The HealthPlan

WEST VIRGINIA MOUNTAIN HEALTH TRUST (WV MEDICAID AND WVCHIP) MEMBER HANDBOOK

SFY 2026

(July 1, 2025 – June 30, 2026)

HELP IN YOUR LANGUAGE

If you do not speak English, call us at 1-888-613-8385. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.

Spanish: "Si usted no habla inglés, llámenos al 1-888-613-8385. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma."

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-888-613-8385 (TTY 711).

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WELCOME

Welcome to The Health Plan's Mountain Health Trust managed care program! The Mountain Health Trust program includes both WV Medicaid and the WV Children's Health Insurance Program (WVCHIP). We are glad that you have enrolled with us. The Health Plan operates in all 55 counties of West Virginia. This handbook will provide you with the information you need to know about your health care plan, also known as a managed care plan. Please read this handbook from cover to cover to understand the way your plan works. This handbook will help you get the most from The Health Plan. It will answer many of the questions that come up about your benefits and the services offered by The Health Plan. You can also ask us any questions you may have by calling us at 1-888-613-8385. If you are speech or hearing impaired, please dial 711. You may also access an electronic copy of the member handbook under the member materials section of our website at:

https://www.healthplan.org/wv-medicaid/current-members/member-materials

https://www.healthplan.org/wv-medicaid/current-members/wvchip-member-materials

ABOUT YOUR PLAN

The Health Plan has a contract with the West Virginia Department of Human Services [DoHS]. Under managed care, we are able to select a group of health care providers to form a provider network. Usually, provider networks are made up of doctors and specialists, hospitals, and other health care facilities. Our providers help to meet the health care needs of people with Medicaid and WVCHIP. The Provider Directory can be found on our website at findadoc.healthplan.org. If you want a hard copy of the provider directory, need larger print or a different format please call Member Services at 1-888-613-8385.

If you want additional information on your provider such as:

- Professional qualifications and specialty
- Medical school attended
- Residency completion
- Board certification status

Contact Member Services at 1-888-613-8385 or visit these websites:

- West Virginia Board of Medicine at wvbom.wv.gov
- American Medical Association (AMA) at ama-assn.org

CONTACT US

You can call Member Services toll-free anytime you have a question about your health plan or a health problem. It will speed up the process if you have your member identification (ID) number with you when you call. You can also visit our website, healthplan.org, for other information.

Member Services Department
Hours of Operation: Monday – Friday, 8:00 a.m. to 5:00 p.m.
Address: 1110 Main Street, Wheeling WV 26003
Toll-free: 1-888-613-8385
TTY: 711
Online: healthplan.org

You can call or visit our website to:

- Ask questions about WV Medicaid or WVCHIP services and benefits, copayments, eligibility, claims, prior authorization requests, or utilization management (more information on utilization management procedures is available upon request)
- Change your primary care provider (PCP) or get help choosing a provider
- File a complaint or appeal
- Replace a lost member ID card
- Get help with referrals
- Let us know if you are pregnant
- Let us know if you give birth to a new baby
- Ask about any change that might affect you or your family's benefits
- Let us know about any changes to personal information
- Request interpreter services or help for people with disabilities
- Find community resources and educational materials
- Access online versions of the member handbook and Provider Directory that you can search

If you do not understand or speak English, we can help. Please call Member Services toll-free at 1-888-613-8385 (TTY: 711). We can answer questions about your benefits in your language. We have free interpreter services and can help

you find a health care provider who can communicate with you in any language.

For people with disabilities, we can help. The Health Plan offers services so that you can communicate effectively with us and your provider. We have access to free sign language interpreter services and a TTY phone number: 711. We can offer this handbook and all written materials including, but not limited to provider directories, appeal and grievances notifications, and denial notifications in many formats, such as large print, a CD or audiotape for listening to plan information, alternate languages or braille at no cost to you. Please call Member Services toll-free at 1-888-613-8385 (TTY: 711) to ask for materials in another format.

For other important phone numbers, please see the list in the back of this handbook.

SECURE MEMBER PORTAL

The Health Plan has a secure online tool, MyPlan, where you can access your personal health information, and other benefit information such as:

- Authorization status.
- Temporary member ID card.
- The name and phone number of your PCP.
- Cost sharing information.

For more information, and to access MyPlan, visit our website at myplan.healthplan.org.

WHAT YOU SHOULD KNOW

CONFIDENTIALITY

We respect your rights to privacy. We will never give out your medical information or social security number without your written permission, unless required by law. To learn more about your rights to privacy, please call Member Services at 1-888-613-8385 or visit our website at healthplan.org.

DISCRIMINATION

Your benefits must comply with the 1964 Civil Rights Act. Discriminatory administration of benefits because of sex, race, color, religion, national origin, ancestry, age, political affiliation, or physical, developmental, or mental challenges is not allowed. If you have questions, complaints, or want to talk

about whether you have a disability according to the Americans with Disabilities Act, you can contact the State ADA Coordinator at:

WV Department of Administration
Building 1, Room E-119
1900 Kanawha Blvd. East,
Charleston, WV 25305
1-304-558-4331

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- On the web: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail:

U.S. Department of Health and Human Services
200 Independence Ave SW
Room 509F HHH Building
Washington, DC 20201

- By phone: 1-800-368-1019 (TTY/TDD 1-800-537-7697)

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

DEFINITIONS

There are special words and phrases that we use to describe how we arrange medical care. The list below explains some of these words and phrases. This list will help you understand the rest of this handbook. The Health Plan will provide a summary of our accreditation report, if applicable, upon request by the member.

The Health Plan must ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Appeal: A way for you to request the review of The Health Plan's decision if you think we made a mistake. For example, you might not agree with a decision that denies a benefit or payment.

Authorized Representative: Any person or entity acting on behalf of a member and with the member's written consent. Some authorized representatives may have the legal right to act on your behalf.

Balanced Billing: When a provider bills you for the difference between the provider's charge and the amount paid by your insurance.

Case Management: A patient-specific process of coordinating resources and creating flexible, quality, cost-effective health care options. It should result in a quality efficient delivery of health care services. This is done by registered nurses that focus on members with a complex illness and/or injury. Members can self-refer for case management services by calling The Health Plan.

Community Resources: The Health Plan Clinical Services Department keeps a list of community resources that may assist you with some services. These are agencies in your local community that help you with social services. They can also help with physical health, behavioral health, and disability needs. The social worker and/or care/case nurse navigators can help you access these services.

Co-payment: A fixed amount you pay each time you get a covered service or supply. For example, if you use the emergency room when it is not an emergency, you might pay $8.

Covered Services: Health care services that The Health Plan pays for. Use The Health Plan ID card to get these services.

Customer Services: People who work at The Health Plan who help you. They can help you find a practitioner or dentist. They can listen to a complaint. They can answer your questions. They can help you understand how The Health Plan works.

Durable Medical Equipment (DME): Certain items your provider orders for everyday or extended use. Examples of these items are wheelchairs, crutches, diabetic supplies, hospital beds, oxygen equipment and supplies, nebulizers, and walkers.

Emergency Medical Condition: A sudden problem that you may think needs immediate care. Emergency care is given in or by a hospital emergency room. It is to evaluate and treat a medical problem caused by sudden, unexpected symptoms that require immediate medical attention. An emergency is usually a sudden and unexpected illness or injury that needs care to prevent (1) serious harm to the health of the person (or unborn child); (2) serious harm to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you receive in an emergency room.

Emergency Services: Covered inpatient and outpatient services that are (1) given by a qualified practitioner and; (2) needed to evaluate or stabilize an

emergency medical condition. This includes emergency services within or outside of the plan.

Excluded Services: Health care services that The Health Plan does not pay for or cover.

Federal Poverty Level (FPL): A measure of income issued every year by the Department of Health and Human Services to determine your eligibility for certain programs and benefits.

Fee-for-Service: Health care services that the Medicaid or WVCHIP program pays for. The Health Plan does not cover these services. These services include nursing home, pharmacy, transplants and non-emergency transportation.

Gender Affirmation Surgery: Surgeries that change the physical appearance and function of a person's sex traits to align with their gender identity.

Gender Dysphoria: A distressed state arising from conflict between a person's gender identity and the sex the person has or was identified as having at birth.

Grievance: A complaint you make, either in writing or orally, about any aspect of service delivery provided or paid for by The Health Plan or our providers. For example, you might complain about the quality of your care.

Habilitation Services and Devices: Health care services and devices that help you keep, learn, or improve skills and functioning for daily living. Examples include occupational theory, speech therapy, and other services for people with disabilities in inpatient and/ or outpatient settings.

Health Insurance: A contract that requires The Health Plan to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home, including limited part-time or intermittent skilled nursing care, home health aide services, occupational therapy, physical therapy speech therapy, medical social services, DME, medical supplies, and other services.

Hospice Services: Services to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Medically Necessary: Health care services or supplies needed to diagnoses or treat an illness or injury, to improve the functioning of a malformed body member, to attain, maintain or regain functional capacity, for the prevention of illness, or to achieve age-appropriate growth and development.

Member Services: People who work at The Health Plan who help you. They can help you find a practitioner or dentist. They can listen to a complaint. They can answer your questions. They can help you understand how The Health Plan works.

Minor: Persons under the age of eighteen (18) years.

Network: A group of providers who has contracted with The Health Plan to give care to members. The list of The Health Plan providers can be found in your Provider Directory. It will be updated whenever there are changes.

Non-medical Home Physician Visit: Health care from a provider that is not the member's PCP.

Non-participating Provider: A doctor, hospital, facility, or other licensed health care professional who has not signed a contract agreeing to provide services to The Health Plan members.

Participating Provider: A doctor, hospital, facility, or other licensed health care professional who has signed a contract agreeing to provide services to The Health Plan members. They are listed in your Provider Directory.

Physician Services: Health care services that a licensed medical physician provides or coordinates.

Plan: An entity that provides, offers, or arranges coverage of certain health care services needed by plan members. You are a member of our health plan, The Health Plan.

Practitioner: All doctors, PCPs, physician assistants, or any persons providing direct services to enrollees.

Premium: The amount you pay for your health insurance every month based on your income. In addition to the premium, you may have to pay a co-payment.

Prescription Drugs: Drugs and medication that, by law, require a prescription.

Prescription Drug Coverage: Health insurance that helps pay for prescription drugs and medications. The Health Plan does not provide prescription drug

coverage. Prescription services are covered under fee-for-service. See important phone numbers for additional information.

Primary Care Physician: Your regular practitioner who will help you arrange your medical care. It is also called a "PCP." The name and phone number of your PCP will be on your ID card.

Primary Care Provider (PCP): A physician, nurse practitioner, physician assistant, or other participating provider you have chosen to be your personal doctor. Your PCP works with you to coordinate your healthcare, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed, or admitting you to the hospital.

Prior Authorization: Approval from The Health Plan that may be required before you get certain services or treatments in order for them to be covered.

Provider Directory: A directory of all the practitioners that you can see with your ID card. You may need to get a referral from your PCP to see some specialty practitioners. Annually, we will remind you that you can ask for an updated practitioner directory at any time by calling the Customer Service Department or view the list on the website.

Provider: Hospitals, clinics, or facilities that give you medical care.

Referral: Permission from your PCP to see certain kinds of practitioners or get certain kinds of health care services.

Rehabilitation Services and Devices: Health care services and devices that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. Examples include occupational therapy, speech therapy, and psychiatric rehabilitation services in inpatient and/ or outpatient settings.

Service Area: The parts of West Virginia where you can use your ID card.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A doctor who focuses on a specific kind of health care such as a surgeon or a cardiologist (heart doctor).

Specialist as Primary Care Provider (PCP): Members with a disabling condition, chronic illness or who are SSI eligible, have the option to submit a request for a specialist physician to serve as their PCP. The specialist physician will provide specialty care and PCP services to the member on a routine basis. However, the

specialist physician may be required to comply with certain procedures such as obtaining prior authorization for certain services or requesting referrals.

Specialty Practitioner: A plan practitioner who provides specialty care to members. The practitioner coordinates with a member's primary or secondary care practitioner on specialty plans of treatment. A referral and approval may be required.

Telehealth: Sometimes called telemedicine, uses video calling and other technologies to help you see your provider without an in-person office visit.

Tertiary Facility: A facility that The Health Plan has contracted with to provide specialty medical and hospital services that are not normally available through local plan providers.

Urgent Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgent care from out-of-network providers when network providers are unavailable or you cannot get to them. Examples of when to get urgent are a sprained ankle, a bad splinter, or the flu.

Well-care: Children ages 20 and under should have regular, well-child/adolescent visits according to the health check periodicity schedule. This is covered by The Health Plan.

Adults should also have an annual well-care visit. This is covered by The Health Plan.

WVCHIP Gold: WVCHIP enrollment group for children in families with incomes at or below 150 percent of the FPL.

WVCHIP Blue: WVCHIP enrollment group for members in families with incomes over 150 percent up to 211 percent of the FPL.

WVCHIP Premium: The enrollment group for members in families with incomes over 211 percent up to 300 percent of the FPL that requires monthly premium payments.

WVCHIP Exempt: The enrollment group members who are Native American/Alaskan Natives who are members of a federally recognized tribe and are exempt from copayments and other cost sharing.

YOUR RIGHTS AND RESPONSIBILITIES

As a member of The Health Plan, you have rights around your health care and to receive information according to contract standards. Each year, The Health Plan submits its annual report to the Bureau for Medical Services (BMS) and

WVCHIP by April 1. This report includes a description of the services, personnel and the financial standing of The Health Plan.

The annual report is available on The Health Plan website. You may also get a copy of the report by calling Member Services at 1-888-613-8385.

You have the right to:

- Ask for and obtain all included information
- Be told about your rights and responsibilities
- Get information about The Health Plan, our services, our providers, and your rights
- Be treated with respect and dignity
- Not be discriminated against by The Health Plan
- Access all services that The Health Plan must provide
- Choose a provider in our network without restriction
- Take part in decisions about your health care
- Refuse treatment and choose a different provider
- Get information on available treatment options or alternative courses of care, presented in a manner appropriate to the member's condition and member's ability to understand, regardless of cost or benefit coverage
- Have your privacy respected
- Ask for and to get your medical records within 30 calendar days of request
- Ask that your medical records be changed or corrected if needed within 60 calendar days of request
- Be sure your medical records will be kept private
- Recommend changes in policies and procedures, including, but not limited to, member rights and responsibilities.
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation
- Get covered services, no matter what cultural or ethnic background or how well you understand English
- Get covered services regardless of if you have a physical or mental disability, or if you are experiencing homelessness
- Refer yourself to in-network and out-of-network family planning providers, with no authorization requirement
- Access emergency services from any provider, with no prior authorization requirement
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services
- Get emergency post-stabilization services

- Get emergency health care services at any hospital or other setting
- Accept or refuse medical or surgical treatment under State law and to make an advance directive
- Have your parent or a representative make treatment decisions when you cannot
- Make complaints and appeals
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services
- Ask for a state fair hearing after a decision has been made about your appeal
- Request and get a copy of this member handbook annually after initial enrollment
- Disenroll from your health plan
- To exercise your rights. Exercising these rights does not adversely affect our treatment of you
- Ask us about our quality improvement program and tell us how you would like to see changes made
- Ask us about our utilization review process and tell us how you would like to see changes made
- Know the date you joined our health plan
- Know that we only cover health care services that are part of your plan
- Know that we can make changes to your health plan benefits as long as we tell you about those changes in writing
- Get news on how providers are paid
- Find out how we decide if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost to you
- Use interpreters who are not your family members or friends
- Know you will not be held liable if your health plan becomes bankrupt (insolvent)
- Know your provider can challenge the denial of service with your permission

MHT Member Responsibilities

As a member of The Health Plan, you also have some responsibilities:

- Read through and follow the instructions in your member handbook
- Work with your PCP to manage and improve your health
- Ask your PCP any questions you may have
- Call your PCP at any time when you need health care

- Give information about your health to The Health Plan and your PCP
- Always remember to carry your member ID card
- Only use the emergency room for real emergencies
- Keep your appointments
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know
- Follow your PCPs recommendations about appointments and medicine
- Go back to your PCP or ask for a second opinion if you do not get better
- Call Member Services at 1-888-613-8385 whenever anything is unclear to you or you have questions
- Treat health care staff and others with respect
- Tell us right away if you get a bill that you should not have gotten or if you have a complaint
- Tell us and your DoHS caseworker right away if you have had a transplant or if you are told you need a transplant
- Tell us and DoHS when you change your address, family status (e.g. birth or death in your family) or other health care coverage
- Know that we do not take the place of workers' compensation insurance

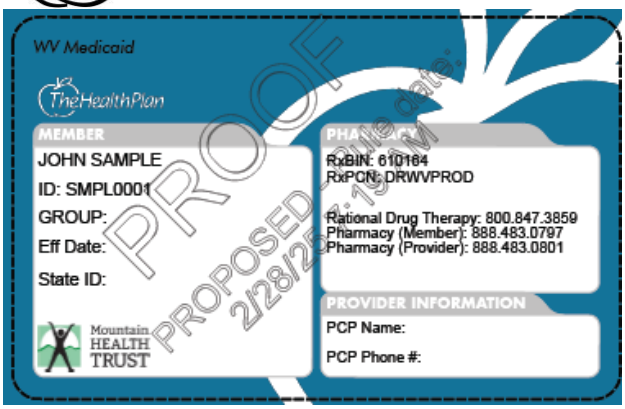
STEPS TO YOUR GETTING CARE

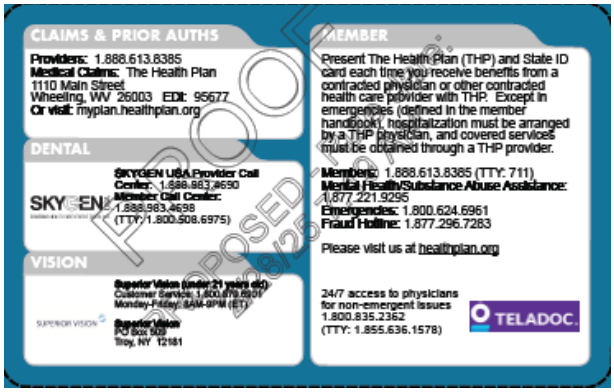
YOUR MEMBER ID CARD

After you join The Health Plan, we will send you your member ID card in the mail. Each member of your family who has joined The Health Plan will receive an individual card. If you have not received your member ID card after 14 business days, please call Member Services at 1-888-613-8385.

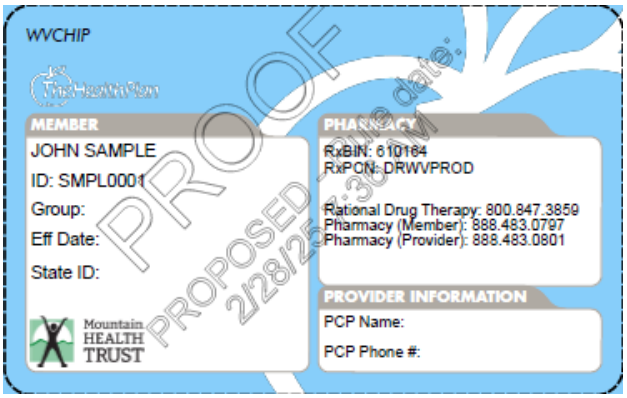
It is important to always keep your member ID card with you. You will need it any time you get care. Your card is your proof that you are a member of The Health Plan.

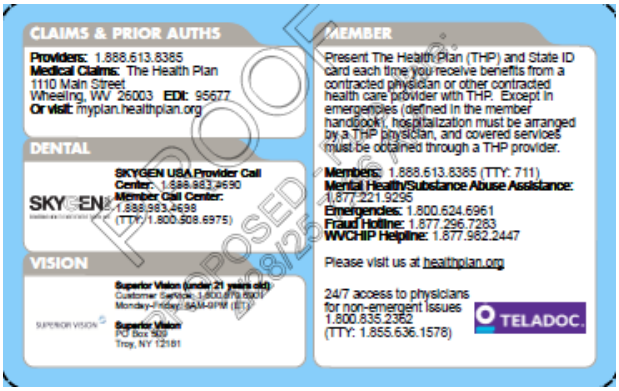
Mountain Health Trust Medicaid members, your card will look like this (see next page):





Mountain Health Trust WVCHIP members, your card will look like this:





You will find some useful information on your card like your Medicaid/WVCHIP ID number, your PCP's name and office phone number, the start date of your health coverage, and other important phone numbers. Having your card out when you call Member Services can help us serve you faster.

Please call Member Services immediately at 1-888-613-8385 if:

- You lose your card
- Your card is stolen
- You have not received your card(s)
- Any of the information on the card(s) is wrong
- You have a baby or add a new member to your family
- You move
- Someone in your family dies

Please call your county DoHS immediately at 1-304-558-0684 if you move to another state or to another county.

CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

Each member of The Health Plan chooses a primary care provider (PCP) from the Provider Directory. A PCP is a specific clinician responsible for coordinating your health care needs. You can find a list of PCPs online at findadoc.healthplan.org. Member Services can help you select a PCP to best fit your needs. If you do not pick a PCP from the directory, we will choose one for you.

If you have a chronic illness, then you may be able to select a specialist as your PCP. As a member with special healthcare needs, you have the right to direct access to a specialist. This means that The Health Plan cannot require you to get a referral or prior authorization to see a specialist that is in our network. Please call Member Services to discuss at 1-888-613-8385. Women can also receive women's health care services from an obstetrical/ gynecological practitioner (OB/GYN) without a referral from your PCP.

Upon request, a description of the method of physician compensation is available to The Health Plan members.

HOW TO SCHEDULE AN APPOINTMENT

You will visit your PCP for all of your routine health care needs. The Health Plan will ensure hours of operation are convenient and do not discriminate against enrollees.

All new members should try to schedule an appointment within 90 calendar days. You can schedule your appointments by calling the PCP's office phone number. Your PCP's name and office phone number will be listed on your member ID card. You can call 24 hours a day, seven days a week. On the day of your visit, remember to bring your member ID card. Please show up on time and call to cancel an appointment if you cannot make it.

Your first appointment:

All new members should set up an initial health assessment or a first exam with your PCP as soon as you can. This first visit with your PCP is important. It is a time to get to know each other, review any health history and needs and come up with a plan to keep you healthy that works for you. If you are an adult, your first health review should be within 90 calendar days of joining The Health Plan. A child should be seen by a PCP within 60 calendar days of joining. If you are an SSI member, you should visit your PCP or specialist who handles your care within 45 calendar days of joining The Health Plan. During the first exam, the PCP can learn about your health care needs and teach you ways to stay healthy.

To schedule a visit with a specialist, first contact your PCP for a referral. Your PCP will call The Health Plan for a referral to a specialist in our network. Your referral must be approved by The Health Plan.

WHAT IF I RECEIVE A BILL OR HAVE TO PAY FOR CARE?

You should contact Member Services if you receive a bill from a provider. We will check to be sure that it is not for a charge the provider should have billed to The Health Plan.

Federal and State regulations do not allow for Medicaid or WVCHIP members to be balanced billed for services. Please contact Member Services before paying for any medical bills.

CHANGING YOUR PCP

If you need to, you can change your PCP for any reason. Let us know right away by calling Member Services at 1-888-613-8385. You can change your PCP at any time. We will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so the provider can get to you know you and your medical history.

Sometimes PCPs leave our network. If this happens, we will let you know by mail within 15 business days for a PCP and within 30 business days for a hospital. We can assign you a new PCP or you can pick a new one yourself within 30 calendar days of the notice. If we need to assign you a new PCP for another reason, we will let you know.

WHERE TO GET MEDICAL CARE

Please read below to understand what type of care to get in different situations. Our providers should offer the same hours of operations for Medicaid members as they do for commercial members.

ROUTINE CARE

You should see your PCP for all routine health care visits. Routine visits are when a delay in medical care would not cause a serious problem with your health. Some reasons to get a routine health care visit include checkups, screenings, physicals, and care for diabetes and asthma. You can call your PCP to schedule these visits at any time. You and your PCP should work together to get you the care you need.

- **Well-Care Visits** – A well care visit is when you or your child sees your PCP for a preventive visit. These visits are not for treating conditions or diseases, so you should schedule a well care visit even if you do not feel sick. During the appointment, your PCP will review your medical history and health. Your PCP may suggest ways to improve your health, too. You can learn

more about well-care visits under the section titled "More Information About Your Coverage."

- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (also called HealthCheck)** - Covered screening services are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth provided by your primary care physician or dentist. At a minimum, these screenings would include:
    - A comprehensive health and developmental history (including assessment of both physical and mental health development);
    - An unclothed physical exam;
    - Laboratory tests (including blood lead screening appropriate for age and risk factors);
    - Vision testing;
    - Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices (ACIP);
    - Hearing testing;
    - Dental services (furnished by direct referral to a dentist for children beginning at six [6] months after the first tooth erupts or by twelve [12] months of age);
    - Behavioral health screening; and
    - Health education (including anticipatory guidance).

- **After Hours Care** – You can reach your PCP even if it is after normal business hours. Just leave a voicemail with your name and phone number. Your PCP or another PCP from the same office will call you back as soon as possible or during office hours. You can also call our 24/7 nurse line at [1-866-687-7347 (TTY: **711**).

TELADOC 24/7 SERVICES

You can call or video chat with Teladoc 24/7 365 days a week.

Access medical, behavioral health and dermatology services from your home, work or when traveling.

Doctors can diagnose, treat and prescribe medication for your non-emergency situation. This includes treatments for flu, sore throat, eye infections, bronchitis and more.

URGENT CARE

You can visit an urgent care center when you have an injury or illness that needs prompt care but is not an emergency. Some examples of when to get urgent care are:

- A sprained ankle
- A bad splinter
- The flu

You can also get urgent care if you are traveling and are too far from your PCP's office. You can schedule an urgent care appointment by calling your PCP. You should explain the medical problem so that your PCP can make your appointment or help you decide what to do.

If you think you might need urgent care when you or your child are away from your home or after hours, you can also call the 24-hour nurse line at [1-866-687-7347 (TTY: **711**). They can help you decide what care your child needs.

EMERGENCY CARE

You should get emergency care when you have a very serious and sudden medical problem. An emergency is when you need to be treated right away. Some examples of an emergency are:

- Vaginal bleeding
- A heart attack
- Severe chest pain
- Seizures
- Rape

You should not go to the emergency room (ER) for things like:

- Colds
- Minor cuts and bruises
- Sprained muscles.

If you believe you have a medical emergency, call 911 immediately or go to the nearest ER. When you get there, show your member ID card. You do not need approval from your PCP or The Health Plan. If you are traveling and away from home when you have a medical emergency, go to the nearest ER. You have the right to go to the nearest hospital, even if it is not in our network. If you're not sure what to do, call your PCP or The Health Plan at 1-888-613-8385. Remember to use the ER only if you have an emergency. You are always covered for emergencies.

If you need to stay in the hospital after an emergency, please make sure The Health Plan is called within 24 hours. If you are told that you need other medical care to treat the problem that caused the emergency, the provider must call The Health Plan. If you are able, call your PCP to let him or her know that you have a medical emergency. You will need to schedule follow-up (called post-stabilization) services with your PCP. Your case manager can also assist you with additional services. Please call our Member Services team at 1-888-613-8385 or your case manager for more assistance.

For more information about emergency transportation and post-stabilization services, please see the Mountain Health Trust Covered Benefits Table.

WV MEDICAID BENEFITS

You can get many services through The Health Plan's Medicaid managed care program in addition to those that come with regular Medicaid. For most benefits, you will need to go through your PCP. There are some services that do not require a referral from your PCP. This means that you do not need approval from your PCP. To get these services, look in your Provider Directory for the list of providers who offer these services. You can schedule the appointment yourself. You have the right to a second opinion from a qualified health care professional within or outside the network, at no cost to you. This second opinion could be in addition to that of a specialist referred by the PCP. If you have any questions, The Health Plan can help. Just call Member Services at 1-888-613-8385. Member Services can explain how to access your services.

WV MEDICAID COVERED SERVICES

Your covered services must be medically necessary. You should get these services from providers in The Health Plan network. Your PCP should provide covered services or refer you to another provider to do so. The services included fall under medical (inclusive of maternity and sexually transmitted disease services), behavioral, dental, and vision. Benefit packages differ depending on your age.

Telehealth lets your provider care for you without an in-person office visit. Telehealth is done online with internet access on your computer, tablet, or smartphone.

- Telehealth visits are covered, just like in-person visits.
- Medicaid/WVCHIP will only pay for telehealth for covered benefits.
- Ask your provider if they do phone or video visits.

Mountain Health Trust (WV Medicaid) Covered Benefits
Medical • **Primary Care/Specialist Office Visits/FQHC/RHC**—Includes physician, physician assistant, nurse practitioner and nurse midwife services. • **Physician Services** – Certain services may require prior authorization or have service limits. May be delivered through telehealth. • **Laboratory and X-ray Services** –Includes lab services related to substance use disorder (SUD) treatment. Services must be ordered by a physician and certain procedures have service limits. Genetic testing requires pre-authorization. • **Clinics**—Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children. • **Private Duty Nursing**—For children ages 0-20. Requires prior authorization limits apply. • **Vaccinations - Vaccinations are included for children and as approved for adults.**
Hospital • **Inpatient** – Includes all inpatient services (including bariatric, long-term acute care (LTAC) and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. Requires pre-authorization. • **Organ and Tissue Transplants**—Corneal transplants only. • **Outpatient** – Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.
Ambulatory Surgical Care • Includes services and equipment for surgical procedures.
Emergency • **Post-stabilization**—Includes care after an emergency health condition is under control. Care provided in a hospital or other setting. • **Emergency Transportation**—Includes ambulance and air ambulance. Out-of-state requires pre-authorization.
Rehabilitation • **Pulmonary Rehabilitation** – Includes procedures to increase strength of respiratory muscle and functions. Must meet plan guidelines. Limited to 3 sessions per week for 12 weeks or 36 sessions per year • **Cardiac Rehabilitation** – Includes supervised exercise sessions with EKG monitoring. Limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery.

- **Inpatient Rehabilitation** – Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals (in a rehabilitation facility) Requires pre-authorization.
- **Physical Therapy** - Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- **Occupational Therapy** - Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- **Speech Therapy** - Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (for children under age twenty-one (21). Some procedures have service limits or need prior approval.
- **Chiropractor Services** - Includes radiological exams and corrections to subluxation. Certain procedures has service limits.

Specialty

- **Podiatry** – Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered. Select procedures require prior authorization. Consult with your doctor before receiving services.
- **Handicapped Children's Services/Children with Special Health Care Needs Services –** Includes coordinated services and limited medical services, equipment and suppliers (for children only).
- **Nutritionist**—Medical nutritionist visits are limited to six visits per calendar year. Medical nutritionist visits for weight loss only if part of evaluation for bariatric surgery requires pre-authorization.

Preventive Care and Disease Management

- **EPSDT**—(ages 0-20) Includes health care services for any medical or psychological condition discovered during screening (for children only). Needs that are identified that are over the allowable or not included in the covered services require a pre-authorization.
- **Tobacco Cessation**—Includes therapy, counseling, and services. Guidance and risk-reduction counseling covered for children. The Health Plan has certified American Lung Association Freedom from Smoking counselors to help you quit smoking. Most people already know that smoking is bad for their health. Our program focuses on how to *quit*, not *why*. Freedom From Smoking is designed to help tobacco users get control of and break their addiction. No one method works for all tobacco users. The Health Plan's program is 90

days. A counselor will call you and help you get any prescriptions approved. They will help you build better habits and break current ones. People who finish the program are six times more likely to be tobacco free one year later than those that quit on their own. If you would like to quit give our counselors a call at 1-888-450-6023.

- **Sexually Transmitted Disease Services**—Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.
- **Preventive Screenings**—Annual pap smear for cervical cancer screening beginning at age 18, earlier if medical necessary.
  Mammography screening: Ages 35-39 at least once, 40-49 every two years unless medically determined that member is at risk, one every year and 50+ one every year.
  Prostate cancer screening: Beginning at age 50.
  Colorectal screening: Age 50 and older without symptoms or under age 50 with symptoms.

Maternity

- **Right From The Start**—Includes prenatal care and care coordination. Services covered through 12-months post-partum and infants less than one year old.
- **Family Planning**—Services to aid recipients of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy. Pregnancy terminations and infertility treatments are not covered. **Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies, pregnancy terminations and infertility treatments are not covered.** Other Family Planning services may be accessed by in network or out of network providers.
- **Maternity Care**—Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Durable Medical Equipment, Orthotics and Prosthetics

- Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. Certain procedures have services limits or need prior authorization. Customized special equipment considered.
- Requires pre-authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

- Requires pre-authorization for all visits. If you revoke three times, you are no longer eligible for hospice. For adults, rights are waived to other Medicaid services related to the terminal illness.

Home Health Care

- Covered for nursing, physical therapy, occupational therapy, and speech therapy. Includes services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Services are limited to any combination of 60 units within a calendar year. Pre-authorization required prior to 2nd certification period.

Dental

For children (ages 0-20)

- Must use participating practitioners (see provider directory or call Skygen Dental at **1-888-983-4698**).
- Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires pre-authorization.

For adults (21 and older)

- Must use participating practitioners (see provider directory or call Skygen Dental at **1-888-983-4698**).
- Accident or injury, tumor removal, or emergency extraction.
- $2,000 for preventive and restorative care, such as cleanings and crowns, every two years
- TMJ is not covered for adults.

Vision

For children (ages 0–20)

- Must use participating vision services practitioners. See provider directory or call Superior Vision.
- Vision screening and therapy.
- One eye exam covered once every 12 months.
- Limited one frame per year.
- Contact lenses covered for certain diagnosis.
- Repairs.

For adults (21 and older)

- Adults limited to medical treatment only.
- Medical contact lenses for adults and children covered for certain diagnosis.
- One pair of glasses up to 60 calendar days after cataract surgery.

Diabetes Management—Members diagnosed with diabetes have the right to access vision services without a PCP referral for an annual examination.

Hearing

For children (ages 0–20)

- Audiology screening/testing does not require authorization (only if referred by a PCP or ENT practitioner).
- One hearing aid every five years.
- Hearing aid evaluations, hearing aid supplies, batteries, and repairs. Certain procedures or devices may have service limits or require prior

authorization. Augmentation communication devices are limited to children under 21 years of age and require prior approval.

For adults (21 and older)

- Requires pre-authorization for functional testing **for specific medical conditions.**
- Hearing aid evaluations, hearing aid supplies, batteries, and repairs are not covered for members aged 21 and older.

Behavioral Health

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility** – Includes services for children (age 20 and under) with mental illness and substance abuse. Limits frequency and amount of services. Certain services require pre-authorization.
- **Inpatient Psychiatric Services –** Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed.
    - **Under age 21** – Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification required. Pre-admission and continued stay prior authorization is required.
    - **Ages 21 to 64** – Includes treatment at an Institution for Mental Diseases (IMD).
- **Outpatient** – Includes services for individuals with mental illness and substance abuse. Limits frequency and amount of services. Providers must be ACT certified. Children's residential treatment is not covered. Certain services require pre-authorization.
- **Psychological Services** – May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. Certain services require pre-authorization.
- **Drug Screening** – Laboratory services to screen for presence of one of more drugs of use. Limits apply and pre-authorization is required for some testing.
- **Substance Abuse Disorder (SUD) Services** – Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance abuse. Prior authorization is required.

Tubal Ligation

- Family planning service for individuals of childbearing age to permanently prevent pregnancy. Service requires informed consent and medical necessity.

Gender Affirmation for Gender Dysphoria

- Procedure that aligns an individual's biological sex with their gender identity. Adults must be twenty-one (21) years or older prior to being considered for the procedure. Prior authorization is required.

Benefits Under Fee-for-Service Medicaid
Abortion – Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Physician certification required. All Federal and State laws regarding this benefit apply.
Early Intervention Services for Children Three and Under – Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.
Nursing Facility Services – Includes nursing, social services, and therapy.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.
Personal Care for Aged/Disabled – Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited on per unit per month basis. Requires physician order and nursing plan of care.
ICF/MR Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for persons with a developmental disability. Requires physician or psychiatrist certification.
Prescription Drugs – Includes dispensed drugs on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Not covered: Drugs for weight gain/loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs.. Call the WVMMIS HelpDesk at 1-888-483-0797 to help you find a pharmacy or to find out if your pharmacy is in network. *You can also find this information at **wvmmis.com**. You can access the WV Medicaid Preferred Drug List (PDL) by visiting: https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/Preferred-Drug-List.aspx *Please note, the PDL is subject to regular updates by the WV Medicaid program. The Health Plan will still cover some drugs. We cover medicines that you get during a hospital stay and in the emergency room. We also cover those you get in the doctor's office, such as injectable medicines like vaccines. Drugs, drug products and related services, which are defined by the Bureau for

Medical Services' Outpatient Drug Pharmacy Program as a non-covered benefit will not be covered by The Health Plan. Hemophilia blood factors and hepatitis C virus related drugs are covered by traditional Medicaid.
Organ Transplant Services – Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/ research nature or for end-stage diseases. Must be used to manage disease.
School-based Services – **Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting. Limited to individuals under age twenty-one (21).** Service limitations are listed in the fee for service Medicaid policy manual.
Transportation – WV Medicaid covers non-emergent medical transportation through a third-party vendor (ModivCare). Members may call 1-844-549-8353 to schedule a trip. Routine transport is required to be scheduled at least 5 business days in advance of your appointment. You may also receive gas mileage reimbursement if you provide self-transport or receive transportation from a friend or family member. ModivCare will provide you with a mileage reimbursement trip log to return to them with your appointment information.
Opioid Treatment Program – Services under the SUD 1115 Waiver Comprehensive opioid MAT program including medication, treatment services and laboratory services.

In addition to your benefits, The Health Plan offers value-added services. When eligible members complete the healthy behaviors listed in the table on page 40, they will receive a reward. We offer these services to encourage health education and to promote health. Copayments may not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services.

WVCHIP COVERED SERVICES

Your covered services must be medically necessary. You should get these services from providers in The Health Plan network. Your PCP should provide covered services or refer you to another provider to do so. The services included fall under medical (inclusive of maternity and sexually transmitted disease services), behavioral, dental, and vision. You can get the services listed in the WVCHIP Benefits table by using The Health Plan member ID card.

Telehealth lets your provider care for you without an in-person office visit. Telehealth is done online with internet access on your computer, tablet, or smartphone.

- Telehealth visits are covered, just like in-person visits.
- Medicaid/WVCHIP will only pay for telehealth for covered benefits.
- Ask your provider if they do phone or video visits.

Note: The fact that a physician has recommended a service as medically necessary does not make it a covered expense. The Health Plan reserves the right to make the final determination of medical necessity based on diagnosis and supporting medical data.

Who May Provide Services: The Health Plan will pay for services rendered by a health care professional/facility if the provider is:

- Licensed or certified under the law of the jurisdiction in which the care is rendered
- Enrolled with WVCHIP as an eligible provider
- Providing treatment within the scope or limitation of the license or certification
- Not sanctioned by Medicare, Medicaid or both; services of providers under sanction will be denied for the duration of the sanction
- Not excluded by WVCHIP or Medicaid due to adverse audit findings
- Not excluded by other states' Medicaid or CHIP Programs

Covered Services: A comprehensive range of health care services are covered in full unless otherwise noted. Some major categories are listed below. If you have questions about covered services, call Member Services at 1-888-613-8385.

Services with an (*) require prior authorization in some or all circumstances.

Mountain Health Trust (WV CHIP) Covered Benefits
Medical • **Primary Care/Specialist Office Visits/FQHC/RHC**—Includes physician, physician assistant, nurse practitioner and nurse midwife services. • **Physician Services** – Certain services may require prior authorization or have service limits. May be delivered through telehealth. • **Laboratory and X-ray Services** –Includes lab services related to substance use disorder (SUD) treatment. Services must be ordered by a physician and certain procedures have service limits. Genetic testing requires pre-authorization. • **Clinics**—Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.

- **Private Duty Nursing**—For children ages 0-20. Requires prior authorization limits apply.
- **Vaccinations** - Vaccinations are included for children and as approved for adults.

Hospital

- **Inpatient** – Includes all inpatient services (including bariatric, long-term acute care (LTAC) and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. Requires pre-authorization.
- **Outpatient** – Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.

Ambulatory Surgical Care

- Includes services and equipment for surgical procedures.

Emergency

- **Post-stabilization**—Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.
- **Emergency Transportation**—Includes ambulance and air ambulance. Out-of-state requires pre-authorization.

Rehabilitation

- **Pulmonary Rehabilitation** – Includes procedures to increase strength of respiratory muscle and functions. Must meet plan guidelines. Limited to 3 sessions per week for 12 weeks or 36 sessions per year
- **Cardiac Rehabilitation** - Includes supervised exercise sessions with EKG monitoring. Limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery.
- **Inpatient Rehabilitation** – Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals (in a rehabilitation facility; limited to 60 days per calendar year). Requires pre-authorization.
- Physical Therapy. Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- Occupational Therapy. Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- Speech Therapy. Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (for children under age twenty-one (21). Some procedures have service limits or need prior approval.
- Chiropractor Services. Includes radiological exams and corrections to subluxation. Certain procedures has service limits.

Specialty

- **Podiatry** – Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered. Select procedures require prior authorization. Consult with your doctor before receiving services.
- **Handicapped Children's Services/Children with Special Health Care Needs Services -** Includes coordinated services and limited medical services, equipment and suppliers (for children only).
- **Nutritionist**—Medical nutritionist visits are limited to six visits per calendar year. Medical nutritionist visits for weight loss only if part of evaluation for bariatric surgery requires pre-authorization.

Preventive Care and Disease Management

- **EPSDT**—(ages 0-20) Includes health care services for any medical or psychological condition discovered during screening (for children only). Needs that are identified that are over the allowable or not included in the covered services require a pre-authorization.
- **Tobacco Cessation**—Includes therapy, counseling, and services. Guidance and risk-reduction counseling covered for children. The Health Plan has certified American Lung Association Freedom from Smoking counselors to help you quit smoking. Most people already know that smoking is bad for their health. Our program focuses on how to *quit*, not *why*. Freedom From Smoking is designed to help tobacco users get control of and break their addiction. No one method works for all tobacco users. The Health Plan's program is 90 days. A counselor will call you and help you get any prescriptions approved. They will help you build better habits and break current ones. People who finish the program are six times more likely to be tobacco free one year later than those that quit on their own. If you would like to quit give our counselors a call at 1-888-450-6023.
- **Sexually Transmitted Disease Services**—Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.
- **Preventive Screenings**—Annual pap smear for cervical cancer screening beginning at age 18, earlier if medical necessary.
  Mammography screening: Ages 35-39 at least once, 40-49 every two years unless medically determined that member is at risk, one every year and 50+ one every year.
  Prostate cancer screening: Beginning at age 50.
  Colorectal screening: Age 50 and older without symptoms or under age 50 with symptoms.

Maternity

- **Right From The Start**—Includes prenatal care and care coordination. Services covered through 12-months post-partum and infants less than one year old.
- **Family Planning**—Services to aid recipients of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy. Pregnancy terminations and infertility treatments are not covered. **Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies, pregnancy terminations and infertility treatments are not covered.** Other Family Planning services may be accessed by in network or out of network providers.
- **Maternity Care**—Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Durable Medical Equipment, Orthotics and Prosthetics

- Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. Certain procedures have services limits or need prior authorization. Customized special equipment considered.
- Requires pre-authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

- Requires pre-authorization for all visits. If you revoke three times, you are no longer eligible for hospice. For adults, rights are waived to other Medicaid services related to the terminal illness.

Home Health Care

- Covered for nursing, physical therapy, occupational therapy, and speech therapy. Includes services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Services are limited to any combination of 60 units within a calendar year. Pre-authorization required prior to 2nd certification period.

Dental

For children (ages 0-20)

- Must use participating practitioners (see provider directory or call Skygen Dental at **1-888-983-4698**).
- Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires pre-authorization.

For adults (21 and older)

- Must use participating practitioners (see provider directory or call Skygen Dental at **1-888-983-4698**).
- Accident or injury, tumor removal, or emergency extraction.
- TMJ is not covered for adults.

- WVCHIP members over age 19 are not subject to any dollar limits on dental services

Vision

For children (ages 0–20)

- Must use participating vision services practitioners. See provider directory or call Superior Vision.
- Vision screening and therapy.
- One eye exam covered once every 12 months.
- Limited one frame per year.
- Contact lenses covered for certain diagnosis.
- Repairs.

For adults (21 and older)

- Adults limited to medical treatment only.
- Medical contact lenses for adults and children covered for certain diagnosis.
- One pair of glasses up to 60 calendar days after cataract surgery.

Diabetes Management—Members diagnosed with diabetes have the right to access vision services without a PCP referral for an annual examination. If annual exam reveals abnormal conditions, any follow-up appointment with a specialist will require pre-authorization from the member's PCP.

Hearing

For children (ages 0–20)

- Audiology screening/testing does not require authorization (only if referred by a PCP or ENT practitioner).
- One hearing aid every five years.
- Hearing aid evaluations, hearing aid supplies, batteries, and repairs. Certain procedures or devices may have service limits or require prior authorization. Augmentation communication devices are limited to children under 21 years of age and require prior approval.

For adults (21 and older)

- Requires pre-authorization for functional testing **for specific medical conditions.**
- Hearing aid evaluations, hearing aid supplies, batteries, and repairs are not covered for members aged 21 and older.

Behavioral Health

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility** – Includes services for children (age 20 and under) with mental illness and substance abuse. Limits frequency and amount of services. Certain services require pre-authorization.
- **Inpatient Psychiatric Services –** Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed.

- **Under age 21** – Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification required. Pre-admission and continued stay prior authorization is required.
- **Ages 21 to 64** – Includes treatment at an Institution for Mental Diseases (IMD).

- **Outpatient** – Includes services for individuals with mental illness and substance abuse. Limits frequency and amount of services. Providers must be ACT certified. Children's residential treatment is not covered. Certain services require pre-authorization.
- **Psychological Services** – May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. Certain services require pre-authorization.
- **Drug Screening** – Laboratory services to screen for presence of one of more drugs of use. Limits apply and pre-authorization is required for some testing.
- **Substance Abuse Disorder (SUD) Services** – Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance abuse. Prior authorization is required.

Tubal Ligation

- Family planning service for individuals of childbearing age to permanently prevent pregnancy. Service requires informed consent and medical necessity.

Benefits Under Fee-for-Service WVCHIP
Abortion – Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Physician certification required. All Federal and State laws regarding this benefit apply.
Early Intervention Services for Children Three and Under – Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.
Prescription Drugs – Includes dispensed drugs on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Not covered: Drugs for weight gain/loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Call the WVMMIS HelpDesk at 1-888-483-0797 to help you find a

pharmacy or to find out if your pharmacy is in network. *You can also find this information at **wvmmis.com**.

The Health Plan will still cover some drugs. We cover medicines that you get during a hospital stay and in the emergency room. We also cover those you get in the doctor's office, such as injectable medicines like vaccines. Drugs, drug products and related services, which are defined by the Bureau for Medical Services' Outpatient Drug Pharmacy Program as a non-covered benefit will not be covered by The Health Plan. Hemophilia blood factors and hepatitis C virus related drugs are covered by WVCHIP FFS.

Organ Transplant Services – Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/ research nature or for end-stage diseases. Must be used to manage disease.

Transportation – WVCHIP covers non-emergent medical transportation through a third-party vendor (ModivCare). Members may call 1-844-549-8353 to schedule a trip. Routine transport is required to be scheduled at least 5 business days in advance of your appointment. You may also receive gas mileage reimbursement if you provide self-transport or receive transportation from a friend or family member. ModivCare will provide you with a mileage reimbursement trip log to return to them with your appointment information.

Opioid Treatment Program – Services under the SUD 1115 Waiver Comprehensive opioid MAT program including medication, treatment services and laboratory services.

VALUE ADDED SERVICES

In addition to your benefits, The Health Plan offers value-added services. When eligible members complete the healthy behaviors in the table that follows, they will receive a reward. We offer these services to encourage health education and to promote health. Copayments may not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services.

***Please note: rewards are limited to one (1) qualifying activity per year.**

Value-Added Services and Rewards

- **Annual well visits:** Ages 20 and under – Receive a $25 gift card.
- **Maternity:** $100 gift card for six prenatal visits and $50 for post-partum visit between 7-84 calendar days of delivery.
- **Diabetes:** $25 gift card for completion of an HbA1c blood test and $25 gift card for a diabetic eye exam for ages 18-75.
- **Dental:** $25 gift card for dental exams for children age 20 and under.
- **Mammogram:** $50 gift card for completion of a mammogram, ages 40+.
- **Pap Smear:** $25 gift card for completion of a Pap smear.
- **Completion of HPV vaccine series:** Ages 9-13. $25 gift card for completion of the entire 2 or 3 HPV vaccines. Number of doses is dependent on the age of the child; check with child's doctor to find out how many doses are required.
- **Colorectal Screening:** $25 gift card for men and women aged 45-64 for completing an exam.
- **Free Cell Phone:** Free cell phone with free minutes for text and voice, unlimited calls to Member Services and free wellness and appointment reminder texts. (Medicaid-only). Available directly through Safelink.
- **Boy and Girl Scouts** annual membership fee for ages 5-18.
- **Participation in Member Advisory Committee:** Assist THP with better understanding how to meet your needs. Members will receive a $25 gift card for each meeting that is participated in.
- **Jobs and Hope West Virginia Assistance:** Assist members in referral program.
- **Teladoc**: 24/7/365 access to providers for non-emergent treatment.

- **Meals for Moms**: New moms may receive a week's worth of meals following discharge from hospital after newborn delivery.
- **Life Coach:** Available to assist with resume development, interview skills and job searches.
- **Smoking Cession:** $25 gift card for completing THP smoking cessation course (effective 1/1/2022)
- **Health Risk Assessment:** $25 gift card for members age 20 and under for completing a Health Risk Assessment
- Enrollment into the State **Children With Special Health Care Needs program**, $25.

These incentives are subject to change January 1 and July 1 each year. Please contact Member Services to verify most current value adds. Please allow up to six (6) months to receive gift card funds.

Smoking Cessation Program Guidelines:

To Graduate from Program and Qualify for $25*:* Members will have two requirements to graduate from the program:

- Minimally, the member must engage in 2 calls with the tobacco cessation counselor. The minimum engagement will require the enrollment and education call, and a follow up call with the counselor at the end of the program. The counselor will have a conversation with each member to determine the member's desired engagement level during the enrollment and education call.
- If the member gets a prescription, they must fill all prescriptions on time. If the member does not get a prescription, they will need to engage in an additional 2 calls to track the member through the program.

How to opt in: Members may self-refer to the program by calling into The Health Plan's tobacco cessation line or enrolling online. They may also be referred to the program through providers or nurse navigators.

COMMUNITY SERVICES

Community services are programs and services that improve the health of people, families, and communities. The programs mentioned below are not a full list of the programs and services available in West Virginia. Please call 1-888-613-8385 or visit our website at www.healthplan.org for a list of resources.

WEST VIRGINIA WOMEN, INFANTS, AND CHILDREN (WIC)

WIC provides nutritional services to improve the health of women, infants and children in West Virginia by providing nutrition and breastfeeding counseling and education; as well as health monitoring and nutritious foods.

The West Virginia WIC program may be able to help you and your family to get better nutrition. To reach the office of the West Virginia WIC program call 304-558-0030 or go to their website at dhhr.wv.gov/wic.

HELP ME GROW

Help Me Grow is a referral service that connects families with developmental resources for their children birth through five (5) years. The goal of Help Me Grow is to identify children at-risk and get them connected to the help they need.

Parents, families and friends can call Help Me Grow directly to speak to a care coordinator who can talk with them about how their child is doing, mail a developmental screening tool and connect them to the appropriate resources. To reach the Help Me Grow hotline call 1-800-642-8522.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

The CSHCN program provides specialized medical care for children who have certain chronic, disabling medical conditions and who meet eligibility requirements.

Children who have a diagnosis covered by CSHCN and receive West Virginia Medicaid or WVCHIP may be eligible to receive care management and/or limited services from the program. For more information, call 1-800-642-9704.

WORKFORCE WEST VIRGINIA

WorkForce West Virginia offers tools to help with job searches, unemployment, and training. Workforce WV has the largest database of job seekers and openings in the state. The education and training opportunities provide work skills needed by businesses. Visit their website at workforcewv.org. If you don't have a job due to a health issue, please contact us at 1-888-348-2922 (TTY: 711).

MORE INFORMATION ABOUT YOUR COVERAGE

Please read below for more details about your coverage. If you have any questions, please call Member Services at 1-888-613-8385.

WELL-CHILD VISITS

Well-child visits, also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, are important to make sure children are healthy and stay healthy. The EPSDT benefit covers all medically necessary and preventive health care services for members age 20 and under. Both sick and well care services are provided by your PCP at no cost.

Some screenings that children can get include:

- Physical exams
- Laboratory tests
- Vision testing
- Immunizations
    - https://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf - provides a summary of vaccines by age for children under 6 years of age.
- Hearing test
- Dental services
- Behavioral health screenings
- Health education
- Health and development history

Checkups and screenings are needed to detect health problems. Your PCP can diagnose and treat any health issues early before they become more serious. Call your PCP or Member Services to schedule a well-child visit. Transportation and scheduling help are also available upon request at no cost.

DENTAL SERVICES

Dental care is important to your overall health. The Health Plan uses a dental benefit manager, Skygen USA, formerly known as Scion Dental, to provide dental services for both children and adult Mountain Health Trust members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Members under 21 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by twelve months of age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Members under 21 can also access the Fluoride Varnish Program,

offered by providers certified from the WVU School of Dentistry. For more information about the fluoride varnish application, ask your provider. Children are covered for non-emergency and emergency dental services.

For adults 21 years and older on Medicaid, THP, in partnership with Skygen, will cover up to $2,000 in preventive and restorative dental care every two (2) years. This includes services such as cleanings, x-rays, crowns and other preventive and restorative services. Any cost above $2,000 will be your responsibility to pay the dentist. The $2,000 benefit resets every two (2) years on July 1. The first benefit period will run July 1, 2024 to June 30, 2026. WVCHIP members over age 19 are not subject to the $2,000 adult dental limit and have no dollar limit for their services.

Emergency dental services are also covered. These services may be provided by a dentist, orthodontist, or oral surgeon. Some examples of a dental emergency include:

- Severe pain
- Hemorrhage
- Traumatic injury to the teeth and surrounding tissue
- Unusual swelling of the face or gums

If you need to speak with Skygen USA, please call 1-888-983-4698.

Hours of Operation: Monday – Friday, 8:00 a.m. to 6:00 p.m.

BEHAVIORAL HEALTH SERVICES

You do not need a referral for behavioral health or substance use disorder (SUD) services. Your PCP or Member Services can help you get these services from behavioral health providers. You can also call 1-877-221-9295.

If there is a mental health or substance abuse emergency, please call 911 right away.

The Health Plan provides inpatient and outpatient services to members. This benefit includes mental health services, substance abuse (alcohol and drugs) services, case management, rehabilitation and clinic services, and psychiatric residential treatment services.

Some services require pre-authorization. Your PCP or Member Services can help you get these services from behavioral health providers. You can also call The Health Plan Behavioral Health Services at 1-877-221-9295. Hours of Operation: Monday – Friday, 8:00 a.m. to 5:00 p.m.

<u>Behavioral Health Services Not Covered:</u>

- Any services that are covered by fee-for-service

- School-based services

Call 911 right away if there is a mental health or substance abuse emergency. Call the Suicide and Prevention Lifeline at 988 if you or another person are having thoughts about harming yourself, mental health or substance use crisis, or any other kind of emotional distress.

COURT ORDERED SERVICES

Medically necessary court ordered treatment services are covered by The Health Plan. Court ordered services are subject to BMS/WVCHIP review and determination.

DRUG FREE MOMS AND BABIES PROGRAM

The Drug Free Moms and Babies (DFMB) program supports healthy outcomes for pregnant and postpartum women and babies in Medicaid and WVCHIP by providing prevention, early intervention, addiction treatment, and recovery support. Covered benefits through this program include:

- Care coordination with The Health Plan case managers, DFMB care coordinators, DFMB community health workers, and DFMB providers.
- Early intervention through provider outreach and education.
- Recovery support services.
- Addiction treatment.
- Assistance with health-related social needs of members.
- Long-term follow-up with recovery coach to help women stay in the path of recovery and access to needed resources.
- Services are limited to the duration of the member's pregnancy and one year postpartum.

COMMUNITY RESOURCES

The Health Plan understands that you may need assistance with finding local resources to help meet other needs in your life. Many factors, such as the ability to pay for food or utilities can impact your overall health. There are many programs available around the State that can help you such as FindHelp (findhelp.org), WV WIC and Workforce WV. If you need help finding a resource to address any needs you have, call us at 1-888-613-8385.

SERVICES NOT COVERED/COVERED UNDER FEE-FOR-SERVICE

Some services are not available through The Health Plan or Medicaid/WVCHIP. If you choose to get these services, you may have to pay the entire cost of the service. The Health Plan is not responsible for paying for these services and others:

- All non-medically necessary services.
- Services from non-enrolled or non-participating providers.
- Services that require a prior authorization, but did not get a prior authorization.
- Sterilization of a mentally incompetent or institutionalized individual.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practice, who is responsible for the diagnosis or treatment of a particular patient's condition.
- Treatment for infertility and the reversal of sterilization.
- All cosmetic services, except in the case of accidents or birth defects.
- Christian science nurses and sanitariums.
- Services considered investigational or experimental.

Services covered under fee-for-service Medicaid:

- Abortion
- Early Intervention Services for Children Three (3) Years and Under (Birth-to-Three Program)
- Intermediate Care Facility for the Mentally Retarded
- Nursing Facility Services
- Personal Care Services
- Aged and Disabled, Intellectual Disability and Traumatic Brain Injury Waiver Services
- Prescription Drugs
- School-Based Health Services
- Organ Transplants, except retina transplants (retina is covered by THP)
- Non-Emergency Medical Transportation
- Certain Substance Use Disorder (SUD) Waiver Services

This is not a complete list of the services that are not covered by The Health Plan. If a service is not covered, not authorized, or is provided by an out-of-network provider, you may have to pay. If you have a question about whether a service is covered, please call Member Services at 1-888-613-8385.

GETTING YOUR BENEFITS

REFERRALS AND SPECIALTY CARE

Referrals are not needed when you go to see your PCP. For women, referrals are not needed for appointments with your OB/GYN. If you need health care that your PCP cannot give, your PCP can refer you to another provider who can. Usually, you will be referred to a specialist in our network. When your PCP refers you, the necessary care you get from a specialist will be covered. To see our list of specialists, please call us at 1-888-613-8385 or visit findadoc.healthplan.org. Member Services can also help you if you believe you are not getting the care you need.

SERVICE AUTHORIZATIONS (PRIOR AUTHORIZATION)

If you need to see a provider who is not on our list or seeking a service that is not covered by WV Medicaid or WVCHIP, your PCP must ask The Health Plan for approval. Asking for an out-of-network referral or non-covered service is called a service (prior) authorization request. If the service is available within The Health Plan's network, there is no guarantee you will be approved to see the out of network providers. It is important to remember that your PCP must ask us for approval before seeing an out-of-network provider. Your PCP can call Member Services at 1-888-613-8385. If you are approved to see a provider who is outside of our plan, your visits will be covered. If we do not approve a service authorization (prior authorization), we will send you a written notice. You can appeal the decision.

OUT-OF-NETWORK SERVICES

If we are unable to provide certain covered services, you may get out-of-network services. The cost will be no greater than it would be if you received the services within our network. Services will be provided in an acceptable and timely manner.

NEW TECHNOLOGY

To make sure you have access to the newest medical treatments, The Health Plan looks for new medical advances, procedures and treatments. The Health Plan uses scientific evidence, medical effectiveness and decisions from government agencies to decide if it will pay for new kinds of treatment.

COST SHARING (WV MEDICAID)

Cost sharing, or a copayment, is the money you need to pay at the time of service. Whenever you see your PCP or a provider you were referred to in our network, you are not responsible for any costs except the copayment. The amount of the copayment will change depending on the service and the federal poverty level. Please see the table below for more details.

Copayments will be collected for:

- Inpatient and outpatient services
- Physician office visits, including nurse practitioner or physician assistant
- Non-emergency use of an emergency room
- Pharmacy services
- Adults aged twenty-one (21) and older that are not specifically exempt, as listed below.

Service	Up to 50.00% FPL	50.01 – 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	$0	$35	$75
Office Visits (Physicians and Nurse Practitioners)	$0	$2	$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (excluding ER)	$0	$2	$4
Non-Emergency Use of Emergency Room	$8	$8	$8

Pharmacy copayments are the same for all Medicaid members regardless of income, however, out of pocket maximums do apply.

Pharmacy	
Total Allowed Charge	**Copayment**
$0.00 - $5.00	$0
$5.01 - $10.00	$0.50
$10.01 - $25.00	$1.00

$25.01 - $50.00	$2.00
$50.01 and above	$3.00

Copayments will not be collected for:

1. Family planning services
2. Emergency services
3. Behavioral health services
4. Substance Use Disorder (SUD) services
5. Dental Services
6. Members under age 21
7. Pregnant women (including 12 months after pregnancy)
8. American Indians and Alaska Natives
9. Hospice Care
10. Nursing Home Services
11. Other members or services not under the State Plan authority
12. Members who have met their household maximum limit for cost-sharing per calendar quarter
13. Members with primary insurance other than Medicaid

You must pay the copays listed above until you and all family members in your household enrolled in the plan get to the household copay maximum. Your household copay maximum is based on your household income. You're assigned to a tier based on your household size and income for the quarter.

Tier	Gross quarterly income range for a household of 2	Copay maximum
Tier 1	$0 -$1,966	$8
Tier 2	$1,967 - $3,932	$71
Tier 3	$3,933 - and above	$143

You'll have no copays for the rest of the quarter once your household meets its copay maximum. You will start each quarter with $0 in copays and build towards your copay maximum.

A quarter is defined as a 3-calendar month term.

- Quarter 1 = January through March
- Quarter 2 = April through June
- Quarter 3 = July through September
- Quarter 4 = October through December

For more information on copayment amounts, please call Member Services at 1-888-613-8385.

COST SHARING (WVCHIP)

Cost sharing, or a copayment, is the money you need to pay at the time of service. The amount of the copayment will change depending on the service, family composition, and your family income related in relation to the federal poverty level. Please see the table below for more details.

WVCHIP members participate in some level of cost sharing (copayments and premiums), except for those children registered under the federal exception for Native Americans or Alaskan Natives.

WVCHIP has three enrollment groups in the plan. Each enrollment group has a different level of cost sharing.

Medical Services and Prescription Benefits	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
Generic Prescriptions	No copay	No copay	No copay
Listed Brand Prescriptions	$5	$10	$15
Non-listed Brand Prescriptions	Full retail cost	Full retail cost	Full retail cost
Multisource Prescriptions	No copay	$10	$15
Primary Care Physician Visit	No copay	No copay	No copay
Physician Visit (non-primary care)	$5	$15	$20
Preventive Services	No copay	No copay	No copay
Immunizations	No copay	No copay	No copay
Inpatient Hospital Admissions	No copay	$25	$25
Outpatient Surgical Services	No copay	$25	$25
Emergency Department (waived if admitted)	No copay	$35	$35
Vision Services	No copay	No copay	No copay
Dental Benefit	No copay	No copay	$25 copay for some non-preventive services
Behavioral Health	No copay	No copay	No copay
SUD Services	No copay	No copay	No copay

There will be no copayments for:

- Preventive services.
- Visits to your PCP.
- Immunizations.
- Maternity services.

- Pregnant women over nineteen (19) years of age.
- Vision services.
- Behavioral Health.
- SUD services.

OUT OF POCKET MAXIMUMS

For WVCHIP members, the maximum copayment amounts applied during a calendar year are as follows:

# Of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
1 Child Medical Maximum	$150	$150	$200
2 Children Medical Maximum	$300	$300	$400
3 or more Children Medical Maximum	$450	$450	$600
Dental Services	Does not apply	Does not apply	$150 per family
Prescription Medications	Contact Gainwell at 1-888-483-0797		

Note: Diabetic supplies, such as lancets and test strips, will count towards out-of-pocket maximums.

Federal regulations exempt Native Americans and Alaskan Natives from cost sharing. This exemption can be claimed by calling 1-877-982-2447 to declare your tribal designation and confirm that it is listed as a federally recognized tribe.

For more information on copayment amounts, please call Member Services at 1-888-613-8385.

ACCESS AND AVAILABILITY GUIDE

The Health Plan offers services in every county of West Virginia. The table below lists how long it should take for you to be seen by a provider in different situations.

The Health Plan wants to make sure your waiting times at practitioner offices are short. All members of The Health Plan should have the same access to medical care. If you feel your waiting time was not the same as other patients, call The Health Plan Member Services Department.

Type of Visit:	When You Should be Seen:
Routine Care	Within 21 Calendar Days
Urgent Care	Within 48 Hours
Initial Prenatal Care	Within 14 Calendar Days of Known Pregnancy
Emergency Care	Immediately

The following table shows what your travel time should be for your appointments.

Traveling to Your:	Should Take No Longer Than:		Should Be No Further Than:	
PCP	30 Minutes		20 Miles	
OB/GYN	30 Minutes		25 Miles	
Specialist You See Often	30 Minutes		20 Miles	
Hospital	Urban: 45 Minutes	Rural: 90 Minutes	Urban: 30 Miles	Rural: 60 Miles
Dentist	30 Minutes		25 Miles	
Dental Specialist	60 Minutes		45 Miles	
Behavioral Health Provider, Clinic or Facility	60 Minutes		45 Miles	
SUD Provider, Clinic or Facility	60 Minutes		45 Miles	

LETTING US KNOW WHEN YOU'RE UNHAPPY

When you have a problem, try speaking with Member Services or your PCP to resolve it. If you are still unhappy or do not agree with a decision we have made about your health care, there are different types of complaints you can make. These are known as grievances and appeals. Information on the number of grievances and appeals and their disposition is available upon request. You can

also request a state fair hearing once you have gone through the process for grievances and appeals.

APPEALS

If you believe your benefits were unfairly denied, reduced, delayed or stopped, you have the right to file an appeal with The Health Plan. You have the right to appeal for many reasons, such as any adverse decision, authorization denial or non-payment of a claim. You have the right to be represented by anyone you choose, such as an attorney, your healthcare provider or a family member, with written consent.

- To file an appeal, you can call The Health Plan at 1.888.613.8385.
- To file an appeal in writing, you will need to fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street, Wheeling, WV 26003.
- If you file an appeal in writing, you will need to send us a letter that has:

o Your name

o Your provider's name

o The date of service

o Your mailing address

o The reason why we should change our decision

o A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal

If you call and give your appeal over the phone, The Health Plan will acknowledge your appeal verbally at the time of receipt and also in a letter within five (5) calendar days. Be sure to read the letter carefully and keep it for your records.

You must file an appeal verbally or in writing within sixty (60) calendar days from the date of the adverse benefit determination or adverse decision by The Health Plan.

We will send you a letter to let you know when we have received your appeal. You have the right to give proof, or claims of fact or law, for your appeal either orally, in person or in writing. You have the right to see and get copies of documents that have to do with your appeal, records, your benefits, documents

explaining how we made our decision and any other related information to your appeal for free. Information may include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits.

We will review your appeal. None of the people reviewing it will have been involved in the initial decision to not authorize or pay for the health services you are appealing. If your appeal involves a medical issue, reviewer will be a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. We will provide the titles and qualifications of individuals who participate in your appeal decision review.

The Health Plan must process and provide notice to you regarding your appeal within thirty (30) calendar days.

If The Health Plan needs more information for the appeal, or if you want to provide more information, you or The Health Plan can ask for fourteen (14) more calendar days to finish the appeal. If The Health Plan decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.

Fast (Expedited) Appeals

If your appeal is about our decision to not approve or pay for some or all of your health care services, and you need an appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal appeal decision, like the one described above, you can ask for a fast appeal by calling The Health Plan at 1.888.613.8385 or by submitting the request in writing within sixty (60) calendar days of the adverse decision. The Health Plan will give a decision notice to you about your fast appeal within 72 hours after we receive your appeal.

If you call and give your fast appeal over the phone, The Health Plan will acknowledge your appeal verbally at the time of receipt and also in a letter. Be sure to read the letter carefully and keep it for your records.

If more information is needed to decide your appeal The Health Plan can ask for fourteen (14) more calendar days to finish the appeal. We will send you a letter within two (2) calendar days telling you why more time is needed. You may file a grievance if you are unhappy with our request for more time. You may also ask for fourteen (14) more days if you need more time to provide information about your appeal.

To file a fast appeal, you will need to provide us with:

- Your name
- Your provider's name.
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal

You can file a fast appeal by either calling us, or mailing or faxing the information to:

The Health Plan
1110 Main Street
Wheeling, WV 26003
Phone Number 1.888.613.8385
FAX – 1.888.450.6025
If we decide your appeal is not a fast appeal, we will handle your appeal like the normal appeals described in the section above. You have the right to file a grievance if you are unhappy with the decision to deny the fast appeal.

You have the right to give proof, or claims of fact or law, for your appeal either orally, in person or in writing, but you must provide this information more quickly under a fast appeal process. Upon receipt of your fast appeal request, you also have access to copies of all materials at no cost.

GRIEVANCES (COMPLAINTS)

You, or your representative with written consent, can file a complaint, also called a grievance, at any time.

If you are unhappy with something that happened to you when you received health care services, you can file a complaint or grievance. Examples of why you might file a complaint or grievance include:

- You feel you were not treated with respect
- You are not satisfied with the health care you got
- It took too long to get an appointment
- You do not agree with a decision that we made

To file a complaint or grievance you should call The Health Plan at 1.888.613.8385 (TTY:711).

To file a complaint or grievance in writing, you may fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street, Wheeling, WV 26003.

You will need to send us a letter that has:

- Your name
- Your mailing address
- The reason why you are filing the complaint and what you want The Health Plan to do
- When and where the issue took place

Your doctor or authorized representative can also file a complaint or grievance for you.

If filing a written grievance, we will send you an acknowledgement letter within five (5) calendar days. Verbal grievances are acknowledged when we take your call. You can file a complaint or grievance at any time after the event about which you are unhappy. The Health Plan will conduct a full investigation after we receive your complaint or grievance. We will usually give you a resolution within thirty (30) calendar days and no later than ninety (90) calendar days, but may ask for extra time to give an answer.

If it is in your best interest, you can ask for a delay in our decision for up to fourteen (14) calendar days. If we need to delay our decision, we will give you written notice within two (2) calendar days.

The Health Plan will provide translation services, as needed, at no cost to you.

KEEPING YOUR APPEALS AND GRIEVANCES

The Health Plan will keep copies of your appeal and grievance documents, records and information about your appeal and grievance for your review for ten (10) years.

STATE FAIR HEARINGS

If you are not happy with The Health Plan's appeal decision, and your appeal is about our decision to deny, reduce, change, or terminate payment for your health care services, you can request a State Fair Hearing. You can only request a state fair hearing after you have received notice that The Health Plan is upholding the decision to reduce, suspend, or stop your benefits for a MHT covered service. Appeals for non-covered services are not eligible for State Fair Hearings, unless requested under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. You will get a notice mailed to you within ten (10) calendar days before any action is taken. You must request a State Fair Hearing

within one-hundred twenty (120) calendar days from the notice of appeal resolution from The Health Plan. You may also request a State Fair Hearing if The Health Plan does not meet the timeframe for making a decision on your appeal.

You should send your request for a State Fair Hearing to:

Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The Bureau for Medical Services will hear your case and a decision will be sent to you in writing within ninety (90) calendar days of the date you asked for the State Fair Hearing.

CONTINUATION OF BENEFITS DURING AN APPEAL OR FAIR HEARING

The Health Plan will continue your benefits during the time of an appeal process or State Fair Hearing when:

- You or your provider file an appeal on a timely basis;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired and;
- You request an extension of benefits within ten (10) days of the MCO determination.

To request an extension of benefits, call member service at 1.888.613.8385. The Health Plan will pay for the services in question when the final result of the appeal is to overturn the original decision. The Health Plan will pay for some or all of the services as determined by the final appeal decision. If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, The Health Plan may take back the money that was paid for the services while the appeal was in process, and you will be responsible for paying for the services.

REPORTING FRAUD

If you suspect fraud, waste, or abuse by a member or provider of The Health Plan, please report it to our special investigative unit (SIU). You do not need to give us your name or information when you call or fill out the form. To report fraud, waste, or abuse, please call 1-877-296-7283. You may also complete the Fraud, Waste, and Abuse Reporting form on our website or by mailing it to us:

healthplan.org

The Health Plan
1110 Main Street
Wheeling, WV 26003

Some examples of fraud, waste, or abuse include, but are not limited to:

- Receiving money or gifts in return for your WVCHIP member number.
- Billing for a non-covered service as a covered service.
- Requesting cash payments from members for office visits.
- Using another person's Medicaid of WVCHIP card.

The Health Plan may contact you to confirm if services billed for were actually received. This allows us to confirm that our providers are not committing fraud and billing inappropriately. We appreciate your help in talking with us about your claims.

OUR POLICIES

ADVANCE DIRECTIVES

Under Federal and State law, you have the right to make decisions about your medical care, including an advance directive. An advance directive is legal document with your wishes regarding medical treatment if there comes a time when you are too sick to make your decisions known. An advanced directive allows you to plan in advance and participate in decision-making around your health. It is a way to let your doctors know what kind of treatment you do or do not want. You can also allow someone you trust to make treatment decisions for you. This would allow that person to make choices about your care and treatment. Many people choose a relative or someone they know well.

You should speak with your doctor about making an advance directive. You do not have to fill one out, but you may want to. If you decide to let someone you trust make treatment decisions for you, be sure to speak with that person. Making an advance directive requires filling out forms and stating your wishes in writing. It will become a part of your medical records. Remember, you can change your advance directive at any time.

Your doctor and Member Services can help you to fill out or answer questions about advance directives.

ENDING YOUR MEMBERSHIP

If you do not wish to be a member of The Health Plan, you have the right to disenroll at any time. You may re-enroll in another managed care organization (MCO) if you choose. The enrollment broker can help you. Just call 1-800-449-8466.

Sometimes members are disenrolled from The Health Plan involuntarily. This can happen if:

- You are no longer eligible for Medicaid or WVCHIP managed care
- You move outside of West Virginia
- You are placed in a nursing facility, state institution, or intermediate care facility for persons with a developmental disability for more than 30 calendar days
- You were incorrectly enrolled in The Health Plan
- You die

If this happens, your services may stop suddenly. The Health Plan Member Services team, 1-888-613-8385, or DoHS Customer Service Center, 1-877-716-1212, can answer any questions you may have about disenrollment.

If you move out of the county or out of state, call the county DoHS office at 1-304-558-0684 to update your information.

APPROPRIATE TREATMENT OF MINORS

The law says that persons under age 18 cannot give valid consent for medical care. The parent or guardian must give consent for medical care for the minor (child). We will permit the enrollee's parent or representative to facilitate care or treatment decisions when the enrollee is unable to do so. We will provide for the enrollee or representative involvement in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment, and comply with requirements of federal and state law with respect to advance directives.

A person over age 16 but under age 18 may ask a court to declare him or her "emancipated." If the court agrees, the person can approve self-directed medical care. Anyone over age 16 who is married is considered emancipated. The parents of an emancipated child have no right to control, nor a duty to give care and money support to the child. Any child who is emancipated can give valid consent to medical care. This person then becomes financially responsible for the costs of the medical treatment.

Mature minors can give medical consent. A person is considered mature based on age, intelligence, experience, living situation, education, and degree of maturity.

Any licensed physician can examine, diagnose, treat, and counsel any minor at the member's request for an addiction or dependency of alcohol or drugs. This can be without the knowledge or consent of the minor's parent or guardian. This is also the same for any venereal disease.

Minors can consent to family planning services. The services must be kept confidential from the parents if the minor asks.

If a minor presents with a medical problem needing immediate care or which could cause immediate danger to the child's health, and no parent or guardian can be found to approve care, then the minor can consent to medical care.

Oral interpreters for minors are available in the case of an emergency.

REPORTING ABUSE AND NEGLECT

If you need to report abuse and neglect of a child or adult, please call the DoHS Centralized Intake for Abuse and Neglect hotline at **1-800-352-6513**. The hotline is operated twenty-four (24) hours a day, seven (7) days a week. If it is an emergency situation, call 911.

THIRD PARTY LIABILITY

If you have insurance other than Medicaid or WVCHIP, please call Member Services to let us know. Please call and let us know if another insurance company has been involved with your:

- Workers' compensation claim
- Personal injury
- Medical malpractice lawsuit
- Car accident

You must use any other health insurance you have first before using Medicaid or WVCHIP. As a WVCHIP member, if you have primary insurance, your WVCHIP coverage will end when you complete your next eligibility review with DoHS.

BALANCE BILLING

Your provider must accept assignment of benefits and cannot bill you for any charges above the fee allowance or for any discount amount applied to a provider's charge to determine payment. This is known as the "prohibition of balance billing" and applies to any MHT provider.

RECOMMENDING CHANGES IN POLICIES OR SERVICES

If you have recommendations or ideas, please tell us about them. You can help us make changes to improve our policies and services. To let us know, please call Member Services at 1-888-613-8385. You can also volunteer to be on our Member Advisory Committee. Contact Member Services to be added. Our Committee meets on a quarterly basis and is an opportunity to hear from you about how we can improve the services we provide. Participants receive a $25 gift card for volunteering their time.

CHANGES TO YOUR HEALTH PLAN

If there are any changes to your benefits or other information in this handbook, we will let you know at least 30 calendar days before the effective date of the change and no later than the actual effective date. Please let us know if you have any questions about program changes.

Quality Improvement

At The Health Plan, we want to make your health better. To do this, we have a Quality Improvement (QI) program. Through this program we:

- Evaluate our health plan to improve it
- Track how happy you are with your PCP
- Track how happy you are with us
- Use the information we get to make a plan to improve our services
- Carry out our plan to help make your health care better

You may ask us to send you information about our QI program. This will include a description of the program and a report on our progress in meeting our improvement goals. Call Member Services at 1-888-613-8385.

ACCREDITATION REPORT

The Health Plan is accredited by the National Committee for Quality Assurance (NCQA). You can request a summary of our accreditation report by calling Member Services at 1-888-613-8385 or by visiting our website at healthplan.org.

IMPORTANT CONTACT INFORMATION

The table below provides information about services that members can call for support. For information about other services you may need, you can call us at: 1-888-613-8385.

Entity	Description	Phone Number	Street Address	Hours of Operation
The Health Plan Member Services	Available to answer questions about your health care needs and services to help you.	Toll-Free: 1-888-613-8385	1110 Main Street Wheeling, WV 26003 OR 141 Summers Street Charleston, WV 25301	Monday-Friday 8:00am-5:00pm
County DoHS	The WV DoHS Office of your county.	1-304-558-0684	Office of the Secretary One David Square, Suite 100 East Charleston, WV 25301	Monday-Friday 8:00am-5:00pm
West Virginia Bureau for Medical Services	The state agency that administers the Medicaid and WVCHIP programs.	1-304-558-1700	350 Capitol Street Charleston, WV 25301	Monday-Friday 8:00am-5:00pm
WVCHIP Help Line		1-877-982-2447	PO Box 40237 Charleston, WV 25364 chip.wv.gov	Monday-Friday 8:00am-4:00pm
Gainwell (Medicaid and WVCHIP Pharmacy)	Available if you need information about your pharmacy or your pharmacy benefit.	1-888-483-0797; wvmmis.com		Monday-Friday 8:00am-5:00pm
Medical Management	Available to ensure you get all the care and services you need.	Toll-Free: 1-888-613-8385		Monday-Friday 8:00am-5:00pm

Enrollment Broker	Available to answer questions you may have about enrolling with an MCO.	1-800-449-8466		Monday-Friday 8:00am – 6:00pm
Emergency	Available for inpatient and outpatient services given by a qualified provider to stabilize an emergency medical condition.	911; 24-hour nurse line 1-866-687-7347		
Dental (Skygen)	THP uses Skygen to answer questions related to dental benefits and connect you to a dental service provider.	1-888-983-4698		Monday-Friday 8:00am-5:00pm
Vision under 21 years old (Superior)	THP uses Superior to answer questions related to vision benefits and connect you to a vision service provider.	1-800-879-6901		Monday-Friday 8:00am – 9:00pm
Behavioral Health	THP handles all inpatient and outpatient services to members.	1-877-221-9295	The Health Plan Behavioral Health Line	Monday-Friday 8:00am – 5:00pm
Teladoc	Access to physicians for non-	1-800-TELADOC (835-2362)		24 hours a day, 7

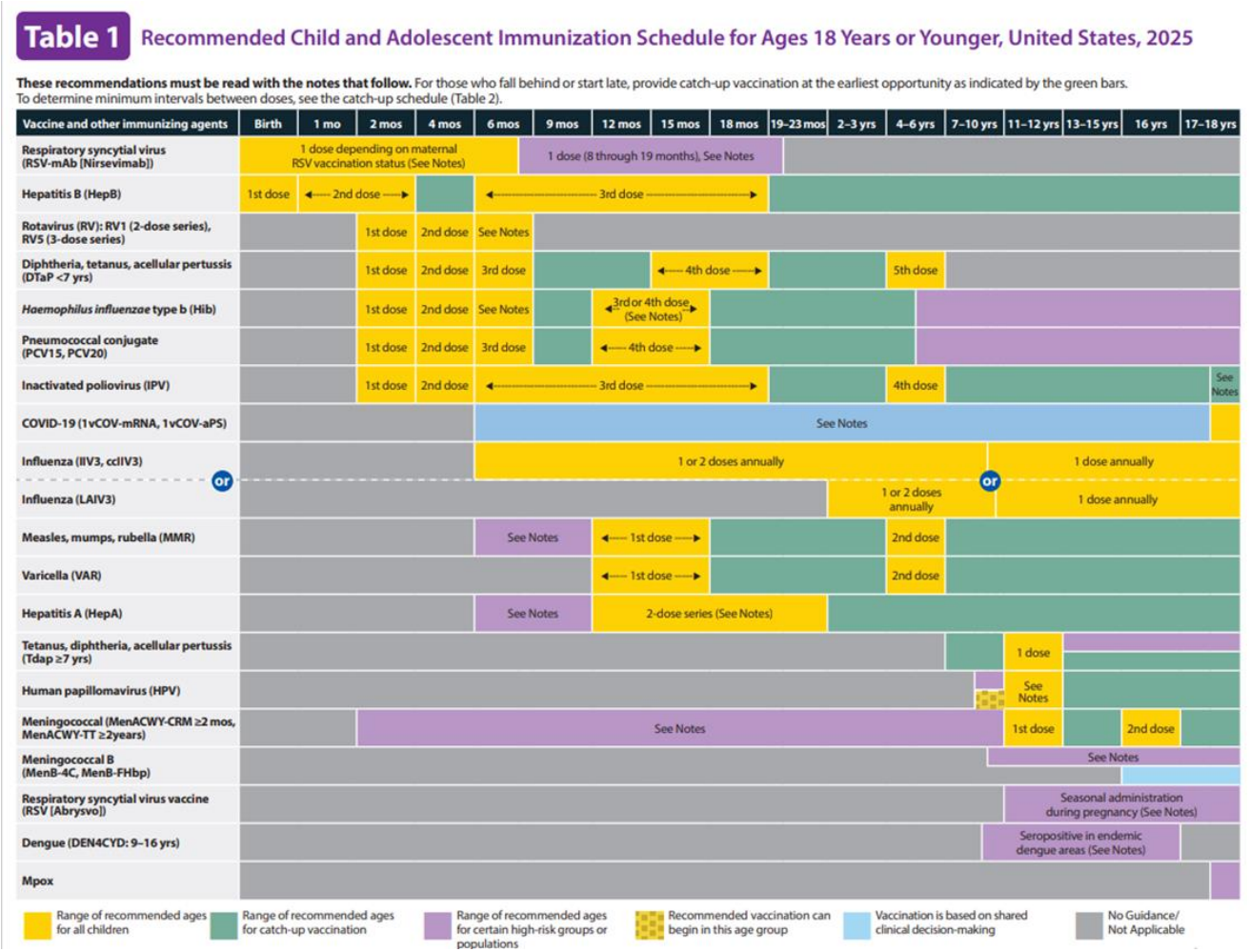
	emergency situations			days a week
inComm (Gift Cards)	Issues gift cards to members on behalf of THP.	Members may access their gift card information at OTCnetwork.com		
Mom's Meals	Provides food kits to new moms after delivery of child.	momsmeals.com		
Ushur (Text Campaigns)	Ushur sends texts to members about healthy activities on behalf of THP.			
Elevate	Assists with evaluating members for Supplemental Security Income (SSI); Elevate will contact you directly to assist with applying for coverage.			
Grievances/ Appeals	Available to assist in filing a grievance or appeal including help in completing forms, offering auxiliary aid or interpreters, and other services.	1-888-613-8385		Monday-Friday 8:00am – 5:00pm
State Fair Hearing	Available to answer questions about requesting a state fair hearing.	304-558-1700	Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251	

			Charleston, WV 25301 Bureau for Medical Services-WVCHIP Office of Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301	
Fraud, Waste, and Abuse	The SIU investigates cases of suspected fraud, waste, or abuse by a The Health Plan member or provider.	1-877-296-7283	The Health Plan FWA hotline	Monday-Friday 8:00am – 5:00pm
Non-Emergency Transportation (ModivCare)	Provide non-emergency transportation services.	1-844-889-1941 After 5:00pm, call: 1-844-549-8353 tripcare.modivcare.com/		
Suicide and Crisis Lifeline	The 988 Suicide & Crisis Lifeline is a United States-based suicide prevention network of over 200+ crisis centers that provides 24/7 service via a toll-free hotline with the number 9-8-8. It is available to anyone in suicidal crisis or emotional distress.	988		24 hours a day, 7 days a week

FindHelp	Provides community resources that can assist with different needs such as utility assistance, food pantries, transportation, etc.	findhelp.org		
WV WIC	The mission of the West Virginia WIC program is to improve the health of women, infants and children in West Virginia by providing quality nutrition and breastfeeding counseling and education; as well as health monitoring and nutritious foods.	1-304-558-0030 dhhr.wv.gov/WIC	Office of Nutrition Services, West Virginia WIC Program 350 Capitol Street, Room 515 Charleston, WV 25301-3715	
WV Kids Thrive Collaborative	The WV Kids Thrive Collaborative provides information on children's mental health resources in WV.	kidsthrive.wv.gov/ 1-844-HELP4WV (1-844-435-7498) Children's Crisis and Referral Line		

IMMUNIZATION SCHEDULES

Immunizations are important to keep your child healthy. The tables below summarize the recommended immunization schedule for children up to age 18. It can also be accessed on the THP website (healthplan.org) or by contacting THP Customer Service at 1-888-613-8385 for a hard copy.



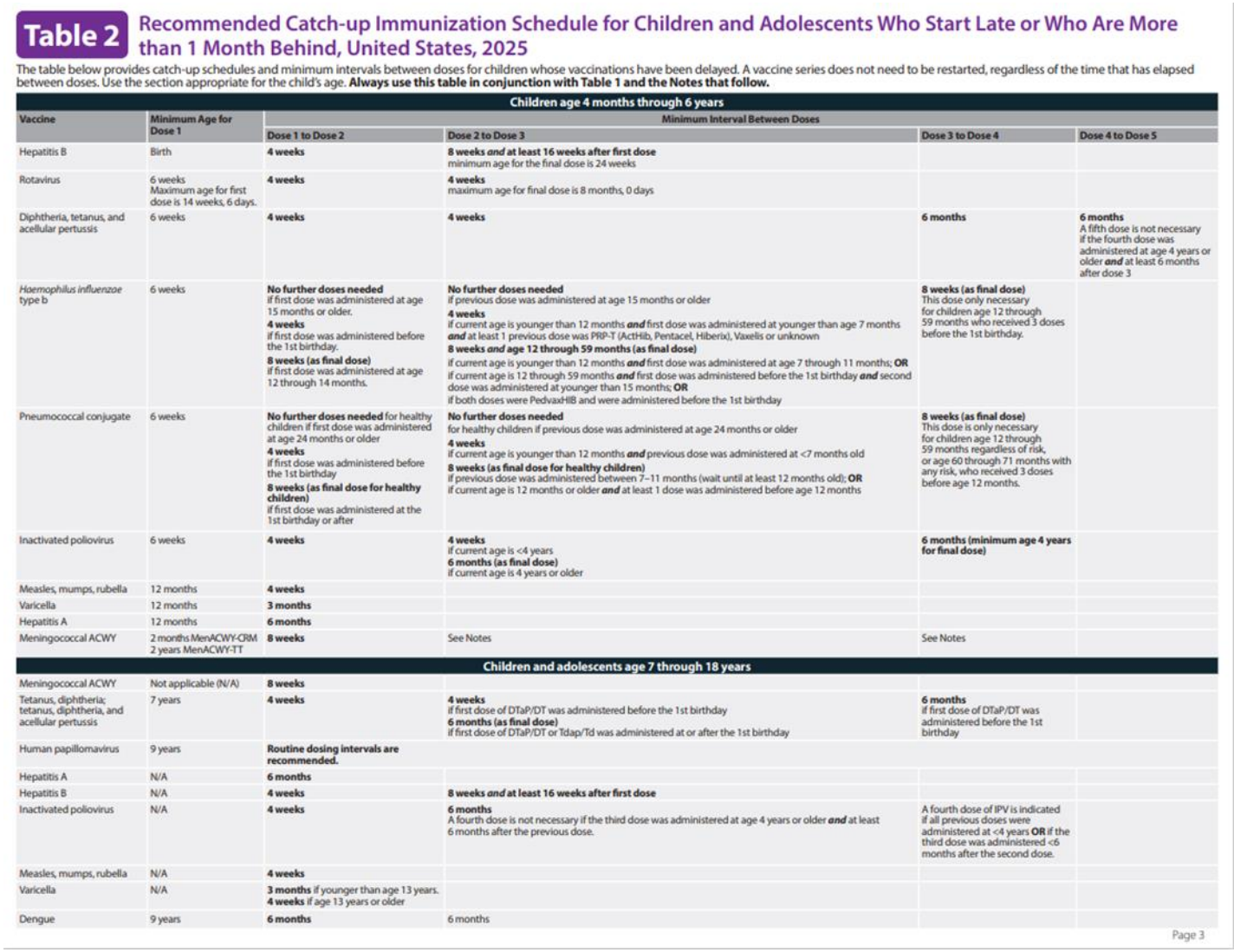


Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2025

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

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months** A fifth dose is not necessary if the fourth dose was administered at age 4 years or older ***and*** at least 6 months after dose 3
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix), Vaxelis or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; **OR** if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; **OR** if both doses were PedvaxHIB and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months ***and*** previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); **OR** if current age is 12 months or older ***and*** at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** This dose is only necessary for children age 12 through 59 months regardless of risk, or age 60 through 71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older ***and*** at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years **OR** if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

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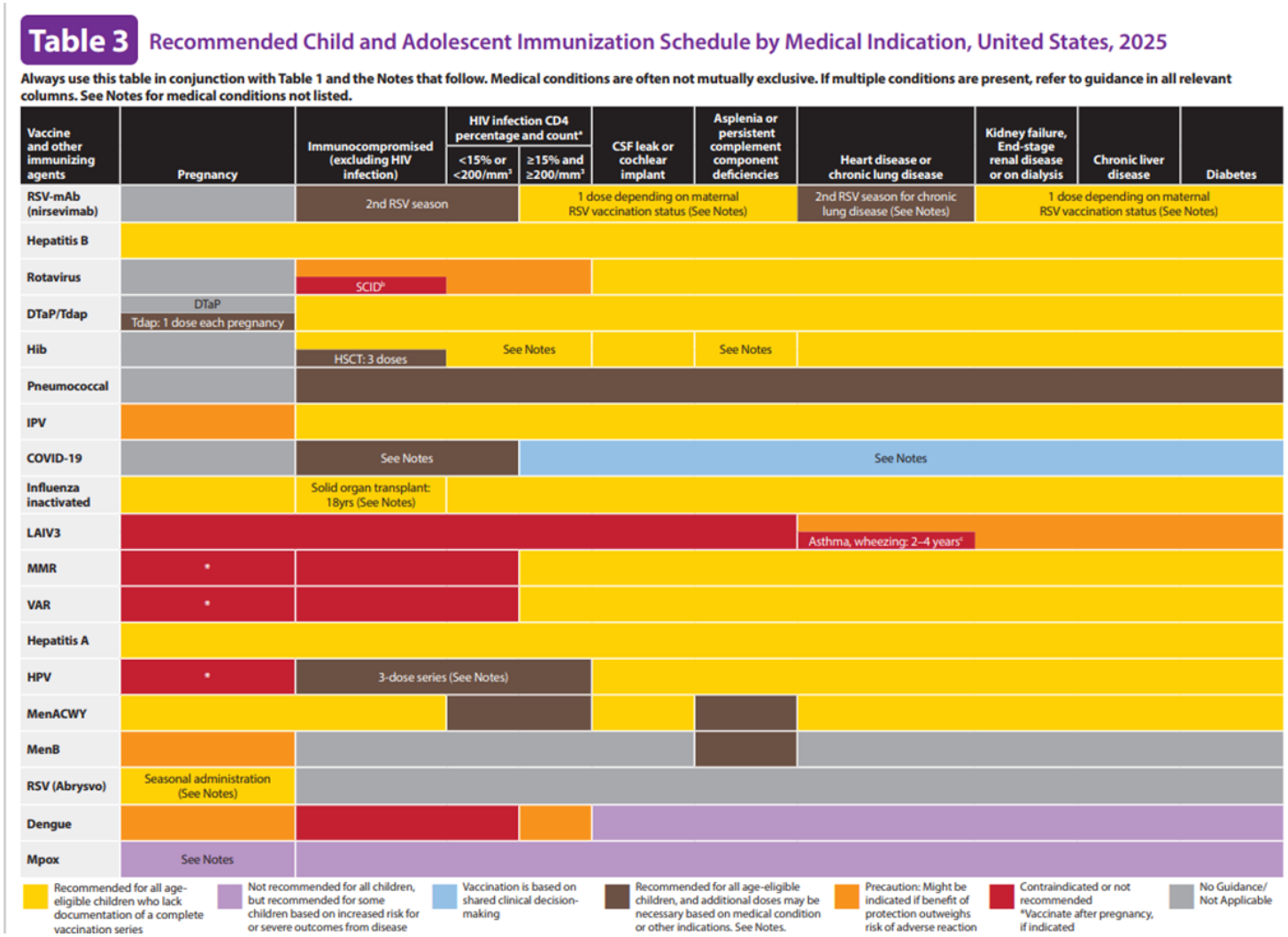

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count[a]		CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease	Diabetes
			<15% or <200/mm³	≥15% and ≥200/mm³						
RSV-mAb (nirsevimab)		2nd RSV season	1 dose depending on maternal RSV vaccination status (See Notes)				2nd RSV season for chronic lung disease (See Notes)	1 dose depending on maternal RSV vaccination status (See Notes)		
Hepatitis B										
Rotavirus		SCID[b]								
DTaP/Tdap	DTaP Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19		See Notes	See Notes							
Influenza inactivated		Solid organ transplant: 18yrs (See Notes)								
LAIV3							Asthma, wheezing: 2–4 years[c]			
MMR	*									
VAR	*									
Hepatitis A										
HPV	*	3-dose series (See Notes)								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration (See Notes)									
Dengue										
Mpox	See Notes									

Recommended for all age-eligible children who lack documentation of a complete vaccination series

Not recommended for all children, but recommended for some children based on increased risk for or severe outcomes from disease

Vaccination is based on shared clinical decision-making

Recommended for all age-eligible children, and additional doses may be necessary based on medical condition or other indications. See Notes.

Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction

Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated

No Guidance/ Not Applicable

For more information on vaccines and immunizations, visit the American Academy of Pediatrics website at: https://www.aap.org/en/patient-care/immunizations/

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communications
- Ask us to limit the information we use or share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Health Information Networks

The Health Plan participates in one or more state health information networks including the West Virginia Health Information Network (WVHIN)and the Ohio Health Information Partnership (through CliniSync). We may use, access, and or

share your information via these state information networks to better coordinate your care. For more information of the WVHIN, visit the WVHIN website at wvhin.org. For more information on the Ohio Health Information Partnership, visit the CliniSync website at clinicsync.org.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 calendar days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request but we will tell you why in writing within 60 calendar days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request and we may say "no" if it would affect your care.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make). We will provider one accounting a year free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has the authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at 1-800-624-6961 (TTY: 711). You can also contact us via our website and healthplan.org.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we shar your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share information when needed to lessen a serious and imminent threat to health and safety.

In these cases, we never hare your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Other Uses and Disclosures

How do we typically use or share your health information?

We can use your health information in the following ways.

Help manage the health care treatment you receive.
We typically use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan and we provide your company with certain statistics to explain the premiums we charge.

How else can we share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we fan share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or deducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see we are complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in a response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in the notice and give you a copy.
- We will not use or share information other than as described here unless you can tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

TheHealthPlan

Discrimination is Against the Law

The Health Plan of West Virginia (The Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex (consistent with the scope of sex discrimination as described by applicable law).
The Health Plan does not exclude people or treat them less favorably because of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex.

The Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Director, Health Equity & Wellness.

If you believe that The Health Plan of West Virginia has failed to provide these services or discriminated in another way on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex, you can file a grievance with: Director, Health Equity & Wellness, 1110 Main Street, Wheeling, West Virginia 26003, Phone: 740.699.6142, TTY: 711, Fax: 740.699.6163, civilrightscoordinator@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director, Health Equity & Wellness is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at The Health Plan's website: healthplan.org.

FFSECTION1557-V2-1

TheHealthPlan

1110 Main Street, Wheeling, WV 26003-2704 | healthplan.org

English
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1.877.847.7907 (TTY: 711) or speak to your provider.

Spanish
Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1.877.847.7907 (TTY: 711) o hable con su proveedor.

Chinese (Simplified)
中文 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提 供适当的辅助工具和服务，以无障碍格式提供信息。致电 1.877.847.7907 (TTY: 711) 或咨询您的服务提供商。

Chinese (Traditional)
中文
注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1.877.847.7907 (TTY: 711) 或與您的提供者討論。

German
Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1.877.847.7907 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Arabic
العربية
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1.877.847.7907 (TTY: 711) أو تحدث إلى مقدم الخدمة.

FFSECTION1557-Rev.1 – 8.26.2024 | Y0038_24_424_C

Pennsylvania Dutch
Hinweis: Wenn du Pennsylvaniä Deitsch redst, kannscht du kostenlose Sprachhilfe-Dienste nutze. Auwersichtliche Hilfsmittel und Dienste, um Information in zugängliche Formate zu gebbe, sin au kostenlos verfügbar. Ruf 1.877.847.7907 (TTY: 711) an oder red mit deinem Anbieter für Hilfe.

Russian
РУССКИЙ
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1.877.847.7907 (TTY: 711) или обратитесь к своему поставщику услуг.

French
Français
ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1.877.847.7907 (TTY: 711) ou parlez à votre fournisseur.

Vietnamese
Việt
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1.877.847.7907 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Korean
한국어
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1.877.847.7907 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Cushite (Oromo)
HUBACHIISA: Afaan Oromoo dubbattu yoo ta'eef, tajaajilli gargaarsa Afaan Hiikuu (Turjumaanaa) bilisaan kan isiniif dhiyaatu ta'a. Gargaarsi walqabataa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa unkaalee dhaqqabamoo ta'aniin kennuunis bilisaan ni argama. 1.877.847.7907 (TTY: 711) irratti bilbilaa ykn dhiyeessaa keessan waliin haasa'aa.

Japanese
日本語
注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1.877.847.7907 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

Italian
Italiano
ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1.877.847.7907 (TTY: 711) o parla con il tuo fornitore.

Dutch
Nederlands
LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1.877.847.7907 (TTY: 711) of spreek met je provider.

Ukrainian
українська мова
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1.877.847.7907 (TTY: 711) або зверніться до свого постачальника.

Romanian
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit ajutoare și servicii auxiliare adecvate pentru a furniza informații în formate accesibile. Sunați la 1.877.847.7907 (TTY: 711) sau vorbiți cu furnizorul dvs.

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1.877.847.7907 (TTY: 711) o makipag-usap sa iyong provider.