planning-program
Phone: **512-776-7796**
Fax: **512-776-7203**
Email: PPCU@dshs.state.tx.us

How and when do I tell my caseworker?
After you have your baby, call your HHSC benefits office to tell them your baby was born.

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

Members with disabilities, special health-care needs, or chronic complex conditions have a right to direct access to a specialist. This specialist may serve as your primary care provider. Please call Member Services at **800-600-4441 (TTY 711)** so this can be arranged.

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

You can have someone make decisions on your behalf if you're too sick to make decisions for yourself. Please call Member Services at **800-600-4441 (TTY 711)** if you would like more information about the forms you need.

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

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

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

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

Recertify your Medicaid benefits on time

What do I have to do if I need help with completing my renewal application?
Don't lose your health-care benefits! You could lose your benefits even if you still qualify. You need to renew your benefits every 12 months. The Health and Human Services Commission (HHSC) will send you a letter telling you it's time to renew your Medicaid benefits. The letter will have instructions to tell you how to renew. If you don't renew by the date in the letter, you'll lose your health-care benefits.

You can apply for and renew benefits online at YourTexasBenefits.com. Select **Manage your account or applications** and set up an account to get easy access to the status of your benefits.

If you have any questions, you can call 2-1-1, pick a language, and then select option 2, or visit the HHSC benefits office near you. To find the office nearest your home, call 2-1-1, pick a language, and then select option 2, or you can go to YourTexasBenefits.com and select **Find an Office** at the bottom of the page.

We want you to keep getting your health-care benefits from us if you still qualify. To renew, go to YourTexasBenefits.com and select **Manage your account or applications**. Follow the directions there to renew.

What happens if I lose my Medicaid coverage?

If you lose Medicaid coverage but get it back again within six (6) months, you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same primary care provider you had before.

If you're no longer eligible for Medicaid based on income, your children may be eligible for the Children's Health Insurance Program (CHIP). To find out more, call 2-1-1, pick a language, and select option 2.

What if I get a bill from my doctor? Who do I call? What information will they need?

Always show your Amerigroup ID card and Your Texas Benefits Medicaid card when you see a doctor, go to the hospital, or go for tests. Even if your doctor told you to go, you must show your Amerigroup ID card and current Your Texas Benefits Medicaid card to make sure you're not sent a bill for services Amerigroup covers. **You don't have to show your Amerigroup ID card before you get emergency care.** If you do get a bill, send the bill with a letter saying you have been sent a bill to the member advocate in your service area at the Amerigroup location nearest you listed in the front of this book.

In the letter, include:

- Your name.
- Your telephone number.
- Your Amerigroup ID number.

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

- The name of the provider you got services from.
- The date of service.
- The provider's phone number.
- The amount charged.
- The account number, if known.

You can call us at **800-600-4441 (TTY 711)** for help.

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and Amerigroup Member Services department at **800-600-4441 (TTY 711)**. Before you get Medicaid services in your new area, you must call Amerigroup, unless you need emergency services. You will continue to get care through Amerigroup until HHSC changes your address.

What if I need to update my address or phone number and I'm in the Adoption Assistance and Permanency Care Assistance Program?

The adoptive parent or permanency care assistance caregiver should contact the DFPS regional adoption assistance eligibility specialist assigned to his or her case. If the parent or caregiver doesn't know who the assigned eligibility specialist is, they can contact the DFPS hotline, **800-233-3405**, to find out. The parent or caregiver should contact the adoption assistance eligibility specialist to assist with the address change.

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

Medicaid and private insurance

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

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

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

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

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

What are my rights and responsibilities?

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.

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

convenience or is meant to force you to do something you do not want to do, or is to punish you.

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

MEMBER RESPONSIBILITIES:

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

Additional member responsibilities while using NEMT services:

1. When requesting NEMT services, you must provide the information requested by the person

arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

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

You and your doctors can get a copy of these rights and responsibilities by mail, fax, or e-mail. Call Member Services at **800-600-4441 (TTY 711)** and ask for a copy. You can also download a copy from our website by going to **myamerigroup.com/TX** to **Benefits, Member Resources, Member Rights & Responsibilities.**

HOW WE MAKE DECISIONS ABOUT YOUR CARE

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

We don’t encourage doctors to underuse services. And we don’t create barriers to getting health care. Providers and others involved in UM decisions don’t get rewarded for limiting or denying care. When we hire, promote, or fire providers or staff, it isn’t based on their likelihood to deny benefits. Doctors in our plan use clinical practice guidelines, medical policies, and the benefits of your plan to determine necessary treatments and services.

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

To speak with someone on our UM team, call Member Services at **800-600-4441 (TTY 711)** Monday through Friday from 7 a.m. to 6 p.m. Central time.

COMPLAINT PROCESS

What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call us toll-free at **800-600-4441 (TTY 711)** to tell us about your problem. An Amerigroup Member Services representative or a member advocate can help you file a complaint. Just call **800-600-4441 (TTY 711)**. Most of the time, we can help you right away or at the most within a few days. Amerigroup won't take any action against you if you file a complaint.

Can someone from Amerigroup help me file a complaint?

Yes, a member advocate or a Member Services representative can help you file a complaint with us or the appropriate state program. Please call Member Services at **800-600-4441 (TTY 711)**.

How long will it take to process my complaint?

Amerigroup will answer your complaint within 30 days from the date we get it.

What are the requirements and time frames for filing a complaint?

You can tell us about your complaint by calling us or writing us. We'll send you a letter within 5 business days of getting your complaint. This means that we have your complaint and have started to look at it. We'll include a complaint form with our letter if your complaint was made by phone. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

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

If your complaint is about an ongoing emergency or hospital stay, it will be resolved as quickly as needed for the urgency of your case and no later than 1 business day from when we receive your complaint.

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

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

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

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

If you file a complaint, Amerigroup won't hold it against you. We'll still be here to help you get quality health care.

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

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

When we get your request, we'll send you a letter within five business days. This means we have your request and started to work on it. You can also call us at **800-600-4441 (TTY 711)** to ask for a complaint appeal panel request form. You must complete the form and return it to us.

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

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

APPEAL PROCESS

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

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

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

You can appeal our decision orally or in writing:

- You can call Member Services at **800-600-4441 (TTY 711)**.

- You can send us a letter or the request form included with our decision letter to:
  Amerigroup Appeals
  PO Box 62429
  Virginia Beach, VA 23466-2429

How will I find out if services are denied?

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

What are the time frames for the appeals process?

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

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

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

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

How can I continue receiving services that were already approved?

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

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

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

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

Can someone from Amerigroup help me file an appeal?

Yes, a member advocate or Member Services representative can help you file an appeal with Amerigroup or with the appropriate state program. Please call Member Services toll-free at **800-600-4441 (TTY 711)**.

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

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

Can I request a state fair hearing only?

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

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

EMERGENCY APPEALS

What is an emergency appeal?

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

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

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

- Call Member Services at **800-600-4441 (TTY 711)**.
- Send a letter or the request form included with our decision letter to:
  Amerigroup Appeals
  PO Box 62429
  Virginia Beach, VA 23466-2429

What are the time frames for an emergency appeal?

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

If your appeal is about an ongoing emergency or hospital stay, we will call you with an

answer within one business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal within 72 hours.

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

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

Who can help me file an emergency appeal?

A member advocate or Member Services representative can help you file an emergency appeal. Please call Member Services at **800-600-4441 (TTY 711)**.

STATE FAIR HEARINGS

Can I ask for a state fair hearing?

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

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

Or you can call Member Services at **800-600-4441 (TTY 711)**.

You have the right to keep getting any service the health plan denied or reduced, based on previously authorized services, at least until the final state fair hearing decision is made if you ask for a state fair hearing by 10 days following the date the health plan mailed the internal appeal decision letter. If you do not request a state fair hearing by this date, the service the health plan denied will be stopped.

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

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

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

EXTERNAL MEDICAL REVIEW INFORMATION

Can a member ask for an external medical review?

If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for an external medical review. An external medical review is an optional, extra step the member can take to get the case reviewed before the state fair hearing occurs. The member may name someone to represent them by contacting the health plan in writing and giving the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the external medical review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the external medical review within 120 days, the member may lose his or her right to an external medical review. To ask for an external medical review, the member or the member's representative may either:

- Fill out the *State fair hearing and external medical review request form* provided as an attachment to the member notice of MCO internal appeal decision letter and mail or fax it to Amerigroup by using the address or fax number at the top of the form; or

- Call Amerigroup at **800-600-4441 (TTY 711)**.

If the member asks for an external medical review within 10 days from the time the health plan mails the appeal decision letter, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final state fair hearing decision is made. If the member does not request an external medical review within 10 days from the time the health plan mails the appeal decision letter, the service the health plan denied will be stopped.

The member may withdraw the member's request for an external medical review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the member's external medical review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an external medical review during member appeal processes related to adverse benefit determinations

based on functional necessity or medical necessity. An external medical review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the external medical review decision is received, the member has the right to withdraw the state fair hearing request. If the member continues with the state fair hearing, the member can also request the Independent Review Organization be present at the state fair hearing. The member can make both of these requests by contacting Amerigroup at **800-600-4441 (TTY 711)** or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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

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

HOW DO I REPORT SUSPECTED ABUSE, NEGLECT, OR EXPLOITATION?

You have the right to respect and dignity, including freedom from Abuse, Neglect, and Exploitation.

What are Abuse, Neglect, and Exploitation?

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

Reporting Abuse, Neglect, and Exploitation
The law requires that you report suspected Abuse, Neglect, or Exploitation, including unapproved use of restraints or isolation that is committed by a provider.

Call 911 for life-threatening or emergency situations.

Report by phone (nonemergency) – 24 hours a day, seven days a week, toll-free to the Health and Human Services Commission (HHSC) by calling 800-458-9858 if the person being abused, neglected, or exploited lives in or receives services from a:

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

Suspected Abuse, Neglect, or Exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

Report all other suspected Abuse, Neglect, or Exploitation to DFPS by calling **800-252-5400**.

Report electronically (nonemergency)
Go to https://txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

Helpful information for filing a report
When reporting Abuse, Neglect, or Exploitation, it is helpful to have the names, ages, addresses, and phone numbers of everyone involved.

FRAUD AND ABUSE INFORMATION

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

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

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

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

- Call the OIG Hotline at **800-436-6184**.
- Visit https://oig.hhs.texas.gov and click on "Report Fraud" to complete the online form.
- Report directly to your health plan:
  Compliance Officer
  Amerigroup
  2505 N. Highway 360, Suite 300
  Grand Prairie, TX 75050
  800-839-6275

Other reporting options include:

- Special Investigations Fraud Hotline: 866-847-8247 (reporting can be anonymous)
- Amerigroup Member Services: **800-600-4441**

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

- When reporting about a provider (a doctor, dentist, counselor, etc.), include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting someone who receives benefits, include:
  - The person's name.
  - The person's date of birth, Social Security number, or case number, if you have it.
  - The city where the person lives.
  - Specific details about the waste, abuse, or fraud.

QUALITY MANAGEMENT

What does quality management do for you?

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

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

We work with our plan providers to teach them and help them care for you. You may get mailings from us about taking preventive health steps or managing an illness. We want you to help us improve by telling us what we can do better. To learn more about our Quality Management program, please call Member Services at **800-600-4441 (TTY 711)**.

What are clinical practice guidelines?

Amerigroup uses national clinical practice guidelines for your care. Clinical practice guidelines are nationally recognized, scientific, proven standards of care. These guidelines are recommendations for physicians and other health-care providers to diagnose and manage your specific condition. If you would like a copy of these guidelines, call Member Services at **800-600-4441 (TTY 711)**.

INFORMATION THAT MUST BE AVAILABLE ONCE A YEAR

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

- Information about network providers — at a minimum, primary care doctors, specialists, and hospitals in our service area; this information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients; and, when applicable, professional qualifications, specialty, medical school attended, residency completion, and board certification status
- Any limits on your freedom of choice among network providers
- Your rights and responsibilities
- Information on complaint, appeal, external medical review, and state fair hearing procedures
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits; this is designed to make sure you understand the benefits to which you are entitled
- How you get benefits, including authorization requirements
- How you get benefits, including family planning services, from out-of-network providers, and/or limits to those benefits
- How you get after-hours and emergency coverage and/or limits to those kinds of benefits, including:
    - What makes up emergency medical conditions, emergency services, and poststabilization services
    - The fact that you do not need prior authorization from your primary care provider for emergency care services
    - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent
    - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid
    - A statement saying you have a right to use any hospital or other settings for emergency care
    - Poststabilization rules
- Policy on referrals for specialty care and for other benefits you cannot get through your primary care provider
- The Amerigroup practice guidelines

MEMBER GUIDE TO MANAGED CARE TERMS

Term	Definition
Appeal	A request for your managed care organization to review a denial or a grievance again.
Complaint	A grievance that you communicate to your health insurer or plan.
Copayment	A fixed amount (for example, $15) you pay for a covered health-care service, usually when you receive the service. The amount can vary by the type of covered health-care service.
Durable Medical Equipment (DME)	Equipment ordered by a health-care provider for everyday or extended use. Coverage for DME may include but is not limited to: oxygen equipment, wheelchairs, crutches, or diabetic supplies.
Emergency Medical Condition	An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.
Emergency Medical Transportation	Ground or air ambulance services for an emergency medical condition.
Emergency Room Care	Emergency services you get in an emergency room.
Emergency Services	Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
Excluded Services	Health-care services that your health insurance or plan doesn't pay for or cover.
Grievance	A complaint to your health insurer or plan.
Habilitation Services and Devices	Health-care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.
Health Insurance	A contract that requires your health insurer to pay your covered health-care costs in exchange for a premium.
Home Health Care	Health-care services a person receives in a home.
Hospice Services	Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
Hospital Outpatient Care	Care in a hospital that usually doesn't require an overnight stay.
Medically Necessary	Health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted

	standards of medicine.
Network	The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health-care services.
Non-participating Provider	A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.
Participating Provider	A provider who has a contract with your health insurer or plan to provide covered services to you.
Physician Services	Health-care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.
Plan	A benefit, like Medicaid, which provides and pays for your health-care services.
Pre-authorization	A decision by your health insurer or plan that a health-care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision or approval, sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.
Premium	The amount that must be paid for your health insurance or plan.
Prescription Drug Coverage	Health insurance or plan that helps pay for prescription drugs and medications.
Prescription Drugs	Drugs and medications that, by law, require a prescription.
Primary Care Physician	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health-care services for a patient.
Primary Care Provider	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health-care services.

Provider	A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health-care professional, or health-care facility licensed, certified, or accredited as required by state law.
Rehabilitation Services and Devices	Health-care services such as physical or occupational therapy that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.
Skilled Nursing Care	Services from licensed nurses in your own home or in a nursing home.
Specialist	A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
Urgent Care	Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.