Hawki

ia health link

Amerigroup
An Anthem Company





Member Handbook

Iowa

IA Health Link • Hawki
Health and Wellness Plan

myamerigroup.com/IA

IA-MHB-0015-20

Member Handbook

Iowa

IA Health Link • Hawki • Iowa Health and Wellness Plan

Member Services • 800-600-4441

myamerigroup.com/IA

IA-MHB-0015-20

Amerigroup Iowa, Inc. follows Federal civil rights laws. We don't discriminate against people because of their:

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

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

Communicating with you is important

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

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

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 800-600-4441 (TTY 711).

Your rights

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

Grievance Coordinator
4800 Westown Parkway, Regency Building 3
West Des Moines, IA 50266

Phone: 800-600-4441 (TTY 711)
Fax: 844-400-3465
Email: iga@amerigroup.com

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

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

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

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 1-800-600-4441 (TTY 711).

Spanish

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos a la línea gratuita al 1-800-600-4441 (TTY 711).

Chinese

您需要醫療保健的幫助嗎？請向我們諮詢，或是閱讀我們寄給您的資料。我們以其他語言和格式提供我們的資料，您無需支付任何費用。請撥打免費電話 1-800-600-4441 (TTY 711).

Vietnamese

Quý vị có cần chúng tôi giúp với việc chăm sóc sức khỏe của quý vị, trao đổi với chúng tôi, hoặc đọc những tài liệu chúng tôi gửi cho quý vị hay không? Chúng tôi cung cấp các tài liệu bằng các ngôn ngữ và định dạng khác, miễn phí cho quý vị. Hãy gọi cho chúng tôi theo số miễn phí 1-800-600-4441 (TTY 711).

Croatian

Da li vam je potrebna pomoć u zdravstvenoj zaštiti, pri razgovoru sa nama ili čitanju onoga što vam šaljemo? Nudimo naše materijale na drugim jezicima I u drugim oblicima bez ikakvih troškova za vas. Pozovite nas na besplatni telefon 1-800-600-4441 (TTY 711).

German

Benötigen Sie Hilfe bei Ihrer medizinischen Versorgung, der Kommunikation mit uns oder beim Lesen unserer Unterlagen? Unsere Materialien sind auf Anfrage auch in anderen Sprachen und Formaten kostenlos erhältlich. Rufen Sie uns gebührenfrei an unter 1-800-600-4441 (TTY 711).

Arabic

هل تحتاج إلى مساعدة في رعايتك الصحية أو في التحدث معنا أو قراءة ما نقوم بإرساله إليك؟ نحن نقدم المواد الخاصة بنا بلغات وتنسيقات أخرى بدون تكلفة عليك. اتصل بنا على الرقم المجاني 1-800-600-4441 (TTY 711)

Lao

ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອກ່ຽວກັບການເບິ່ງແຍງດູແລສຸຂະພາບຂອງທ່ານ, ລົມກັບພວກເຮົາ ຫຼື ອ່ານສິ່ງທີ່ພວກເຮົາສົ່ງໃຫ້ທ່ານບໍ? ພວກເຮົາສະໜອງເອກະສານຂອງພວກເຮົາໃຫ້ເປັນພາສາອື່ນ ແລະ ຢູ່ໃນຟໍແມັດຕ່າງໆໃຫ້ແກ່ທ່ານໂດຍບໍ່ເສຍຄ່າ. ກະລຸນາໂທຫາພວກເຮົາໄດ້ຟຣີທີ່ເບີ 1-800-600-4441 (TTY 711).

Korean

의료 서비스, 당사와의 소통 또는 당사에서 보내는 자료 읽기와 관련해 도움이 필요하십니까? 무료로 자료를 다른 언어나 형식으로 제공해 드립니다. 무료 전화 1-800-600-4441 (TTY 711).

Hindi

क्या अपनी स्वास्थ्य देखभाल के बारे में, हमसे बात करने के लिए या हमारे द्वारा भेजी गई सामग्री पढ़ने के लिए आपको सहायता चाहिए? हम आपको अपनी सामग्री अन्य भाषाओं और फ़ॉर्मेट में बिना किसी शुल्क के उपलब्ध कराते हैं। हमें टोल फ्री नंबर 1-800-600-4441 (TTY 711).

Vous avez besoin d’aide pour vos soins médicaux, pour communiquer avec nous ou pour lire les documents que nous vous envoyons ? Nous fournissons nos publications dans d’autres langues et sous d’autres formats, et c’est gratuit. Appelez-nous sans frais au 1-800-600-4441 (TTY 711). *French*

คุณต้องการความช่วยเหลือในการดูแลทางด้านสุขภาพของคุณ การพูดคุยกับเรา หรือการอ่านสิ่งที่เราส่งให้คุณหรือไม่ เรามีคู่มือของเราในภาษาและรูปแบบอื่นๆ ให้กับคุณโดยไม่เสียค่าใช้จ่าย โทรหาเราได้ฟรี 1-800-600-4441 (TTY 711). *Thai*

Kailangan ninyo ba ng tulong sa inyong pangangalagang pangkalusugan, sa pamamagitan ng pakikipag-usap sa amin, o pagbasa kung ano ang ipinapadala namin sa inyo? Nagbibigay kami ng aming mga materyal sa ibang mga wika at anyo na wala kayong gagastusin. Tawagan kami nang walang bayad sa 1-800-600-4441 (TTY 711). *Filipino*

နလိၣ်ဘၣ်တၢ်မၤစၢၤလၢနတၢ်ကွၢ်ထွဲတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အဂ့ၢ်, တၢ်ကတိၤတၢၤဉ်ပိၣ်သကိး တၢ်ဒီးပှၤ မ့တမ့ၢ် တၢ်ဖးတၢ်သ့ၣ်တဖၣ်လၢပဆုၢန့ၢ်နၤဓါ. ပအိၣ်ဒီးတၢ်ရဲၣ်ကျဲၤဟ့ၣ်လီၤပ တၢ်ဂ့ၢ်တၢ်ကျိၤတဖၣ်လၢကျိာ်ဒီးကွိၣ်ဒိအဂၤတဖၣ်လၢတဘၣ်လၢာ်စ့လၢနဂီၢ်နှၣ်လီၤ. ကိးလိ တဲစိဆူပအိၣ်ဒီးလိတဲစိကျိၤလၢတလၢာ်စ့ဖဲ 1-800-600-4441 (TTY 711) တကွၢ်. *Karen*

Вам нужна помощь с медицинским обслуживанием, консультацией или материалами, которые мы вам прислали? Мы можем бесплатно предоставить вам материалы на других языках и в других форматах. Позвоните в нам по бесплатному телефону 1-800-600-4441 (TTY 711). *Russian*

For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call 711.

Llame al 711, (teléfono de texto para personas con problemas de audición, del habla y ceguera) si necesita asistencia telefónicamente.

MEMBER HANDBOOK

IA-MHB-0015-20

TABLE OF CONTENTS

WELCOME

A Special Note from Amerigroup Iowa, Inc.

Welcome to Amerigroup Iowa, Inc. Thank you for being our member! As your managed care organization (MCO), we look forward to providing you with quality healthcare benefits and services.This member handbook helps you understand how to work with us and how to get healthcare for you or your family when you need it.

Your Amerigroup member identification (ID) card will be sent to you in a separate mailing. Please check your ID card as soon as you receive it. If any information is not right, please call us at 800-600-4441 (TTY 711). We'll send you a new ID card with the correct information.

When you join our plan, we'll ask you to complete a health risk assessment to help us learn about your health and arrange your care in a way that meets your individual needs. It's simple and only takes a few minutes to do. Your information will remain private. To complete it:

- Fill out and return the paper copy you receive in the mail in the postage-paid, self-addressed return envelope provided or
- Log in and complete the health risk assessment online at myamerigroup.com/IA

Based on your answers, you may qualify for case management. **There is no cost to you for this service**. Learn more about case management in the **Case Management** section of this document.

You can get Healthy Rewards debit card dollars for completing the health screener. Go to the **Value-Added Services** section of this document to learn more about Healthy Rewards.

Thank you again for being an Amerigroup member.

Important Contact Information

Amerigroup Member Services
800-600-4441
Hours of operation:

- Monday through Friday from 7:30 a.m. to 6 p.m. Central time, except for holidays.
- If you call after 6 p.m., leave a voicemail message, and one of our Member Services representatives will call you back the next working day.

Our Member Services representatives can answer your questions about how to get a new ID card, find a new primary care provider (PCP), and more.

Online tools available 24/7
Register online at myamerigroup.com/IA and:

- Change your PCP.
- Send us a secure message.
- Print your ID card.
- Tell us how you want to get information about your health plan — by mail or electronically.

Without logging in, you can always:

- View the latest provider directory and search for a PCP in our plan.
- Find helpful tips to stay healthy.

You can also email or send a letter to Member Services with questions or concerns at:

- Email: mpsweb@amerigroup.com
- Mail:
  Amerigroup Iowa, Inc.
  P.O. Box 62509
  Virginia Beach, VA 23466-2509

24-hour Nurse HelpLine
866-864-2544 (TTY 711)

24-hour Nurse HelpLine is here for you 24 hours a day, 7 days a week, 365 days a year. A nurse can:

- Help you set up an appointment with a doctor for an urgent medical issue.
- Answer your health questions.
- Give you advice on how soon you need to get care and how to take care of yourself before you see the doctor.

Non-Emergency Medical Transportation (NEMT): Access2Care
For reservations, call 844-544-1389.
For help with your ride, call Where's My Ride at 844-544-1390.

Call these numbers to arrange transportation to an IA Health Link-covered service or to learn how to get paid back for mileage, meals, or lodging for a medical appointment. Some limits apply.

Vision: Superior Vision
For vision services, call 800-879-6901.

State Contact Information

Iowa Medicaid Enterprise (IME) Member Services
800-338-8366
Call this number for MCO choice counseling and enrollment for IA Health Link members. IME Member Services can also help with premium payments and financial hardship requests for Iowa Health and Wellness Plan members.
Hours: Monday to Friday, 8 a.m. to 5 p.m.
You can also email IME Member Services at IMEMemberServices@dhs.state.ia.us.

Hawki Customer Service
800-257-8563
Call this number for MCO choice counseling and enrollment for Hawki members. Hawki Customer Service can also help with premium payments and questions.
Hours: Monday to Friday, 8 a.m. to 5 p.m.

Iowa Department of Human Services (DHS) Contact Center
855-889-7985
Call this number if you are new to Medicaid and have application questions.
Hours: Monday to Friday, 7 a.m. to 6 p.m.

Iowa Department of Human Services (DHS) Income Maintenance Customer Service Center
877-347-5678
Call this number to report changes for continued Medicaid eligibility, such as when employment starts and ends.
Find your local DHS office: https://dhs.iowa.gov/dhs_office_locator
Hours: Monday to Friday, 7 a.m. to 6 p.m.

Your ID Cards

If you're a new member, your Amerigroup member ID card is sent separately from your new member packet. You'll also get an Iowa Medicaid card. If you're enrolled in Medicare, you have an ID card through the Medicare program, too. It's important you carry your ID cards with you at all times. You'll need to show them each time you get medical care or fill prescriptions at a pharmacy.

Your Amerigroup ID card tells providers and hospitals:

- You're a member of our health plan.
- We'll pay for the medically necessary covered benefits listed in the section **Covered Benefits and Services.**

Your Amerigroup ID card shows:

- The name and phone number of your PCP (if you're not enrolled in Medicare).
- Your Medicaid or Hawki identification number.
- The date you became an Amerigroup member.
- Your date of birth.
- Your Amerigroup identification number.
- Phone numbers you need to know, such as:
  - Our Member Services department.
  - 24-hour Nurse HelpLine.
  - Getting help with finding a network vision care provider.
- What you need to do if you have an emergency.

Need your Amerigroup ID card right away but don't have it with you?
We offer printable ID cards — just log in to our secure website. Or get our free Amerigroup mobile app on your smartphone or tablet and:

- View your Amerigroup member ID card.
- View Amerigroup member ID cards for family members who live with you.
- Email or fax your card to your doctor, yourself, or someone else.

If your Amerigroup ID card is lost or stolen, call us right away at 800-600-4441 (TTY 711). We'll send you a new one.

ACCESSIBILITY

ACCESSIBLITY

We want to make sure you understand your benefits. If you have trouble reading what we send you or communicating with us, we can help.

To get a large print, braille, or an audio CD version of this handbook or any other written material, call Member Services at 800-600-4441 (TTY 711). We'll mail it to you, free of charge.

For members who don't speak English, we offer help in many different languages. Call Member Services to get any of these services at no cost to you:

- Over-the-phone interpreter services
- Interpretation at your doctor visits, within 24 hours' notice
- This member handbook or any other written materials in your preferred language

For members who are deaf or hard of hearing:

- Call 711 using a TTY relay service.
- We'll set up and pay for you to have a person who knows sign language help you during your doctor visits, with 24 hours' notice.

ELIGIBILITY

If you move

Call to report your new address to:

- The Department of Human Services, Income Maintenance Customer Call Center (DHS-IMCSC) at 877-347-5678, or
- Hawki Customer Service at 800-257-8563 (TDD 515-457-8051 or 888-422-2319)

You must first update your address with DHS at one of the phone numbers above. Then, call Amerigroup Member Services and let us know.

You'll continue to get healthcare services before and after your move.

If you are no longer eligible for Medicaid or Hawki

You'll be disenrolled from Amerigroup if you're no longer eligible for Medicaid or Hawki benefits. If you're ineligible for Medicaid for two months or less and then become eligible again, you'll be re-enrolled in Amerigroup. If possible, you'll be given the same primary care provider (PCP) you had when you were enrolled in Amerigroup before.

Renewal and changes in your coverage

Keep your health coverage! Renew your family's IA Health Link or Hawki benefits each year with these simple steps.

Step 1: Watch your mail

You'll receive a renewal form from the Iowa Department of Human Services (DHS).

- Look for your form up to 45 days before your coverage will end.
- Moved? Make sure DHS has your current address. Call 877-347-5678 if your address has changed.

Step 2: Complete the renewal form

Complete the renewal form when you receive it.

- Fill out all the information on each page.
- Be sure to sign the signature page.

Step 3: Return the renewal form

Return the form to DHS by the due date.

- Use the prepaid, self-addressed envelope you received with your form.

- Don’t have the envelope? You can mail the renewal form to the image center listed on the renewal form or return it to any DHS office.

You’re almost finished! Look for next steps in the mail from DHS.

- If DHS needs more information, you’ll receive a letter that tells you what they need.
- If DHS has all the information, you’ll receive a Notice of Action (NOA) that tells you if your coverage will change.

Not sure what you need to do? We can help. Call an Amerigroup retention specialist toll free at 877-269-5707 (TTY 711), or call the DHS Contact Center at 855-889-7985.

Change in benefits

Sometimes, Amerigroup may have to change the way we work, your covered services, or our network providers and hospitals. The Iowa Department of Human Services may also change the covered services that we arrange for you. If this happens, we’ll send you a letter telling you about changes to your plan benefits.

Notice of significant change about your PCP

Your PCP’s office may move, close or leave our plan. If this happens, we’ll tell you within 15 days of the change. We can help you pick a new PCP and send you a new ID card within five working days after you pick a new PCP. Call Member Services at 800-600-4441 (TTY 711).

IA HEALTH LINK

Most members who get health coverage from Iowa Medicaid are enrolled in the IA Health Link managed care program. A Managed Care Organization, or MCO, is a health plan that coordinates your care. Amerigroup Iowa, Inc. is your MCO. The benefits you receive from Amerigroup depend on the type of Medicaid coverage you have. To learn more about the benefits and services you may be able to get, refer to the **Covered Benefits and Services** section of this document.

IOWA HEALTH AND WELLNESS PLAN

The Iowa Health and Wellness Plan provides health coverage at low or no cost to Iowans. Members are between the ages of 19 and 64. Eligibility is based on household income. To learn more about the benefits and services you may be able to get, refer to the **Covered Benefits and Services** section of this document.

Healthy Behaviors for Iowa Health and Wellness Plan Members

Members in the Iowa Health and Wellness Plan can get free* healthcare if they complete what are known as Healthy Behaviors. To participate in the Healthy Behaviors program and avoid monthly payments after the first year, each year Iowa Health and Wellness Plan members must:

1. Get a Wellness Exam -OR- Get a Dental Exam
AND
2. Complete a Health Risk Assessment

Monthly Contributions

- Members will receive free* health coverage under the Iowa Health and Wellness Plan in their first year of eligibility.
- Members must complete their Healthy Behaviors in their first year, and every year after, to continue to receive free health services for the following year.
- Members who do not complete their Healthy Behaviors every year may be required to pay a small monthly contribution that depends on their family income.
- Monthly contributions are either $5 or $10, depending on a member's family income.
- Members who do not complete their Healthy Behaviors and do not pay their monthly bill after 90 days, depending on their income, may be disenrolled from the Iowa Health and Wellness Plan.

* There are very few, or no, costs for the first year and very few costs after that. A small monthly payment may be required based on income. There is an $8 copay for using the emergency room for non-emergency services.

Wellness Exam

In a wellness exam, your healthcare provider will do things like check your blood pressure and pulse, listen to your lungs with a stethoscope, recommend preventive screenings or take a blood sample to check your cholesterol.

Dental Exam
In a dental exam, your dentist will go over your dental health. You may receive a cleaning or basic X-rays.

Health Risk Assessment (HRA)
In addition to your Wellness Exam -OR- Dental Exam, you must also complete a Health Risk Assessment. Set aside 15–40 minutes to complete a survey that asks questions about your health and your experience in getting health services.

To complete your HRA contact Amerigroup Member Services: 800-600-4441 (TTY 711)

Financial Hardship
If you are unable to pay your contribution, you may check the hardship box on your monthly statement and return the payment coupon OR call the Iowa Medicaid Enterprise (IME) Member Services at 800-338-8366. Important: Claiming financial hardship will apply to that current month's amount due only. You will still be responsible for amounts due from past months. You will also be responsible for amounts due in future months unless you claim hardship in those months. Any payment that is more than 90 days past due will be subject to recovery and, depending on your income, you may be disenrolled.

Notice: Dental Wellness Plan members also have 'Healthy Behaviors' to complete for dental coverage. Find information on these in the 'Dental Benefit' section of this handbook.

Hawki

The Healthy and Well Kids in Iowa (Hawki) program offers health insurance to children who have no other health insurance. Members are under 19 years of age. Eligibility is based on household income. No family pays more than $40 per month. Some familiespay nothing at all. To learn more about the benefits and services you may be able to get, refer to the **Covered Benefits and Services** section of this document.

COVERED BENEFITS AND SERVICES

Medical benefits

Below is a summary of the healthcare services and benefits you have access to. Check the chart based on whether or not you're in IA Health Link, Iowa Health and Wellness Plan, or Hawki. Your primary care provider (PCP) will either:

- Give you the care you need or
- Refer you to a provider who can give you the care you need

Services ** prior authorization may be required*	IA Health Link	Iowa Health and Wellness Plan	Hawki
	Covered	Covered	Covered
1915(C) HOME- AND COMMUNITY-BASED SERVICES*	✓ Must meet the level of care for the specific waiver		
1915(I) HABILITATION SERVICES*	✓ Must meet the need-based eligibility criteria, with an income below 150 percent Federal Poverty Level (FPL)		
ABORTIONS	✓ Certain circumstances must apply. Contact Amerigroup Member Services.	✓ Certain circumstances must apply. Contact Amerigroup Member Services.	✓ Certain circumstances must apply. Contact Amerigroup Member Services.
ALLERGY TESTING AND INJECTIONS	✓	✓	✓
ANESTHESIA*	✓	✓	✓
ASSERTIVE COMMUNITY TREATMENT (ACT)	✓		

Services ** prior authorization may be required*	IA Health Link	Iowa Health and Wellness Plan	Hawki
	Covered	Covered	Covered
(b)(3) SERVICES (INTENSIVE PSYCHIATRIC REHABILITATION, COMMUNITY SUPPORT SERVICES, PEER SUPPORT, RESIDENTIAL SUBSTANCE USE TREATMENT, INTEGRATED SERVICES AND SUPPORTS, RESPITE)*	✓		
BARIATRIC SURGERY FOR MORBID OBESITY*	✓		✓
BEHAVIORAL HEALTH INTERVENTION SERVICES (INCLUDING APPLIED BEHAVIOR ANALYSIS)*	✓	✓ Residential not covered	
BREAST RECONSTRUCTION (FOLLOWING BREAST CANCER AND MASTECTOMY)*	✓	✓	✓ Limitations may apply.
CARDIAC REHABILITATION*	✓	✓	
CERTIFIED NURSE MIDWIFE SERVICES	✓	✓	✓
CHEMOTHERAPY*	✓	✓	✓
CHILD CARE MEDICAL SERVICES	✓		
CHIROPRACTIC CARE (LIMITATIONS APPLY)*	✓	✓	✓ Limitations may apply.
COLORECTAL CANCER SCREENING*	✓	✓	
COMMUNITY-BASED NEUROBEHAVIORAL SERVICES	✓	✓ **(Medically exempt only)**	
CONTRACEPTIVE DEVICES	✓	✓	✓

Services ** prior authorization may be required*	IA Health Link Covered	Iowa Health and Wellness Plan Covered	Hawki Covered
DIABETES EQUIPMENT AND SUPPLIES	✓ Medically necessary equipment and supplies and education services are covered.	✓ Medically necessary equipment and supplies and education services are covered.	✓
DIABETIC SELF-MANAGEMENT TRAINING	✓	✓	✓
DIAGNOSTIC GENETIC TESTING*	✓	✓	✓ Limitations may apply.
DIALYSIS	✓	✓	✓
DURABLE MEDICAL EQUIPMENT AND SUPPLIES (LIMITATIONS MAY APPLY; CONTACT AMERIGROUP MEMBER SERVICES*)	✓	✓	✓ Limitations may apply.
EMERGENCY ROOM SERVICES	✓ Nonemergent visits will be subject to copay.	✓ Nonemergent visits will be subject to copay.	✓ Emergency services for nonemergent conditions are subject to a $25 copay if the family pays a premium for the Hawki program.
EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)	✓ Covered up to age 21.	✓ Covered up to age 21.	
PRIVATE DUTY NURSING/PERSONAL CARES (EPSDT HOME CARE BENEFITS)	✓ Covered up to age 21.	✓ Covered up to age 21.	

Services ** prior authorization may be required*	IA Health Link	Iowa Health and Wellness Plan	Hawki
	Covered	Covered	Covered
EMERGENCY MEDICAL TRANSPORTATION	✓ Emergency transportation is subject to review for medical necessity.	✓ Emergency transportation is subject to review for medical necessity.	✓ Emergency transportation is subject to review for medical necessity.
FAMILY PLANNING-RELATED SERVICES AND SUPPLIES	✓	✓	✓
FOOT CARE (BY PODIATRISTS)	✓ Care must be related to a medical condition of the foot and/or ankle. Routine foot care services are not covered.	✓ Care must be related to a medical condition of the foot and/or ankle. Routine foot care services are not covered.	✓ Care must be related to a medical condition of the foot and/or ankle. Routine foot care services are not covered.
GENETIC COUNSELING*	✓ Covered with prior authorization.	✓ Covered with prior authorization.	✓ Limitations may apply.
GYNECOLOGICAL EXAM	✓	One visit per year covered.	✓
HEALTH HOMES, CHRONIC CONDITIONS HEALTH HOMES	✓	✓ Covered if member has been determined to be medically exempt.	
HEALTH HOMES, INTEGRATED HEALTH HOMES	✓	✓ Covered if member has been determined to be medically exempt.	
HEARING AIDS*	✓	✓ Covered for ages 19–20.	✓
HEARING EXAMS	✓	✓	✓

Services ** prior authorization may be required*	IA Health Link Covered	Iowa Health and Wellness Plan Covered	Hawki Covered
	One hearing exam per year covered.	One hearing exam per year covered.	
HOME HEALTH SERVICES* **(HOME HEALTH AIDE, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, SKILLED NURSING)**	✓ Limitations apply.	✓ Limitations apply.	✓
HOSPICE CARE* • **Daily Categories:** – Routine care – Facility respite or – Inpatient hospital • **Hourly Category:** – Continuous care (in home) • **Nursing Facility Room and Board:** – 95 percent of Nursing Facility daily rate in semi-private room	✓	✓	✓
ICF/ID (INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES)	✓ Level of care must be met.		
IMMUNIZATIONS (SHOTS) **Vaccines for children — covers shots for children up to age 21**	✓	✓ Travel immunizations are not covered.	✓
INJECTIONS (PHYSICIAN'S OFFICE AND HOSPITAL)	✓	✓	✓
LAB AND DIAGNOSTIC TESTS*	✓	✓	✓
MAMMOGRAPHY	✓	✓	✓
MATERNITY AND PREGNANCY SERVICES	✓	✓	✓

Services ** prior authorization may be required*	IA Health Link	Iowa Health and Wellness Plan	Hawki
	Covered	Covered	Covered
MENTAL/BEHAVIORAL HEALTH INPATIENT TREATMENT*	✓	✓ Residential treatment is not covered.	✓ Residential treatment is not covered.
MENTAL/BEHAVIORAL HEALTH OUTPATIENT TREATMENT*	✓	✓	✓
NEWBORN CHILD COVERAGE	✓	✓	✓
NONEMERGENCY MEDICAL TRANSPORTATION	✓		
NURSING FACILITY/NURSING FACILITY FOR THE MENTALLY ILL*	✓		
ORGAN/BONE MARROW TRANSPLANTS (WITH LIMITATIONS)	✓	✓	✓ Limitations may apply.
ORTHOTICS (SOME LIMITATIONS MAY APPLY)	✓	✓	✓ Limitations may apply.
OUTPATIENT SURGERY*	✓	✓	✓
OUTPATIENT THERAPY (PHYSICAL, OCCUPATIONAL, SPEECH, PULMONARY, RESPIRATORY)*	✓	✓ Limited to 60 visits per year.	✓ Limitations may apply.
OXYGEN THERAPY (INHALATION THERAPY)*	✓	✓ Limited to 60 visits in a 12-month period.	✓ Limitations may apply.
PAP SMEARS	✓	✓	✓
PATHOLOGY	✓	✓	✓
PELVIC EXAMS	✓	✓	✓
PHYSICIAN SERVICES, PCPs and SPECIALISTS	✓	✓	✓
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)	✓		

Services ** prior authorization may be required*	IA Health Link Covered	Iowa Health and Wellness Plan Covered	Hawki Covered
PREVENTIVE CARE	✓ ACA preventive services Routine checkups	✓ ACA preventive services Routine checkups Limitations may apply.	✓ Routine preventive physical exams, including well-child care and gynecological exams
PROSTATE CANCER SCREENING	✓	✓	
PROSTHETICS*	✓	✓	✓
RADIATION THERAPY*	✓	✓	✓
RECONSTRUCTIVE SURGERY (NON-COSMETIC)	✓	✓	To restore function lost or impaired as the result of illness, injury, or birth defect (even it there is an incidental improvement in physical appearance).
SECOND SURGICAL OPTION	✓	✓	✓
SEXUALLY TRANSMITTED INFECTION (STI) AND SEXUALLY TRANSMITTED DISEASE (STD) TESTING	✓	✓	✓
SKILLED NURSING FACILITY*	✓ Level of care must be met.	✓ Limited to 120 days.	✓
SLEEP STUDY TESTING*	✓	✓ Treatment for snoring is not covered. Claims must be for a diagnosis of sleep apnea.	✓

Services ** prior authorization may be required*	IA Health Link	Iowa Health and Wellness Plan	Hawki
	Covered	Covered	Covered
SPECIAL POPULATION NURSING FACILITY (SKILLED PREAPPROVAL)	✓ Amerigroup prior authorization required for this out-of-state benefit.		✓
SUBSTANCE USE DISORDER INPATIENT TREATMENT*	✓	✓	✓
SUBSTANCE USE DISORDER OUTPATIENT TREATMENT*	✓	✓	✓
TEMPOROMANDIBULAR JOINTS (TMJ) TREATMENT*	✓		✓ **Services are medically necessary; osteotomy is not covered.**
TOBACCO CESSATION — NICOTINE REPLACEMENT THEREAPY (NRT) PRODUCTS	✓	✓	✓ **Members must be age 18 to get NRT products**
TOBACCO CESSATION COUNCELING	✓	✓	✓
URGENT CARE CENTERS/FACILITIES EMERGENCY CLINICS (NON-HOSPITAL BASED)	✓	✓	✓
X-RAY PROCEDURES, ROUTINE AND ADVANCED PROCEDURES SUCH AS MRIs, CAT SCANS, AND PET SCANS*	✓	✓	✓

The list above does not show all your covered benefits. To learn more about your benefits, call Member Services at 800-600-4441 (TTY 711).

Prior authorizations

Some services and benefits require prior approval. This means your provider must ask Amerigroup to approve certain services or prescription drugs before you get them. Your provider will work with us to get any needed approvals.

If there are services that were approved before your health benefits started with us, those services will still be approved for the first 30 days you're enrolled with Amerigroup. This includes approvals for services from both providers who are or are not in our plan.

After the first 30 days you're enrolled in Amerigroup, if you wish to keep getting services from a provider who is not in our plan (out-of-network) or if the services require prior approval, your provider must ask us to approve them before you can get the services.

These services do not require prior approval:

- Emergency services
- Post-stabilization care (after you get out of the hospital)
- Urgent care
- Family planning services
- Routine provider visits with in-network providers in our plan (in-network)
  - Some tests or procedures may require prior approval.
- Certain behavioral health and substance use disorder services
  - Check first with your provider if prior approval is needed.
- Inpatient days, if involuntary detentions or commitments (96-hour detentions or court-ordered commitments) are in effect

To which services do or do not require prior approval, see the **Covered Benefits and Services** section. If you have questions about an approval request, call Member Services at 800-600-4441 (TTY 711).

If your provider asks for prior approval of a service and a decision is made that the service is not medically needed, your provider will have the chance to discuss this decision with Amerigroup. If the decision remains the same, you, your approved representative, or your provider on your behalf and with your written consent can appeal the decision. See the section, **Appeals** to learn more.
We'll let you know prior approval decisions no later than:

- Fourteen (14) calendar days after we get the request for standard approval
- Three (3) working days after we get the request for expedited (fast) approval

If you have a question about your benefits, call Member Services at 800-600-4441 (TTY 711) for help.

Vision benefits

Services	IA Health Link	Iowa Health and Wellness Plan	Hawki
	Covered	Covered	Covered
EYEGLASSES AND CONTACT LENSES	✓ New glasses are covered: • Up to three times per year for members up age 1 • Up to four times per year for members ages 3 • One pair per year for members ages 4–7 • One pair every 24 months for members age 8 or older Limitations may apply.	✓ • For members ages 19 up to 21, frames and lenses are covered.	✓ Frames or lenses are covered up to $100 a year.
VISION SERVICES	✓ One visit per year is covered.	✓ One visit per year is covered.	✓ One visit per year is covered.

Transportation benefits

IA Health Link members can call Access2Care toll free for help with getting a ride to nonemergent medically necessary appointments and treatments:

- Appointments can be in or out of the community where you live.
- Callers should be age 16 or older.
- Members age 11 and younger must ride with a parent or guardian.
- Members ages 12–16 must ride with a parent or guardian unless Access2Care has a signed Minor Consent form on file. Call Access2Care for a copy of the Minor consent form.
- Pregnant members of any age and emancipated minors can ride without a Minor Consent form.
- Rides must be set up at least 48 hours prior to the appointment.

To make a reservation, call 844-544-1389.
For information about your ride after you set it up, call Where's My Ride at 844-544-1390.

You can also call Member Services at 800-600-4441 (TTY 711) for help.

If you need to go to the pharmacy after a medical appointment
You can ask the Access2Care driver to stop at a pharmacy after a medical appointment to pick up prescriptions if the pharmacy is within 10 miles of your return address. The driver will wait, if possible. If not, call Where's My Ride at 844-544-1390 to schedule a pick-up.

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

- Be sure to tell the hospital staff you're an Amerigroup member.
- Get in touch with your PCP as soon as you can so your PCP can:
  - Arrange your treatment.
  - Help you get hospital care.

Dental benefits

Amerigroup only covers dental procedures done in a hospital setting.

Medicaid Dental Benefit: Dental services are available to Iowa Medicaid members age 18 and younger through the Iowa Medicaid Fee-for-Service (FFS) program. These services are not part of those provided by MCO. For questions about your dental benefits, call Iowa Medicaid Member Services at 800-338-8366.

Hawki Dental: Dental services are available to Hawki members through a dental carrier. The services are not part of those provided by the MCO. For questions about your dental benefits, call Hawki Customer Service at 800-257-8563.

Dental Wellness Plan: The Dental Wellness Plan provides dental coverage for adult Iowa Medicaid members age 19 and older. The services are not part of those provided by Amerigroup. Dental coverage is provided by a dental carrier. For questions about your dental benefits, call Iowa Medicaid Member Services at 800-338-8366 or visit https://dhs.iowa.gov/dental-wellness-plan.

Healthy Behaviors for Dental Wellness Plan Members

All Dental Wellness Plan members have full dental benefits during the first year. You must complete Healthy Behaviors during this year to keep your full benefits in the next year. Healthy Behaviors include completion of **both**:

1. Oral Health Self-Assessment
AND
2. Preventive Service

What Happens If I Don't Complete My Healthy Behaviors? Depending on your income, you may have to pay a monthly premium after the first year if you don't complete Healthy Behaviors. Complete Healthy Behaviors each year to waive your monthly premiums for the next year.

If you have a monthly premium after your first year and do not make payments, you will only have emergency dental benefits.

How Much Will I Have To Pay? Monthly premiums for the Dental Wellness Plan are no more than $3 per month. If you are unable to pay, you may check the hardship box on your monthly statement and return the payment coupon OR call Iowa Medicaid Member Services at 800-338-8366.

Notice: *Iowa Health and Wellness Plan members also have Healthy Behaviors to complete for medical coverage. Find information on these Healthy Behaviors in the 'Iowa Health and Wellness Plan' section of this handbook.*

GOING TO THE DOCTOR

Your Primary Care Provider (PCP)

Amerigroup members who aren't eligible for Medicare must have a family doctor. This doctor is called a primary care provider (PCP).

- Your PCP must be in our plan.
- Your PCP will give you a medical home. That means he or she will get to know you and your health history.
- Your PCP can help you get quality care.
- Your PCP will give you all of the basic health services you need. He or she will also send you to other doctors or hospitals when you need special medical services.

If you're re-enrolled in Amerigroup and not eligible for Medicare, you'll be assigned to the PCP you had before unless:

- You ask for a new PCP.
- The PCP has left our plan or reached the highest number of patients he or she can see.

Picking your PCP

Your PCP can be any of the following, as long as he or she is in our plan:

- Family or general practitioner
- Advanced registered nurse practitioner
- Internist
- Physician assistant (under the supervision of a physician)
- Pediatrician
- A physician specializing in geriatric care (caring for the elderly)
- Obstetrician or gynecologist
- Attending specialist (for members requiring specialty care for their acute or chronic conditions, or condition related to a disability)
- Federally Qualified Health Centers and Rural Health Clinics
- Indian Tribe, Tribal Organization or Urban Indian Organization

If you're already seeing a PCP, you can check the online provider directory to see if they are in our plan. If so, you can tell us you want to keep that PCP. Family members don't have to have the same PCP.

If you would like to learn more about providers who are in our plan, please call Member Services at 800-600-4441 (TTY 711) or view our provider directory online at myamerigroup.com/IA. We can also help you pick a PCP.

An obstetrician and/or gynecologist as a PCP
Female members can see an obstetrician and/or gynecologist (OB/GYN) in our plan for OB/GYN health needs. You also don't need a referral from your PCP to see a plan OB/GYN. These services include:

- Well-woman visits.
- Prenatal care.
- Care for any female medical condition.
- Family planning (you can also see a provider not in our plan (non-network) for this service).
- Referral to a special provider in our plan.

If you don't want to go to an OB/GYN, your PCP may be able to treat you for your OB/GYN health needs. Ask them if they can give you OB/GYN care. If not, you'll need to see an OB/GYN.

While pregnant, your OB/GYN can be your PCP if he or she agrees to. Our nurses can help you decide if you should see your PCP or an OB/GYN. To speak with a nurse, call our 24-hour Nurse HelpLine at 866-864-2544.

If you need help picking an OB/GYN, go online to our provider directory at myamerigroup.com/IA or call Member Services.

Picking a PCP for your newborn
Expectant moms can choose a PCP for their newborns by calling Member Services at 800-600-4441 (TTY 711). If you don't choose a PCP for your newborn, we'll assign one for you. You can always choose a new PCP by going online to myamerigroup.com/IA or by calling Member Services for help.

If you're an American Indian or an Alaskan Native
You may use an Indian Health Services or Tribal 638 provider anytime you wish. You may also choose a PCP from the Amerigroup network that is not an Indian Health or Tribal 638 provider, and Amerigroup will pay for your care.

Notice of significant change about your PCP
Your PCP's office may move, close, or leave our plan. If this happens, we'll tell you within 15 days. We can help you pick a new PCP and send you a new ID card within five working days after you pick a new PCP. Call Member Services at 800-600-4441 (TTY 711).

If you had a different primary care provider before you joined Amerigroup
You may have been seeing a PCP who is not in our plan for an illness or injury before you joined Amerigroup. In some cases, you may be able to keep seeing this PCP for care while you pick a new one.

- Call Member Services to find out more.
- Amerigroup will make a plan with you and your providers. We'll do this so we all know when you need to start seeing your new PCP.

If you want to go to a doctor who is not your PCP

If you want to go to a doctor who is not your PCP, talk to your PCP first. You may need a referral. A referral means that your PCP must give you approval to see someone that is not your PCP. If you don't get approval, we may not cover the services. There are certain specialists in which you do not need a referral, such as women's health specialists.

Second opinion

You have the right to ask for a second opinion about a diagnosis, the options for surgery or other treatment options for a health condition. You can get a second opinion from a provider in our plan. If a plan provider is not available, you can go to one not in our plan (non-network provider).

Ask your PCP to submit a request for you to have a second opinion. This is at no cost to you. Once the request for a second opinion is approved:

- Your PCP will let you know the date and time of the appointment.
- Your PCP will also send copies of medical records to the doctor who will provide the second opinion.

Your PCP will let you and Amerigroup know the outcome of the second opinion.

Changing your PCP

If you need to change your PCP, you may pick a new one in our plan. Either:

- Go to myamerigroup.com/IA to view the provider directory online, or
- Call Member Services for help or to request a provider directory at 800-600-4441 (TTY 711).

When you ask to change your PCP:

- We can make the change the same day you ask for it.
- The change will be effective no later than the next calendar day.
- You'll get a new ID card in the mail within five working days after your PCP has been changed.

Call the PCP's office if you want to make an appointment. The phone number is on your new Amerigroup ID card. If you need help, Member Services can help you make the appointment.

Your PCP asks for you to change to another PCP

They may do this if:

- Your PCP doesn't have the right experience to treat you.

- The assignment to your PCP was made in error (like an adult assigned to a child's PCP).
- You fail to keep your appointments.
- You don't follow their medical advice over and over again.
- Your PCP feels that a change is best for you.

Going to Your PCP

Once you become our member, you should make an appointment with your PCP. Call your PCP for a wellness visit (a general checkup) within 90 days of enrolling with us. If you want our help setting up your first visit, just call Member Services.

If you had been seeing your PCP before you joined our plan, call them to see if it's time for a wellness visit. If it is, set it up with your PCP as soon as you can.

Going to your PCP for wellness visits helps your PCP learn about your health and find or prevent health issues before they start. Your PCP can provide preventive services, including an assessment or screening of possible risk for certain diseases or conditions.

How to make an appointment

It's easy to set up a visit with your PCP.

- The phone number is on your Amerigroup ID card.
- Let the person you talk to know what you need (for example, a checkup or a follow-up visit).
- When your PCP's office is closed, an answering service will take your call and should call you back within 30 minutes.

If you need help, call Member Services. We'll help you make the appointment.

What to bring when see your PCP

When you go to your PCP's office for your visit, be sure you bring:

- Your ID card.
- Any medicines you are currently taking.
- Names and phone numbers of other providers you see regularly.
- Any questions you may want to ask your PCP.

If the appointment is for your child, be sure you bring your child's:

- ID card.
- Shot records.
- Any medicine he or she is currently taking.

Cancelling an appointment with any provider

If you make an appointment with a provider and can't make it:

- Call their office at least 24 hours before you're supposed to be there. This will let someone else see the provider at that time.
- Tell the office to cancel the visit.
- Make a new appointment when you call (if needed).
- If you set up a ride to get to your provider's office, call Access2Care and let them know your appointment has been canceled. You can schedule a ride to your new appointment (if needed) by calling 844-544-1389.

If you don't call to cancel appointments or you don't show up to your appointments on a regular basis, your provider may ask for you to be changed to a new one.

Wait times for appointments and transportation

You'll be able to see providers as follows. For members who live in nursing facilities, the nursing facility is responsible for transportation within 30 miles of the facility.

Amerigroup appointment wait times	
Emergency medical services appointment wait times	
Type of service	**How soon you'll see a provider after requesting an appointment**
Facilities with emergency medical services	Available 24 hours a day, 7 days a week
Follow-up emergency room (ER) visits	According to ER attending provider's discharge orders
Visits to your primary care provider appointment wait times	
Type of service	**How soon you'll see a provider after requesting an appointment**
Routine, nonurgent, or preventive care visits	Within 3 weeks of request for an appointment
Urgent care	Within 1 day of request

Pregnancy-related services appointment wait times	
Type of service	**How soon you'll see a provider after requesting an appointment**
Newly enrolled pregnant women within their first trimester	Within 14 days of request
Newly enrolled pregnant women in the second trimester	Within 7 days of request
Newly enrolled pregnant women in the third trimester	Within 3 working days of request or immediately if an emergency
High-risk pregnancy	Within 3 working days of request or immediately if an emergency
Postpartum exam	Between 3 to 8 weeks after delivery
Behavioral health services appointment wait times	
Type of service	**How soon you'll see a provider after requesting an appointment**
Care for non-life-threatening emergency	Within 6 hours
Urgent care	Within 24 hours
Initial visit for routine care	Within 3 weeks
Follow-up routine care	Within 3 weeks

Amerigroup transportation wait times

Long-term care services transportation wait times

Type of transportation service	How long you'll wait for your ride
Service standards for transport time to medical appointments	• 15-minute leeway before and after pick-up time for scheduled, nonemergency appointments • 60-minute leeway before and after pick-up time for non-scheduled, nonemergency appointments

Behavioral health services transportation wait times

Type of transportation service	How long you'll wait for your ride
Service standards for transport time to medical appointments	• 15-minute leeway before and after pick-up time for scheduled, nonemergency appointments • 60-minute leeway before and after pick-up time for nonscheduled, nonemergency appointments
Behavioral health services	• Emergency — within 15 minutes of presentation at a service delivery site • Nonemergency: – 15-minute leeway before and after pick-up time for scheduled, nonemergency appointments – 60-minute leeway before and after pick-up time for nonscheduled, nonemergency appointments

Hospital care transportation wait times

Type of transportation service	How long you'll wait for your ride
Service standards for transport time to medical appointments	• 15-minute leeway before and after pick-up time for scheduled, nonemergency appointments • 60-minute leeway before and after pick-up time for nonscheduled, nonemergency appointments

Vision services transportation wait times	
Type of transportation service	**How long you'll wait for your ride**
Service standards for transport time to medical appointments	• 15-minute leeway before and after pick-up time for scheduled, nonemergency appointments • 60-minute leeway before and after pick-up time for nonscheduled, nonemergency appointments

Lab and X-ray services transportation wait times	
Type of transportation service	**How long you'll wait for your ride**
Service standards for transport time to medical appointments	• 15-minute leeway before and after pick-up time for scheduled, nonemergency appointments • 60-minute leeway before and after pick-up time for nonscheduled, nonemergency appointments

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

Except in the case of an emergency (see previous section) or when you need care that does not need a referral, you should always call your PCP **first** before you get medical care. If you call your PCP's office when it is closed, leave a message with your name and phone number. Or call 24-hour Nurse Helpline at 866-864-2544 for help.

If it's an emergency, call 911 or go to the nearest emergency room right away.

How to get healthcare when you are out of town

If you need emergency services when you are out of town or outside of Iowa, go to the nearest hospital emergency room or call 911.

If you are outside of the United States and get healthcare services, they will not be covered by Amerigroup or fee-for-service Medicaid.

If you need urgent care:

- Call your PCP. If your PCP's office is closed, leave a phone number where you can be reached. Your PCP or someone else should call you back.
- Follow your PCP's instructions. You may be told to get care where you are if you need it right away.
- Call 24-hour Nurse HelpLine at 866-864-2544 if you need help.

If you need routine care like a checkup:

- Call your PCP.
- Call 24-hour Nurse HelpLine at 866-864-2544 if you need help.

How to get healthcare when you cannot leave your home

If you cannot leave your home, we will find a way to help take care of you. Call Member Services right away. We will put you in touch with a case manager who will help you get the medical care you need.

Specialists

Your primary care provider (PCP) can take care of most of your healthcare needs, but you may also need care from other kinds of providers. Amerigroup offers services from many different kinds of providers who provide other medically necessary care. These providers are called specialists because they have training in a special area of medicine.

Examples of specialists are:

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

Your PCP will refer you to a specialist in the network if he or she feels it's needed.

Sometimes, a specialist can be your PCP. This may happen if you have a special healthcare need that should be taken care of by a specialist. If you believe you have special healthcare needs, you can:

- Talk to your PCP.
- Call Member Services.

If you can't get a covered service you need from a provider in our plan, we'll still cover the service through a provider not in our plan. We'll make sure your cost (if any) is no more than what it would be if the service was through a plan provider.

PHARMACY

Prescriptions

We arrange your pharmacy benefits, and we cover:

- Medically necessary prescribed drugs.
- Some over-the-counter drugs (see the section **Over-the-Counter Medicines** to learn more).

You can get prescriptions filled at any pharmacy in our plan including most major chains and many independent community pharmacies.

For a complete list of pharmacies in our plan:

- Go to myamerigroup.com/IA to view the provider directory online, or
- Call Member Services to request a provider directory.

If you don't know if a pharmacy is in our plan, ask the pharmacist or call Member Services at 800-600-4441.

Getting your prescriptions filled is easy!

Medicines work best when you take them the way your doctor prescribed. Part of that is making sure you get them refilled on time. To fill your prescriptions:

- Take the prescription from your provider to the pharmacy; or your provider can call in the prescription.
- Show your Amerigroup member ID card to the pharmacy.
- If you use a new pharmacy, tell the pharmacist about all of the medicines you're taking including over-the-counter (OTC) medicines, too.

It's good to use the same pharmacy each time. This way, your pharmacist:

- Will know all the medicines you are taking.
- Can watch for problems that may occur.

You can get prescriptions delivered to your home with IngenioRx Home Delivery Pharmacy. To order your prescriptions:

- Visit myamerigroup.com/IA.
- Call 833-203-1737.

There may be limitations on the types of drugs covered.

The Preferred Drug List

The preferred drug list (PDL) is a list of drugs recommended to the Iowa Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that have been identified as being therapeutically equivalent within a drug class, and that provide cost benefits to the Medicaid program. You, your doctor or your child's doctor, and your pharmacy have access to this drug list, located at iowamedicaidpdl.com.

A drug listed on the PDL as preferred means it provides medical equivalency in a cost-effective manner and does not require prior authorization. A preferred drug is designated "P" on the PDL.

The recommended drug list is a voluntary list of drugs recommended to the Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee informing prescribers of cost effective alternatives that do not require prior authorization.

A recommended drug is a drug on a voluntary list designed to inform prescribers of cost-effective alternatives and does not require prior authorization. If used, the recommended drug will result in cost savings to the Medicaid program. A recommended drug is designated "R" on the PDL.

Medication Therapy Management

Based on your use of prescription medicines, you may be asked to have a Medication Therapy Management (MTM) consult with a pharmacist. During this time, the pharmacist will review the medicines you take and look for ways to:

- Make your medicines safer.
- Help you get the most value from your medicines to help improve your health.
- Provide tips to help you remember to take your medicines.

Lock-in Program

Members who use covered services or items in a way that is considered overuse may be locked in to getting them from assigned providers. If you're placed in the Lock-in

program, we'll send you a letter to let you know. You'll be assigned to a team that will include:

- A primary care provider (PCP) to arrange your medical care.
- One pharmacy to fill your prescriptions.
- One hospital for emergent needs that can't be treated by your PCP.

If you're placed in the Lock-in program and have questions, please call Amerigroup Member Services at 800-600-4441 (TTY 711).

Over-the-Counter (OTC) Medicines

We cover many OTC medicines at no cost when your doctor writes a prescription. Take your prescription to any network pharmacy to fill. Remember to show your Amerigroup member ID card.

For a complete list of covered OTCs, go to myamerigroup.com/IA or call Member Services at 800-600-4441 (TTY 711).

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EMERGENCY AND URGENT CARE

Emergencies

What is an emergency? An **emergency** is when you need to get care right away. If you don't get care, it could cause your death or cause very serious harm to your body.

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

- Trouble breathing
- Chest pains
- Loss of consciousness
- Bleeding that doesn't stop
- Very bad burns
- Shakes called convulsions or seizures

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

You should be able to see a provider right away.

If you want advice about emergency care, call your PCP or 24-hour Nurse HelpLine at 866-864-2544 (TTY 711). Medical emergencies don't need prior approval.

After you visit the emergency room:

- Call your PCP as soon as you can.
- If you can't call, have someone else call for you.

Urgent Care

Some injuries and illnesses are not emergencies but can turn into emergencies if they aren't treated within 48 hours. This type of care is called **urgent care**. Some examples are:

- Throwing up
- Minor burns or cuts
- Earaches
- Headaches
- Sore throat
- Fever over 101 degrees Fahrenheit
- Muscle sprains/strains

If you need urgent care:

- Call your PCP. Your PCP will tell you what to do.
- Follow what your PCP says. Your PCP may tell you to go to:
  - His or her office right away.
  - Some other office to get care right away.
  - The emergency room at a hospital for care.

You can also call 24-hour Nurese HelpLine at 866-864-2544 if you need advice about urgent care.

Hospital Services

The following hospital services are covered:

Services ** prior authorization may be required*	Medicaid	Iowa Health and Wellness Plan	Hawki
	Covered	Covered	Covered
HOSPITAL INPATIENT SERVICES* • **ROOM AND BOARD (SEMI-PRIVATE)** • **MISCELLANEOUS**	✓	✓	✓

Routine Care

In most cases, when you're not feeling well and need medical care, you call your primary care provider (PCP) to make an appointment. Then you go to see your PCP. This type of care is known as **routine care**. Some examples are:

- Most minor illnesses and injuries.
- Regular checkups.

But this is only part of your PCP's job. Your PCP also takes care of you before you get sick. This is called **wellness care**. See the section **Wellness care for children and adults**.

Post-stabilization Care

Post-stabilization care services are Amerigroup-covered services you get after emergency medical care. You get these services to:

- Help keep your condition stable, or
- Improve or resolve your condition.

This includes all medical and behavioral health services that may be needed.

Call your PCP within 24 hours after you go to the emergency room. If you can't call, have someone call for you. Your PCP will give or arrange any follow-up care you need.

Coverage guidelines for post-stabilization services include coverage for:

- Services Amerigroup or a plan provider pre-approves, whether received in or out of the plan.
- Services Amerigroup doesn't pre-approve, whether received in or out of the plan, if Amerigroup doesn't respond and approve the services asked for within one hour of the request for approval.
- Added services needed to keep your condition stable that aren't pre-approved by Amerigroup within one hour of the request for approval.
- Services when:
  - Amerigroup can't be contacted or doesn't respond within one hour of the request for prior approval.
  - Amerigroup and the treating provider can't agree on your care and a network provider isn't free for consult; if this occurs, we'll give the treating provider the chance to consult with a network provider, and the treating provider may continue your care until a network provider is reached or one of the following conditions is met:
    - A network provider with privileges at the treating hospital becomes responsible for your care.
    - Amerigroup and the treating provider reach an agreement concerning your care.
    - You are discharged; if the treating hospital or facility and Amerigroup don't agree on whether you are stable enough for transfer or discharge, or the medical benefits of transferring you outweigh the risks, if you're not stable enough for transfer, the judgment of the attending provider(s) caring for you at the treating facility will be followed; if you are being discharged from a hospital or other inpatient setting and home health services are needed upon discharge, we can request those services for you.

You will not pay any amount greater than what you would pay if the services were provided by an Amerigroup provider.

For locations where you can go for emergency or post-stabilization care:

- Register at myamerigroup.com/IA and search for a location or view the latest provider directory online, or
- Call 24-hour Nurse HelpLine at 866-864-2544 (TTY 711).

MEMBER COSTS

Copays

A copay is a set dollar amount you pay when you get certain services or treatment. It's your share of the cost for covered healthcare services.

The only services in which a copay may apply are nonemergency ER visits:

- Iowa Health and Wellness Plan members will be charged an $8 copay for each visit to the emergency room that is not considered an emergency.
- Hawki members will be charged a $25 copay for each visit to the emergency room that is not considered an emergency.
- All other Iowa Medicaid members will be charged a $3 copay for each nonemergency visit to the emergency room.

There are no other copays under your Amerigroup health plan.

- Your Amerigroup ID card has information on copays.
- You're responsible to pay the copays listed on your ID card to the provider of service.
- If you think you paid more than five percent of your family's income for the calendar quarter on healthcare (copays or premium payments), call Member Services at 800-600-4441 (TTY 711). We can tell you the amount you paid in copays, if any. If you're a Hawki member and have questions about premium payments, call Hawki Customer Service at 800-257-8563.

  Quarter periods are:
  - January–March 31
  - April–June 30
  - July–September 30
  - October–December 31

Copays don't apply to American Indian, Alaskan Native, pregnant members, and Medicaid members under age 21.

If you receive a service from a provider and we don't pay for that service, you may receive a notice from us called an Explanation of Benefits (EOB). **This is not a bill.** The EOB will tell you:

- The date you received the service.
- The type of service.
- The reason we cannot pay for the service.

If you receive an EOB:

- **You don't need to call or do anything at that time.**
- You aren't liable for payment.
- It tells you how you can appeal this decision.

Member Liability/Client Participation

Some members have a member liability, also called client participation. This means you must pay for part of the cost of your services. The member liability must be met before Medicaid pays for covered services. This includes certain members eligible for Medicaid as follows:

- Members in an institutional setting
- 1915(c) home- and community-based services waiver members

If you have a member liability, your provider will collect this amount from you at the time services are received.

VALUE-ADDED SERVICES

VALUE-ADDED SERVICES

Amerigroup offers extra benefits to eligible members. These extra benefits are called value-added services. Call Member Services at 800-600-4441 (TTY 711) to learn more about these benefits. We offer the following:

Amerigroup value-added services		
SERVICE NAME	**SERVICE DESCRIPTION**	**HOW TO GET SERVICES**
ALL MEMBERS		
DENTAL HYGIENE KIT **Who is eligible:** All Amerigroup members	Taking care of your teeth and gums is an important part of being healthy. That's why we will provide you with a dental hygiene kit every year. These kits have educational materials and supplies like: **For members from birth through age 1:** • Educational materials on dental health for young children • Children's toothpaste • A child's toothbrush **For members ages 2–11:** • Kid-focused educational materials and activities • Children's toothpaste • A child's toothbrush **For members ages 12 and older:** • Toothpaste • A toothbrush • Dental floss • Kits, available in soft or medium brush type	Log on to the Benefit Reward Hub to redeem your value added benefits and view the benefits you're eligible for at myamerigroup.com/IA or call Member Services at 800-600-4441 (TTY 711). *Limitations and restrictions apply. Benefits may change.*

Amerigroup value-added services		
SERVICE NAME	**SERVICE DESCRIPTION**	**HOW TO GET SERVICES**
AMERIGROUP COMMUNITY RESOURCE LINK **Who is eligible:** All Amerigroup members	We offer an easy-to-use online resource so you can easily find free and low-cost services available in your community. Amerigroup Community Resource Link is searchable by ZIP code and has information about programs and events offered near you.	Visit myamerigroup.com/IA. If you can't get on a computer or smartphone with Internet service, call Member Services at 800-600-4441 (TTY 711). They'll be happy to help.
HOME-DELIVERED MEALS **Who is eligible:** Amerigroup members who have been recently discharged from the hospital and are deemed eligible by a case manager	When you leave the hospital, we don't want you to worry about anything but getting better. If you were recently discharged, we'll have meals for you and three family members delivered straight to your door for up to five days.	Please tell your case manager if you would like this benefit. They will let you know if you are eligible and give you more information.
AMERIGROUP MOBILE PROGRAM We want to help you stay connected! If you have SafeLink as your Lifeline Assistance carrier, you get extra minutes just for being our member. Our mobile health program includes: • Mobile health coaching programs.	Choose the Lifeline service that's right for you! If you qualify for the federal Lifeline Assitance program, you could bet extra minutes if you have have SafeLink as your Lifeline carrier. Amerigroup members who have SafeLink get: • 200 bonus minutes when you enroll with Amerigroup. • 100 bonus minutes during your birth month. The bonus minutes are in addition to:	To get Lifeline services through SafeLink, you can apply: • **Online**: Visit safelinkwireless. com and apply online. • **By mail**: Complete/return SafeLink application in the prepaid postage envelope.

Amerigroup value-added services		
SERVICE NAME	**SERVICE DESCRIPTION**	**HOW TO GET SERVICES**
• Tips and reminders via text for you and your family to stay healthy. **Who is eligible:** Amerigroup members or the parent or guardian of an Amerigroup member get free support from our mobile health program if you qualify for free mobile phone service from the federal Lifeline Assistance program.	• 1000 monthly minutes. • 1.5 GB of data*. • Unlimited text messages. • Free calls to Member Services. Already have Lifeline? You may be able to switch from your current Lifeline carrier to SafeLink. *If you keep your own smartphone, you will get 1.5 GB of data for the first three months, and 1 GB of data starting on the fourth month.	• **By phone**: Call 877-631-2550 and apply over the phone. Lifeline Assistance is a government assistance program and is non-transferable. Enrollment is available to individuals who qualify based on federal or state-specific eligibility criteria. You may qualify based on: • Household income, or • If you or a member of your household participates in certain public assistance programs. You may need to provide proof of income or proof of program participation. The Lifeline Assistance program is available for only one wireless or wireline account per household.

Amerigroup value-added services		
SERVICE NAME	**SERVICE DESCRIPTION**	**HOW TO GET SERVICES**
ADULTS OVER 18		
WW® (FORMERLY CALLED WEIGHT WATCHERS) **Who is eligible:** Amerigroup members who are: • 18 or older. • Diagnosed as obese by their doctor. • Referred by their case manager or treating provider.	We know it can be hard to lose weight, but we can help! With Amerigroup, you can get a WW voucher to help you develop a healthy lifestyle and meet your weight-loss goals. With this voucher, you'll get: • No sign-up fees. • 13 weeks of free weight management classes.	Call Member Services at 800-600-4441 (TTY 711) and let us know that you would like the voucher. If you are eligible, we will mail your voucher to your home address.
Medline deluxe electric breast pump kit **Who is eligible:** Pregnant women or breastfeeding women who have delivered within the past six months.	We want to support your choice to breastfeed. This extra benefit includes Medline's custom lightweight, portable pump with single and double pumping capability with quiet motor. A tote bag with breast shields, bottle and bottle supplies, cooler bag, 2 ice packs and 9V AC adapter are also included. One year warranty.	Member may request a pump by phone or online: • Phone: 833-881-1424 • Complete the application online at: athome.medline.com/amerigroupia Member will need to provide the following: • State and health plan/insurance information • Contact information Medline will tell members when the pump will ship with tracking information

Amerigroup value-added services		
SERVICE NAME	**SERVICE DESCRIPTION**	**HOW TO GET SERVICES**
		once it's confirmed they're eligible.
PERSONAL EXERCISE KIT **Who is eligible:** Amerigroup members who are: • 18 or older. • Diagnosed as obese. • Referred by their case manager or treating provider.	Getting regular exercise is good for your body and mind. With Amerigroup, you can get a personal exercise kit to help you get moving at home. Your kit will include equipment to help you: • Maintain muscle tone while increasing strength, flexibility and mobility. • Improve your overall health. * Exercise kit, which may include a duffle bag, towel, water bottle, and pedometer.	Log on to the Benefit Reward Hub to redeem your value added benefits and view the benefits you're eligible for at myamerigroup.com/IA or call Member Services at 800-600-4441 (TTY 711). *Limitations and restrictions apply. Benefits may change.*
HELP GETTING READY FOR THE HIGH SCHOOL EQUIVALENCY TEST (HiSET) **Who is eligible?** Any Amerigroup member, 18 or older, who has not completed high school.	We want to help you pass the High School Equivalency Test (HiSET). We'll cover the cost of a prep course, and after you pass the prep course, we'll give you a voucher so you can take the test for free.	Call Member Services at 800-600-4441 (TTY 711).
FOR KIDS		
FREE BOYS & GIRLS CLUB MEMBERSHIP	Children should have a safe place to get active, make friends and have fun. Boys & Girls Clubs offer all of this and more to kids in your community. And with Amerigroup,	Show your Amerigroup member ID card at your local participating Boys & Girls Club.

Amerigroup value-added services		
SERVICE NAME	**SERVICE DESCRIPTION**	**HOW TO GET SERVICES**
Who is eligible: All Amerigroup members ages 6–18	you can get a membership, worth up to $40, for free.	Call Member Services at 800-600-4441 (TTY 711) for a list of participating clubs in your area.
HEALTHY FAMILIES PROGRAM **Who is eligible:** All Amerigroup families with children ages 7–17 who are one of the following: • Overweight • Obese • At risk for becoming overweight or obese • Interested in taking part in weight management, increasing their activity level, or developing healthier nutrition habits	Healthy Families is a six-month program designed to help families with overweight or obese children form healthier habits. You'll learn about the importance of good nutrition and exercise, with: • Help from a health coach you can call to get health tips and advice. • Educational materials to help your family learn how to eat and live healthier.	If your family qualifies for the Healthy Families program, we may call you and ask if you'd like to join. If you do, we'll give you all the information you need to get started. If you don't get a call from us and you'd like to join the Healthy Families program, call us at 888-830-4300 (TTY 711). Let us know you'd like to be a part of the program. If your family qualifies, we'll help you get started.
COMFORT ITEM **Who is eligible:** All IA Health Link Amerigroup members participating in one of these waiver programs: • Foster Care	Moving around can be tough, especially for children.The comfort item is a "buddy" that offers soothing and calmness in difficult and traumatic situations, while promoting a sense of stability. Members may choose a stuffed animal or journal.	Log on to the Benefit Reward Hub to redeem your value added benefits and view the benefits you're eligible for at myamerigroup.com/IA or call Member Services at 800-600-4441 (TTY 711).

Amerigroup value-added services		
SERVICE NAME	**SERVICE DESCRIPTION**	**HOW TO GET SERVICES**
• Subsidized Adoptions		*Limitations and restrictions apply. Benefits may change.*
CERTAIN WAIVER AND OTHER PROGRAM MEMBERS		
SELF-ADVOCACY MEMBERSHIPS **Who is eligible:** Amerigroup members participating in one of these waiver programs: • Brain Injury • Health and Disability • Intellectual Disability • Physical Disability	Want to improve your public speaking skills? Learn about how to keep a job? Know more about your rights as a person with disabilities? There are organizations in Iowa that coach people with disabilities on how to live a full, independent life. We offer eligible members some money every year to use to attend a conference or event sponsored by: • Iowans with Disabilities in Action • NAMI-Iowa • Area Agencies on Aging You can also get a yearly membership in one of these advocacy groups: • National Council on Independent Living • TASH • Self-Advocates Becoming Empowered • Autistic Self-Advocacy Group	You can call Member Services at 800-600-4441 (TTY 711) and request a membership.
COMMUNITY REINTEGRATION	Moving from a facility to a home-based setting?	You must have approval from your case manager.

Amerigroup value-added services		
SERVICE NAME	**SERVICE DESCRIPTION**	**HOW TO GET SERVICES**
Who is eligible: Amerigroup members: • Participating in a Home- and Community-based Services (HCBS) waiver program and currently residing in a nursing facility or • An ICF/ID eligible member who wishes to transition back into a homebased setting and whose needs are greater than the current benefits offered through the Money Follows the Person program.	We will help make the change easier. Eligible members can get a one-time benefit up to $2,500 to help with the move. The benefit can be used on expenses such as: • Household goods • Deposits for utilities • Rent	Please call your case manager if you would like help moving home from a facility. She or he will let you know if you are eligible and work with you to decide what kind of help and services you need.

Healthy Rewards

Our Healthy Rewards program rewards you for doing things that are good for your health. You can earn $5–$50 for your efforts to stay healthy. Your Healthy Rewards dollars can be redeemed for gift cards from a variety of merchants and retails such as Amazon, Target, Kohl's, Home Depot, Domino's, Subway, Uber, and more!

To enroll in Healthy Rewards and see which activities you qualify for, log in to your Amerigroup account at myamerigroup.com/IA and visit the Benefits page to navigate to the Healthy Rewards portal. Or, to find out more about the Healthy Rewards program, you can also call 888-990-8681 Monday through Friday from 8 a.m. to 7 p.m. Central time.

Limitations and restrictions apply. You must be enrolled in Healthy Rewards to earn rewards. Rewards are subject to change.

Amerigroup Healthy Rewards			
Incentive	**Population**	**Individual Amount**	**Limits**
For all members			
Complete the Health Risk Assessment (HRA) within 90 days of enrollment with Amerigroup	All members	$25	One per member within the first 90 days of enrollment
Complete the Health Risk Assessment (HRA) each year	All members	$25	One per member each year
For adults			
Fill antidepressant medication prescription	For members ages 18 or older	$10	Once per quarter to encourage consistent refills
High blood pressure medication refill	For members ages 18–75	$10	Up to once per quarter to encourage consistent refills
Get a flu shot	For members age 21 years and older	$10	Once every 12 months
Complete annual wellness visit	For members ages 21 and older	$25	Once every 12 months
For children			
Complete 6 well-baby visits within the first 15 months of life	For members ages 0 to 15 months	$50	One-time award upon completion of all well-baby visits through 15 months of life

Amerigroup Healthy Rewards			
Incentive	**Population**	**Individual Amount**	**Limits**
Complete 2 well-child visits	For members ages 15 months to 2 1/2 years	$25	One-time award upon completion of all well-child visits between the ages of 15–30 months of life
Complete annual well-child visit	For members ages 3 to 21 years	$25	Once every 12 months
Get all recommended childhood vaccines (Combo 10 — see page 67 for which ones)	For members ages zero through 24 months (by their 2nd birthday)	$25	One-time award upon completion of all vaccines and doses
Get all recommended adolescent vaccines (Combo 1 — see page 67 for which ones)	For members ages 11 to 13	$25	One-time award upon completion of all vaccines and doses
For members with diabetes (excluding gestational diabetes)			
Complete blood sugar (HbA1c) screening	For members ages 18–75 with diabetes	$25	Once every 12 months
Complete a diabetic eye exam (retinal)	For members ages 18–75	$25	Once every 12 months
Complete the Diabetes Education quiz	For members ages 18–75	$5	Once every 12 months
For women			
Complete breast cancer screening	For members ages 50–74	$50	Once every 24 months
Complete first prenatal care visit during 1st	Pregnant women	$25	Once per pregnancy

Amerigroup Healthy Rewards			
Incentive	**Population**	**Individual Amount**	**Limits**
trimester or within 42 days of enrollment			
Complete postpartum visit between 7 and 84 days after delivery	Pregnant women	$50	Once per pregnancy

WELLNESS CARE

Wellness Care for Adults

Staying healthy means seeing your primary care provider (PCP) for regular checkups.

Use the following chart to make sure you are up-to-date with your yearly wellness exams.

WELLNESS VISITS SCHEDULE FOR ADULT MEMBERS

Males and Females of All Ages

EXAM TYPE	WHO NEEDS IT?	HOW OFTEN?
Blood Pressure Check	Members age 18 and over High blood pressure is 140/90 or higher	Every two years if 120/80 or below
		Every year if 120/80 or higher
Cholesterol Screening	At-risk members: age 20 and over Men age 35 and older should be screened for lipid disorders. At-risk members should begin screenings at age 20. Women age 45 and older should be screened for lipid disorders. At-risk members should begin screenings at age 20.	As recommended by your PCP
Diabetes Screening	At-risk members	As recommended by your PCP
Colorectal Cancer (CRC) Screening	Members age 50 and over	As recommended by your PCP
	At-risk members: May need to begin screenings before age 50	

WELLNESS VISITS SCHEDULE FOR ADULT MEMBERS		
Males and Females of All Ages		
EXAM TYPE	**WHO NEEDS IT?**	**HOW OFTEN?**
Other Cancer Screenings	Based on members' personal health history	As recommended by your PCP
Depression	Members should talk to their PCP if they have been feeling down or sad	Ask for a referral
Problem Drinking and Substance Use Disorder Screening	Members should share any history of drug or alcohol use with their PCP	Ask for a referral
Females		
Pap Test	Women ages 21-65	Every 3 years
Chlamydia Test	Women under age 24 who are sexually active	As recommended by your PCP
	Women age 24 and older who are at increased risk	
Mammogram	Most doctors recommend a mammogram screening every one to three years for members age 50 and older	As recommended by your PCP
Osteoporosis Testing	Women: under age 65	As recommended by your PCP
	Age 65 and older	At least once
Males 50-65 and Older		
Screening for Sexually Transmitted Diseases (STDs)	At-risk men	As recommended by your PCP
Screening for Abdominal Aortic Aneurysm	Men ages 65–75 who have ever smoked	One-time screening

Wellness Care for Children

Children need more wellness visits than adults. IA Health Link and Hawki offer wellness visits for children. Your child may have special needs or an illness like asthma or diabetes. If so, one of our case managers can help your child get checkups, tests, and shots. Your child can get checkups from his or her PCP or any provider in our plan. You don't need a referral for these visits.If you or your child doesn't get a wellness visit on time:

- Set up a visit with the PCP as soon as you can
- Call Member Services if you need help setting up the visit

Well-child care in your baby's first year of life

The first well-child visit will be in the hospital. This happens right after the baby is born. For the next seven visits, you must take your baby to his or her PCP's office.

Set up a visit with the doctor when the baby is:

- Between 2–5 days old
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old

At these wellness visits, your baby's PCP will:

- Make sure your baby is growing well.
- Help you care for your baby, talk to you about what to feed your baby, and how to help your baby go to sleep.
- Discuss how your baby grows and develops at different stages and what you can do to help and how to prevent childhood accidents and diseases.
- Answer questions you have about your baby.
- See if your baby has any problems that may need more healthcare.
- Give your baby shots that will help protect him or her from illnesses.

Well-child care in your baby's second year of life

Starting in your baby's second year of life, he or she should see the doctor at least four more times at:

- 15 months
- 18 months
- 24 months
- 30 months*

Well-child care for children ages 3 through 20

Your child should see the doctor again at ages 3, 4, 5, and 6. Your child should see his or her PCP at least one time each year for a well-child checkup.

Be sure to set up these visits. It's important to take your child to his or her PCP when scheduled.

Blood lead screening
Your child's PCP will give your child a blood lead test at ages 1, 2, and 3 unless your child's PCP decides it should be done at other times. Your child's PCP will also give your child blood lead tests between 3 and 6 years of age if he or she hasn't been tested before.

Your child's PCP will take a blood sample by pricking your child's finger or taking blood from his or her vein. The test will tell if your child has lead in his or her blood.

Vision screening
Your child's PCP should:
- Check your child's vision at every well-child visit.
- Perform a vision screening starting at age 3 and every year after the initial screening.

Hearing screening
Your child's PCP should:
- Check your child's hearing at every well-child visit.
- Perform a hearing screening starting at age 3 and every three years after the initial screening.

Dental screening
Your child's PCP should check your child's teeth and gums as part of each well-child visit. Children should start seeing a dentist when they get their first tooth or before their first birthday. Your child should then keep seeing a dentist every six months.

Immunizations (shots)
It's important for your child to get shots on time. Follow these steps:
1) Take your child to the doctor when his or her PCP says a shot is needed.
2) Use the following chart as a guide to help keep track of the shots your child needs.

You can also find easy-to-read immunization charts for all ages on the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/vaccines/schedules.

IMMUNIZATION (SHOT) SCHEDULE FOR CHILDREN															
AGE ➡ VACCINE ⬇	Birth	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	19–23 mo	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–18 yrs
Hepatitis B	HepB	HepB			HepB								HepB Series if not given		
Rotavirus			RV	RV	RV, if needed										
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP			DTaP				DTaP	Tdap if not given	Tdap	Tdap if not given
Haemophilus influenzae type b			Hib	Hib	Hib if needed		Hib								
Pneumococcal			PCV	PCV	PCV		PCV				PPSV if high-risk		PPSV if high-risk		
Inactivated Poliovirus			IPV	IPV	IPV							IPV	IPV Series if not given		
Influenza					Influenza (Yearly)								Influenza (Yearly)		
Measles, Mumps, Rubella							MMR					MMR	MMR Series if not given		
Varicella							Varicella					Vari-cella	Varicella Series if not given		
Hepatitis A							HepA (2 doses)				HepA Series if high-risk				
Meningococcal						MCV4 if high-risk								MCV4	MCV4 if not given (booster at age 16)
Human Papillomavirus														HPV (3 doses) (both males and females)	HPV 3-dose Series if not given

CARE FOR PREGNANT MEMBERS

Taking Care of Baby and Me® is the Amerigroup program for all pregnant members. It's very important to see your primary care provider (PCP), obstetrician or gynecologist (OB/GYN) for care when you're pregnant. This kind of care is called **prenatal care**. It can help you have a healthy baby. Prenatal care is always important even if you've already had a baby. With our program, members receive health information and rewards for getting prenatal and postpartum care.

Our program also helps pregnant members with complicated healthcare needs. Nurse case managers work closely with these members to provide:

- Education.
- Emotional support.
- Help in following their doctor's care plan.
- Information on services and resources in your community, such as transportation, WIC, home-visitor programs, breastfeeding support, and counseling.

Our nurses also work with doctors and help with other services members may need. The goal is to promote better health for members and the delivery of healthy babies.

Quality care for you and your baby

We want to give you the very best care during your pregnancy. That's why we invite you to enroll in My Advocate®, which is part of our Taking Care of Baby and Me program. My Advocate gives you the information and support you need to stay healthy during your pregnancy.

Get to know My Advocate

My Advocate delivers maternal health education by phone, text message, web, and smartphone app that's helpful and fun. You'll get to know MaryBeth, My Advocate's automated personality. MaryBeth will respond to your changing needs as your baby grows and develops. You can count on:

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

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

Helping you and your baby stay healthy

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

- Pregnancy and postpartum care.
- Well-child care.
- Dental health.
- Immunizations.
- Healthy living tips.

When you become pregnant

If you think you're pregnant:

- Call your PCP or OB/GYN doctor right away. You don't need a referral from your PCP to see an OB/GYN doctor.
- Call Member Services if you need help finding an OB/GYN in the Amerigroup network.

When you find out you're pregnant, you must also call Amerigroup Member Services.

We'll send you a pregnancy education package. It will include:

- A letter welcoming you to the Taking Care of Baby and Me program.
- A self-care book with information about your pregnancy; you can also use this book to write down things that happen during your pregnancy.
- A *Labor, Delivery and Beyond* booklet with information on what to expect during your third trimester.
- The Taking Care of Baby and Me reward program brochure.
- A My Advocate flier that tells you about the program and how to enroll and get health information to your phone by automated voice, text message or smartphone app.
  - *Having a Healthy Baby* brochure with helpful resources such as CenteringPregnancy and the importance of a flu shot.

While you're pregnant, you need to take good care of your health. You may be able to get healthy food from the Women, Infants, and Children (WIC) program if you qualify for

Medicaid. Member Services can give you the phone number for the WIC program close to you. Just call us at 800-600-4441 (TTY 711).

When you're pregnant, you must go to your PCP or OB/GYN at least:
- Every four weeks for the first six months.
- Every two weeks for the seventh and eighth months.
- Every week during the last month.

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

When you have a new baby

When you deliver your baby, you and your baby may stay in the hospital at least:
- 48 hours after a vaginal delivery.
- 72 hours after a cesarean section (C-section).

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

After you have your baby, you must:
- Call Amerigroup Member Services as soon as you can to let your case manager know you had your baby. We'll need to get details about your baby.
- Call the DHS Contact Center at 855-889-7985 to apply for Medicaid for your baby.

After you have your baby

Amerigroup will send you the Taking Care of Baby and Me postpartum education package after you have your baby. It will include:
- A letter welcoming you to the postpartum part of the Taking Care of Baby and Me program.
- A baby-care book with information about your baby's growth; you can also use this book to write down things that happen during your baby's first year.
- Taking Care of Baby and Me reward program brochure about going to your postpartum visit and taking your baby to his or her well-child visits.
- A brochure about postpartum depression.
- A brochure with information on making a family life plan.

If you enrolled in My Advocate and received health promotion calls during your pregnancy, you will still get these calls while enrolled in the program for up to 12 weeks after your delivery.

It's important to set up a visit with your PCP or OB/GYN after you have your baby for your postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.

- Your doctor will want you to be seen within three weeks of delivery for an initial visit and will schedule a follow-up visit as needed. A follow-up visit is usually between 256 days after delivery.
- Your doctor may want to see you sooner than three weeks if you had certain issues before or during delivery such as high blood pressure or if you have a cesarean section (c-section).

The Neonatal Intensive Care Unit (NICU)

If your baby is admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program. Parents receive education and support to be involved in the care of their babies, visit the NICU, interact with hospital care providers, and prepare for discharge. Call Amerigroup Member Services for more information.

CASE MANAGEMENT

Case management
We provide case management for eligible members. We know everyone's health is different. Our case managers can help you understand your ongoing health conditions and help you learn how to care for them. If you think you could benefit from case management, we'll refer you to a case manager.

Our case managers will:
- Ask you about your health, your health supporters, and lifestyle needs.
- Explain how the program can help.
- Ask if you'd like to sign up.

Your case manager will work with you and your family to:
- Set up a plan of care (with input from your doctor) to help you live life to the fullest.
- Set up healthcare services.
- Get referrals and preapprovals.
- Send records to your other doctors (when they need them).
- Review your plan of care as needed.

We also have complex case management for certain members with unique health and wellness needs. We may call you about this program if you need more help with:
- Serious physical problems.
- Mental health conditions.

If you think you need case management or complex case management, call Member Services at 800-600-4441 (TTY 711).

We identify possible members for case management through our internal referral processes, from providers, and when a member or their caregiver requests case management.

Through this process, a case manager will work with you and your family (or a representative) to review your strengths and needs. The review should result in a service plan that:
- You, your family or representative, and case manager agree on.
- Meets all your needs (medical, functional, social and behavioral health) in the most unified setting.

The case manager can help with:

- Assessing your healthcare needs.
- Developing a plan of care.
- Giving you and your family the information and training needed to make informed decisions and choices.
- Giving providers the information they need about any changes in your health to help them in planning, delivering, and monitoring services.

To collect and assess this information, your case manager will conduct phone interviews or home visits with you or your representatives. To complete the assessment, the case manager will also get information from your primary care provider, specialists, and other sources to set up and decide your current medical and nonmedical service needs.

BEHAVIORAL HEALTH

Behavioral health issues are very common. With treatment, most people can get better. If you feel you may have a behavioral health issue, such as a mental health or substance use disorder, the best thing you can do is get help. Your PCP can help you figure out what help is right for you. You can also seek help from:

- Any one of several behavioral health professionals.
- An Amerigroup clinical associate.

Getting help from a behavioral health professional

You don't need a referral to see a behavioral health professional. You can simply call and make an appointment. To find a community mental health center or substance use disorder provider near you, call Member Services at 800-600-4441 (TTY 711) for help.

Getting help from an Amerigroup clinical associate

You can also get help from an Amerigroup clinical associate. You don't need a referral. You can call 24-hour Nurse HelpLine toll free at 866-864-2544. We can:

- Help in a crisis; if you have a serious, life-threatening emergency, you or your family member or caregiver should call 911 right away.
- Help if you have a less serious condition; our Member Services staff can:
  - Talk with you, your family or your caregiver, as fitting, about your needs.
  - Help you get the help you need quickly.
- Help if you have a less urgent need; we can give you:
  - The names and phone numbers of helping agencies in your area and
  - The name of a behavioral health professional who will see you if you need one.

  You don't need a referral from your PCP.
- Help if you need special clinical and therapy services for conditions like autism; to find out how to access the clinical and therapy services from an autism specialist, call Member Services toll free at 800-600-4441 (TTY 711).
- Give you help finding the Community Mental Health Center nearest you; call us toll free at 800-600-4441 (TTY 711).
- Answer your questions about the covered services you are eligible to receive.

Your first visit with a behavioral health provider

During your first visit, the provider will ask a lot of questions. He or she will do this to try to understand the best way to help you. Many people get anxious or forget what they

want to get from this visit. So here are some helpful tips to follow before and after your first visit:

How to prepare for the first visit

- Write down what is bothering you and what you'd like help with.
- Think of things your family and friends have brought up that you may need help with.
- Think of questions you and your family may have; write them down so you can mention them when you see your provider.
- If you wish, bring a friend or family member to support you; he or she can stay in the waiting room if you wish or come in to help you discuss your needs.

What to expect after the first visit

- Be sure to leave the provider's office with a clear plan of next steps for getting help; this will usually include a follow-up appointment.
- If you or a family member starts a new behavioral health medicine, expect to see your provider:
  - One to three weeks later and
  - No more than one month later.

  Your provider should set up this appointment before you leave the office; if this is not the case, call Member Services at 800-600-4441 (TTY 711) for help.

Follow-up visits with a behavioral health provider

To get the best help, you should:

- See your behavioral health provider on a regular basis.
- Follow the steps you and your provider agreed upon; this includes:
  - Taking medicines regularly and as prescribed.
  - Letting your provider know right away if you don't wish to take the prescribed medicines or have bad side effects; he or she will work with you to find a new way to help you get well or stay well.
  - Letting your provider know if a treatment is not working for you; he or she will work with you to set up a different type of treatment.

If you wish to change your provider, you may do so. We'll be happy to help you find a new provider to meet your needs. But as a rule, changing providers a lot is not helpful. This means you have to start over with someone new.

Keeping yourself well

Once you're feeling better, it's helpful to write down all the things that helped you get better and stay better. You can write down:

- All the things you would like to do the next time you're feeling bad, and
- All the things you would like to do to stop yourself from feeling worse.

This is called a **recovery plan**. It can help you keep in mind what to do the next time you start to feel bad.

Make sure your recovery plan includes these steps:

- Take care of your physical health; catching an illness early means you are less likely to get hurt by the illness.
- Try to schedule a visit with your PCP at least once a year.
- Make sure your behavioral health provider or PCP checks your weight and blood pressure.
- Follow up with your behavioral health provider or PCP to see if you need to get regular screens for diabetes, cholesterol and/or cancer.
- If you're taking certain medicines such as antipsychotics or if you have been told you have symptoms of schizophrenia and bipolar disorder, or get at least yearly screens for diabetes and cholesterol problems; your behavioral health provider or PCP can help you get these screenings. You can also call us for help at 800-600-4441.

Behavioral health covered services

Your provider may refer you for some kinds of behavioral health services. Most services that are medically necessary are covered; these services do not need initial prior approval. You do not need a referral from your PCP to get these services. To learn more on what services are covered, see the section **Your Healthcare Benefits**.

Inpatient behavioral health services

These services are covered and can be accessed through:

- Your behavioral health provider.
- Your PCP.
- Amerigroup.

If you or a family member needs inpatient behavioral healthcare, call Amerigroup Member Services toll free at 800-600-4441. If you or your family member is admitted to an inpatient behavioral health unit, let your providers know:

- What they can do to help you get and stay better.
- What medicines you may take and how these medicines affect you.
- The outpatient providers you see and the people who help and support you.

Before you leave an inpatient setting, you should be given a discharge sheet. This sheet:

- Tells you what you can do to stay well once you leave the hospital

- Should include an appointment to see an outpatient provider within seven days of discharge; **if you are not given this appointment, call us toll free at 800-600-4441 for help**.

LONG-TERM SERVICES AND SUPPORTS (LTSS)

Long-Term Services and Supports (LTSS) service coordination

Our service coordination program offers individualized services to support the behavioral, social, environmental and functional needs of members who are:

- Part of an HCBS waiver program.
- Nursing facility residents.
- Skilled nursing facility (SNF) residents.
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) residents.
- Residents in a nursing facility for the mentally ill (NF/MI).

What does service coordination mean to you?

It means a person-centered approach to coordinating your services to make sure your needs are met. Service coordination includes but is not limited to:

- Identifying your needs
- Conducting a health assessment
- Deciding a course of action
- Coordinating necessary services

What can you expect from your LTSS Community-Based Case Manager (CBCM)?

Your LTSS community-based case manager will:

- Conduct face-to-face meetings at your home to assess your physical, behavioral, functional, social, and long-term services and supports needs.
- Include your family members, caregivers and natural supports to help assess your needs, if you approve.
- Work with you, your family members, and natural supports to develop a service plan to address your individual needs identified during your meetings.
  - You will receive a comprehensive assessment once a year, or if you have a significant change in your health needs.
- Help coordinate timely access to services.
- Coordinate services that meet your medical and functional needs.

We help you get the care and support you need

Long-term services and supports

With Amerigroup, you have a team of people working with you to support your physical, behavioral, functional, social, and long-term services and supports needs. Your LTSS community-based case manager:

- Visits you in your home to assess your long-term services and supports needs.

- Collects information to help you get the right kind of care and access needed and preferred services.
- Creates a services plan with you and the people who are important to you.
- Supports you to ensure access to services.

Your LTSS community-based case manager will:

- Work closely with you to make sure you are aware of all resources available to you in your community.
- Have access to information to help you make better health decisions and meaningful lifestyle choices and ensure better health outcomes.

We can also help if you have questions about your benefits and services through Amerigroup. You can reach us Monday through Friday from 7:30 a.m. to 6 p.m. Central time. Call 800-600-4441 (TTY 711).

Integrating physical healthcare

Your LTSS community-based case manager will:

- Coordinate services that are medically needed, including:
  - Durable medical equipment.
  - Inpatient and outpatient services.
- Make you aware of special programs (some nationally certified) such as diabetes management, depression, asthma, and more.

Integrating behavioral healthcare

Your LTSS community-based case manager can arrange access to behavioral health case management services that address:

- Behavioral health concerns
- Substance use disorder programs, and
- Services offered by Community Mental Health Centers for members and their family support systems.

Accessing services

Your LTSS community-based case manager will help you get the care and services you need by:

- Adding services to your existing plan of care when you need them.
- Providing support and offering creative thinking on resources offered in your community.
- Making sure you have access to benefits and services such as transportation, dental care, medical checkups, behavioral healthcare, and respite care, plus the extra benefits we offer.
- Helping you get prescriptions filled and solve any problems with your pharmacy.
- Helping you order over-the-counter items (e.g., Tylenol, lotion, etc.).

Home- and Community-Based Services (HCBS)

Home- and Community-Based Services are available to people who are eligible for the following programs:

- AIDS/HIV Waiver
- Brain Injury Waiver
- Children's Mental Health Waiver
- Elderly Waiver
- Habilitation
- Health and Disability Waiver
- Intellectual Disability Waiver
- Physical Disability Waiver

AIDS/HIV Waiver

AIDS/HIV Waiver services may be available to people who:

- Are diagnosed by a physician as having AIDS or HIV infection.
- Are determined to need ICF or hospital level of care.

Based on your assessed needs, covered services may include:

AIDS/HIV Waiver Services
• Adult day care • Consumer-directed attendant care • Counseling services • Home-delivered meals • Home health aide • Homemaker services • Nursing care • Respite • Consumer choices option

Brain Injury Waiver

Brain Injury (BI) Waiver services may be available to people who are:

- Determined to have a brain injury diagnosis, as defined under the Iowa Administrative Code.
- Determined to need Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) level of care.
- At least 1 month of age.

Based on your assessed needs, covered services may include:

Brain Injury Waiver Services
• Adult day care • Behavioral programming • Consumer-directed attendant care • Family counseling and training • Home and vehicle modifications • Interim medical monitoring and treatment • PERS (Personal emergency response system) • Prevocational services • Respite • Specialized medical equipment • Supported community living • Supported employment • Transportation • Consumer Choices Option

Children's Mental Health Waiver

Children's Mental Health (CMH) Waiver services may be available to people who:

- Are aged from birth to age 18.
- Have a diagnosis of serious emotional disturbance as verified by a psychiatrist, psychologist, or mental health professional within the past 12 months.
- Are determined to need hospital level of care.

Based on your assessed needs, covered services may include:

Children's Mental Health Waiver Services
• Environmental modifications, adaptive devices, and therapeutic resources • In-home family therapy • Family and community supports • Respite

Elderly Waiver

Elderly Waiver services may be available to people who are:

- Age 65 or older.
- Determined to need ICF or skilled level of care.

Based on your assessed needs, covered services may include:

Elderly Waiver Services
• Adult day care • Assistive devices • Assisted living • Chore services • Consumer-directed attendant care

Elderly Waiver Services
• Emergency response system • Home and vehicle modifications • Home-delivered meals • Home health aide • Homemaker services • Mental health outreach • Nursing care • Nutritional counseling • Respite • Senior companions • Transportation • Consumer Choices Option

Habilitation

Habilitation services may be available to people who experience functional limitations typically associated with chronic mental illness.

Based on your assessed needs, covered services may include:

Habilitation Waiver Services
• Home-based habilitation (hourly and daily services) • Day habilitation • Prevocational • Supported employment

Health and Disability Waiver

Health and Disability (HD) Waiver services may be available to people who:

- Are under age 65 and blind or determined disabled by receipt of Social Security disability benefits or through the Iowa Department of Human Services' disability decision process.
- Are ineligible for Supplemental Security Income (SSI) if over age 21; members receiving HD Waiver services when reaching age 21 may continue to be eligible, regardless of SSI eligibility until they reach age 25.
- Meet all nonfinancial requirements for Medicaid.
- Are determined to need Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) level of care.

Based on your assessed needs, covered services may include:

Health and Disability Waiver Services
• Adult day care • Consumer-directed attendant care

Health and Disability Waiver Services
• Counseling services • Home and vehicle modifications • Home-delivered meals • Home health aide • Homemaker services • Interim medical monitoring and treatment • Nursing services • Nutritional counseling • Personal Emergency Response System (PERS) • Respite • Consumer Choices Option

Intellectual Disability Waiver

Intellectual Disability (ID) Waiver services may be available to people who:

- Have a diagnosis of intellectual disability as decided by a psychologist or psychiatrist.
- Are determined to need ICF/ID level of care.

Based on your assessed needs, covered services may include:

Intellectual Disability Waiver Services
• Adult day care • Consumer-directed attendant care • Day habilitation • Home and vehicle modifications • Home health aide • Interim medical monitoring and treatment • Nursing • PERS • Prevocational services • Respite • Supported community living • Supported community living — residential based • Supported employment • Transportation • Consumer Choices Option

Physical Disability Waiver

Physical Disability (PD) Waiver services may be available to people who:

- Have a physical disability.
- Are ages 18 to 64.
- Are determined blind or disabled by receipt of Social Security disability benefits or through the Iowa Department of Human Services' disability determination process.

Based on your assessed needs, covered services may include:

Physical Disability Waiver Services
• Consumer-directed attendant care • Home and vehicle modification • PERS • Specialized medical equipment • Transportation • Consumer Choices Option

CONSUMER CHOICES OPTION

In Iowa, there are two self-direction programs:

- Consumer Choices Option (CCO) program
- Consumer-Directed Attendant Care (CDAC) program (see the next section)

These programs:

- Allow individuals with a disability to self-direct services — you can choose services and employees to help better suit your needs, separate from the traditional services you receive.
- Give members more choice, control, and flexibility over their services — you can choose to take part in or withdraw from consumer direction of home- and community-based services (HCBS) at any time.

With the Consumer Choices Option (CCO) program, you have:

- Control over your Medicaid waiver dollars so you can set up a plan to meet your needs by:
  - Hiring your own employees directly and/or
  - Purchasing other goods and services.
- An Independent Support Broker (ISB) to help you develop a budget based on the monthly funds approved by your case manager.

To participate in the CCO program, you must:

- Live in the state of Iowa.
- Be eligible for HCBS services (excluding the Children's Mental Health Waiver and Habilitation).
- Complete the Self-assessment form with your ISB and Amerigroup Community-Based Case Manager.

If you choose the CCO, you can get extra help. You must choose an ISB and use them at least quarterly to help you:

- Create your own budget.
- Hire employees.

You must also work on a monthly basis with a qualified Financial Management Services (FMS) provider who will:

- Manage your budget for you, and

- Pay your workers on your behalf.

See the section **Financial Management Services** to learn more.

We work with Veridian Fiscal Solutions to manage the CCO program. As the Financial Management Services provider for the program, Veridian will work with you to:

- Help you complete your enrollment in the program, including processing background checks on the workers you choose to hire.
- Verify that all required documents you and the ISB provide are processed and CCO services can begin.
- Enter the budget you and the ISB develop in the Veridian system.
- Arrange for payment to workers on your behalf, including:
  - Processing approved timesheets you submit to Veridian for payment and
  - Reconciling differences with timesheets or payments.

To learn more about:

- The CCO program, visit dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option.
- Veridian Fiscal Solutions, visit veridianfiscalsolutions.org/cco.

Financial Management Services

Financial Management Services (FMS) are offered to members getting self-directed services through these HCBS waiver programs:

- AIDS/HIV
- Brain Injury
- Elderly
- Health and Disability
- Intellectual Disability
- Physical Disability

When you or your representative chooses an FMS provider, you or your representative must be fully informed by the FMS provider of your rights and responsibilities to:

- Choose and direct support services.
- Choose and direct the workers who provide the services.
- Perform the roles and responsibilities as an employer.
- Know the roles and responsibilities of the FMS provider.
- Get initial and ongoing skills training as asked for.

Once fully informed, you or your representative must discuss, review, and sign an FMS Service Agreement, which is:

- Set up and offered by the state of Iowa, and

- Distributed by the FMS provider.

The FMS Service Agreement will:

- Name your and your FMS provider's negotiated roles and responsibilities, and
- State the responsibilities of each party.

If you or your representative decides to self-direct any part of your HCBS services, you must work closely with FMS to know:

- Your rights and responsibilities.
- The FMS provider's rights and responsibilities.

Below is a guide to help you when hiring a business or individual to perform:

- Self-directed personal care services.
- Individual-directed goods and services.
- Self-directed community supports and employment.

A business must:

- Have all required licenses and permits to operate that follow federal, state, and local laws.
- Have current liability and workers' compensation coverage.

An individual must:

- Have all required licenses and permits to operate, based on federal, state, and local laws, including a valid driver's license if giving rides.

All personnel must:

- Meet the minimum age requirement.
  - At least age 16 for self-directed personal care services
  - At least age 18 for individual-directed goods and services and self-directed community supports and employment
- Be able to communicate with you successfully so you understand.
- Not get respite services paid through home- and community-based services on your behalf, if you get these services.
- Not get respite services paid through the consumer choice option on your behalf, if you get this option.
- Not be the parent or stepparent of a minor child member or spouse of a member.

You can choose to self-direct some or all eligible waiver services.

You, or the responsible party who has the right to direct services, can decide to:

- No longer self-direct services, and
- Receive prior approved waiver services without penalty.

To find out more, go to http://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option.

CONSUMER-DIRECTED ATTENDANT CARE

With the Consumer-Directed Attendant Care (CDAC) program, you can choose which services you want to be self-directed; you can:

- Choose whether to use an independent CDAC provider or one affiliated with an agency.
- Develop a plan of care with the interdisciplinary team.
- Using the budget approved in the service plan, complete the Consumer-Directed Attendant Care Agreement and establish service hours to be worked and the employee payment rate.
  - Sign the agreement; make sure the employee signs it, too.
  - Give a copy to the CBCM.
- Approve employee timesheets; make sure:
  - They are correct and in line with the service authorization, and
  - Employees submit their monthly timesheet directly to Amerigroup for claims reimbursement.
- Let employee and CBCM know if there are any changes or concerns.

The CDAC program can be for skilled and unskilled services:

- Unskilled services include help with normal daily life activities such as:
  - Getting dressed and undressed.
  - Cleaning up for meals.
  - Getting into and out of bed.
  - Scheduling appointments.
  - Communicating with others.
  - Going to the doctor.
  - Fixing meals.
  - Handling money.
  - Taking a bath.
  - Shopping.
  - Taking medicine.
  - Running errands.
  - Housekeeping.
- Skilled services are more medical in nature; a licensed nurse or therapist must supervise the provider who does these things for you; examples of skilled services are:

- Monitoring medicines.
- Post-surgical nursing care.
- Parenteral injections.
- Recording vital signs.
- Tube feedings.
- Catheter care.
- Colostomy care.
- Therapeutic diets.
- Intravenous therapy.

Like the CCO program, the CDAC program gives you the chance to be in charge of hiring your own employees:

- The employee must be at least age 18.
- The employee can be a family member, friend, or neighbor.
- The employee cannot be the member's wife or husband.
- The employee cannot be your parent, stepparent, or guardian if the member is under age 18.
- The employee must have either the training or experience to help you with the member's needs.
- The provider cannot benefit from respite services paid through the waiver on your behalf; if your provider needs a break, you can hire another CDAC provider.
- You can have a back-up plan where you hire other providers or use an agency in case the regular provider cannot provide your services.
- You can have as many CDAC providers as you need to meet your service needs.

To learn more about the Consumer Directed Attendant Care program, visit the Iowa Medicaid website at dhs.iowa.gov/ime/members/Medicaid-a-to-z/cdac.

Members in these waiver groups may choose to self-direct services:

- Brain Injury
- Elderly
- AIDS/HIV
- Physical Disability
- Health and Disability
- Intellectual Disability

HEALTH HOME PROGRAM

Amerigroup offers a Health Home program to support you and your health by coordinating the care and services you receive. Your health home will oversee all your healthcare needs and make sure you get the best care available to you.

What is a health home?

A health home is a program that offers you extra support through a team of professionals, which may include a nurse, family support specialist, peer support specialist, care coordinator, or health coach. This program is offered through your Amerigroup health plan. Amerigroup welcomes you taking part in the program. It is a way to help make sure you can be as healthy as possible by giving you some special services. These services include:

- Someone to help you develop a health action plan to guide you and your doctors and other providers.
- Someone to meet with you to help you get the right services at the right time.
- Help with learning about your conditions and how you can help yourself be healthier.
- Help when coming out of the hospital to make sure you can get important follow-up visits to doctors and other providers.
- Help with understanding how your family or other helpers support you in reaching your health goals.
- Help getting other services and support you need to stay in your home.

Why choose a health home?

There are many benefits to being in a health home, including:

- All those who provide your services and supports work together to give you quality healthcare.
- A care coordinator to help you manage all your services and supports among your providers; your care coordinator also will:
  - Help identify services and supports that may be helpful for you.
  - Help you learn about your medicines.
  - Give support to your family or other people who care for and support you.
  - Follow up with you after being in the hospital or in the emergency room.
  - Answer questions you may have about your health.
- One point of contact for your healthcare services and supports if you have questions or problems.

Chronic Condition Health Home

You are eligible for health home services if you have two of these chronic conditions, or one chronic condition and the risk of developing another:

- Mental health condition
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- Body Mass Index (BMI) over 25
- Hypertension
- Child BMI greater than the 85th percentile

Integrated Health Home

To be eligible for Integrated Health Home (IHH) services, you must have one of the following clinical conditions:

- An adult with a serious mental illness (SMI): psychiatric disorder, schizophrenia, schizoaffective disorder, major depression, delusional disorder, obsessive-compulsive disorder, or bipolar disorder; or
- A child or youth with a serious emotional disturbance (SED): a diagnosable mental, behavioral, or emotional disorder that impairs function.

Members who are enrolled in the Habilitation and Children's Mental Health Waiver are also enrolled in an IHH.

Being in the Health Home program is your choice. You can choose to be in a Health Home program, change your Health Home or leave the program at any time.

If you wish to change your Health Home, you can:

- Request this change through your current health home or through the Health Home in which you would like to transfer, or
- Call Amerigroup Member Services for help at 800-600-4441 (TTY 711).

Changing your Health Home will not change your benefits, as long as you are eligible for the program.

Health Home program services are extra support to help you meet your health goals. If you have questions about the Health Home program or to see if you are eligible for a Health Home, call Member Services at 800-600-4441 (TTY 711).

YOUR RIGHTS AND RESPONSIBILITIES

Amerigroup wants you to know your rights and responsibilities. We will tell you about them:

- When you enroll.
- Every year.
- 30 days before a change is made.

If you have questions about your rights, responsibilities or how to request information, call Member Services at 800-600-4441 (TTY 711).

Your rights

As an Amerigroup member, you have the right to:

Be sure your medical record is private; be cared for with dignity and without discrimination. That includes the right to:

- Be treated fairly and with respect.
- Know your medical records and discussions with your providers will be kept private and confidential.
- Receive a copy of your medical records (one copy at no cost to you); request additional copies of your medical records (you may be charged a fee for these copies); request that the records be amended or corrected.
- Receive information on available treatment options and alternatives.
- Take part in decisions concerning your healthcare, including the right to:
  - Refuse treatment.
  - Create an advance directive.
  - File grievances and appeals.
  - Have a candid discussion on medically necessary treatment options for your health condition(s), regardless of cost or benefits covered.

Take part in making decisions about your healthcare

Consent to or refuse treatment and actively take part in treatment decisions.

Receive care without restraint

Not be restrained or secluded if doing so is:

- For someone else's convenience.
- Meant to force you to do something you do not want to do.
- To get back at you or punish you.

Have access to healthcare services

Get healthcare services that are similar in amount and scope to those given under fee-for-service Medicaid. That includes the right to:

- Get healthcare services that will achieve the purpose for which the services are given.
- Get healthcare services from out-of-network providers; the out-of-network provider must obtain a prior authorization and if granted, the member may receive services at a cost no greater than it would be if services were furnished within the network (prior authorizations are not required if you have an emergency medical condition).
- Get services that are fitting and are not denied or reduced due to:
  - Diagnosis.
  - Type of illness.
  - Medical condition.

Receive all information in a manner that may be easily understood

Be given information in a manner and format you can understand. That includes:

- Enrollment notices.
- Information about your health plan rules, including the healthcare services you can get and how to get them.
- Treatment options and alternatives, regardless of cost or whether it is part of your covered benefits.
- A complete description of disenrollment rights at least annually.
- Notice of any key changes in your benefits package at least 30 days before the effective date of the change.
- Information on the grievance, appeal, and administrative hearing procedures
- Information on advance directive policies.

Receive information about the Amerigroup health plan before you join

Receive information about Amerigroup so you can make an informed choice. That includes:

- Basic features of programs offered by Amerigroup.
- The responsibility of Amerigroup to arrange care in a timely manner.

Receive information on Amerigroup services

Receive information on IA Health Link services offered through Amerigroup. That includes:

- Covered benefits.
- Procedure for getting benefits, including any prior approval requirements.
- Service area.
- How to request and get a provider directory at any time.

- Names, locations, and phone numbers of, and non-English languages spoken by, current contracted providers, including, at a minimum:
  - Primary care providers (PCPs).
  - Specialists.
  - Hospitals.

  See the latest provider directory at myamerigroup.com/IA.
- Any restriction on your freedom of choice of network providers.
- Names of providers who are not accepting new patients.
- Benefits not offered by Amerigroup but that members can obtain and how to get them; this includes how transportation is offered.
- Service utilization policies, including:
  - How to find a network provider.
  - How to recommend changes in policies or services.
  - Cost-sharing responsibility, if any.
  - Information on physician incentive plans.
  - Information on the organization and operation of Amerigroup.
  - How to obtain services, including maternity, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), behavioral health, pharmacy, and dental services .
  - How to obtain emergency transportation, medically needed transportation, and nonemergency transportation.
  - Referrals for specialty care and other services.

Get information on emergency and after-hours coverage

Receive detailed information on this coverage. That includes:

- What constitutes an emergency medical condition, emergency services and post-stabilization services. (Post-stabilization care services are Medicaid-covered services that you receive after emergency medical care. You get these services to help keep your condition stable.)
- Post-stabilization rules.
- Notice that emergency services do not require prior approval, regardless of whether the services were received from a provider in our network.
- The process and procedures for getting emergency services.
- The locations of any emergency settings and other sites where providers and hospitals furnish emergency and post-stabilization-covered services.
- Your right to use any hospital or other setting for emergency care.

Get the Amerigroup policy on referrals
Receive the Amerigroup policy on referrals for specialty care and other benefits not given by your PCP, if applicable.

Get oral interpretation services
Receive oral interpretation services. That includes the right to:

- Receive these services at no cost to you for all non-English languages, not just those known to be common.
- Be told these services are offered and how to access them.

Exercise your rights without adverse effects
Exercise your rights without adverse effects on the way Amerigroup, our providers or the Iowa Department of Human Services treats you. That includes the right to:

- Tell us your complaint or file an appeal about Amerigroup or the care or services you receive from our providers.
- Know the requirements and time frames for filing a grievance or appeal, including:
  - How to get help with the filing process.
  - The toll-free numbers to file by phone.
  - The state fair hearing process, including:
    - The right to a hearing.
    - The rules governing representation at the hearing.
- Make recommendations regarding your rights and responsibilities as an Amerigroup member.
- Voice concerns or complaints to Amerigroup anytime by calling 800-374-3631, ext. 106-103-5185.

Your responsibilities

As an Amerigroup member, you have the responsibility to:

Learn about your rights
Learn and understand each right you have under the IA Health Link and Hawki programs. That includes the responsibility to:

- Ask questions if you do not understand your rights.
- Learn what choices of health plans are available in your area.

Learn and follow your health plan and IA Health Link and Hawki rules
Abide by the health plan policies and procedures. That includes the responsibility to:

- Carry your ID card at all times when getting healthcare services.
- Let your health plan know if your ID card is lost or stolen.

- Let your health plan know right away if you have a workman's compensation claim or a pending personal injury or medical malpractice lawsuit or been involved in an auto accident.
- Learn and follow your health plan and Medicaid rules.
- Make any changes in your health plan and PCP in the ways established by IA Health Link and Hawki and by the health plan.
- Keep scheduled appointments.
- Cancel appointments in advance when you cannot keep them.
- Always contact your PCP first for your nonemergency medical needs.
- Talk to your PCP before going to a specialist.
- Understand when you should and should not go to the emergency room.

Tell your providers about your healthcare needs
Share information relating to your health status with your PCP and become fully informed about service and treatment options.

That includes the responsibility to:
- Tell your PCP about your health.
- Talk to your providers about your healthcare needs and ask questions about the different ways healthcare problems can be treated.
- Help your providers get your medical records.
- Provide your providers with the right information.
- Follow the prescribed treatment of care recommended by the provider or let the provider know the reasons the treatment cannot be followed as soon as possible.

Take part in making decisions about your health
Actively participate in decisions relating to service and treatment options, make personal choices and take action to maintain your health. That includes the responsibility to:
- Work as a team with your provider in deciding what healthcare is best for you.
- Understand how the things you do can affect your health.
- Do the best you can to stay healthy.
- Treat providers and staff with respect.

Call Amerigroup Member Services if you have a problem and need help.
Amerigroup provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, race, age, religion, national origin, physical or mental disability, or type of illness or condition.

OTHER INSURANCE AND BILLS

If You Have Medicare

If you have Medicare coverage, your Medicare or Medicare HMO coverage is primary and your IA Health Link coverage through Amerigroup is secondary.

Medicare or your Medicare HMO will cover services from participating physicians, hospitals and other network providers. Medical services are based on the guidelines of that program.

Because you have Medicare as your primary health insurance, you do not have to choose a primary care provider through the IA Health Link program.

Please call your Amerigroup community-based case manager at 800-600-4441 (TTY 711) to talk about the services offered to you. Your community-based case manager will help you arrange for services through Medicare and the services and supports you get through the IA Health Link program.

GRIEVANCE AND APPEALS

Grievances

You, your approved representative, or your provider on your behalf and with your written consent may file a grievance if:

- You are not satisfied with Amerigroup for any reason
- You have a problem with our services or network providers concerning such things as the quality of care they provide
- You have difficulty getting access to care
- You feel your rights and dignity have been disrespected, or
- You have experienced rude behavior from a provider or an Amerigroup associate.

Filing a grievance with Amerigroup

If you aren't happy with something with Amerigroup and would like to file a grievance, you can:

- Call Member Services toll free at 800-600-4441 (TTY 711). A Member Services representative can help you submit your grievance. Be sure to tell the representative what happened, the date the problem happened, and the people involved.
- Send us your grievance by mail. Be sure to include in a letter what happened, the date the problem happened, and the people involved. Send your letter to:
  Grievances and Appeals Department
  Amerigroup Iowa, Inc.
  4800 Westown Parkway, Ste. 200
  West Des Moines, IA 50266

When we get your letter, our grievance team will:

- Send you a letter within three working days to let you know we received your grievance.
- Look into your grievance when we get it.
- We will respond within 30 calendar days from when we received your grievance by sending you a letter. It will tell you our decision and all the information we received.

If your grievance is urgent or emergent, we'll respond within 72 hours of when you tell us about it. You may ask us to extend the grievance process for an extra 14 calendar days if you have more details we should see. Amerigroup may also request an extension by 14 calendar days if it is in the enrollee's best interest and the state allows

it. If we extend the grievance process, a written notice explaining the reason and the time frame for resolution will be mailed to you. It will explain why the extension is in your best interest. You also have the right to file a grievance if you disagree.

Appeals

If we deny, reduce or end services, you'll get an adverse benefit determination letter from us. The adverse benefit determination will:

- Explain why we will not pay for care or services your provider asked for.
- Give you instructions on your right to appeal this decision.

You, your approved representative, or your provider on your behalf and with your written consent can appeal the decision.

You must file an appeal within 60 calendar days from the date in our first letter (adverse benefit determination) that says we will not pay for a service.

You can appeal our decision in two ways — call or mail a letter:

- Call: Member Services at 800-600-4441 (TTY 711) to file your appeal. Let us know if you want someone else to help you with the appeal process, such as a family member, friend, or your provider.
  - If you call to file the appeal, you must follow up with a written appeal within 10 calendar days of the date you called us.
  - If you don't follow up with a written appeal after you call us:
    - Your appeal will stop; we will send you a letter to let you know we stopped your appeal.
    - You must follow up in writing by filling out the Written Appeal Form or sending us a letter, if you want your appeal to continue.

Mail (include information such as the care you are looking for and the people involved):

Grievances and Appeals Department
Amerigroup Iowa, Inc.
4800 Westown Parkway, Ste. 200
West Des Moines, IA 50266

When we get your letter or appeal form, we'll send you a letter within three working days. The letter will let you know we got your appeal.

After we get your appeal:

- A different provider than the one who made the first decision will look at your appeal.
- We'll send you and your provider a letter with the answer to your appeal:
  - Within 72 hours if your appeal is expedited.

  - Within 30 calendar days from when we get your appeal if your appeal is not expedited.
- We may also request an extension by 14 calendar days if it's in your best interest. If we extend the appeal process, a written notice explaining the reason and the time frame for resolution will be mailed to you. It will explain why we feel the extension is in your best interest. You also have the right to file a grievance if you disagree with the extension.

Our letter will:

- Let you and your provider know what we decide.
- Tell you and your provider how to find out more about the decision and your rights to a fair hearing.

Expedited appeals

If you or your provider feels that taking the time for the standard appeals process, which is usually 30 calendar days, could seriously harm your life or your health, you can ask us to review your appeal quickly.

We'll call you and let you know the answer to your expedited appeal. We'll also send you a letter. We'll do this within 72 hours.

If our clinical staff doesn't feel your health or life could be in serious harm, your appeal won't be reviewed within 72 hours, and we will:

- Call you right away, and
- Send you a letter within two working days to let you know your appeal will be reviewed as a standard appeal, and we will give you our decision within 30 calendar days.

If the decision on your expedited appeal upholds our first decision and we won't pay for the care your doctor asked for, we'll call you and send you a letter. This letter will:

- Let you know how the decision was made.
- Tell you about your rights to file a grievance.

Continuation of benefits — appeals and state fair hearing

You can keep getting covered services while you appeal or during the state fair hearing process if all of the following apply:

- The appeal or state fair hearing request is filed:
  - Within 10 calendar days from the date we mailed the adverse benefit determination, or
  - Before the effective date of this notice.
- The appeal or state fair hearing request is related to reduced or suspended services or to services that were previously authorized for you.

- The services were ordered by an authorized provider.
- The authorization period for the services has not ended.
- You asked that the service continue.

If your benefits are continued while an appeal or state fair hearing request is pending, the services must be continued until one of the following happens:

- You decide not to continue the appeal or state fair hearing.
- You don't request a state fair hearing within 10 days from the date we mailed the adverse benefit determination.
- The authorization for services expires, or service authorization limits are met.
- A hearing decision is issued in the state fair hearing that is adverse to you.

If a decision is made in your favor as a result of the appeal process, we'll:

- Start to cover services as quickly as you have need for care and no later than seven calendar days from the date we get written notice of the decision.
- Approve and pay for the services we denied coverage of before.

You may have to pay for the cost of any continued benefit if the final decision is not in your favor.

State fair hearing

You, your approved representative, or your provider on your behalf and with your written consent has the right to ask for a state fair hearing after you have gone through our appeal process. You must ask for a state fair hearing within 120 calendar days from the date on the letter from us that tells you the result of your appeal. If you wish to continue the benefits we have denied until your fair hearing is held, you must meet all the requirements listed in the section, **Continuation of benefits — appeals and state fair hearing**.

You can appeal in person, by phone or in writing. To appeal in writing, do one of the following:

- Complete an appeal electronically at http://dhs.iowa.gov/node/966, or
- Write a letter telling the department why you think the decision is wrong.

If you want to appeal by phone, call the Department of Human Services Appeals Section at 515-281-3094. Or mail, fax or take your appeal to:

Department of Human Services Appeals Section
1305 E. Walnut St., 5th Floor
Des Moines, IA 50319
Fax: 515-564-4044

Tell the Department of Human Services Appeals Section:

- The reason you want a hearing.
- What service was denied.
- The date the service was denied.
- The date the appeal was denied.

Be sure to include your name, address and phone number, too.
You can:

- Represent yourself at the hearing.
- Approve a person to assist you at the hearing; or
- Ask an attorney to represent you.

If a decision is made in your favor as a result of the state fair hearing, we'll:

- Start to cover services as quickly as you have need for care and no later than seven calendar days from the date we get written notice of the decision.
- Approve and pay for the services we denied coverage of before.

You may have to pay for the cost of any continued benefit if the final decision is not in your favor.

If you'd like to learn more about your right to file an appeal and the notices to expect from us throughout the process, you can find more details in Section 441, Chapter 7 of the Iowa Administrative Code here: https://www.legis.iowa.gov/docs/ACO/chapter/441.7.pdf.

Ombudsman
Iowa Managed Care Ombudsman Program

Call Member Services for help with your issue. However, if you still need help and receive long-term care services or home- and community-based waiver services, independent advocacy services are available.

The Managed Care Ombudsman can assist you with:

- Education and information
- Advocacy
- Outreach
- Complaint resolution
- Grievances, appeals, and state fair hearings

Members receiving long-term care services or home- and community-based waiver services may contact the Managed Care Ombudsman Program to receive independent advocacy services. The Managed Care Ombudsman Program may be reached at:

Managed Care Ombudsman Program
510 East 12th St.
Des Moines, IA 50319
515-725-3333 or 866-236-1430 (toll free nationwide)

ESTATE RECOVERY

ESTATE RECOVERY

If you received Medicaid benefits, which includes capitation fees paid to an MCO, the state of Iowa has the right to ask for money back from your estate after your death. Members affected by the state recovery policy are those who are:

- Age 55 or older, regardless of where they are living, or
- Under age 55 and:
  - Reside in a nursing facility, an intermediate care facility for persons with an intellectual disability or a mental health institute, and
  - Cannot reasonably be expected to be discharged and return home.

For more information, call Iowa Medicaid Member Services at 800-338-8366 or 515-256-4606 (when calling within the Des Moines area) (TTY 800-735-2942) Monday through Friday from 8 a.m. to 5 p.m.

MAKING A LIVING WILL

Emancipated minors and members over 18 years old have rights under advance directive law. An advance directive talks about making a living will. A living will says you may not want medical care if you have a serious illness or injury and may not get better.

The advance directive tells your doctor and family:

- What kind of healthcare you do or do not want if you:
  - Lose consciousness
  - Can no longer make healthcare decisions, or
  - Cannot tell the doctor or family what kind of care you want for any other reason.
- If you want to donate your organ(s) after your death.
- If you want someone else, a friend or family member, to decide about your healthcare if you can't.

Having an advance directive means your loved ones or your doctor can make medical choices for you based on your wishes.

Talk to your doctor, family, friends, and those close to you.

- Put decisions about your medical care in writing now.
- You can cancel an advance directive at any time.
- If you are incapacitated at the time you enroll in Amerigroup and cannot get, or are not clear if you have received, information on advance directives, it can be given to a family member or someone who stands in for you. Once you are able to receive this information, it will be given to you directly.

If you wish to sign a living will, you can:

- Ask your primary care provider (PCP) for a living will form.
- Fill out the form by yourself or call us for help.
- Take or mail the completed form to your PCP or specialist. Your PCP or specialist will then know what kind of care you want to get.

You can change your mind anytime after you have signed a living will.

- Call your PCP or specialist to remove the living will from your medical record.
- Fill out and sign a new form if you wish to make changes in your living will.

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

You have the right to request the Amerigroup policy on advance directives. To do this, contact Member Services.

Ask your PCP or specialist about these forms.

Objections to advance directives

If your provider has a conscious objection to your advance directive, he or she is required to:

- Notify you upon admission for service
- Identify the legal authority for the objection, and
- Identify the manner in which this may affect treatment decisions.

We respect the advance directives of our members. If we have a conscious objection to your advance directive, we'll:

- Clarify if the objection is our objection or one raised by your provider
- Identify the legal authority for the objection, and
- Describe the range of medical conditions or procedures affected by the conscious objection.

We're not required to:

- Cover care that is not in line with your advance directive.
- Implement an advance directive if, as a matter of conscience, we can't fulfill an advance directive and state law allows any healthcare provider (or their agent) to conscientiously object.

FRAUD, WASTE AND ABUSE

We want to make sure our health plan runs smoothly, and one way we do that is by preventing fraud, waste and abuse. You can help! First, understand what healthcare fraud, waste, and abuse are and how to identify it:

- *Fraud* — when a provider or member intentionally makes false claims for medical services.
- *Waste* — usually happens when resources are misused, such as overusing services, or other practices that, directly or indirectly, result in unnecessary costs but usually aren't intentional actions.
- *Abuse* — when healthcare providers don't follow good medical practices which causes excessive costs, incorrect payment, or misuse of codes or services that are not medically necessary.

Here are some different ways fraud, waste and abuse can occur. Providers can commit fraud, waste and abuse by:

- Altering medical records to misrepresent actual services provided.
- Billing for services not provided.
- Billing for medically unnecessary tests or procedures.
- Billing professional services performed by untrained or unqualified personnel.
- Misrepresenting a diagnosis or services.
- Asking for, offering, or getting kickbacks or bribes.
- Unbundling services — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code.
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed.

Members can commit fraud, waste and abuse by:

- Forging, altering, or selling prescriptions.
- Letting someone else use their member ID card or using someone else's member ID card.
- Getting the same prescription from multiple providers.

If you know someone who is misusing the IA Health Link, IA Health and Wellness, or Hawki programs, you can report them anonymously and you won't be retaliated against for doing so.

To report providers, clinics, hospitals, nursing homes, or Medicaid members, write or call Amerigroup at:

Medicaid Special Investigations Unit
Amerigroup Iowa, Inc.
4425 Corporation Lane
Virginia Beach, VA 23462
877-660-7890

You san also send an email or report fraud, waste and abuse online:

- Email the Medicaid Special Investigations Unit at MedicaidFraudInvestigations@amerigroup.com.
- Go online at myamerigroup.com/IA.
    - Click the link for **Report Waste, Fraud & Abuse** to report details about a possible issue.
    - The information you provide is sent directly to the email address above, which is checked every working day.

You can also report suspected Medicaid fraud to the state of Iowa by:

- Calling the Iowa Department of Human Services Customer Service Center 800-831394 Monday through Friday from 7 a.m. to 6 p.m.
- Contacting the U.S. Department of Health and Human Services at the Office of Inspector General website, dhs.iowa.gov/report-abuse-and-fraud.
- Contacting the IME Program Integrity Unit at 877-446-3787 (toll free) or 515-256-4615 (locally in Des Moines).

When you report a provider who you think is commiting fraud, waste or abuse, please include:

- Name, address, and phone number of the provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility (if you have it).
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

If someone you know is committing Medicaid fraud, waste and abuse, you'll need to include:

- The member's name.

- The member's date of birth, Social Security number, or case number (if you have it).
- The city where the member lives.
- Specific details describing the fraud, waste or abuse.

Investigation process and acting on our findings

We investigate all reports of fraud, waste and abuse for all services provided under the contract, including those provided by other companies we work with. If needed, we'll report allegations and findings to the state, federal government, and/or law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse the provider:

- Will be referred to the Special Investigations Unit.
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including termination.

NOTICE OF PRIVACY PRACTICES

The original effective date of this notice was April 14, 2003. The most recent revision date is February 13, 2018, and the notice was most recently reviewed in October 2020.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

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

We get information about you from state agencies for IA Health Link and Hawki after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

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

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

When is it OK for us to use and share your PHI?

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

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care.
  - When we say we'll pay for healthcare or services before you get them.
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, healthcare operations, and treatment. If you

don't want this, please visit **myamerigroup.com/pages/privacy.aspx** for more information.

- **For healthcare business reasons**
  - To help with audits, fraud, and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research, or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

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

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

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

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.

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

What do we have to do?

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

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

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at **800-600-4441**. If you're deaf or hard of hearing, call **TTY 711**.

What if you have a complaint?

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

Write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
601 E. 12th St., Room 353
Kansas City, MO 64106
Phone: 800-368-1019
TDD: 800-537-7697
Fax: 816-426-3686

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the Web at **myamerigroup.com/pages/privacy.aspx**.

Race, ethnicity, and language
We receive race, ethnicity, and language information about you from state agencies for IA Health Link and Hawki. We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Develop and send health education information.
- Let doctors know about your language needs.
- Provide translator services.

We do **not** use this information to:
- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Disclose to unapproved users.

We offer translation and oral interpretation services for all languages at no charge. To get these services, call Member Services toll free at 800-600-4441 (TTY 711).

Ofrecemos servicios de traducción e interpretación oral para todos los idiomas sin costo. Para recibir estos servicios, llame a la línea gratuita de Servicios al Miembro al 800-600-4441 (TTY 711).

OTHER PLAN DETAILS

Special Amerigroup services for healthy living

Health information

Learning more about health and healthy living can help you stay healthy. Here are some ways to get health information:

- Ask your primary care provider (PCP).
- Call us. 24-hour Nurse HelpLine is available to answer your questions 24 hours a day, 7 days a week at 866-864-2544. They can answer your health questions when your PCP's office is closed.

Health education

Amerigroup works to help keep you healthy with our health education programs. We will also mail a member newsletter to you once a year. This gives you health news about well-care and taking care of illnesses.

Disease Management

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

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

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What programs do we offer?

You can join a Disease Management program to get healthcare and support services if you have any of these conditions:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult
- Major depressive disorder — child/adolescent
- Schizophrenia
- Substance use disorder

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

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

Our DM team and your primary care provider (PCP) are here to help you with your healthcare needs.

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

When you call, we'll:

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

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

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

Useful phone numbers
In an emergency call 911.

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

After-hours:
Call Amerigroup 24-hour Nurse HelpLine
24 hours a day, 7 days a week
866-864-2544 (TTY 711)

Healthy Families
Healthy Families is a six-month program for members ages 7–17. The goal of the program is to help families form healthy eating habits and become more active.

For kids who qualify, parents will get one-on-one coaching phone calls with us to:

- Create health goals just for your child that are clear and that they can meet.
- Make a plan to reach those goals.
- Talk about getting and staying active and healthy food choices.
- Help find resources to support a healthy life in your area.
- Find out if your health plan has extra benefits to help with living a healthier life.

Learn more and join
Give us a call at 844-421-5661 Monday through Friday 8:30 a.m.–5:30 p.m. local time to find out more about the Healthy Families program. We'll ask you some questions about your child's health to see if they qualify.

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

- Get details about us, such as:
    - Programs and services we offer.
    - Our staff and their qualifications (skills or education).
    - Any contractual relationships (deals we have with other companies).
- Opt out of DM services.
- Know which DM case manager is handling your DM services and how to ask for a change.
- Get support from us to make healthcare choices with your healthcare providers.
- Ask about all DM-related treatment options (choices of ways to get better) mentioned in clinical guidelines (even if a treatment is not part of your health plan), and talk about options with treating healthcare providers.
- Have personal data and medical information kept private.
- Know who has access to your information and how we make sure your information stays secure, private, and confidential.
- Receive polite, respectful treatment from our staff.

- Get information that is clear and easy to understand.
- File grievances to Amerigroup by calling 888-830-4300 (TTY 711) toll free from 8:30 a.m. to 5:30 p.m. local time Monday through Friday and:
    - Get help on how to use the grievance process.
    - Know how much time Amerigroup has to respond to and resolve issues of quality and grievances.
    - Give us feedback about the Disease Management program.

You also have a responsibility to:

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

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

You can log in to your secure account, or register, at myamerigroup.com/IA to ask us to join a DM program. You'll need your member ID number to register (located on your member ID card).
Using your secure account, you can send a secure message to Disease Management and ask to join the program.

What does medically necessary mean?

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

Medically necessary services mean health services that are:

- Suited and needed for the symptoms, diagnosis, or treatment of your condition.
- Provided for the diagnosis or direct care and treatment of your condition, allowing you to make reasonable progress in treatment.
- Within the standards of professional practice and given at the right time and in the right setting.
- Not mainly for your convenience or your physician's or other provider's convenience.
- The most appropriate level of covered services that can be provided safely and based on your condition.

Waiver programs have different requirements for waiver services than do medical services. Amerigroup will follow the guidelines for each waiver program.

If you have questions about a benefit or service, call Amerigroup Member Services toll free at 800-600-4441. The Amerigroup medical director, in talking with the Medicaid medical director, may decide to approve services on a case-by-case basis.

Utilization management notice

All Utilization Management (UM) decisions are based solely on a member's medical needs and the benefits offered. The Amerigroup policies do not encourage and do not support the underutilization of services through our UM decision guide. Practitioners and others involved in UM decisions do not receive any type of reward for denial of care or coverage.

Access to utilization management staff

We offer a UM program. Through this program, we help you get the right care when you need it. Utilization management includes but is not limited to:

- Preservice review
- Urgent, concurrent review
- Post-service review
- Filing an appeal

Our Utilization Review team looks at service approval requests. The team will decide if:

- The service is needed.
- The service is covered by your health plan.

You or your doctor can ask for a review if we say we will not pay for care. We'll let you and your doctor know after we get the request. The request can be for services that:

- Are not approved.
- Have changed in amount, length or scope, resulting in a smaller amount than first requested.

If you have questions about an approval request or a denial you received, call Member Services. A member of our Utilization Review team can speak with you if you like.

You can also call us if you have questions about getting special care, or questions about your doctor. Call 800-600-4441 (TTY 711). You can reach us Monday through Friday from 8 a.m. to 5 p.m. Central time. If you call and we're closed, you can speak with an on-call nurse or leave a message. Someone will call you back the next working day. The person who calls you will let you know they are calling from Amerigroup and tell you their name and title.

Calls received after normal business hours will be returned the next working day. Calls received after midnight, Monday through Friday will be returned the same working day.

New technology

The Amerigroup medical director and our participating providers assess new medical advances (or changes to existing technology) in:

- Medical procedures
- Behavioral health procedures
- Pharmaceuticals
- Devices

They also look at scientific literature and whether these new medical advances and treatments:

- Are considered safe and effective by the government.
- Give equal or better outcomes than the covered treatment or therapy that exists now.

They do this to see if these advances are suited as covered benefits.

If you get a bill

In most cases, if you see a network provider for covered services, your provider should not send you a bill. Always show your Amerigroup ID card to make sure you aren't sent a bill for services covered by Amerigroup .

If you do get a bill, send it to us with a letter saying you have been sent a bill. Mail the letter to:
Member Grievances and Appeals
Amerigroup Iowa, Inc.
4800 Westown Parkway, Ste. 200
West Des Moines, IA 50266

You can also call Member Services at 800-600-4441 (TTY 711) for help.

If you have other health insurance (coordination of benefits)

Please call Amerigroup Member Services, DHS Customer Service Call Center and Hawki Customer Service if you or your children have other insurance, including employer-sponsored insurance.

Always show your Amerigroup ID card and other health insurance cards when you see a provider, go to the hospital or go for tests. The other insurance plan needs to be billed for your healthcare services before Amerigroup can be billed. Amerigroup will work with the other insurance plan on payment for these services.

You should also call Amerigroup Member Services if you have:

- A Workman's Compensation claim.
- A pending personal injury or medical malpractice lawsuit.
- Been involved in an auto accident.

How to tell Amerigroup about changes you think we should make

We want to know what you like and don't like about Amerigroup.

- Call Member Services to tell us your ideas, or
- Join our member advisory group; they meet every three months — you can find out more about us, ask questions and give us suggestions for improvement. To join, call Member Services at 800-600-4441 (TTY 711).

We may also call to ask how you like Amerigroup. Your ideas will help us make Amerigroup better.

We also keep track of your services and how pleased you are with the care you receive through our Quality Management program. We get this information through:

- Healthcare Effectiveness Data and Information Set (HEDIS®) — This tool helps us make sure you get the preventive and screening services you need to help keep you healthy and find health problems early so you can be treated sooner.
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, also called the member satisfaction survey — the survey is sent to a random sample of members and asks questions about how you like Amerigroup; if we send you a survey, please fill it out and send it back.

If you would like more information on our Quality Management program, call Member Services.

How to disenroll from Amerigroup

You can change your health plan with good cause for reasons such as:

- You move out of the service area.
- If we don't cover the service you are seeking due to moral or religious objections.
- You need related services (for example a cesarean section and a tubal ligation) to be performed at the same time and not all related services are offered within the network, and your provider decides that getting the services separately would put you at risk.
- Other reasons, including but not limited to:
  - Poor quality of care
  - Lack of access to covered services
  - Lack of access to providers experienced with your healthcare needs, or

- Your eligibility and choice to participate in a program not offered through managed care (i.e., PACE).

If you believe you have a good-cause reason to change to a new health plan, you may call Iowa Medicaid Member Services at 800-338-8366 or 515-256-4606 (when calling within the Des Moines area) (TTY 800-735-2942) Monday through Friday from 8 a.m. to 5 p.m. to explain this. For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call Relay Iowa TTY at 800-735-2942. A request for this change, called disenrollment, will require good cause.

You can do so by asking to file a grievance. Please call Amerigroup Member Services at 800-600-4441 (TTY 711). You can also write to us at:
Grievances and Appeals Department
Amerigroup Iowa, Inc.
4800 Westown Parkway, Ste. 200
West Des Moines, IA 50266

State-initiated disenrollment may occur based on changes in conditions, including:

- You are no longer eligible for Medicaid.
- You move to another state.
- The agency decides that participating in the Health Insurance Premium Payment Program (HIPP) is more cost-effective than enrollment in the contract.
- Death.

GLOSSARY OF TERMS

GLOSSARY OF TERMS

Adverse benefit determination: A written notice to a member or provider to explain an action being taken.

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or a member's authorized representative may request an appeal following a decision made by Amerigroup.

Amerigroup actions that a member may choose to appeal:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or in part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of the MCO to act within required time frames.
- For a resident of a rural area with only one MCO, the denial of services outside the network.

Members may file an appeal directly with MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with the Department of Human Services (DHS) or they may ask to ask for a state fair hearing.

Appeal process: The Amerigroup process for handling of appeals, which complies with:

- The procedures for a member to file an appeal
- The process to resolve the appeal
- The right to access a state fair hearing, and
- The timing and manner of required notices.

Care coordination: Case management responds to a member's needs when the member's diagnosis or condition requires care and treatment for a long period of time. Service coordination gives support and responds to the needs of persons who have long-lasting limits caused by an illness, an injury, or a disability.

Case Management: Care Management helps you manage your complex healthcare needs. It may include helping you get other social services, too.

Chronic Condition: Chronic Condition is a persistent health condition or one with long-lasting effects. The term chronic is often applied when the disease lasts for more than three months.

Chronic Condition Health Home: Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions.

A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

Client Participation: Client Participation is what a Medicaid member pays for Long-Term Services and Supports (LTSS) services such as nursing home or home supports.

Community-Based Case Management (CBCM): Community-Based Case Management helps Long-Term Services and Supports (LTSS) members manage complex healthcare needs. It includes planning, facilitating, and advocating to meet the member's needs. It promotes high quality care and cost effective outcomes. Community-Based Case managers (CBCMs) make sure that the member's care plan is carried out. They make updates to the care plan as needed.

Consumer Directed Attendant Care (CDAC): Consumer Directed Attendant Care (CDAC) helps people do things that they normally would for themselves if they were able.

CDAC services include:

- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

Co-payment (Copay): Some medical services have a co-payment, which is your share of the cost. If there is a co-payment, you will pay it to the provider. The provider will tell you how much it is.

- Iowa Health and Wellness Plan members will be charged an $8 co-payment for each visit to the emergency room that is not considered an emergency.
- Hawki members will be charged a $25 co-payment for each visit to the emergency room that is not considered an emergency.
- All other Iowa Medicaid members* will be charged a $3 co-payment for each visit to the emergency room.

** Children under the age of 21 and pregnant women will not be charged a co-payment for any services.*

Covered services: The services Amerigroup provides under the IA Health Link and Healthy and Well Kids in Iowa (Hawki) programs.

Durable Medical Equipment: Durable Medical Equipment (DME) is reusable medical equipment for use in the home. It is rented or owned by the member and ordered by a provider.

Emergency Medical Condition: An Emergency Medical Condition is any condition that you believe endangers your life or would cause permanent disability if not treated immediately. A physical or behavioral condition medical condition shown by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of medical attention right away to result in:

- Placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or body part.

If you have a serious or disabling emergency, you do not need to call your provider or Amerigroup. Go directly to the nearest hospital emergency room or call an ambulance. The following are examples of emergencies:

- A Serious Accident
- Stroke
- Severe Shortness of Breath
- Poisoning
- Severe Bleeding
- Heart Attack
- Severe Burns

Emergency Medical Transportation: Emergency Medical Transportation provides stabilization care and transportation to the nearest emergency facility.

Emergency Room Care: Emergency Room Care is provided for Emergency Medical Conditions.

Emergency Services: Covered inpatient or outpatient services that are:

- Given by a provider who is qualified to provide these services.
- Needed to assess and stabilize an emergency medical condition.

Emergency Services are provided when you have an Emergency Medical Condition.

Excluded Services: Excluded services are services that Medicaid does not cover. The member may have to pay for these services.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT): A program of preventive healthcare, including well-child exams with appropriate tests and shots, which is called the Care for Kids program in Iowa.

Fee-for-service: The payment method by which the state pays providers for each medical service given to a patient; this member handbook includes a list of services covered through fee-for-service Medicaid.

Fraud: An act by a person, which is intended to deceive or misrepresent with the knowledge that the deception could result in an unauthorized benefit to himself or some other person; it includes any act that is fraud under federal and state laws and rules; this member handbook tells members how to report fraud.

Good Cause: You may request to change your MCO during your 12 months of closed enrollment. A request for this change, called disenrollment, will require a Good Cause reason.

Some examples of Good Cause for disenrollment include:

- Your provider is not in the MCO's network.
- You need related services to be performed at the same time. Not all related services are available within the MCO's provider network. Your primary care provider or another provider determined that receiving the services separately would subject you to unnecessary risk.
- Lack of access to providers experienced in dealing with your healthcare needs.
- Your provider has been terminated or no longer participates with your MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by your MCO.
- The MCO plan does not cover the services you need due to moral or religious objections.

Grievance: You have the right to file a grievance with Amerigroup. A grievance is an expression of dissatisfaction about any matter other than a decision. You, your representative, or provider who is acting on your behalf and has your written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred. Examples include but are not limited to:

- You are unhappy with the quality of your care.
- The doctor who you want to see is not an Amerigroup doctor.
- You are not able to receive culturally competent care.
- You got a bill from a provider for a service that should be covered by Amerigroup.
- Rights and dignity.
- You are commended changes in policies and services.
- Any other access to care issues.

Habilitation Services: Habilitation Services are HCBS services available to members who experience functional limitations typicaly associated with chronic mental illness.

Healthcare Coordinator: A Healthcare Coordinator is a person who helps manage the health of members with chronic health conditions.

Health insurance: benefits that pay for or partially pay for medical services such as doctor visits, hospital stays, and more.

Health Risk Assessment: A Health Risk Assessment (HRA) is a short survey with questions about your health.

Healthy Behaviors Program: Members in the Iowa Health and Wellness Plan can get free* healthcare if they complete what are known as Healthy Behaviors. To participate in the Healthy Behaviors program and avoid monthly payments after the first year, each year Iowa Health and Wellness Plan members must:
1. Get a Wellness Exam -OR- Get a Dental Exam
AND
2. Get a Health Risk Assessment

** There are very few, or no, costs for the first year and very few costs after that. A small monthly payment may be required based on income. There is an $8 copay for using the emergency room for non-emergency services.*

Home- and Community-Based Services (HCBS): Home- and Community-Based Services (HCBS) provide supports to keep Long-Term Services and Supports (LTSS) members in their homes and communities.

Home Health: Home Health is a program that provides services in the home. These services include visits by nurses, home health aides, and therapists.

Hospice services: care for people who are terminally ill to help them be comfortable during their final days.

Hospital Inpatient Care: Hospital Inpatient Care, or Hospitalization, is care in a hospital that requires admission as an inpatient. This usually requires an overnight stay. These can include serious illness, surgery, or having a baby. (An overnight stay for observation could be outpatient care.)

Hospital Outpatient Care: Hospital Outpatient Care is when a member gets hospital services without being admitted as an inpatient. These may include:

- Emergency services
- Observation services
- Outpatient surgery
- Lab tests
- X-rays

Integrated Health Home: An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

Level of Care: Members asking for HCBS waivers or facility care must meet Level of Care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of Care is determined by an assessment approved by DHS.

Long-Term Services and Supports (LTSS): Long-Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.

Long-Term Care Services:

- Home- and Community-Based Services (HCBS)
- Intermediate Care Facilities for Persons with Intellectual Disabilities
- Nursing Facilities and Skilled Nursing Facilities

Medically Necessary: Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

Network: Amerigroup has a network of providers across Iowa who you may see for care. You don’t need to call us before seeing one of these providers. Before getting services from your providers, please show them your Amerigroup ID card to ensure they are in our network.

There may be times when you need to get services outside of our network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to you than if provided in-network.

Noncovered services: Services that Amerigroup and/or fee-for-service Medicaid may not pay for, including services that have been denied because they are not medically needed.

Non-participating Provider: A Non-participating Provider is a provider who does not have a contract with Amerigroup to provide services to you. Before receiving services from your providers, please show them your Amerigroup ID card.

Over-the-Counter Medications (OTC): Amerigroup covers many over-the-counter (OTC) medications that are on the state's approved list. A provider must write you a prescription for the OTC medication you need.

Participating Provider: A Participating Provider has a contract with Amerigroup to provide services to you.

Person-centered Plan: A Person-centered Plan is a written individual plan based on your needs, goals and preferences. This is also referred to as a plan of care, care plan, individual service plan (ISP), or individual education plan (IEP).

Physician Services: Physician Services are necessary medical services performed by doctors, physician assistants and nurse practitioners. They must be licensed to practice.

Plan: Amerigroup is your health plan, or Plan, which pays for and coordinates your healthcare services.

Post-stabilization care: Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition.

Premium: A Premium is the amount you pay for your health insurance every month. Most IA Health Link members are not required to pay a premium. Some Iowa Health and Wellness Plan members and some Hawki members must pay monthly premiums depending on their income.

Prescription Drug Coverage: Amerigroup provides Prescription Drug Coverage by paying for your prescription drugs.

Prescription Drugs: Prescription Drugs are drugs that, by law, require a prescription.

Preventive care: Preventive care from your primary care provider can help you stay healthy; examples of preventive care are:

- Immunizations (shots)
- Yearly physicals
- Pap smears

Prevocational Services: Prevocational Services are services where the member can gain skills that lead to paid employment.

Primary Care Physician: A Primary Care Physician directly provides or coordinates your healthcare services. A Primary Care Physician is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals.

Primary Care Provider: A Primary Care Provider (PCP) is either a physician, a physician assistant, or nurse practitioner, who directly provides or coordinates your healthcare services. A PCP is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals.

Prior Authorization: Some services or prescriptions require approval from Amerigroup for them to be covered. This must be done before you get that service or fill that prescription.

Provider: A provider is a healthcare professional who offers medical services and support.

Referral: A referral means that your primary care provider must give you approval to see someone that is not your primary care provider. If you don't get approval we may not cover the services. There are certain specialists in which you do not need a referral, such as women's health specialists.

Rehabilitation Services and Devices: Rehabilitation Services and Devices help you keep, get back, or improve skills for daily living after you were sick, hurt, or disabled. This may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation.

Routine care: In most cases when you are not feeling well and need medical care, you call your PCP to make an appointment. Then you go to see your PCP. This type of care is known as routine care. Some examples are:

- Most minor illnesses and injuries.
- Regular checkups.

You should be able to see your PCP within three weeks for routine care.

Serious Emotional Disturbance (SED): Serious Emotional Disturbance (SED) is a mental, behavioral, or emotional disturbance. An SED impacts children. An SED may last a long time and interferes with family, school, or community activities. SED does not include:

- Neurodevelopmental disorders.
- Substance-related disorders.
- Other conditions that may be a focus of clinical attention, unless they co-occur with another (SED).

Service Plan: A Service Plan is a plan of services for HCBS members. Your service plan is based on your needs and goals. It is created by you and your interdisciplinary team to meet HCBS Waiver criteria.

Skilled Nursing Care: Nursing facilities provide 24-hour care for members who need nursing or Skilled Nursing Care. Medicaid helps with the cost of care in nursing facilities. You must be medically and financially eligible. If your care needs require that licensed nursing staff be available in the facility 24 hours a day to provide direct care or make decisions regarding your care, then a skilled level of care is assigned.

Skilled Nursing Facility Level of Care: Skilled Nursing Facility Level of Care describes the type and amount of skilled nursing care a nursing facility resident needs.

Specialist: Specialists are healthcare professionals who are highly trained to treat certain conditions.

Supported Employment: Supported Employment means ongoing job supports for people with disabilities. The goal is to help the person keep a job at or above minimum wage.

Urgent Care: Urgent care is when you are not in a life-threatening or a permanent disability situation and have time to call your MCO or provider. If you have an urgent care situation, you should call your provider or MCO to get instructions. The following are some examples of urgent care:

- Fever
- Earaches
- Upper Respiratory Infection
- Stomach Pain
- Sore Throat
- Minor Cuts and Lacerations

APPENDIX

Domestic violence

Domestic violence is abuse. Abuse is unhealthy. Abuse is unsafe. It's never OK for someone to hit you. It's never OK for someone to make you afraid. Domestic violence causes harm and hurt on purpose. Domestic violence in the home can affect your children, and it can affect you. If you feel you may be a victim of abuse, call or talk to your PCP. Your PCP can talk to you about domestic violence. He or she can help you understand you have done nothing wrong and don't deserve abuse.

Safety tips for your protection:

- If you're hurt, call your PCP.
- Call 911 or go to the nearest hospital if you need emergency care. Please see the section **Emergency care** for more information.
- Have a plan on how you can get to a safe place (like a women's shelter or a friend or relative's home).
- Pack a small bag and give it to a friend to keep until you need it.

If you have questions or need help:

- Call the 24-hour Nurse HelpLine at 866-864-2544.
- Call the National Domestic Violence hotline number at 800-799-7233 (TTY 800-787-3224).

Child or adult abuse

Child abuse is any of the following inflicted upon a child:

- Physical injury
- Physical neglect
- Emotional injury
- Sexual act

Several signs, including a child's actions, may point to child abuse.

If a child reports he or she is a victim of abuse or neglect:

- Assure the child that is telling you about what happened is OK and safe.
- Respect the child's privacy.

- Don’t press for details.
- Don’t show shock or disapproval of the parents, child, or situation.

Tell the child you’re going to call someone who will help.

If you suspect child abuse, Iowa law requires you to report this. Call the Abuse Hotline at 800-362-2178.

If you suspect abuse or neglect of an adult in the community, call the Abuse Hotline at 800-362-2178. Phone lines are staffed 24 hours a day, 7 days a week. In an emergency, call your local police force or call 911.

Iowa Department of Public Health (IDPH) Program

IDPH-funded substance use disorder services may be available to people who:

- Have a family income at or below 200 percent of the Federal Poverty Level (FPL).
- Are not insured or whose insurance does not cover substance use disorder benefits.
- Are seeking substance use disorder services.
- Require substance use treatment related to a conviction or court order.

For more information about program eligibility, call Iowa Medicaid Member Services at 800-338-8366.

The covered services you can get through IDPH are listed below.

IDPH-Covered Substance Use Services
• Intake, assessment, and all necessary medical testing to determine substance use disorder diagnosis • Screening for contagious diseases • Evaluation, treatment planning and service coordination • All services provided as part of substance use disorder treatment. Depending on the level of care, services may include: – Food and lodging – Services from a doctor, nurse, social worker, psychologist, or other staff – Rehabilitation therapy and counseling – Family counseling and intervention for the primary recipient of services – Substance use-related lab tests, X-rays, or urine screenings – Equipment and supplies – Cost of prescription drugs • Outpatient and intensive outpatient services • Partial hospitalization (day treatment) • Residential Treatment (Clinically Managed Low, Medium and High) • Medically managed intensive inpatient treatment

Minors

For most Amerigroup members under age 18, our network doctors and hospitals can't give them care without a parent's or legal guardian's consent. This doesn't apply if emergency care is needed.

Parents or legal guardians also have the right to know what's in their child's medical records. Members under age 18 can ask their PCP not to tell their parents about their medical records, but the parents can still ask the PCP to see the medical records.

These rules don't apply to emancipated minors. Members under age 18 may be emancipated minors if they're married, are pregnant, or have a child.

Emancipated minors may make their own decisions about their medical care and the medical care of their children. Parents no longer have the right to see the medical records of emancipated minors.

Services covered under the state plan or other entity

There are certain services Amerigroup doesn't cover but may be paid for by the state (*member cost sharing may apply)* or other entity. These services include:

- **Services through the Program of All-Inclusive Care for the Elderly (PACE)** — PACE is a program for members who:
  - Are age 55 or older.
  - Live in select Iowa counties.
  - Meet a nursing facility level of care due to chronic illness or disability but can live safely in their homes with help from PACE services.

  If you think you may qualify for PACE services or have questions about what's covered, call Iowa Medicaid Member Services at 800-338-8366.
- **Dental services provided outside of a hospital setting** — To learn more about dental services covered by the state, call 800-338-8366.
- **Money Follows the Person (MFP) Grant services** — These services help Iowa members move out of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) or a nursing facility and into their own homes in the community of their choice. To learn more about the services offered through the MFP grant, call the state's MFP coordinator at 515-256-4637.
- **Services provided in an Iowa Veteran's Home (IVH)** — IVH is a facility that solely supports Iowa veterans, spouses and widowed spouses. Contact them toll free at 800-645-4591 if you:
  - Have questions about the services offered at IVHs or whether you qualify.
  - Would like information on cost-sharing.

- **School-based services provided by the Areas Education Agencies (AEAs) or Local Education Agencies** — This could include the following school-based services provided by AEAs to children with disabilities:
  — Speech
  — Occupational or
  — Physical therapy.
  To contact AEAs to find out more about the services offered, call 712-335-3588 or visit their website at www.iowaaea.org.

If you need help arranging a ride for services, call Amerigroup Member Services at 800-600-4441 (TTY 711).

Premiums

The Health Insurance Premium Payment (HIPP) program is a service available to people who get Medicaid. The HIPP program helps people get or keep health insurance through their employer by reimbursing the cost of the health insurance premium.

To complete an application by phone or for questions, call 888-346-9562. For a paper application, please visit www.dhsstate.ia.us/hipp.

Applications may be returned by fax at 515-725-0725 or email at hipp@dhs.state.ia.us.

Member Services ■ 800-600-4441