Amerigroup

September 2022





Member Handbook

STAR+PLUS

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

Members with Medicare and Medicaid Coverage

800-600-4441 (TTY 711)

myamerigroup.com/TX

TEXAS STAR PLUS Your Health Plan ★ Your Choice

TEXAS Health and Human Services

1039298TXMENAGP 08/22

Amerigroup

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Dear Member:

Welcome to Amerigroup! We're glad you chose us as your health plan.

This member handbook helps you understand how to work with Amerigroup and how to help keep your family healthy. It tells you how to get health care when you need it.

You will get your Amerigroup ID card from us in a few days. Please check the information on the ID card right away. If any of the information is not right, please call us at **800-600-4441 (TTY 711)**. We'll send you a new ID card with the correct information. You can also register online at **myamerigroup.com/TX** to update your address.

We want to hear from you.

- Call **800-600-4441 (TTY 711)** Monday through Friday from 7 a.m. to 6 p.m. Central time if you need to reach us for any reason. You can talk to a Member Services representative about your benefits.
- If you need medical advice or want to speak to a licensed nurse, call 24-hour Nurse HelpLine at the same toll-free number — any time, day or night.
- You can search for network providers with our online provider directory tool. Visit **myamerigroup.com/TX** and select the **Find a Doctor** link to search by provider name or specialty type. We make it easy to find a doctor near you. If you need help finding a doctor or would like a printed directory, call Member Services.

Thanks, again, for being our member. We look forward to working with you.

AMERIGROUP
STAR+PLUS PROGRAM
MEMBER HANDBOOK FOR MEMBERS
WITH BOTH MEDICARE AND MEDICAID COVERAGE

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

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

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

Table of Contents

WELCOME TO AMERIGROUP!

Information about your new health plan

Welcome to Amerigroup. We are a managed care organization, and we want to help you get the right care close to home. Amerigroup STAR+PLUS provides your long-term services and supports through the Texas Medicaid program. Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company. All other Amerigroup members in Texas are served by Amerigroup Texas, Inc. We have a large network of providers, so you can get the care you need, from the doctor you choose. To find out about providers in your area, visit **myamerigroup.com/TX** or contact Member Services at **800-600-4441 (TTY 711)**.

Our records show you get your regular care (acute care) from your Medicare primary care provider. You get your prescription drugs through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes Part D prescription coverage. You may have picked the Amerigroup Amerivantage Plan, our Medicare Advantage Plan, for your Medicare benefits. If you are enrolled in the Amerivantage Plan, please see the Amerivantage Evidence of Coverage for complete details on your Medicare and prescription drug benefits and how they work together with your Medicaid benefits. If you have Medicare coverage with another Medicare insurer, refer to the handbook and information they sent you.

Your Amerigroup member handbook

This handbook will help you understand your Amerigroup health plan and the STAR+PLUS Medicaid long-term services and supports benefits you get from us. Your Amerigroup benefits are your STAR+PLUS Medicaid benefits and the extra value-added benefits you get for being our member. You might get your Medicare benefits from us or from another health plan. You should have information your Medicare plan sent you for your Medicare benefits.

If you have questions about anything you read in this book, call our Member Services department. You can also 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
- Long-term services and supports

- Service coordination and accessing services
- What to do in an emergency or crisis
- Special kinds of health care
- Healthy living
- Complaints and medical appeals
- Rights and responsibilities

For members who do not 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 for more information.

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

If you 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 seven 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 any time, day or night.

Amerigroup 24-hour Nurse HelpLine

24-hour Nurse HelpLine is available to all members 24 hours a day, seven 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.

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 **844-867-2837**.

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.

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

Other important phone numbers

Texas Client Notification Line	**800-414-3406**
STAR+PLUS Program Help Line	**877-782-6440**
Ombudsman Managed Care Assistance Team	**866-566-8989**
Dental Care for members age 20 and under	
DentaQuest	**800-516-0165**
MCNA Dental	**800-494-6262**
UnitedHealthcare Dental	**877-901-7321**

YOUR AMERIGROUP ID CARD

What information is on my Amerigroup ID card?

If you do not have your Amerigroup ID card yet, you will get it soon. Please carry it with you at all times. You may also print your ID card from our website at **myamerigroup.com/TX**. You will need to register and log in to the website to access your ID card information.

Since you are enrolled in Amerigroup for long-term services and supports STAR+PLUS only, show your Amerigroup ID card to any long-term services and supports provider you see. No primary care

doctor will be listed on the card because your regular (acute) care is covered through Medicare.

If you are enrolled in the Amerivantage plan from Amerigroup, you will get an ID card to present to providers. You must use your Amerivantage ID card to get covered services. Your Amerivantage ID card will tell providers that you have Medicare, Medicaid, and Medicare Part D prescription drug coverage through Amerivantage. If your Medicare coverage is with another Medicare insurer, you will have a card from them.


Amerigroup
An Anthem Company
AMERIGROUP TEXAS, INC.
www.myamerigroup.com/TX
Member Name: JOHN Q SAMPLE
Medicaid Number:
Amerigroup Service Coordination: 1-800-600-4441
Pharmacy Member Services: 1-833-235-2022
Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS
LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY
You receive primary, acute, and behavioral health services through Medicare.
You receive only long-term services and supports through Amerigroup.
SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Amerigroup.

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


Amerigroup
An Anthem Company
AMERIGROUP INSURANCE COMPANY
www.myamerigroup.com/TX
Member Name: JOHN Q SAMPLE
Medicaid Number:
Amerigroup Service Coordination: 1-800-600-4441
Pharmacy Member Services: 1-833-235-2022
Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS
TRUE CHOICE
LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY
You receive primary, acute, and behavioral health services through Medicare.
You receive only long-term services and supports through Amerigroup.
SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Amerigroup.

How do I read my Amerigroup STAR+PLUS ID card?
The card tells long-term services and supports providers and hospitals you are an Amerigroup member. It also says that Amerigroup will pay for the benefits listed in the **My Benefits** section.

Your Amerigroup ID card shows the date you became an Amerigroup member. It also lists many of the important phone numbers you need to know, like our Member Services department and 24-hour Nurse HelpLine.

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

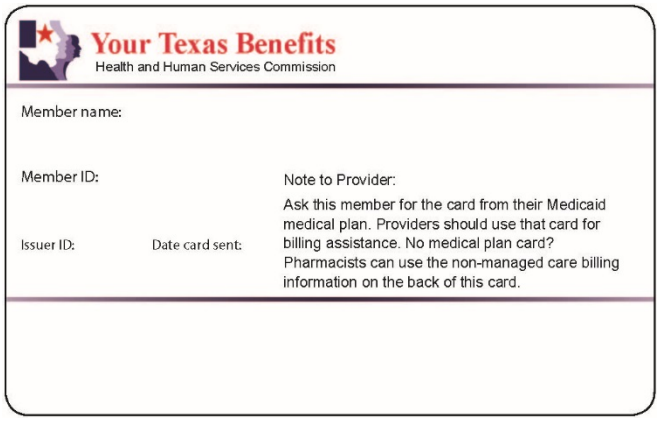
Your Texas Benefits (YTB) Medicaid Card

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

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

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

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



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

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

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

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

The YourTexasBenefits.com Medicaid Client Portal

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

- View, print, and order a YTB Medicaid card
- See your medical and dental plans
- See your benefit information
- See 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, go to YourTexasBenefits.com.

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

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

What if I need a temporary ID verification form?

If you have 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 into your account.

PRIMARY CARE PROVIDERS

What is a primary care provider?

A primary care provider is the main doctor you see for most of your regular health care. Your primary care provider is also called a family doctor. He or she will get to know you and your health history to help you get the best possible care. He or she will also send you to specialists, other doctors, or hospitals when you need special care or services.

Because you have Medicare coverage, your regular (acute) care is covered through your Medicare plan. You choose a primary care provider with your Medicare plan. Please look at the Evidence of Coverage for your Medicare plan to understand the role of a primary care provider, who can be a primary care provider, how to change your primary care provider, and how to get care.

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

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

- Your regular Medicare ID card or your Medicare Advantage plan ID card.
  - If your Medicare plan is the Amerigroup Amerivantage plan, show your Amerivantage ID card.
- Your Texas Benefits Medicaid card.
- Any medicines you are taking.
- Your shot records.

Your doctor should bill the state's fiscal agent, Texas Medicaid Healthcare Partnership (TMHP), for your Medicare coinsurance and deductibles.

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+PLUS Program Helpline at **877-782-6440**. 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 will work with you to try to fix the problem. If you are still not happy, you can change to another health plan.

Who do I call?

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

How many times can I change health plans?

You can change health plans as often as you want.

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 be dropped from their health plan for noncompliance?

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

You could be disenrolled from Amerigroup if:

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

If you have any questions about your enrollment, call Member Services at **800-600-4441 (TTY 711)**.

MY BENEFITS

What are my health-care benefits?

Since you have Medicare and Medicaid, you have benefits for both regular (acute) care and long-term services and supports. Your acute care benefits such as doctor visits, hospitalizations, prescriptions, and behavioral health services are covered by Medicare or the Medicare plan you chose. Your Medicaid long-term services and supports benefits are called STAR+PLUS and are covered by Amerigroup. Long-term services and supports benefits help you live in your home or your community instead of in a long-term care facility. Long-term services and supports benefits can include help with light housekeeping, fixing meals, bathing, and dressing. You may not need these now, but you can get them if you need them in the future.

The kind of long-term services and supports benefits you can get is based on your category of Medicaid eligibility. There are three Medicaid eligibility categories:

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

The chart below provides an overview of Medicare and STAR+PLUS benefits by type and category of coverage.

Service Types	Medicare with Other Community Care (OCC) benefits	Medicare with Community First Choice (CFC) benefits	Medicare with HCBS STAR+PLUS Waiver (SPW) benefits
	Acute Care Services		
Medical (such as doctor's visits and hospital services) and Behavioral Health Services	Medicare or Medicare Advantage Plan	Medicare or Medicare Advantage Plan	Medicare or Medicare Advantage Plan
Prescription drugs	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor
Medicare coinsurance and deductibles	State's fiscal agent (TMHP) for regular Medicare; Medicare Advantage Plan	State's fiscal agent (TMHP) for regular Medicare; Medicare Advantage Plan	State's fiscal agent (TMHP) for regular Medicare; Medicare Advantage Plan
	Long-term Services and Supports		
Primary Home Care/Personal assistance services	Amerigroup*	Amerigroup*	Amerigroup*

Service Types	Medicare with Other Community Care (OCC) benefits	Medicare with Community First Choice (CFC) benefits	Medicare with HCBS STAR+PLUS Waiver (SPW) benefits
Day Activity and Health Services (DAHS)	Amerigroup*	Amerigroup*	Amerigroup*
Consumer-directed attendant care	Amerigroup*	Amerigroup*	Amerigroup*
Nursing services (in home)	Medicare/Medicare Advantage Plan	Medicare/Medicare Advantage Plan	Amerigroup* or Medicare/Medicare Advantage Plan
Acquisition, maintenance, and enhancement of skills services		Amerigroup*	Amerigroup*
Emergency response services (emergency call button)		Amerigroup*	Amerigroup*
Dental services			Amerigroup*
Home-delivered meals			Amerigroup*
Minor home modifications			Amerigroup*
Adaptive aids			Amerigroup*
Durable medical equipment	Medicare/Medicare Advantage Plan	Medicare/Medicare Advantage Plan	Amerigroup*
Medical supplies			Amerigroup*
Physical, occupational, and speech therapy	Medicare/Medicare Advantage Plan	Medicare/Medicare Advantage Plan	Amerigroup*
Adult foster care/personal home care			Amerigroup*
Assisted living			Amerigroup*
Transition assistance services (for members leaving a nursing facility) – $2,500 maximum			Amerigroup*
Respite (with or without self-directed models)			Amerigroup*
Dietitian/Nutritional service			Amerigroup*

Service Types	Medicare with Other Community Care (OCC) benefits	Medicare with Community First Choice (CFC) benefits	Medicare with HCBS STAR+PLUS Waiver (SPW) benefits
Cognitive rehabilitation therapy			Amerigroup*
Financial management services			Amerigroup*
Support consultation/management		Amerigroup*	Amerigroup*
Employment assistance			Amerigroup*
Supported employment			Amerigroup*

* Call Member Services or your service coordinator to find out if you qualify.

How do I get these services?

Your primary care provider will help you get the acute care services you need. To get long-term services and supports benefits or to learn about these benefits, call your Amerigroup service coordinator or Member Services at **800-600-4441 (TTY 711)**. You can reach a service coordinator by calling the phone numbers in the **How do I get these services? Who do I call?** section under **What are my long-term services and supports benefits?**

Are there limits to any covered services?

You can learn about the limits to your acute care services from your Medicare plan by calling 800-MEDICARE (TTY 877-486-2048), on the Internet at medicare.gov, or in the "Medicare and You" handbook you receive each year. For long-term services and supports benefits, Amerigroup only offers services covered by fee-for-service Medicaid. For more details on long-term services and supports benefits, call your Amerigroup service coordinator or Member Services at **800-600-4441 (TTY 711)**.

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

You do not have to pay for covered Medicaid benefits. You do not have to pay any premiums, enrollment fees, deductibles, copays, or cost sharing for the Medicaid part of your coverage. To learn more about your Medicare benefit costs, contact your Medicare plan or refer to the plan information they sent you.

What are my acute care benefits?

Your acute care benefits are covered through Medicare. You can learn more about these benefits by:

- Calling 800-MEDICARE (TTY 877-486-2048).
- Going online to medicare.gov.
- Reading the "Medicare and You" handbook you receive each year.
- Reading the Evidence of Coverage you received from your Medicare plan.

Some of your Medicare benefits are listed below:

- Primary care provider office services

- Specialist services when referred by your primary care provider
- Inpatient and outpatient medical hospital services
- Family planning services by any qualified health-care provider
- Coverage for pregnancy and newborn baby services
- Ambulance services in an emergency
- Chiropractic services treatment
- Emergency room and urgent care services
- Outpatient mental health services
- Outpatient chemical dependency services
- Inpatient mental health and chemical dependency services
- Routine medical care

You may also get acute care services from Medicaid, including services, supplies, and outpatient drugs and biologicals that are available under the Texas Medicaid program when:

- Medicaid covers a service that Medicare does not cover.
- Medicare services become a Medicaid expense when your Medicare limits have been met.

What acute care services are covered by Medicaid?

Medicaid covers some services, supplies, and medications that are not covered by Medicare. These are called wrap-around services. These services (like drugs) will be covered by fee-for-service Medicaid.

How do I get these services?

Call your primary care doctor or your Medicare plan for help getting acute care services.

What number do I call to find out about these services?

Call your Medicare plan or 800-MEDICARE (TTY 877-486-2048) for questions about your regular care benefits.

What are my long-term services and supports benefits?

Some people want to live in their own homes but need help with everyday tasks, like eating, light housekeeping, fixing meals, or personal care. Our service coordinators can help you get the services you need. If you allow it, he or she will talk to you and your doctors to determine the kinds of help you need. Then, the service coordinator will tell you how we can help. After your service has started, your service coordinator will call to see how you're doing. You **must** talk to your service coordinator first to get any long-term services and supports benefits.

If you do need long-term services and supports benefits, the kind of benefits you can get is based on your category of Medicaid eligibility. An overview of Medicare and STAR+PLUS benefits by type and category of coverage is shown in the **What are my health-care benefits?** section.

How do I get these services? Who do I call?

If you think you need long-term services and supports, call Member Services toll-free at the number below for your service area:

Bexar	**800-589-5274, ext. 106-103-5201**
El Paso	**877-405-9871, ext. 106-103-5197**
Harris and Jefferson	**800-325-0011, ext. 106-103-5198**
Lubbock	**877-405-9872, ext. 106-103-5200**
Tarrant	**800-839-6275, ext. 106-103-5199**
Travis	**800-315-5385, ext. 106-103-5202**
West Medicaid Rural Service Area	**800-839-6275, ext. 106-103-5199**

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

If we have not talked to you during your first month as a new member, please call Member Services right away. Call sooner if you recently changed your address or phone number, or think you need long-term services and supports. An Amerigroup service coordinator will talk with you or visit your home to find out more about your health and need for services. We'll ask about your health and any problems you may have with daily living tasks. You may want a family member or friend to talk with us, too.

What is service coordination?

Service coordination helps make sure you're getting the services you need from the right providers. We will assign you a personal service coordinator:

- If you ask for one.
- If we find you need one based on your health or support needs.

A qualified service coordinator will manage and oversee all your care and services. He or she will get to know you and will work with you and your providers to make sure the care you get is the right care for you.

Service coordination can include, but is not limited to, the following:

- Identifying your needs through an assessment
- Creating a care plan to meet those needs
- Discussing the care plan with you, your family, and your representative (if needed) to make sure you understand and agree with it
- Making appointments with your providers and arranging for you to get the services you need
- Working as a team with you and your primary care provider

Your Amerigroup service plan

Your service coordinator works with you to find out if you need special services like long-term services and supports or case management. Examples of long-term services and supports are assisted living care and adult day care. We give case management services to members who have conditions such as cancer, HIV, congestive heart failure, end-stage renal disease, sickle cell, diabetes, asthma, or who need pulmonary and wound care.

Your service coordinator will work with you and your caregivers to create your service plan. The plan tells the types of services you need and how often you need them. **You are the most important part**

of your service coordination team. Once you understand and agree to the services in your plan, your service coordinator will help you get them. We approve coverage of the services as needed. They may be the same services you had in the past, or they may be a little different.

How do I change my Amerigroup service plan?

Your service coordinator will call you or visit you periodically to check on you. If something changes in your health or ability to take care of yourself, you should call your service coordinator right away. You don't have to wait for him or her to contact you. Your service coordinator wants to know about any changes in your health or any problems you start having with everyday tasks, like getting dressed, bathing, or taking your medicines. Your service coordinator will work with the rest of your team to help you get other services or care you need. Your service coordinator will review your service plan at least once a year. He or she will change it if needed.

What will a service coordinator do for me?

When you first become an Amerigroup member, the state will send us information about the health and services you have been getting from Medicaid. Your service coordinator will read this information to find out more about you. He or she will learn which providers to call to be sure you keep getting the right care. He or she will ask you how helpful your Medicaid services have been. We will talk to your Medicaid providers about the care you have been getting. If you agree, we will talk to your doctors about your health-care needs.

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

- Visiting you in your home to learn more about your needs and to help you get the right kind of care.
- Working with you to create a service plan that meets your needs.
- Helping you see your providers when you need to and get the services you need (including the right preventive health services).
- Making sure all of your long-term services and supports coordinate with your acute care services and other social services you get outside Amerigroup.
- Helping you get authorizations for medically needed services.
- Encouraging you to take part in your care to help you live independently.

How can I talk with a service coordinator?

You can reach a service coordinator by calling the phone numbers in the **How do I get these services? Who do I call?** section under **What are my long-term services and supports benefits**? or by calling Member Services at **800-600-4441 (TTY 711)**.

How do I know who my service coordinator is?

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

What is Electronic Visit Verification (EVV)?

EVV is an electronic system used to document and verify certain long-term services and supports. If you get personal attendant services, your attendant must record his or her visits using an EVV system. The EVV system records things like the date and time the service begins and ends, the name of the attendant, and the service provided.

EVV is free. Your attendant will use your home phone to call a toll-free number when your services start and end. If you don't have a landline phone in your home, you can have a small device installed in your home so your attendant can accurately record the time services start and stop. The agency that provides your services can install the device in your home.

EVV will also be used for private duty nursing services. Contact your service coordinator or Member Services if you have any questions about EVV.

Will my STAR+PLUS benefits change if I am in a nursing facility?

Your long-term services and supports benefits will change if you move to a nursing facility. You would be eligible for nursing facility long-term services and supports benefits instead of community-based long-term services and supports benefits. These benefits include:

- Daily care nursing facility services.
- Nursing facility add-on services.
- Medicare coinsurance for daily care services.

Your acute care benefits, such as hospitalization, doctor visits, and prescriptions covered by Medicare, will not change if you move to a nursing facility.

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

If you can't get a covered benefit from a network provider, we will arrange for you to get services with an out-of-network provider. We will pay the out-of-network provider according to state rules. You must call Member Services first at **800-600-4441 (TTY 711)** to get approval for out-of-network services. You don't need to call us to approve out-of-network services in an emergency. If you have an emergency, call 911 or go to the nearest hospital emergency room right away.

What services are not covered*?*

For long-term services and supports benefits, Amerigroup only offers services that are covered by fee-for-service Medicaid. To learn more about which acute care services aren't covered by Medicare:

- Call 800-MEDICARE (TTY 877-486-2048).
- Go online to medicare.gov.
- Read the "Medicare and You" handbook you get each year.
- Read the Evidence of Coverage from your Medicare plan.

What are my prescription drug benefits?

Use your Medicare Part D coverage first to get your medicine. If Medicare doesn't cover your medicine, Medicaid pays for most medicine your doctor says you need.

What if I also have Medicare?

Medicare Part D covers most medicines. Show your Medicare card to the pharmacist to fill your prescriptions.

How do I find a network drugstore?

If you do not know if a drugstore takes your Medicare plan or Amerigroup, ask the pharmacist. You can also call your Medicare Part D insurer or Amerigroup Member Services at **800-600-4441 (TTY 711)**.

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

The pharmacist will explain they don't accept your Medicare plan or Amerigroup STAR+PLUS. You will need to take your prescription to a pharmacy that accepts your coverage.

What do I bring with me to the drugstore?

When you go to the drugstore, you should bring:

- Your prescription(s) or medicine bottles.
- Your Medicare Part D Prescription 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 medications, please call your Medicare Part D insurer or Amerigroup 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 prior authorization from your Medicare plan or Amerigroup. A prior authorization means you need to get approval from either your Medicare plan or Amerigroup before you get that medicine. 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 Amerigroup at **833-235-2022 (TTY 711)** for help with your medications and refills. Ask your pharmacist to dispense a 3-day supply.

What if I lose my medication(s)?

If your medicine is lost or stolen, have your pharmacist call your Medicare Part D insurer or Amerigroup at **800-454-3730**.

How do I get my medications if I am in a nursing facility?

The nursing facility will provide you with all required medications.

What if I need durable medical equipment or other products normally found in a pharmacy?

Some durable medical equipment and products normally found in a pharmacy are covered by both Medicare and Medicaid. For items both Medicare and Medicaid cover, Medicare will pay first, and

your Amerigroup Medicaid plan will pay second. These include items such as nebulizers, ostomy and diabetic supplies, and other covered supplies and equipment if they are medically necessary. Medicaid may also pay for items found in a pharmacy that are not covered by Medicare such as medically necessary prescribed over-the-counter drugs, diapers, and some vitamins and minerals. You should verify your pharmacy is participating with Medicare or is part of your Medicare and/or Medicaid health plan.

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

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

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

Value-added benefit	How to get it
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)**.
Pest control services every 3 months	Call **800-600-4441 (TTY 711)** or go to **myamerigroup.com/TX** for more information. Members can get this service at one location.
Eight hours of respite services each year for families and caregivers of members ages 21 and older (not available to HCBS STAR+PLUS Waiver members)	Call **800-600-4441 (TTY 711)** or your service coordinator.
Free cellphone/smartphone through the Lifeline program with monthly minutes, data, and texts. If you qualify, you also get: • Unlimited calls to Member Services, member advocates, and service coordinators 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.

Value-added benefit	How to get it
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)**.
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**.
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**.
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*.

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

What health education classes does Amerigroup offer?

We work to help keep you healthy with our health education programs. We can help you find classes near your home. Call Member Services to find out where and when these classes are held.

Some of the classes include:

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

Disease Management

If you have a long-term health issue, you don't have to go it alone. Our disease management program can help you get more out of life. The program is private and on hand at no cost to you. It's called the Disease Management (DM) program. A team of licensed nurses and social workers, called DM case managers, are available to teach you about your health issue and help you learn how to manage your health. Your primary care provider and our DM team are here to help you with your health-care needs.

You can join the program 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
- Schizophrenia
- Substance use disorder

We also offer weight management services.

DM case managers work with you to make health goals and help you build a plan to reach them. As a member in the program, you will benefit from having a case manager who:

- Listens to you.
- Takes the time to understand your specific needs.
- Helps you make a care plan to reach your health-care goals.
- Gives you the tools, support, and community resources that can help you improve your quality of life.
- Gives you health information that can help you make better choices.
- Helps you coordinate care with your providers.

As an Amerigroup member enrolled in the DM program, you have certain rights and responsibilities. You have the right to:

- Have information about Amerigroup. This includes:
  - All Amerigroup programs and services
  - Our staff's education and work experience
  - Contracts we have with other businesses or agencies
- Refuse to take part in or leave programs and services we offer.
- Know who your case manager is and how to ask for a different case manager.

- Have Amerigroup help you make choices with your doctors about your health care.
- Learn about all DM-related treatments; these include anything stated in the clinical guidelines, whether covered by Amerigroup or not. You have the right to talk about all options with your doctors.
- Have personal data and medical information kept private.
- Know who can access your information and know our procedures used to ensure security, privacy, and confidentiality.
- Be treated with courtesy and respect by Amerigroup staff.
- File complaints with Amerigroup and get guidance on how to use the complaint process, including how long it will take us to respond and resolve issues of quality and complaints.
- Get information that is clear and easy to understand.

You should:

- Follow health-care advice offered by Amerigroup.
- Give Amerigroup information needed to carry out our services.
- Tell Amerigroup and your doctors if you decide to disenroll from the DM program.

If you have one of these health issues or would like to know more about our DM, please call **888-830-4300** Monday through Friday from 8:30 a.m. to 5:30 p.m. local time. Ask to speak with a DM case manager. You can also visit our website at **myamerigroup.com/TX** or call DM if you would like a copy of DM information you find online. Calling can be your first step on the road to better health.

What is Complex Case Management?

In addition to our disease management program, we have a Complex Case Management program. In the program, case managers help manage your health care if you have special needs. A case manager may be able to help you if you have experienced a critical event or have been diagnosed with a serious health condition such as diabetes. We have special case managers for members with a high risk pregnancy, a multiple pregnancy, history of preterm delivery with a past pregnancy, or current preterm labor.

How do I get these services?

You do not need a referral from your doctor. You can contact the Complex Case Management program by calling Member Services at **800-600-4441 (TTY 711)** and asking to speak to a complex case manager. Our case managers are licensed nurses and social workers available Monday through Friday from 8 a.m. to 5 p.m. Central time. Case managers also have confidential voice mail available 24 hours a day.

What is a Member with Special Health Care Needs?

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

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

We have a system for identifying and contacting MSHCN. You may also request to be assessed to

determine if you meet the criteria for MSHCN.

For MSHCN, we develop a care plan to provide covered services to meet the special needs for treatment of the member's condition. We also provide access to treatment by a multidisciplinary team when needed.

MSHCN can have direct access to specialists if needed for their condition and identified needs, such as a standing referral to a specialist. MSHCN may also have a specialist serve as their primary care provider.

Call us at **800-600-4441 (TTY 711)** if you need help getting these services.

What other services can Amerigroup help me get?

Community events
Amerigroup is in your community! We sponsor and participate in free community events and family fun days. At these events, you can get health information and have a good time. You can learn about topics like healthy eating, asthma, and stress. We'll be there to answer questions about your benefits, too. Call Member Services or check the member section of our website at **myamerigroup.com/TX** to find out when and where these events will be.

HEALTH-CARE AND OTHER SERVICES

Except in the case of an emergency (see the section on **What is emergency care?**), you should always call your provider **first** before you get medical care. If you have questions about your health when your provider's office is closed, call 24-hour Nurse HelpLine for help.

What does medically necessary mean?

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

Medically necessary means:

1) For members 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, 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:
      i) Must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole (including the Alberto N., et al. v. Traylor, et al. partial settlement agreements) and
      ii) May include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b—g) of this paragraph.
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 member's diagnoses
   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 Member Services 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 will consider covering new technology only if the technology provides equal or better outcomes than the existing covered treatment or therapy.

What is routine medical care?

Routine care includes regular checkups, preventive care, and appointments for minor injuries and illnesses. Your primary care provider sees you when you're not feeling well, but that is only part of his or her job. He or she also takes care of you before you get sick. This is called well care.

How soon can I expect to be seen?
Your Medicare plan will determine how soon you should be able to see your primary care provider 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 your Medicare plan. 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 your Medicare plan.

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 advice, call your primary care provider or 24-hour Nurse HelpLine seven days a week at **800-600-4441 (TTY 711)**. The most important thing is to 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 women, serious jeopardy to the health of a woman or her unborn child.

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

1. Requires immediate intervention and/or medical attention without which the member would present an immediate danger to himself, herself, or others.
2. Renders the member incapable of controlling, knowing, or understanding the consequences of his or her actions.

Emergency services and emergency care means:
Covered inpatient and outpatient services furnished by a provider who 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 poststabilization care services.

When can I expect to be seen?
You should be able to see your primary care provider immediately for emergency care.

What is poststabilization?

Poststabilization care services are services covered by Medicaid that keep your condition stable following emergency medical care.

What if I am out of the country?
Medical services performed out of the country are not covered by Medicaid.

How can I ask for a second opinion?

Contact your Medicare plan to ask how to get a second opinion for Medicare covered services.

Can someone interpret for me when I talk with my long-term services and supports provider?

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

Who do I call for an interpreter?
Call Member Services to learn more.

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

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

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.

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.

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.

What if I am pregnant?

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from the Women, Infants, and Children (WIC) program. Call us for the phone number for the WIC program close to you.

When you are pregnant, you must go to your primary care provider or OB/GYN at least:

- Every four weeks for the first six months.
- Every two weeks for the seventh and eighth months.
- Every week during the last month.

Your primary care provider or OB/GYN may want you to visit more than this based on your health needs.

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 are an Amerigroup member when you have your baby, your baby will be enrolled with Amerigroup on his or her date of birth.

How and when do I tell Amerigroup?

Remember to call Amerigroup Member Services as soon as you can to let your service coordinator or care manager know you had your baby. We will need to get information about your baby, too. You may have already picked a primary care provider for your baby before he or she was born. If not, we can help you pick a primary care provider for him or her.

How and when do I tell my caseworker?

After you have your baby, call your HHSC benefits office to tell them he or she has been born.

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**

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 9-1-1 for life-threatening or emergency situations.

Report by phone (non-emergency) — 24 hours a day, seven days a week, toll-free
Report 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 (non-emergency)
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.

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

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

What are advance directives?
Emancipated minors and members 18 years of age or older have rights under advance directive laws. An advance directive talks about making a living will. A living will says you may not want medical care if you have a serious illness or injury and may not get better. To make sure you get the kind of care you want if you are too sick to decide for yourself, you can sign a living will. This is a type of advance directive. It is a paper that tells your doctor and your family what kinds of care you do or do not want if you are 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 cannot offer legal advice or serve as a witness. According to Texas law, you must either have two witnesses or have your form notarized. After you complete the form, take it or mail it to your doctor. Your doctor will then know what kind of care you want to get.

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

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

What happens if I lose my Medicaid coverage?

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

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. Every 12 months you will need to renew your benefits. The Health and Human Services Commission (HHSC) will send you a packet about 60 days before the due date telling you it is time to renew your Medicaid benefits. The packet will have instructions to tell you how to renew. If you do not renew your eligibility by the due date, you will lose your health-care benefits.

You can apply for and renew benefits online at YourTexasBenefits.com. Click on **View My Case** 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, you can call 2-1-1, pick a language and then select option 2 or you can go to YourTexasBenefits.com and click on **Find an Office** at the top of the page.

We want you to keep getting your health-care benefits from us if you still qualify. Your health is very important to us. To renew, go to YourTexasBenefits.com and click on **View my case**. Follow the directions there to renew.

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

Always show your Medicare ID or Medicare plan card and current 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 Medicare or Medicare plan ID card and current Your Texas Benefits Medicaid card to make sure you are not sent a bill for services covered by Medicare and/or Medicaid. **You do not have to show your Amerigroup ID card before you get emergency care.** If you do get a bill, send the bill along with a letter saying that you have been sent a bill to the member advocate in your service area at the Amerigroup location nearest you listed in the front of this book.

In the letter, include:

- Your name
- 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 also call Member Services toll-free at **800-600-4441 (TTY 711)** for help.

What information do they need?

In the letter, include your name, the telephone number you can be reached at, and your Amerigroup ID number. If you are unable to send a copy of the bill, be sure to include in the letter the name of the provider you got services from, the date of service, the provider's phone number, the amount charged, and the account number, if known.

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

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

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and the Amerigroup Member Services department at **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 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 as an Amerigroup member?

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.
   c. Change your health plan without penalty.

d. Be told how to change your health plan

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health-care needs to you and talk to you about the different ways your health-care problems can be treated.
   b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid and get a timely response to complaints, appeals, external medical reviews, and state fair hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for an external medical review and state fair hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a state fair hearing without an external medical review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers; that includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, seven days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health-care provider's office; this includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan; interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health-care services you can get and how to get them
7. You have the right to not be restrained or secluded when it is for someone else's convenience, 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 in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your nonemergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health-care needs and ask questions about the different ways your health-care problems can be treated.
   c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications.

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.

QUALITY MANAGEMENT

What does quality management do for you?

The Amerigroup Quality Management program is here to make sure you are being cared for. We look at services you have received to check if you are getting the best preventive health care. If you have a chronic disease, we check if you are 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 network 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)**.

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

Can someone from Amerigroup help me file a complaint?

Yes, a member advocate or Member Services representative can help you file a complaint with Amerigroup or with the appropriate state program. A member advocate can also help you file an appeal with your Medicare plan or directly with Medicare. Please call Member Services toll-free at **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 will send you a letter within 5 business days of getting your complaint. This means we have your complaint and have started to look at it. We will include a complaint form with our letter if your complaint was made by telephone. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

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

If your complaint is an emergency, we will look into it within 72 hours of getting your call or complaint form.

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 send 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.

APPEALS 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.

FRAUD AND ABUSE

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 he or she has to get benefits.

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

- Call the OIG Hotline at 800-436-6184
- Visit 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

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

- When reporting 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.

INFORMATION THAT MUST BE AVAILABLE ON AN ANNUAL BASIS

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

- Information about network providers — at a minimum, primary care doctors, specialists, and hospitals in our service area; this information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients; and, when applicable, professional qualifications, specialty, medical school attended, residency completed, 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 to get benefits, including authorization requirements
- How to get benefits, including family planning services, from out-of-network providers, and/or limits to those benefits
- How to 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
- Amerigroup practice guidelines

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

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.