2024 Pennsylvania Medicaid Member Handbook

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Because Life.™

HighmarkWholecare.com

HealthChoices

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare"). **Your managed care plan may not cover all your health care expenses. Read your member handbook carefully to determine which health care services are covered.**

Highmark Wholecare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Highmark Wholecare does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Highmark Wholecare provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Highmark Wholecare provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Highmark Wholecare at 1-800-392-1147

If you believe that Highmark Wholecare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Member Appeals,
P.O. Box 22278
Pittsburgh, PA 15222
1-800-392-1147, [TTY/PA Relay 711],
Fax# (844)325-3435

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: (717) 787-1127, TTY/PA Relay 711,
Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Highmark Wholecare and the Bureau of Equal Opportunity are available to help you.

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

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-392-1147 (TTY 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-392-1147 (TTY/PA RELAY 711)**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-392-1147 (телетайп/PA RELAY 711)**.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-392-1147 (TTY/PA RELAY 711)** 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-392-1147 (TTY/PA RELAY 711)**.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-392-1147** (رقم هاتف الصم والبكم 711).

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-800-392-1147 (टिटिवाइ/PA RELAY 711)** ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-392-1147 (TTY/PA RELAY 711)** 번으로 전화해 주십시오.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-392-1147 (TTY/PA RELAY 711)** ។

ATTENTION :Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le **1-800-392-1147 (ATS/PA RELAY 711)**.

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် **1-800-392-1147 (TTY/PA RELAY 711)** သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-392-1147 (TTY/PA RELAY 711)**.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-392-1147 (TTY/PA RELAY 711)**.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-392-1147 (TTY/PA RELAY 711)**।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-800-392-1147 (TTY/PA RELAY 711)**.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-392-1147 (TTY/PA RELAY 711)**.

Section – 1

Welcome

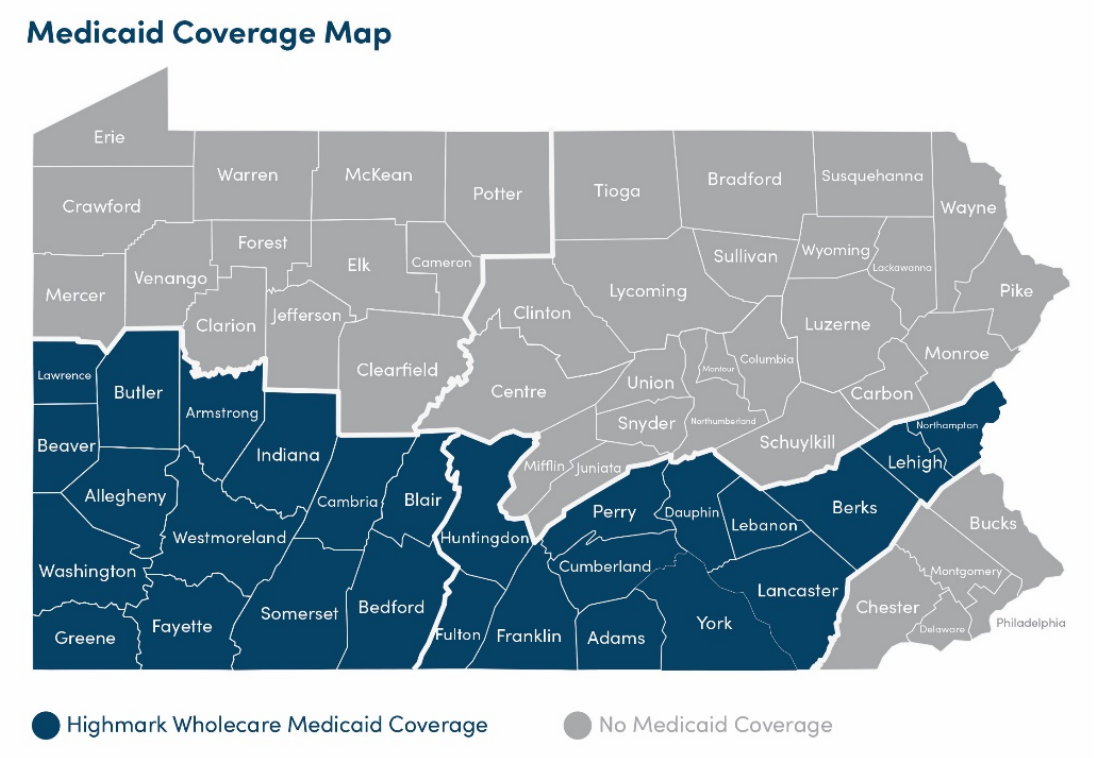
Introduction

What is HealthChoices?

HealthChoices is Pennsylvania's Medical Assistance managed care program. The Office of Medical Assistance Programs (OMAP) in Pennsylvania's Department of Human Services (DHS) oversees the physical health portion of HealthChoices. Physical health services are provided through the physical health managed care organizations (PH-MCOs). Behavioral health services are provided through behavioral health managed care organizations (BH-MCOs). For more information on behavioral health services, see page 81.

Welcome to Highmark Wholecare

Highmark Wholecare welcomes you as a member in HealthChoices and Highmark Wholecare! Highmark Wholecare is a managed health care plan licensed by the Pennsylvania Department of Health and the Pennsylvania Insurance Department. Through contracts with DHS, Highmark Wholecare offers coverage to eligible Medical Assistance recipients in 27 Pennsylvania counties.



Highmark Wholecare has a network of contracted providers, facilities, and suppliers to provide covered physical health services to members. It is important to know which

providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. Exceptions include emergencies and cases in which Highmark Wholecare authorizes use of out-of-network providers.

Member Services

Staff at Member Services can help you with:

- Questions about your Highmark Wholecare benefits
- Choosing or changing your Primary Care Provider (PCP)
- Finding a specialist or other health care provider
- Ordering a replacement member ID card
- Changing your address or phone number
- Claims or billing issues
- Filing a complaint or grievance
- Explaining what is a non-covered service

Highmark Wholecare's Member Services are available Monday through Friday, between 8 a.m. and 8 p.m. and can be reached at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Member Services can also be contacted in writing at:

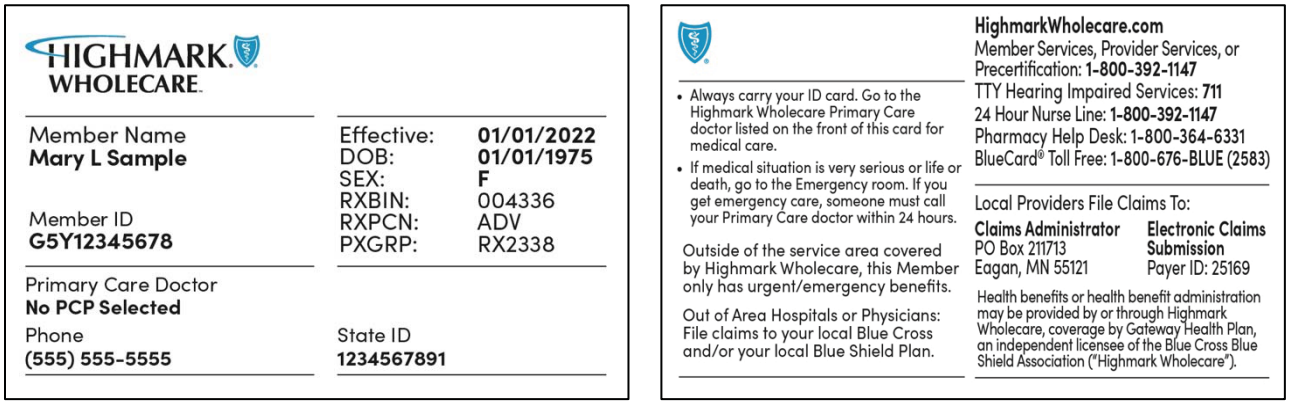
Highmark Wholecare
Attn: Member Services
PO Box 535191
Pittsburgh, PA 15253-5191

And

You can join the member portal on our website at **HighmarkWholecare.com**. The member portal will allow you to view authorizations as well as chat with a member services representative. The portal will also permit you to see claims, obtain an ID card, change your primary care physician, and review formulary medications. This easy access information does not require a call to the plan.

Member Identification Cards

Each member of your family who is enrolled with Highmark Wholecare will receive their own ID card. If you did not get your member card, you should very soon. Please call us right away if there are any mistakes on the card.



Here is what is printed on your member card:

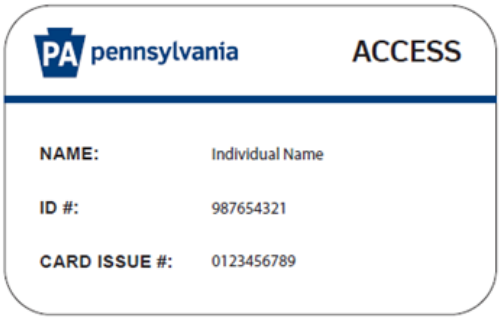
- Your ID card effective date
- Your name, gender and date of birth
- Your Highmark Wholecare member identification number
- Your State issued Medicaid ID number
- Your PCP's name and phone number
- Your assigned lab name
- Important Highmark Wholecare phone numbers

You can start using your member card on the "effective date" printed on the top right corner of the card. The card is good for as long as you stay on Medical Assistance and stay a member of Highmark Wholecare. Show your Highmark Wholecare member card each time you go to the doctors, hospital, or any other health care provider. If your Highmark Wholecare member card is lost or stolen, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984). Covered services will be available to you while you wait to receive your new card.

You will also get an ACCESS or EBT card. You will need to present this card along with your Highmark Wholecare ID card at all appointments. If you lose your ACCESS or EBT card, call your County Assistance Office (CAO). The phone number for the CAO is listed later in the **Important Contact Information** section. You will receive the following card.

The MA (Medical Assistance) cards with the Capitol and cherry blossoms may be used for cash assistance, the Supplemental Nutritional Assistance Program (SNAP) and MA. Additionally, if a Member is eligible for cash assistance, they are automatically eligible for MA. Typically, this card is issued to the person who the cash assistance and/or SNAP benefit is directed to, or for MA it is issued to the head of household.

The “Blue Card(s)” are issued only for MA to all other members of the household.



Older MA cards that may still be active are shown here. The green/blue card with yellow “ACCESS” may also serve as the head of household’s EBT card for SNAP and cash assistance, and their MA card. The yellow card is only for MA for all other members of the household.

Until you get your Highmark Wholecare ID card, use your ACCESS or EBT card for your health care services that you get through HealthChoices.

Important Contact Information

The following is a list of important phone numbers you may need. If you are not sure who to call, please contact Member Services for help: 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Emergencies

Please see Section 3, Covered Physical Health Services, beginning on page 32, for more information about emergency services. If you have an emergency, you can get help by going to the nearest emergency department, calling 911, or calling your local ambulance service.

Important Contact Information – At a Glance

Name	Contact Information: Phone or Website	Support Provided
Pennsylvania Department of Human Services Phone Numbers		
County Assistance Office/COMPASS	1-877-395-8930 or 1-800-451-5886 (TTY/TTD) or **www.compass.state.pa.us** or myCOMPASS PA mobile app for smart phones	Change your personal information for Medical Assistance eligibility. See page 16 of this handbook for more information.
Fraud and Abuse Reporting Hotline, Department of Human Services	1-844-DHS-TIPS (1-844-347-8477)	Report member or provider fraud or abuse in the Medical Assistance Program. See page 31 of this handbook for more information.
Other Important Phone Numbers		
Highmark Wholecare Nurse Hotline	1-855-805-9408 TTY users call 711 or 1-800-654-5984	Talk with a nurse 24 hours a day, 7 days a week, about urgent health matters. See page 21 of this handbook for information.
Enrollment Assistance Program	1-800-440-3989 1-800-618-4255 (TTY)	Pick or change a HealthChoices plan. See page 15 of this handbook for more information.
Insurance Department,	1-877-881-6388	Ask for a Complaint form, file a Complaint, or talk to a consumer services representative.

Bureau of Consumer Services		
Protective Services	1-800-490-8505	Report suspected abuse, neglect, exploitation, or abandonment of an adult over age 60 or an adult between age 18 and 59 who has a physical or mental disability.

Other Phone Numbers

Childline	1-800-932-0313
County Assistance Office	See page 106
Crisis Intervention Services	988
Legal Aid	1-800-322-7572
Medical Assistance Transportation Program	See page 105
Mental Health/Intellectual Disability Services	See page 81

Suicide and Crisis Lifeline

The 988 Suicide and Crisis Lifeline number is available 24/7

Call: 988
Text: 988
Visit or Chat: **988lifeline.org**

If mental health care or support is needed, you can learn more about services in PA at **https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/default.aspx**.

Communication Services

Highmark Wholecare can provide this Handbook and other information you need in languages other than English at no cost to you. Highmark Wholecare can also provide your Handbook and other information you need in other formats such as compact disc, Braille, large print, DVD, electronic communication, and other formats if you need them, at no cost to you. Please contact Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984)- to ask for any help you need. Depending on the information you need, it may take up to 5 business days for Highmark Wholecare to send you the information.

Highmark Wholecare will also provide an interpreter, including for American Sign Language or TTY services, if you do not speak or understand English or are deaf or hard of hearing. These services are available at no cost to you. If you need an interpreter, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and Member Services will connect you with the interpreter service that meets your needs. For TTY services, call our specialized number at 711 or 1-800-654-5984 or call Member Services who will connect you to the next available TTY line.

If your PCP or other provider cannot provide an interpreter for your appointment, Highmark Wholecare will provide one for you. Please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) if you need an interpreter for an appointment.

Enrollment

In order to get services in HealthChoices, you need to stay eligible for Medical Assistance. You will get paperwork or a phone call about renewing your eligibility. It is important that you follow instructions so that your Medical Assistance does not end. If you have questions about any paperwork you get or if you are unsure whether your eligibility for Medical Assistance is up to date, call Highmark Wholecare Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or your CAO.

Enrollment Services

The Medical Assistance Program works with the Enrollment Assistance Program (EAP) to help you enroll in HealthChoices. You received information about the EAP with the information you received about selecting a HealthChoices plan. Enrollment specialists can give you information about all of the HealthChoices plans available in your area so that you can decide which one is best for you. If you do not pick a HealthChoices plan, a HealthChoices plan will be chosen for you. Enrollment specialists can also help you if you want to change your HealthChoices plan or if you move to another county.

Enrollment specialists can help you:

- Pick a HealthChoices plan
- Change your HealthChoices plan
- Pick a PCP when you first enroll in a HealthChoices plan
- Answer questions about all of the HealthChoices plans
- Determine whether you have special needs, which could help you decide which HealthChoices plan to pick
- Give you more information about your HealthChoices plan

To contact the EAP, call 1-800-440-3989 or 1-800-618-4225 (TTY).

Changing Your HealthChoices Plan

You may change your HealthChoices plan at any time, for any reason. To change your HealthChoices plan, call the EAP at 1-800-440-3989 or 1-800-618-4225 (TTY). They will tell you when the change to your new HealthChoices plan will start, and you will stay in Highmark Wholecare until then. It can take up to 6 weeks for a change to your HealthChoices plan to take effect. Use your Highmark Wholecare ID card at your appointments until your new plan starts.

Changes in the Household

Call your CAO and Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) if there are any changes to your household.

For example:

- Someone in your household is pregnant or has a baby
- Your address or phone number changes
- You or a family member who lives with you gets other health insurance
- You or a family member who lives with you gets very sick or becomes disabled
- A family member moves in or out of your household
- There is a death in the family

A new baby is automatically assigned to the mother's current HealthChoices plan. You may change your baby's plan by calling the EAP at **1-800-440-3989**. Once the change is made you will receive a new HealthChoices member ID card for your baby.

Remember that it is important to call your CAO right away if you have any changes in your household because the change could affect your benefits.

What Happens if I Move?

If you move out of your county, you may need to choose a new HealthChoices plan. Contact your CAO if you move. If Highmark Wholecare also serves your new county, you can stay with Highmark Wholecare. If Highmark Wholecare does not serve your new county, the EAP can help you select a new plan.

If you move out of state, you will no longer be able to get services through HealthChoices. Your caseworker will end your benefits in Pennsylvania. You will need to apply for benefits in your new state.

Loss of Benefits

There are a few reasons why you may lose your benefits completely.

They include:

- Your Medical Assistance ends for any reason. If you are eligible for Medical Assistance again within 6 months, you will be re-enrolled in the same HealthChoices plan unless you pick a different HealthChoices plan.
- You go to a nursing home outside of Pennsylvania.
- You have committed Medical Assistance fraud and have finished all appeals.
- You go to prison or are placed in a youth development center.

There are also reasons why you may no longer be able to receive services through a physical health MCO and you will be placed in the fee-for service program.

They include:

- You are placed in a juvenile detention center for more than 35 days in a row.
- You are 21 years of age or older and begin receiving Medicare Part D (Prescription Drug Coverage).
- You go to a state mental health hospital

You may also become eligible for Community HealthChoices. If you become eligible for Medicare coverage or become eligible for nursing facility or home and community-based services, you will be eligible for Community HealthChoices. For more information on Community HealthChoices visit **www.healthchoices.pa.gov**.

You will receive a notice from DHS if you lose your benefits or if you are no longer able to receive services through a physical health MCO and will begin to receive services through the fee-for-service system or Community HealthChoices.

Information About Providers

The Highmark Wholecare provider directory has information about the providers in Highmark Wholecare's network. The provider directory is located online here: **HighmarkWholecare.com**. You may call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) to ask that a copy of the provider directory be sent to you or to request information about where a doctor went to medical school or their residency program. You may also call Member Services to get help finding a provider. The

provider directory includes the following information about network providers:

- Name, address, website address, email address, telephone number
- Whether or not the provider is accepting new patients
- Days and hours of operation
- The provider's credentials and board certifications
- The provider's specialty and services offered by the provider
- Whether or not the provider speaks languages other than English and, if so, which languages
- Whether or not the provider locations are wheelchair accessible

The information in the printed provider directory may change. You can call Member Services to check if the information in the provider directory is current. Highmark Wholecare updates the printed provider directory monthly. The online directory is updated at least monthly.

Picking Your Primary Care Provider (PCP)

Your PCP is the doctor or doctors' group who provides and works with your other health care providers to make sure you get the health care services you need. Your PCP refers you to specialists you need and keeps track of the care you get by all of your providers.

A PCP may be a family doctor, a general practice doctor, a pediatrician (for children and teens), or an internist (internal medicine doctor). You may also pick a certified registered nurse practitioner (CRNP) as a PCP. A CRNP works under the direction of a doctor and can do many of the same things a doctor can do such as prescribing medicine and diagnosing illnesses.

Some doctors have other medical professionals who may see you and provide care and treatment under the supervision of your PCP.

Some of these medical professionals may be:

- Physician Assistants
- Medical Residents
- Certified Nurse-Midwives

If you have Medicare, you can stay with the PCP you have now even if your PCP is not in Highmark Wholecare's network. If you do not have Medicare, your PCP must be in Highmark Wholecare's network.

If you have special needs, you can ask for a specialist to be your PCP. The specialist needs to agree to be your PCP and must be in Highmark Wholecare's network.

Enrollment specialists can help you pick your first PCP with Highmark Wholecare. If you do not pick a PCP through the EAP within 14 days of when you picked Highmark Wholecare, we will pick your PCP for you.

Changing Your PCP

If you want to change your PCP for any reason, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) to ask for a new PCP. If you need help finding a new PCP, you can go to **HighmarkWholecare.com**, which includes a provider directory, or ask Member Services to send you a printed provider directory.

Highmark Wholecare will send you a new ID card with the new PCP's name and phone number on it. The Member Services representative will tell you when you can start seeing your new PCP.

When you change your PCP, Highmark Wholecare can help coordinate sending your medical records from your old PCP to your new PCP. In emergencies, Highmark Wholecare will help to transfer your medical records as soon as possible.

If you have a pediatrician or pediatric specialist as a PCP, you may ask for help to change to a PCP who provides services for adults.

Office Visits

Making an Appointment with Your PCP

To make an appointment with your PCP, call your PCP's office. If you need help making an appointment, please call Highmark Wholecare's Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

If you need help getting to your doctor's appointment, please see the Medical Assistance Transportation Program (MATP) section on page 70 of this Handbook or call Highmark Wholecare's Member Services at the phone number above.

If you do not have your Highmark Wholecare ID card by the time of your appointment, take your ACCESS or EBT card with you. You should also tell your PCP that you selected Highmark Wholecare as your HealthChoices plan.

Appointment Standards

Highmark Wholecare's providers must meet the following appointment standards:

- Your PCP should see you within 10 business days of when you call for a routine appointment.
- You should not have to wait in the waiting room longer than 30 minutes unless the doctor has an emergency.
- If you have an urgent medical condition, your provider should see you within 24 hours of when you call for an appointment.
- If you have an emergency, the provider must see you immediately or refer you to an emergency room.
- If you are pregnant and
    - In your first trimester, your provider must see you within 10 business days of Highmark Wholecare learning you are pregnant.
    - In your second trimester, your provider must see you within 5 business days of Highmark Wholecare learning you are pregnant.
    - In your third trimester, your provider must see you within 4 business days of Highmark Wholecare learning you are pregnant.
    - Have a high-risk pregnancy, your provider must see you within 24 hours of Highmark Wholecare learning you are pregnant.

Referrals

A referral is when your PCP sends you to a specialist. A specialist is a doctor (or a doctor's group) or a CRNP who focuses his or her practice on treating one disease or medical condition or a specific part of the body. If you go to a specialist without a referral from your PCP, you may have to pay the bill.

If Highmark Wholecare does not have at least 2 specialists in your area and you do not want to see the one specialist in your area, Highmark Wholecare will work with you to see an out-of-network specialist at no cost to you. Your PCP must contact Highmark Wholecare to let Highmark Wholecare know you want to see an out-of-network specialist and get approval from Highmark Wholecare before you see the specialist.

Your PCP will help you make the appointment with the specialist. The PCP and the specialist will work with you and with each other to make sure you get the health care you need.

Sometimes you may have a special medical condition where you need to see the specialist often. When your PCP refers you for several visits to a specialist, this is called a standing referral.

For a list of specialists in Highmark Wholecare's network, please see the provider directory on our website at **HighmarkWholecare.com** or call Member Services to ask for help or a printed provider directory.

Self-Referrals

Self-referrals are services you arrange for yourself and do not require that your PCP arrange for you to receive the service. You must use a Highmark Wholecare network provider unless Highmark Wholecare approves an out-of-network provider.

The following services do not require referral from your PCP:

- Prenatal visits
- Routine obstetric (OB) care
- Routine gynecological (GYN) care
- Routine family planning services (may see out-of-network provider without approval)
- Routine dental services
- Routine eye exams
- Emergency services

You do not need a referral from your PCP for behavioral health services. You can call your behavioral health managed care organization for more information. Please see section 7 of the handbook, page 81 for more information.

After-Hours Care

You can call your PCP for non-emergency medical problems 24 hours a day, 7 days a week. On-call health care professionals will help you with any care and treatment you need.

Highmark Wholecare has a toll-free nurse hotline at 1-855-805-9408 (TTY: 711 or 1-800-654-5984) that you can also call 24 hours a day, 7 days a week. A nurse will talk with you about your urgent health matters.

Member Engagement

Suggesting Changes to Policies and Services

Highmark Wholecare would like to hear from you about ways to make your experience with HealthChoices better. If you have suggestions for how to make the program better or how to deliver services differently, please contact Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Highmark Wholecare Health Education Advisory Committee (HEAC)

Highmark Wholecare has a Health Education Advisory Committee (HEAC) that includes members and network providers. The Committee provides advice to Highmark Wholecare about the experiences and needs of members like you. For more information about the Committee, please call 1-800-392-1147 (TTY users call 711 or 1-800-654-5984) or visit the website at **HighmarkWholecare.com**.

Highmark Wholecare Quality Improvement Program

Highmark Wholecare's Quality Improvement and Utilization Management (QI/UM) Program tries to make sure you are receiving the best health care and services possible. Highmark Wholecare is always looking at how well we help you:

- Get care to keep from getting sick
- Get care for health issues you have had for a while
- Know about the medicines you take
- Stay out of the hospital
- Have access to doctors
- Make and keep doctor visits
- Share health information with doctors
- Get care in a way that respects your culture
- Keep healthy and safe

The Quality Program uses tools to see how we are doing and to help set goals for the future. Some of these tools include survey results, medical record reviews, and the Healthcare Effectiveness Data Information Set (HEDIS®). We also work with our doctors to keep an eye on the care and services our members are getting, and to figure out what we can do to be better.

Highmark Wholecare has a QI/UM Work Plan that details all the things that happen in our Quality Program. This Work Plan is checked every three months to look for issues so that we can address them.

Highmark Wholecare also reviews its Quality Program every year to see how well we are meeting the health care and service needs of our members. The Quality Improvement Program evaluation is performed annually to see how well we have done at meeting our goals, what new programs to put in place, and learned where we can improve.

As part of the Quality Program review, Highmark Wholecare conducts Performance Improvement Projects (PIPs). PIPs are studies that meet State contract requirements based on either clinical care or non-clinical services. The PIPs address key quality areas of focus for improvements. Please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) if you would like to more information about our Quality

Program, QI/UM Work Plan, a summary evaluation of the annual QI/UM Program or outcomes from the PIPs, available upon request.

Section – 2

Rights and Responsibilities

Member Rights and Responsibilities

Highmark Wholecare and its network of providers do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

As a Highmark Wholecare member, you have the following rights and responsibilities.

Member Rights

You have the right:

1. To be treated with respect, recognizing your dignity and need for privacy, by Highmark Wholecare staff and network providers.

2. To get information in a way that you can easily understand and find help when you need it.

3. To get information that you can easily understand about Highmark Wholecare, its services, and the doctors and other providers that treat you.

4. To pick the network health care providers that you want to treat you.

5. To get emergency services when you need them from any provider without Highmark Wholecare's approval.

6. To get information that you can easily understand and talk to your providers about your treatment options, risks of treatment, and tests that may be self-administered without any interference from Highmark Wholecare.

7. To make all decisions about your health care, including the right to refuse treatment. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.

8. To talk with providers in confidence and to have your health care information and records kept confidential.

9. To see and get a copy of your medical records and to ask for changes or corrections to your records.

10. To ask for a second opinion.

11. To file a Grievance if you disagree with Highmark Wholecare's decision that a service is not medically necessary for you.

12. To file a Complaint if you are unhappy about the care or treatment you have received.

13. To ask for a DHS Fair Hearing.

14. To be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.

15. To get information about services that Highmark Wholecare or a provider does not cover because of moral or religious objections and about how to get those services.

16. To exercise your rights without it negatively affecting the way DHS, Highmark Wholecare, and network providers treat you.

17. To create an advance directive. See Section 6 on page 75 for more information.

18. To make recommendations about the rights and responsibilities of Highmark Wholecare's members.

Member Responsibilities

Members need to work with their health care service providers. Highmark Wholecare needs your help so that you get the services and supports you need.

These are the things you should do:

1. Provide, to the extent you can, information needed by your providers.

2. Follow instructions and guidelines given by your providers.

3. Be involved in decisions about your health care and treatment.

4. Work with your providers to create and carry out your treatment plans.

5. Tell your providers what you want and need.

6. Learn about Highmark Wholecare coverage, including all covered and non-covered benefits and limits.

7. Use only network providers unless Highmark Wholecare approves an out-of-network provider or you have Medicare.

8. Get a referral from your PCP to see a specialist.

9. Respect other patients, provider staff, and provider workers.

10. Make a good-faith effort to pay your co-payments.

11. Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

Privacy and Confidentiality

Highmark Wholecare must protect the privacy of your protected health information (PHI). Highmark Wholecare must tell you how your PHI may be used or shared with others. This includes sharing your PHI with providers who are treating you or so that Highmark Wholecare can pay your providers. It also includes sharing your PHI with DHS. This information is included in Highmark Wholecare's Notice of Privacy Practices. To get a copy of Highmark Wholecare's Notice of Privacy Practices, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or visit **HighmarkWholecare.com**.

Co-payments

A co-payment is the amount you pay for some covered services. It is usually only a small amount. You will be asked to pay your co-payment when you get the service, but you cannot be denied a service if you are not able to pay a co-payment at that time. If you did not pay your co-payment at the time of the service, you may receive a bill from your provider for the co-payment.

Co-payment amounts can be found in the Covered Services chart starting on page 33 of this Handbook.

The following members do not have to pay co-payments:

- Members under age 18
- Pregnant women (including 1 year after the child is born (the post-partum period))
- Members who live in a long-term care facility, including Intermediate Care Facilities for the Intellectually Disabled and Other Related Conditions or other medical institution
- Members who live in a personal care home or domiciliary care home
- Members eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program
- Members eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance

The following services do not require a co-payment:

- Emergency services

- Laboratory services
- Family planning services, including supplies
- Hospice services
- Home health services
- Tobacco cessation services
- Antipsychotic medications
- Antidiabetic medications, including insulin
- Antineoplastic medications (cancer drugs)
- Antiparkinson medications
- Antiglaucoma medications
- Antihypertensive medications
- Anticonvulsant medications
- Cardiovascular medications (Antiarrhythmics, antianginals, anticoagulants, lipid lowering agents)
- HIV/AIDS medications
- Naloxone
- Influenza, Pneumonia and Zoster vaccines

What if I Am Charged a Co-payment and I Disagree?

If you believe that a provider charged you the wrong amount for a co-payment or a co-payment you believe you should not have had to pay, you can file a Complaint with Highmark Wholecare. Please see Section 8, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint, or call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Billing Information

Providers in Highmark Wholecare's network may not bill you for medically necessary services that Highmark Wholecare covers. Even if your provider has not received payment or the full amount of his or her charge from Highmark Wholecare, the provider may not bill you. This is called balance billing.

When Can a Provider Bill Me?

Providers may bill you if:

- You did not pay your co-payment.
- You received services from an out-of-network provider without approval from Highmark Wholecare and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received services that are not covered by Highmark Wholecare and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.

- You received a service from a provider that is not enrolled in the Medical Assistance Program.

What Do I Do if I Get a Bill?

If you get a bill from a Highmark Wholecare network provider and you think the provider should not have billed you, you can call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

If you get a bill from a provider for one of the above reasons that a provider is allowed to bill you, you should pay the bill or call the provider.

Third-Party Liability

You may have Medicare or other health insurance. Medicare or your other health insurance is your primary insurance. This other insurance is known as “third party liability” or TPL. Having other insurance does not affect your Medical Assistance eligibility. In most cases, your Medicare or other insurance will pay your PCP or other provider before Highmark Wholecare pays. Highmark Wholecare can only be billed for the amount that your Medicare or other health insurance does not pay.

You must tell both your CAO and Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) if you have Medicare or other health insurance. When you go to a provider or to a pharmacy you must tell the provider or pharmacy about all forms of medical insurance you have and show the provider or pharmacy your Medicare card or other insurance card, ACCESS or EBT card, and your Highmark Wholecare ID card. This helps make sure your health care bills are paid timely and correctly.

Coordination of Benefits

If you have Medicare and the service or other care you need is covered by Medicare, you can get care from any Medicare provider you pick. The provider does not have to be in Highmark Wholecare’s network. You also do not have to get prior authorization from Highmark Wholecare or referrals from your Medicare PCP to see a specialist. Highmark Wholecare will work with Medicare to decide if it needs to pay the provider after Medicare pays first if the provider is enrolled in the Medical Assistance Program.

If you need a service that is not covered by Medicare but is covered by Highmark Wholecare, you must get the service from a Highmark Wholecare network provider. All Highmark Wholecare rules, such as prior authorization and specialist referrals, apply to these services.

If you do not have Medicare but you have other health insurance and you need a service or other care that is covered by your other insurance, you must get the service from a provider that is in both the network of your other insurance and Highmark Wholecare’s network. You need to follow the rules of your other insurance and

Highmark Wholecare, such as prior authorization and specialist referrals. Highmark Wholecare will work with your other insurance to decide if it needs to pay for the services after your other insurance pays the provider first.

If you need a service that is not covered by your other insurance, you must get the services from a Highmark Wholecare network provider. All Highmark Wholecare rules, such as prior authorization and specialist referrals, apply to these services.

Recipient Restriction/Lock-in Program

The Recipient Restriction/Member Lock-In Program requires a member to use specific providers if the member has abused or overused his or her health care or prescription drug benefits. Highmark Wholecare works with DHS to decide whether to limit a member to a doctor, pharmacy, hospital, dentist, or other provider.

How Does it Work?

Highmark Wholecare reviews the health care and prescription drug services you have used. If Highmark Wholecare finds overuse or abuse of health care or prescription services, Highmark Wholecare asks DHS to approve putting a limit on the providers you can use. If approved by DHS, Highmark Wholecare will send you a written notice that explains the limit.

You can pick the providers, or Highmark Wholecare will pick them for you. If you want a different provider than the one Highmark Wholecare picked for you, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984). The limit will last for 5 years even if you change HealthChoices plans.

If you disagree with the decision to limit your providers, you may appeal the decision by asking for a DHS Fair Hearing, within 30 days of the date of the letter telling you that Highmark Wholecare has limited your providers.

You must sign the **written** request for a Fair Hearing and send it to:
Department of Human Services
Office of Administration
Bureau of Program Integrity - DPPC
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

If you need help asking for a Fair Hearing, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or contact your local legal aid office.

If your appeal is postmarked within 15 days of the date on Highmark Wholecare's notice, the limits will not apply until your appeal is decided. If your appeal is postmarked more than 10 days but within 30 days from the date on the notice, the limits will be in

effect until your appeal is decided. The Bureau of Hearings and Appeals will let you know, in writing, of the date, time, and place of your hearing. You may not file a Grievance or Complaint through Highmark Wholecare about the decision to limit your providers.

After 5 years, Highmark Wholecare will review your services again to decide if the limits should be removed or continued and will send the results of its review to DHS. Highmark Wholecare will tell you the results of the review in writing.

Reporting Fraud or Abuse

How Do I Report Member Fraud or Abuse?

If you think that someone is using your or another member's Highmark Wholecare card to get services, equipment, or medicines, is forging or changing their prescriptions, or is getting services they do not need, you can call the Highmark Wholecare Fraud and Abuse Hotline at 1-844-718-6400 (TTY: 711 or 1-800-654-5984) to give Highmark Wholecare this information. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

How Do I Report Provider Fraud or Abuse?

Provider fraud is when a provider bills for services, equipment, or medicines you did not get or bills for a different service than the service you received. Billing for the same service more than once or changing the date of the service are also examples of provider fraud. To report provider fraud you can call the Highmark Wholecare's Fraud and Abuse Hotline at 1-844-718-6400 (TTY: 711 or 1-800-654-5984). You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

Section 3 –

Physical Health Services

Covered Services

The chart below lists the services that are covered by Highmark Wholecare when the services are medically necessary. Some of the services have limits or co-payments, or need a referral from your PCP or require prior authorization by Highmark Wholecare. If you need services beyond the limits listed below, your provider can ask for an exception, as explained later in this section.

Limits do not apply if you are under age 21 or pregnant.

All medically necessary Medicaid-coverable services in any amount are covered for individual members under the age of 21.

Service		Children	Adults
Primary Care Provider	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Specialist	Limit	N/A	No
	Co-payment	$0	$2 per visit
	Prior Authorization / Referral	N/A	No/Yes
Certified Registered Nurse Practitioner	Limit	N/A	No
	Co-payment	$0	$0 or $2 per visit[1]
	Prior Authorization / Referral	N/A[1]	No/No[1]
Federally Qualified Health Center / Rural Health Center	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Outpatient Non-Hospital Clinic	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes[2]/N/A[2]	Yes[2]/No[2]
Outpatient Hospital Clinic	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes[3]/N/A	Yes[3]/No
Podiatrist Services	Limit	N/A	No
	Co-payment	$0 per visit	$2 per visit
	Prior Authorization / Referral	N/A	No/Yes
Chiropractor Services	Limit	N/A	No
	Co-payment	$0 per visit	$2 per visit
	Prior Authorization / Referral	Yes/N/A	Yes/No
Optometrist Services	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Hospice Care	Limit	N/A	No
	Co-payment	$0	$0

Service		Children	Adults
	Prior Authorization / Referral	Yes/N/A	Yes/No
Dental Care Services	Limit	See Dental Care Services on Page 45	See Dental Care Services on Page 45
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes[4]/N/A	Yes[4]/No
Radiology (ex. X-rays, MRIs, CTs)	Limit	N/A	No
	Co-payment	$0 per service	$1 per service
	Prior Authorization / Referral	Yes[5]/N/A	Yes[5]/No
Outpatient Hospital Short Procedure Unit	Limit	N/A	No
	Co-payment	$0 per service	$3 per service
	Prior Authorization / Referral	Yes[6]/N/A	Yes[6]/No
Outpatient Ambulatory Surgical Center	Limit	N/A	No
	Co-payment	$0 per service	$3 per service
	Prior Authorization / Referral	Yes[7]/N/A	Yes[7]/No
Non-Emergency Medical Transport	Limit	Contact your County MATP provider. See page 105	Contact your county MATP provider. See page 105
	Co-payment	Contact your county MATP provider. See page 105	Contact your county MATP provider. See page 105
	Prior Authorization / Referral	N/A	No/No
Family Planning Services	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes[8]/N/A	Yes[8]/No
Renal Dialysis	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Emergency Services	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Urgent Care Services	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Ambulance Services	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Inpatient Hospital	Limit	N/A	No
	Co-payment		$3 Per Day /

Service		Children	Adults
		$0 Per Day	$21 Max Per Admission
	Prior Authorization / Referral	Yes/N/A	Yes/No
Inpatient Rehab Hospital	Limit	N/A	No
	Co-payment	N/A	$3 Per Day / $21 Max Per Admission
	Prior Authorization / Referral	N/A	Yes/No
Maternity Care	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Prescription Drugs	Limit	34-day supply	34-day supply
	Co-payment	$0	$1 generic $3 brand
	Prior Authorization / Referral	See formulary	See formulary
Enteral/Parenteral Nutritional Supplements	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes/N/A	Yes/No
Nursing Facility Services	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes/N/A	Yes/No
Home Health Care including Nursing, Aide, and Therapy Services	Limit	N/A	28 Days Unlimited/15 Days Per Month Thereafter
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes[9]/N/A	Yes[9]/No
Durable Medical Equipment	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes10/N/A	Yes10/No
Prosthetics and Orthotics	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes/N/A	Yes/No
Eyeglass Lenses	Limit	No limits, but after 4 standard lenses per calendar year, additional lenses in that	See Vision Care Services on Page 49

Service		Children	Adults
		year must be prior authorized	
	Co-payment	$0	See Vision Care Services on Page 49
	Prior Authorization / Referral	Prior Auth.: No Referral: No	No/No
Eyeglass Frames	Limit	No limits, but after 2 standard frames per calendar year, additional frames in that year must be prior authorized	See Vision Care Services on Page 49
	Co-payment	$0	See Vision Care Services on Page 49
	Prior Authorization / Referral	Prior Auth.: No Referral: No	No/No
Contact Lenses	Limit	No limits, but after 4 lenses per calendar year, additional lenses in that year must be prior authorized.	See Vision Care Services on Page 49
	Co-payment	$0	See Vision Care Services on Page 49
	Prior Authorization / Referral	Prior Auth.: No Referral: No	No/No
Contact Lenses Fitting	Limit	Covered when medically necessary	
	Co-payment	$0	
	Prior Authorization / Referral	Prior Auth.: No Referral: No	
Medical Supplies	Limit	N/A	No

Service		Children	Adults
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No
Therapy (Physical, Occupational, Speech)	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	Yes/N/A	Yes/No
Laboratory	Limit	N/A	No
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No11/No
Tobacco Cessation	Limit	70 Visits Per Calendar Year	70 Visits Per Calendar Year
	Co-payment	$0	$0
	Prior Authorization / Referral	N/A	No/No

1. Certified Registered Nurse Practitioner – Copayments dependent on place of service (Primary Care or Specialist).
2. Outpatient Non-Hospital Clinic – Prior authorization required on certain services.
3. Outpatient Hospital Clinic – Certain outpatient hospital procedures require prior authorization, such as heart surgeries, implants or changing someone's gender or preventing pregnancy.
4. Dental – Services for children that require prior authorization include crowns, surgical extractions, periodontal services, root canals and braces; Services for adults that require prior authorization include extractions and root canals (if performed by a general dentist). Adult services that require an exception include crowns, periodontal services, additional evaluations, cleanings, dentures, and other services above the frequency or lifetime limit.
5. Radiology – Advanced x-rays, such as CT scan, MRI or PET scan require prior authorization. Simple x-rays do not.
6. Outpatient Hospital Short Procedure Unit – Certain outpatient day surgeries require prior authorization, such as some heart surgeries or implants or changing someone's gender or preventing pregnancy.
7. Outpatient Ambulatory Surgical – Certain outpatient ambulatory surgery procedures require prior authorization, such as implants or changing someone's gender or preventing pregnancy.
8. Family Planning – Sterilization procedures require prior authorization.
9. Home Health Care including Nursing, Aide, and Therapy Services – Shift care nursing or home therapy requires prior authorization. Home health nurse or aide visits do not.
10. Durable Medical Equipment – Such as crutches, canes or walkers do not require prior authorization. More advanced equipment, such as power wheelchairs and scooters require prior authorization.
11. Laboratory – Highmark Wholecare members are required to have all of their outpatient laboratory work completed through the member's designated laboratory. The member's designated laboratory is listed on the member's ID card. BRCA/genetic testing and sleep testing requires prior authorization.

Services That Are Not Covered

There are physical health services that Highmark Wholecare does not cover. If you have any questions about whether or not Highmark Wholecare covers a service for you, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

MCOs may choose to cover experimental medical procedures, medicines, and equipment based on your specific situation. MCOs must provide coverage for routine patient care costs for beneficiaries participating in qualifying clinical trials.

Second Opinions

You have the right to ask for a second opinion if you are not sure about any medical treatment, service, or non-emergency surgery that is suggested for you. A second opinion may give you more information that can help you make important decisions about your treatment. A second opinion is available to you at no cost other than a co-pay.

Call your PCP to ask for the name of another Highmark Wholecare network provider to get a second opinion. If there are not any other providers in Highmark Wholecare's network, you may ask Highmark Wholecare for approval to get a second opinion from an out-of-network provider.

What is Prior Authorization?

Some services or items need approval from Highmark Wholecare before you can get the service. This is called Prior Authorization. For services that need prior authorization, Highmark Wholecare decides whether a requested service is medically necessary before you get the service. You or your provider must make a request to Highmark Wholecare for approval before you get the service.

What Does Medically Necessary Mean?

Medically necessary means that a service, item, or medicine does one of the following:

- It will, or is reasonably expected to, prevent an illness, condition, or disability;
- It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
- It will help you to get or keep the ability to perform daily tasks, taking into consideration both your abilities and the abilities or someone of the same age.

If you need any help understanding when a service, item, or medicine is medically necessary or would like more information, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Utilization Review

Doctors and nurses who work for Highmark Wholecare make decisions about the care that is most likely to help you by using specific guidelines (rules) for medical decisions. First, you must be currently enrolled as a Highmark Wholecare member. The guidelines are based on whether the service is medically necessary as defined by the Department of Human Services. There is no extra payment given to the doctors and nurses no matter what they decide about your care. Also, there is no extra payment given to

doctors and nurses for under-utilization (not using enough) of medical services. In other words, Highmark Wholecare's doctors and nurses are not rewarded for reducing the amount of care provided.

If you need a service that must be approved by Highmark Wholecare before it is done, your doctor will call the Health Services Department to get an approval. The doctors and nurses in Health Services will look at all the medical facts given by your doctor within certain time limits to decide if this service is the best way to take care of you. Medication (drug) requests are reviewed by pharmacists, nurses, and doctors. When Highmark Wholecare approves care, you will get a letter telling you the approval decision. When Highmark Wholecare denies, reduces, or approves a request differently than your doctor's request, you will get a letter (notice) explaining Highmark Wholecare's decision. This letter contains important information on how to contact Highmark Wholecare and get help if you disagree with the decision.

How to Ask for Prior Authorization

If you need a service that must be approved by Highmark Wholecare in advance, your PCP or specialist will call Highmark Wholecare to get an approval. The doctors and nurses in Highmark Wholecare's Health Services Department will look at all of the medical facts given by your doctor and will work with your doctor to choose the best way to take care of you. Highmark Wholecare's doctors and nurses make the choice based on if the care is medically necessary and needed for you.

If you need help to better understand the prior authorization process, talk to your PCP or specialist or call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

If you or your provider would like a copy of the medical necessity guidelines or other rules that were used to decide your prior authorization request, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

What Services, Items, or Medicines Need Prior Authorization?

The following chart identifies some, but not all services, items, and medicines that require prior authorization.

1. Specific inpatient stays including skilled nursing facility, rehabilitation, organ transplant, and gender transition services.

2. Services provided outside the hospital can include, but not be limited to:

    - Certain outpatient procedures or day surgeries
    - Home health care visits
    - Home care provided in shifts
    - BRCA/genetic testing
    - Sleep tests in a lab

- Weight loss surgery in the hospital or offsite
- Changing someone's gender in the hospital or offsite
- Outpatient physical therapy/occupational therapy/speech therapy
- Chiropractic services
- Non-participating Ambulances except in emergencies
- End of life care
- Abortion and surgery to prevent pregnancy
- Advanced x-rays (For example: MRI/CT Scans)
- Radiation treatment
- Non Participating Providers

3. Experimental and investigational services such as research studies outside of usual medical practices.

4. Care from providers outside of the Highmark Wholecare network.

5. A service or item that is not provided or is more than what is provided in Medicaid. Your doctor can make a request.

6. Plastic surgery to rebuild parts of the face or body.

7. Certain types of durable medical equipment, such as power wheelchairs or scooters.

For those services that have limits, if you or your provider believes that you need more services than the limit on the service allows, you or your provider can ask for more services through the prior authorization process.

If you are or your provider is unsure about whether a service, item, or medicine requires prior authorization, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Prior Authorization of a Service or Item

Highmark Wholecare will review the prior authorization request and the information you or your provider submitted. Highmark Wholecare will tell you of its decision within 2 business days of the date Highmark Wholecare received the request if Highmark Wholecare has enough information to decide if the service or item is medically necessary.

If Highmark Wholecare does not have enough information to decide the request, we must tell your provider within 48 hours of receiving the request that we need more information to decide the request and allow 14 days for the provider to give us more information. Highmark Wholecare will tell you of our decision within 2 business days after Highmark Wholecare receives the additional information.

You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

Prior Authorization of Home Accessibility Durable Medical Equipment

Home Accessibility Durable Medical Equipment (DME) is equipment and appliances that are used to serve a medical purpose and are generally not useful to a person without a disability, illness, or injury. These items can withstand repeated use and can be reusable or removable.

Covered items include:

- Wheelchair lifts
- Stair glides
- Ceiling lifts
- Metal accessibility ramps
- Other items used by a member with a mobility impairment to enter and exit the home
- Are used to support activities of daily activities
- Are removable and reusable

Also covered are:

- Installation costs
- Medically necessary repairs to the equipment
- Parts or supplies recommended by the manufacturer
- Labor to attach or mount the item
- Required permits
- Installing an electrical outlet or connection to an existing electrical source
- Pouring a concrete slab or foundation
- External supports such as bracing a wall
- Removing/replacing an existing railing or banister as needed to accommodate the equipment

Home modifications, such as home repairs, or changes to the home, are not a covered benefit.

A prior authorization request must include a letter of medical necessity or other clinical information from your doctor telling us:

- Why you need the equipment and/or appliance
- That the equipment and/or appliance can be safely installed
- That you can safely use the equipment and/or appliance
- That you or your caretaker can activate and control the equipment and/or appliance
- That you have an on-going need for the equipment and/or appliance

Required information also needed for the prior authorization is permission from either the property owner or the landlord to perform the installation of the equipment and the total cost and bill for the items.

Prior Authorization of Covered Drugs

Highmark Wholecare will review a prior authorization request for outpatient drugs, which are drugs that you do not get in the hospital, within 24 hours from when Highmark Wholecare gets the request. You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

If you go to a pharmacy to fill a prescription and the prescription cannot be filled because it needs prior authorization, the pharmacist will give you a temporary supply unless the pharmacist thinks the medicine will harm you. If you have not already been taking the medicine, you will get a 72-hour supply. If you have already been taking the medicine, you will get a 15-day supply. Your provider will still need to ask Highmark Wholecare for prior authorization as soon as possible.

What if I Receive a Denial Notice?

If Highmark Wholecare denies a request for a service, item, or drug or does not approve it as requested, you can file a Grievance or a Complaint. If you file a Complaint or a Grievance for denial of an ongoing medication, Highmark Wholecare must authorize the medication until the Complaint or Grievance is resolved. See Section 8, Complaints, Grievances, and Fair Hearings, starting on page 86 of this Handbook for detailed information on Complaints and Grievances.

Program Exception Process

For those services that have limits, if you or your provider believes that you need more services than the limits on the service allows, you or your provider can ask for a program exception (PE). The PE process is different from the Dental Benefit Limit Exception process described on page 47.

To ask for a PE, your PCP or specialist must contact Highmark Wholecare's Utilization Management Department. Highmark Wholecare will review a PE for services without a code/fee on the Medicaid Fee Schedule. We will also review a PE for services that exceed fee schedule limits. We will ask for your health information that relates to the request. This will help determine medical necessity based on the HealthChoices program for members less than 21 years old. Or this will help determine rare or special situations for members age 21 and older.

Potential reasons for a PE are:

- Paying for the service is not allowed. The service is covered by the program. And the service is accepted by the medical community.
- The service is not experimental.

- The value of the service has been scientifically documented.

Service Descriptions

Emergency Services

Emergency services are services needed to treat or evaluate an emergency medical condition. An emergency medical condition is an injury or illness that is so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person's life or long-term health. If you have an emergency medical condition, go to the nearest emergency room, dial 911, or call your local ambulance provider. You do not have to get approval from Highmark Wholecare to get emergency services and you may use any hospital or other setting for emergency care.

Below are some examples of emergency medical conditions and non-emergency medical conditions.

Emergency medical conditions
- Heart attack
- Chest pain
- Severe bleeding
- Intense pain
- Unconsciousness
- Poisoning

Non-emergency medical conditions
- Sore throat
- Vomiting
- Cold or flu
- Backache
- Earache
- Bruises, swelling, or small cuts

If you are unsure if your condition requires emergency services, call your PCP or the Highmark Wholecare Nurse Hotline at 1-855-805-9408 (TTY: 711 or 1-800-654-5984) 24 hours a day, 7 days a week.

Emergency Medical Transportation

Highmark Wholecare covers emergency medical transportation by an ambulance for emergency medical conditions. If you need an ambulance, call 911 or your local ambulance provider. Do not call MATP (described on page 105 of this Handbook) for emergency medical transportation.

Urgent Care

Highmark Wholecare covers urgent care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition. This is when you need attention from a doctor, but not in the emergency room.

If you need urgent care, but you are not sure if it is an emergency, call your PCP or the Highmark Wholecare Nurse Hotline at 1-855-805-9408 (TTY: 711 or 1-800-654- 5984) first. Your PCP or the hotline nurse will help you if you need to go to the emergency room, the PCP's office, or an urgent care center near you. In most cases if you need urgent care, your PCP will give you an appointment within 24 hours. If you are not able to reach your PCP or your PCP cannot see you within 24 hours and your medical condition is not an emergency, you may also visit an urgent care center or walk-in clinic within Highmark Wholecare's network. Prior authorization is not required for services at an urgent care center.

Some examples of medical conditions that may need urgent care include:

- Vomiting
- Coughs and fever
- Sprains
- Rashes
- Earaches
- Diarrhea
- Sore throats
- Stomach aches

If you have any questions, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Dental Care Services

Members Under 21 Years of Age

Highmark Wholecare provides all medically necessary dental services for children under 21 years of age. Children may go to a participating dentist within the Highmark Wholecare network.

Dental visits for children do not require a referral. If your child's first tooth comes in, or your child is 1 year old or older and does not have a dentist, you can ask your child's PCP to refer your child to a dentist for regular dental checkups. You can also choose a participating dentist on your own. For more information on dental services, contact Highmark Wholecare Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Dental services that are covered for members under the age of 21 include the following:

Anesthesia	Dental emergencies	Fluoride treatments[2]
Braces[1]	Dental surgery	Periodontal services
Check-ups	Dentures	Root canals
Cleanings	Extractions	Sealants
Crowns	Fillings	X-rays

1. If braces were put on before the age of 21, services will be covered until they are completed or until age 23, whichever comes first. This is as long as the patient remains eligible for Medical Assistance.

2. Members age 0 through 20 are eligible for application of fluoride varnish by a doctor, CRNP, or physician assistant.

Prior Authorization is required for the following services:

- Orthodontics (Permanent teeth)
- Crowns
- Extraction(s) of impacted tooth/teeth; Oral surgical services (removal of lesions/biopsies are a medical benefit. Contact Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) for more information)
- Periodontal services (except full mouth debridement which requires post-operative review
- Medically necessary anesthesia

Members 21 Years of Age and Older

Highmark Wholecare covers some dental benefits for members 21 years of age and older through dentists in the Highmark Wholecare network. Some dental services have limits.

Dental services that are covered for members over the age of 21 include the following:

Medically necessary anesthesia	Dentures
Check-up (1 per 180 days)	X-rays
Cleanings (1 per 180 days)	Fillings

Dental Emergencies	Extractions/Oral surgical services (removal of lesions/biopsies are a medical benefit. Contact Member Services for more information)

In a lifetime, an adult member can get:

- One partial or one full upper denture; and
- One partial or one full lower denture

Your dentist may need to request prior approval from Highmark Wholecare for some services such as:

- Extraction(s) of impacted tooth/teeth
- Root canals for members 21 and older if performed by a General Dentist. Root canals performed by Endodontists do not require a pre-authorization.

You can get the following services only if you get special approval, called a benefit limit exception:

- Crowns and related services[1]
- Periodontal services (deep cleaning)
- Additional evaluations, cleanings, and dentures

[1] Related services include: Additional oral evaluations above the one per 180 day limit; Additional prophylaxis above the 180 day limit; additional dentures above the lifetime limit of one per upper arch, full or partial and one per lower arch, full or partial; crowns and adjunctive services; periodontic services.

Dental Benefit Limit Exception

Some dental services are only covered with a Benefit Limit Exception (BLE). You or your dentist can also ask for a BLE if you or your dentist believes that you need more dental services than the limits allow.

Highmark Wholecare will approve a BLE if:

- You have a serious or chronic illness or health condition and without the additional service your life would be in danger; OR

- You have a serious or chronic illness or health condition and without the additional service your health would get much worse; OR

- You would need more expensive treatment if you do not get the requested service;

  OR

- It would be against federal law for Highmark Wholecare to deny the exception.

Your dental service may also be covered by a BLE if you have one of the following underlying medical/dental condition(s).

1. Diabetes
2. Coronary Artery Disease or risk factors for the disease
3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin)
4. Intellectual Disability
5. Current Pregnancy including post-partum period
6. Chemotherapy and Radiation
7. Immunocompromised
8. Human Immunodeficiency Virus (HIV)
9. Transplant Recipient

To ask for a BLE before you receive the service, you or your dentist can call Highmark Wholecare Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or send the request to:

Benefit Limit Exceptions
PO Box 2190
Milwaukee, WI 53201

BLE requests must include the following information:

- Your name
- Your address
- Your phone number
- The service you need
- The reason you need the service
- Your provider's name
- Your provider's phone number

Time Frames for Deciding a Benefit Limit Exception

If you or your provider asks for an exception before you get the service, Highmark Wholecare will let you know whether or not the BLE is approved within 21 days.

If your dentist asks for an exception after you got the service, Highmark Wholecare will let you know whether or not the BLE request is approved within 30 days of the date Highmark Wholecare gets the request.

If you disagree with or are unhappy with Highmark Wholecare's decision, you may file a Complaint or Grievance with Highmark Wholecare. For more information on the Complaint and Grievance process, please see Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings on page 86.

Vision Care Services

Members Under 21 Years of Age

Highmark Wholecare covers all medically necessary vision services for children under 21 years of age. Children may go to a participating vision provider within the Highmark Wholecare network.

Service	Limits	Copayments	Prior Authorization
Vision Examination and Refraction	**No limits, but after 2 examinations per calendar year, additional examinations in that year must be prior authorized**	$0	No
Standard Eyeglass Lenses	**No limits, but after 4 standard lenses per calendar year, additional lenses in that year must be prior authorized**	$0	No
Standard Eyeglass Frames	**No limits, but after 2 standard frames per calendar year, additional frames in that year must be prior authorized**	$0	No
Contact Lenses	**No limits, but after 4 standard lenses per calendar year, additional lenses in that year must be prior authorized**	$0	No

Low Vision Aids	**No limits, but after 1 low vision aid every 2 years, additional low vision aids in that time period must be prior authorized**	$0	Yes
Eye Prostheses	**No limits, but after 1 prosthesis every 2 years, additional prostheses in that time period must be prior authorized**	$0	Yes

Please Note: If you choose eyeglass frames, eyeglass lenses, and contact lenses that are not considered standard, you may have to pay out of pocket for these items. Your eye doctor will let you know if you have to pay extra for any of these services. If you have questions, you can call Highmark Wholecare Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

- Standard frames and eyeglass lenses*, or
- Standard contact lenses and fittings, or
- Standard frames and eyeglass lenses* and standard contact lenses
- Contact lens fitting is covered for members under age 21

*Lens options include: basic single lenses, and/or bifocals, and/or trifocal lenses and/ or polycarbonate lenses. High index lenses are also available and do have a co-pay. Contact Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) for more information.

Replacement of eyeglasses or contact lenses if lost, broken, stolen or if the prescription changes.

Members under the age of 21 are given a $20 allowance for non-standard frames and eyeglass lenses. You will be required to pay for any amount over $20.00.

You must get all eyeglasses and contact lenses from a Highmark Wholecare participating optical supplier. If you need help locating a participating eye doctor or optical supplier, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984). If medically necessary, exception to limits can be made with written documentation. See the Program Exception Process on page 43 for additional information.

Members 21 Years of Age and Older

Highmark Wholecare covers some vision services for members 21 years of age and older through providers within the Highmark Wholecare network.

Members are covered for two (2) medically necessary eye exams each calendar year. Members are given a $100 credit for each calendar year to be used toward standard frames, eyeglass lenses and contact lenses combined.

If medically necessary, members age 21 and older who are diagnosed with Aphakia are covered for the following each calendar year:

- Two pairs of standard frames and eyeglass lenses, or
- Two pairs of standard contact lenses, or
- One pair of standard frames and eyeglass lenses and one set of standard contact lenses
- Contact lens fitting and evaluation are not a covered benefit

You must get all eyeglasses and contact lenses from a Highmark Wholecare participating optical supplier. If you need help locating a participating eye doctor or optical supplier, call Highmark Wholecare Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Pharmacy Benefits

Highmark Wholecare covers pharmacy benefits that include prescription medicines and over-the-counter medicines and vitamins with a doctor's prescription.

Prescriptions

When a provider prescribes a medication for you, you can fill your prescription at any pharmacy that is in Highmark Wholecare's network. You will need to have your Highmark Wholecare ID card with you and you may have a co-payment if you are over the age of 18. Highmark Wholecare will pay for any medicine listed on the Statewide PDL and Highmark Wholecare's supplemental formulary and may pay for other medicines if they are prior authorized. Either your prescription or the label on your medicine will tell you if your doctor ordered refills of the prescription and how many refills you may get. If your doctor ordered refills, you may only get 1 refill at a time. If you have questions about whether a prescription medicine is covered, need help finding a pharmacy in Highmark Wholecare's network, or have any other questions, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Statewide Preferred Drug List (PDL) and Highmark Wholecare Supplemental Formulary

Highmark Wholecare covers medicines listed on the Statewide Preferred Drug List (PDL) and the Highmark Wholecare supplemental formulary. This is what your PCP or other doctor should use when deciding what medicines you should take. Both the Statewide PDL and Highmark Wholecare supplemental formulary cover both brand name and generic drugs. Generic drugs contain the same active ingredients as brand name drugs. Any medicine prescribed by your doctor that is not on the Statewide PDL and Highmark Wholecare's supplemental formulary needs prior authorization. The Statewide PDL and Highmark Wholecare's supplemental formulary can change from time to time, so you should make sure that your provider has the latest information when prescribing a medicine for you.

If you have any questions or to get a copy of the Statewide PDL and Highmark Wholecare's supplemental formulary, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or visit Highmark Wholecare's website at **https://hwc.fyi/pdl**.

There are rules for coverage or limits on certain drugs. These rules and limits help you use these drugs in a safe and useful way. A team of doctors and/or pharmacists work to create these rules and limits. The rules for coverage or limits on certain drugs are as follows:

Prior Authorization: Certain drugs need approval in advance from Highmark Wholecare. This is called "prior authorization." Some drugs need added information from your doctor. This is to make sure the drug is being used safely and will work well in treating your condition. This means that your doctor will need to get approval from Highmark Wholecare before you fill your prescription. If they don't get prior approval, Highmark Wholecare will not cover the drug.

Quantity Limits: For certain drugs, Highmark Wholecare limits the amount that can be given to you over a certain time period. For example, we will give up to 28 tablets of the prescription antibiotic ciprofloxacin every 30 days. The Food and Drug Administration (FDA) developed these quantity limits for safety purposes. Prescriptions over the covered quantity limit require prior authorization. Your doctor can explain to Highmark Wholecare why an amount over the quantity limit is needed.

Step Therapy: For some drugs, Highmark Wholecare may require you to try a less costly, but just as effective, drug first before we cover another drug. For example, if Drug A and Drug B both treat your medical condition, we may need your doctor to order Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: In most cases, when a generic version of a brand-name drug is available, our network pharmacies will provide you with the generic version. We usually will not cover the brand-name drug when a generic version is available. If your doctor

feels that there is a medical reason for you to take the brand-name drug, he or she must contact Highmark Wholecare to have that request reviewed.

Medical Assistance **does not** cover all drugs. Some of the drugs that are **not covered** are:

- Experimental or investigational drugs
- DESI drugs
- Drugs used for cosmetic purposes like wrinkles or hair growth
- Drugs used for infertility or drugs used for sexual or erectile dysfunction
- Drugs marketed by a drug company that does not participate in the Federal Medicaid Drug Rebate Program
- Drugs ordered by a physician who has been barred or suspended from participating in the Medical Assistance Program

Reimbursement for Medication

If you paid for a medication out-of-pocket that would have been otherwise covered by Highmark Wholecare, you will be reimbursed. Reimbursement will be limited to emergency or unusual situations. If you choose to utilize a non-participating pharmacy on a routine basis, you will not receive reimbursement.

You must complete and submit a Prescription Reimbursement Claim Form along with a receipt. You may access this form on the Highmark Wholecare website.

The claim for reimbursement will be processed subject to the Statewide PDL and Highmark Wholecare supplemental formulary and plan design on the date of service of the original claim.

- Reimbursement will not be provided for a medication that would not have been approved through the normal payment process
- Reimbursement will be less any applicable member co-payment

The standard turnaround time for processing a claim for reimbursement is 14 business days. If the claim is approved, you will be reimbursed. If the claim is denied, you will be notified in writing.

Specialty Medicines

The Statewide PDL and Highmark Wholecare's supplemental formulary includes medicines that are called specialty medicines. A prescription for these medicines needs to be prior authorized. You may have a co-payment for your medicine. To see the Statewide Preferred Drug List, the Highmark Wholecare's supplemental formulary, a complete list of specialty medicines and whether your medicine is considered a specialty medicine call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or visit Highmark Wholecare's website at **https://hwc.fyi/pdl**.

You will need to get these medicines from a specialty pharmacy. A specialty pharmacy can mail your medicines directly to you and will not charge you for the mailing of your medicines. The specialty pharmacy will contact you before sending your medicine. The pharmacy can also answer any questions you have about the process. You can pick any specialty pharmacy that is in Highmark Wholecare's network. For the list of network specialty pharmacies, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or see the provider directory on Highmark Wholecare's website at **https://hwc.fyi/pdl**. For any other questions or more information please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Over-the-Counter Medicines

Highmark Wholecare covers over-the-counter medicines when you have a prescription from your provider. You will need to have your Highmark Wholecare ID card with you and you may have a co-payment. The following are some examples of covered over-the-counter medicines:

- Sinus and allergy medicine
- Tylenol or aspirin
- Vitamins
- Cough medicine
- Heartburn medicine such as antacids and famotidine
- Contraceptives (condoms, contraceptive jellies, emergency contraceptives)
- Eye drops

You can find more information about covered over-the-counter medicines by visiting Highmark Wholecare's website at **HighmarkWholecare.com** or by calling Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Tobacco Cessation

Do you want to quit smoking? Highmark Wholecare wants to help you quit!

If you are ready to be smoke free, no matter how many times you have tried to quit smoking, we are here to help you.

Medicines

The Statewide PDL covers the following medicines to help you quit smoking.

PDL – Preferred Drugs	PDL – Non-Preferred Drugs
Nicotine Gum/Lozenge	Nicotrol Nasal Spray
Nicotine Patch	Nicotrol Inhaler
Bupropion SR 150mg tablet	
Varenicline	

These medicines may be subject to prior authorization. Refer to the PDL/Supplemental Formulary for the most updated information.

Contact your PCP for an appointment to get a prescription for a tobacco cessation medicine.

Counseling Services

Counseling support may also help you to quit smoking. Highmark Wholecare covers the following counseling services: 70 tobacco cessation counseling services per calendar year. Highmark Wholecare knows that not every time you try to quit you are successful. Every time you try, you will get closer to reaching your goal. This means that you will always have Highmark Wholecare's support when you need it. Contact your Primary Care Provider for an appointment to get these counseling and support services.

Behavioral Health Treatment

Some people may be stressed, anxious, or depressed when they are trying to become smoke-free. Highmark Wholecare members are eligible for services to address these side effects, but these services are covered by your BH-MCO. To find the BH-MCO in your county and its contact information:

- See the information that came with your welcome kit, or
- Go to **https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-MCOs.aspx**, or
- Go to page 83 for a listing of the BH-MCO in your county, or
- Call Highmark Wholecare Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) for help in contacting your BH-MCO.

Case Management Programs

The Case Management program offers tobacco cessation education. If you would like to speak to a care manager about quitting tobacco, call 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and select the option for the Special Needs Unit. The care manager can answer your questions, refer you to your best option for quitting, and provide you with the information you need to be successful.

Other Tobacco Cessation Resources

For further assistance with quitting tobacco, you can call the PA Free Quitline at 1-800-QUITNOW. This organization will help you prepare a quit plan, understand your tobacco triggers, and teach you how to manage your cravings. They may also talk about quit therapies, overcoming the challenges of quitting, and keeping you on track, all at no cost to you. The PA Free Quitline will set you up with counseling services over the phone at your convenience. You can visit the PA Free Quitline's website at **pa.quitlogix.org** for more tobacco cessation information and self-help tools, or to sign up for their free counseling program. You can also visit **smokefree.gov**. This website has a lot of online information and materials that are also free.

Other agencies that provide online resources and help with quitting tobacco include:

American Cancer Society
cancer.org/latest-news/how-to-quit-smoking.html

American Heart Association
heart.org/en/healthy-living/healthy-lifestyle/quit-smoking-tobacco/the-benefits-of-quitting-smoking-now

American Lung Association
lung.org/quit-smoking

Remember Highmark Wholecare is here to help support you in becoming healthier by becoming smoke-free. **Do not wait!** Please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) so we can help to get you started.

Family Planning

Highmark Wholecare covers family planning services. You do not need a referral from your PCP for family planning services. These services include pregnancy testing, testing and treatment of sexually transmitted diseases, birth control supplies, and family planning education and counseling. You can see any doctor that is a Medical Assistance provider, including any out-of-network provider that offers family planning services. There is no co-payment for these services. When you go to a family planning provider that is not in the Highmark Wholecare network, you must show your Highmark Wholecare and ACCESS or EBT card.

For more information on covered family planning services or to get help finding a family planning provider, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Maternity Care

Care During Pregnancy

Prenatal care is the health care a Member receives throughout pregnancy and delivery from a maternity care provider, such as an obstetrician (OB or OB/GYN) or a nurse-midwife. Early and regular prenatal care is very important for you and your baby's health. Even if you have been pregnant before, it is important to go to a maternity care provider regularly through each pregnancy.

If you think you are pregnant and need a pregnancy test, see your PCP or a family planning provider. If you are pregnant, you can:

- Call or visit your PCP, who can help you find a maternity care provider in Highmark Wholecare's network.
- Visit a network OB or OB/GYN or nurse-midwife on your own. You do not need a referral for maternity care.
- Visit a network health center that offers OB or OB/GYN services.
- Call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) to find a maternity care provider.

You should see a doctor as soon as you find out you are pregnant. Your maternity care provider must schedule an appointment to see you:

- If you are in your first trimester, within 10 business days of Highmark Wholecare learning you are pregnant.

- If you are in your second trimester, within 5 business days of Highmark Wholecare learning you are pregnant.

- If you are in your third trimester, within 4 business days of Highmark Wholecare learning you are pregnant.

- If you have a high-risk pregnancy, within 24 hours of Highmark Wholecare learning you are pregnant.

If you have an emergency, go to the nearest emergency room, dial 911, or call your local ambulance provider.

It is important that you stay with the same maternity care provider throughout your pregnancy and postpartum care (1 year after your baby is born). They will follow your health and the health of your growing baby closely. It is also a good idea to stay with the same HealthChoices plan during your entire pregnancy.

Highmark Wholecare has specially trained maternal health coordinators who know what services and resources are available for you.

If you are pregnant and are already seeing a maternity care provider when you enroll in Highmark Wholecare, you can continue to see that provider even if he or she is not in Highmark Wholecare's network. The provider will need to be enrolled in the Medical Assistance Program and must call Highmark Wholecare for approval to treat you.

Care for You and Your Baby After Your Baby is Born

You should visit your maternity care provider between 7 to 84 days after your baby is delivered for a check-up unless your maternity care provider wants to see you sooner.

Your baby should have an appointment with the baby's PCP when he or she is 3 to 5 days old, unless the doctor wants to see your baby sooner. It is best to pick a doctor for your baby while you are still pregnant. If you need help picking a doctor for your baby, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Maternity Program

Highmark Wholecare has a special program for pregnant women called MOM Matters Program.

This program gives education and support throughout your pregnancy to help you have a healthy baby. Specially trained case managers can answer your questions about your pregnancy. The case managers can also help with community service referrals. Highmark Wholecare is also offering a Maternal Home Visiting Program to support you and your new baby/family. Home visitors will support you, assist with any questions or needs identified, and make referrals as needed. To learn more about the MOM Matters program, call 1-800-392-1147 (TTY: 711 or 1-800-654-5984). Select the option for the Special Needs Unit, then select the option for MOM Matters.

Highmark Wholecare also covers certain special services to help you have a healthy baby. These include childbirth classes. Also included are visits by a home health nurse during and after your pregnancy. You may also get a breast pump when your doctor orders it as Durable Medical Equipment (DME) for you and your baby's needs.

Durable Medical Equipment and Medical Supplies

Highmark Wholecare covers Durable Medical Equipment (DME), including home accessibility DME, and medical supplies. DME is a medical item or device that can be used many times in your home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury. Medical supplies are usually disposable and are used for a medical purpose. Some of these items need prior authorization, and your physician must order them. DME suppliers must be in the Highmark Wholecare network. You may have a co-payment.

Highmark Wholecare will not be held liable for reimbursement regarding the out-of-pocket cost for DME (durable medical equipment) purchased from a retail store or online retail dealer (e.g. Amazon). Retail stores and suppliers are not covered by your medical DME benefit for safety reasons. Highmark Wholecare offers a wide network of participating DME providers who are credentialed to meet Medicare and Medicaid standards and requirements.

Examples of DME include:

- Oxygen tanks
- Wheelchairs
- Crutches
- Walkers
- Splints
- Special medical beds

Examples of home accessibility DME include:

- Wheelchair lifts
- Stair glides
- Ceiling lifts
- Metal accessibility ramps

Highmark Wholecare covers installation of the home accessibility DME, but not home modifications.

Examples of medical supplies include:

- Diabetic supplies (such as syringes, test strips)
- Gauze pads
- Dressing tape
- Incontinence supplies (such as pull ups, briefs, underpads)

If you have any questions about DME or medical supplies, or for a list of network suppliers, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Outpatient Services

Highmark Wholecare covers outpatient services such as physical, occupational, and speech therapy as well as x-rays and laboratory tests. Your PCP will arrange for these services with one of Highmark Wholecare's network providers. Physical, occupational, and speech therapy, and chiropractic care need prior authorization. Your Primary Care or other provider must order all outpatient care. Please refer to page 40 for a complete list of all services that require prior authorization.

If you have any questions about outpatient services or for a list of network providers, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Nursing Facility Services

Highmark Wholecare covers medically necessary nursing facility services. If you need long term nursing facility services (longer than 30 days), you can apply for the Community HealthChoices Program. You will be evaluated to see if you are eligible for participation in the Community HealthChoices Program. If you have any questions or need more information, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Hospital Services

Highmark Wholecare covers inpatient and outpatient hospital services. If you need inpatient hospital services and it is not an emergency, your PCP or specialist will arrange for you to be admitted to a hospital in Highmark Wholecare's network and will follow your care even if you need other doctors during your hospital stay. Inpatient hospital stays must be approved by Highmark Wholecare. To find out if a hospital is in the Highmark Wholecare network, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or check the provider directory on Highmark Wholecare's website at **https://hwc.fyi/directory**.

If you have an emergency and are admitted to the hospital, you or a family member or friend should let your PCP know as soon as possible but no later than 24 hours after you were admitted to the hospital. If you are admitted to a hospital that is not in Highmark Wholecare's network, you may be transferred to a hospital in Highmark Wholecare's network. You will not be moved to a new hospital until you are stable enough to be transferred to a new hospital.

It is very important to make an appointment to see your PCP within 7 days after you leave the hospital. Seeing your PCP right after your hospital stay will help you follow any instructions you got while you were in the hospital and prevent you from having to be readmitted to the hospital.

Sometimes you may need to see a doctor or receive treatment at a hospital without being admitted overnight. These services are called outpatient hospital services.

If you have any other questions about hospital services, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Preventive Services

Highmark Wholecare covers preventive services, which can help keep you healthy. Preventive services include more than just seeing your PCP once a year for a check-up. They also include immunizations (shots), lab tests, and other tests or screenings that let

you and your PCP know if you are healthy or have any health problems. Visit your PCP for preventive services. He or she will guide your health care according to the latest recommendations for care.

Members can also go to a participating OB/GYN for their yearly Pap test and pelvic exam, and to get a prescription for a mammogram.

Preventive Exams and Screenings for Adults

Exam/Screening	
Routine Checkup	Ages 21 to 49: Every one to two years Ages 50 and older: Once a year
Blood Pressure Monitoring	At routine checkup
Cholesterol Screening	Ages 21 and older: Once every five years. High risk adults may need to be screened more often. Talk with your PCP.
Colorectal Cancer Screening	Ages 45 and older: Every 1 to 10 years depending on test
Diabetes (Blood Sugar) Screening	Ages 35 and older: Once every three years for non-diabetics. High risk adults may need to be screened more often. Talk with your PCP.
Hepatitis B and C Screening	If high risk. It is recommended that all normal risk members 18 and older should receive at least one Hepatitis C screening in their lifetime.
Bone Mineral Density Screening	If at high risk for a fracture.
Sexually Transmitted Disease/HIV Screening	Sexually active adults talk with your PCP
Pelvic and Breast Exam	Once a year
Breast Cancer Screening (Mammogram)	High risk: May benefit from screening starting at age 40 Average risk: Every two years starting at age 50 Talk with your PCP to determine your risk
Cervical Cancer Screening (Pap Smear)	Ages 21 to 65: Every 3 years

Physical Exam

You should have a physical exam by your PCP at least once a year. This will help your PCP find any problems that you may not know about. Your PCP may order tests based on your health history, age, and sex. Your PCP will also check if you are up to date on immunizations and preventive services to help keep you healthy.

If you are unsure about whether or not you are up to date with your health care needs, please call your PCP or Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984). Member Services can also help you make an appointment with your PCP.

New Medical Technology

Highmark Wholecare may cover new medical technologies such as procedures and equipment if requested by your PCP or specialist. Highmark Wholecare wants to make sure that new medical technologies are safe, effective, and right for you before approving the service.

We have a committee of doctors and pharmacists who review new technologies to decide if they should be included as a covered benefit. New technologies include physical and behavioral health medical services. This also includes procedures, medical equipment and drug treatments. New drugs may be added to the PDL and/or the supplemental formulary on an ongoing basis.

If the committee recommends that a new technology be included in Highmark Wholecare's benefits package, it will be shared with Highmark Wholecare's Senior Management Team. The team will assess it for approval. The team may recommend that the new technology be approved on a case-by-case basis.

If you need more information on new medical technologies, call Highmark Wholecare Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Home Health Care

Highmark Wholecare covers home health care provided by a home health agency. Home health care is care provided in your home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy. Your physician must order home health care.

If you are over age 21, there are limits on the number of home health care visits that you can get unless you or your provider asks for an exception to the limits.

OR

Highmark Wholecare has a program that includes home health care visits directly relating to a special health care need such as wound care or managing new medications.

OR BOTH

You should contact Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) if you have been approved for home health care and that care is not being provided as approved.

Patient Centered Medical Homes

A patient-centered medical home (PCMH) or health home is a team approach to providing care. It is not a building, house, or home health care service.

PCMH is a form of care in which a primary care provider manages a member's care with a team. This type of care is ongoing. It allows for the best health outcomes. This model focuses on the whole person. It includes caring for your physical and behavioral health. PCMH providers treat and provide care for all of the members health needs. They also provide wellness care and prevention of disease.

Highmark Wholecare has a provider facing team. They work with medical staff to improve outcomes, enhance member experience, and lower the cost of care.

Disease Management

Highmark Wholecare has voluntary programs to help you take better care of yourself if you have one of the health conditions listed below. Highmark Wholecare has care managers who will work with you and your providers to make sure you get the services you need. You do not need a referral from your PCP for these programs, and there is no co-payment.

Lifestyle Management programs offer training, self-care and doctor support and education. You do not have to do anything to sign up. If you have one of the conditions listed below, you are already signed up in Lifestyle Management.

Asthma is a chronic lung disease that sometimes makes it hard to breathe. Our Asthma Program will help you learn about and manage your asthma. We will help so it doesn't interfere with your daily life.

Diabetes is when you have high levels of sugar in your blood. Our Diabetes Program helps you to better understand diabetes. It teaches you how to manage your blood sugar and what tests are important to prevent complications.

Chronic Obstructive Pulmonary Disease (COPD) is a lung disease that causes shortness of breath. If you are living with COPD, our program can help you to manage your symptoms.

Heart Disease If you have Heart Disease or Heart Failure, our Heart Management Program will aim to help you become active in your own care, improve your health and quality of life, and help you understand your heart condition.

Hypertension also called high blood pressure. Blood pressure is the amount of force it takes for your heart to pump blood through your body. When your blood pressure is high, it can lead to other health problems. Our Hypertension Program can help you make short and long-term goals that will help you manage your blood pressure.

Healthy Weight Management offers health coaching, nursing and nutrition support and care coordination to assist you to make healthy choices, achieve weight loss goals and develop a healthy lifestyle.

HIV/AIDS Services If you have HIV or AIDS, you can speak with a Highmark Wholecare care manager to discuss services and resources that are available to you. Our primary purpose is to make sure each member with HIV or AIDs has access to Primary Care Providers and specialists as needed. We want members to have access to all covered services based on their condition.

Health Risk Assessment Survey We all want to be as healthy as possible and try to take care of ourselves. But sometimes we need extra help – a little encouragement and information. That's why new Highmark Wholecare members are mailed a Health Risk Assessment survey. The purpose of the survey is to ensure you are getting the needed care you deserve by creating a personalized prevention care plan, which includes recommendations for getting healthy and staying healthy. Completing the Health Risk Assessment survey is easy and takes a few minutes. If you'd like, you can also go online and complete the survey at **HighmarkWholecare.com**. Your answers assist Highmark Wholecare in identifying services and programs that will address your health concerns. Should you have any questions or need help completing the survey, call 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and select the option for the Special Needs Unit.

By following your provider's plan of care and learning about your disease or condition, you can stay healthier. Highmark Wholecare care managers are here to help you understand how to take better care of yourself by following your doctor's orders, teaching you about your medicines, helping you to improve your health, and giving you information to use in your community. If you have any questions or need help, please call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Expanded Services

Wellness Coaching

In addition to the above services, we also offer wellness coaching over the phone. Wellness coaches can help you to set your goals and make plans to reach your goals. They do this by helping you to make lifestyle changes and to improve your health and well-being. Wellness coaches can also work with you to prevent or reduce falls, help with questions about healthy eating, and help you take control of your diabetes.

To speak with a care manager or wellness coach, call 1-800-392-1147 (TTY: 711 or 1-800-654-5984). Select the option for the Special Needs Unit.

Goodness Rewards
Goodness Rewards is a program that rewards Highmark Wholecare members for completing important health activities. You can find more information about Goodness Rewards by visiting **GoodnessRewards.com**.

1. Sign up for the Goodness Rewards Program online or over the phone.
2. Complete a rewardable activity.
3. Receive your Goodness Reward.

You can find more information about Goodness Rewards by visiting **GoodnessRewards.com** or by calling Highmark Wholecare member services.

24-Hour Nurse Line
If you ever have a question about your health, medicines or treatment options, call 1-855-805-9408 (TTY: 711) and select the option for the 24-Hour Nurse Line. This free service is available to all Highmark Wholecare members. It is available 7 days a week, 365 days a year to ask basic health questions about:

- A recent diagnosis, treatment choices or surgery
- Current symptoms
- Medicine side effects
- Self-care home treatments
- When to go to the doctor
- When to go to the Urgent Care Center or Emergency Room

A nurse will take the time to understand what's happening and provide information just for you at no cost.

Safelink Wireless Free Phone Program
Highmark Wholecare partners with *Tracfone Wireless* to provide the SafeLink Wireless Program. Once enrolled in the program, you will receive:

- A free smartphone or the option to use your own smartphone
- 350 talk minutes per month
- Unlimited text messaging
- 3 GB of data per month
- UNLIMITED free calls to Highmark Wholecare at 1-800-392-1147

For more information on the Safelink Wireless Program, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984). TracFone Wireless Inc. is a separate company that offers the SafeLink program for Highmark Wholecare.

GED Benefit
No cost GED testing for members 17 and older that are Pennsylvania residents and not enrolled in any other school program. For more information or to request a voucher, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT services are available for children under the age of 21. They are sometimes also referred to as well-baby or well-child checkups. Your child may be seen by a pediatrician, family practice doctor, or CRNP. The provider you choose for your child will be your child's PCP. The purpose of this service is to detect potential health problems early and to make sure your child stays healthy. If you have questions or want more information, contact Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

When Should an EPSDT Exam be Completed?

Children and young adults should have their examinations completed based on the schedule listed below. It is important to follow this schedule even if your child is not sick. Your provider will tell you when these visits should occur. Infants and toddlers will need several visits per year, while children between the ages of 3 to 20 will need just 1 visit per year.

Recommended Screening Schedule			
3-5 Days	0-1 Months	2-3 Months	4-5 Months
6-8 Months	9-11 Months	12 Months	15 Months
18 Months	24 Months	30 Months	
Children ages 3-20 should be screened yearly			

What Will the Provider Do During the EPSDT Exam?

Your provider will ask you and your child questions, perform tests, and check how much your child has grown. The following services are some of the services that may be performed during an exam depending on the child's age and needs of the child:

- A complete physical exam
- Immunizations
- Vision test
- Hearing test
- Autism screening
- Tuberculosis screening
- Oral health examination
- Blood pressure check
- Health and safety education
- Check of the child's body mass index (BMI)
- Screen and/or counsel for tobacco and alcohol use and substance use starting at age 11
- Urinalysis screening
- Blood lead screening test

- Developmental screening
- Depression screening starting at age 12
- Maternal depression screening

Highmark Wholecare covers services that are needed to treat health problems that are identified during the EPSDT exam.

Additional services are available for children with special needs. Talk to your provider about whether or not your child may need these additional services.

Section 4 –

Out-of-Network
and
Out-of-Plan Services

Out-of-Network Providers

An out-of-network provider is a provider that does not have a contract with Highmark Wholecare to provide services to Highmark Wholecare's members. There may be a time when you need to use a doctor or hospital that is not in the Highmark Wholecare network. If this happens, you can ask your PCP to help you. Your PCP has a special number to call to ask Highmark Wholecare that you be allowed to go to an out-of-network provider. Highmark Wholecare will check to see if there is another provider in your area that can give you the same type of care you or your PCP believes you need. If Highmark Wholecare cannot give you a choice of at least 2 providers in your area, Highmark Wholecare will cover medically necessary services provided by an out-of-network provider.

Getting Care While Outside of Highmark Wholecare's Service Area

If you are outside of Highmark Wholecare's service area and have a medical emergency, go to the nearest emergency room or call 911. For emergency medical conditions, you do not have to get approval from Highmark Wholecare to get care. If you need to be admitted to the hospital, you should let your PCP know.

If you need care for a non-emergency condition while outside of the service area, call your PCP or Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) who will help you to get the most appropriate care.

Highmark Wholecare will not pay for services received outside of the United States and its territories.

Out-of-Plan Services

You may be eligible to get services other than those provided by Highmark Wholecare. Below are some services that are available but are not covered by Highmark Wholecare. If you would like help in getting these services, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Non-Emergency Medical Transportation

Highmark Wholecare does not cover non-emergency medical transportation for most HealthChoices members. Highmark Wholecare can help you arrange transportation to covered service appointments through programs such as Shared Ride or the MATP described below.

Highmark Wholecare does cover non-emergency medical transportation if:

- You live in a nursing home, and need to go to any medical appointment or an urgent care center or a pharmacy for any Medical Assistance service, DME or medicine
- You need specialized non-emergency medical transportation, such as if you need to use a stretcher to get to your appointment

If you have questions about non-emergency medical transportation, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Medical Assistance Transportation Program

MATP provides non-emergency transportation to and from qualified MA-enrolled medical providers and pharmacies of your choice who are generally available and used by other residents of your community. This service is provided at no cost to you. The MATP in the county where you live will determine your need for services and provide the right type of transportation for you. Transportation services are typically provided in the following ways:

- Where public transportation such as buses, subways or trains are available, MATP provides tokens or passes or repays you for the public transportation fare if you live within ¼ mile of a fixed route service stop.
- If you or someone else has a car that you can use to get to your appointment, MATP may pay you an amount per mile plus parking and tolls with valid receipts.
- Where public transportation is not available or is not right for you, MATP provides rides in paratransit vehicles, which include vans, vans with lifts, or taxis. Usually the vehicle will have more than 1 rider with different pick-up and drop-off times and locations.

If you need transportation to a medical appointment or to the pharmacy, contact your local MATP to get more information and to register for services. A complete list of county MATP contact information can be found online at: **http://matp.pa.gov/CountyContact.aspx**. See page 105 of this handbook for a complete list of county MATP contact information.

MATP will confirm with Highmark Wholecare or your doctor's office that the medical appointment you need transportation for is a covered service. Highmark Wholecare works with MATP to help you arrange transportation. You can also call Member Services for more information at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Women, Infants, and Children Program

The Women, Infants, and Children Program (WIC) provides healthy foods and nutrition services to infants, children under the age of 5, and women who are pregnant, have given birth, or are breastfeeding. WIC helps you and your baby eat well by teaching you about good nutrition and giving you food vouchers to use at grocery stores. WIC helps

babies and young children eat the right foods so they can grow up healthy. You can ask your maternity care provider for a WIC application at your next visit or call 1-800-WIC-WINS (1-800-942-9467). For more information visit the WIC website at **pawic.com**.

Domestic Violence Crisis and Prevention

Domestic violence is a pattern of behavior where one person tries to gain power or control over another person in a family or intimate relationship.

There are many different types of domestic violence. Some examples include:

- Emotional abuse
- Physical violence
- Stalking
- Sexual violence
- Financial abuse
- Verbal abuse
- Elder Abuse
- Intimate partner violence later in life
- Intimate partner abuse
- Domestic Violence in the LGBTQIA+ Community

There are many different names used to talk about domestic violence. It can be called: abuse; domestic violence; battery; intimate partner violence; or family, spousal, relationship or dating violence.

If any of these things are happening to you, or have happened, or you are afraid of your partner, you may be in an abusive relationship.

Domestic violence is a crime and legal protections are available to you. Leaving a violent relationship is not easy, but you can get help.

Where to get help

National Domestic Violence Hotline

1-800-799-7233 (SAFE)
1-800-787-3224 (TTY)

Pennsylvania Coalition Against Domestic Violence

The services provided to domestic violence victims include: crisis intervention; counseling; going along to police, medical, and court appointments; and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are also provided to lower the risk of domestic violence in the community.

1-800-932-4632 (in Pennsylvania)

Sexual Violence and Rape Crisis

Sexual violence includes any type of unwanted sexual contact, words or actions of a sexual nature that is against a person's will. A person may use force, threats, manipulation, or persuasion to commit sexual violence. Sexual violence can include:

- Rape
- Sexual assault
- Incest
- Child sexual assault
- Date and acquaintance rape
- Grabbing or groping
- Sexting without permission
- Ritual abuse
- Commercial sexual exploitation (for example: prostitution)
- Sexual harassment
- Anti-LGBTQIA+ bullying
- Exposure and voyeurism (the act of being viewed, photographed, or filmed in a place where one would expect privacy)
- Forced participation in the production of pornography

Survivors of sexual violence can have physical, mental or emotional reactions to the experience. A survivor of sexual violence may feel alone, scared, ashamed, and fear that no one will believe them. Healing can take time, but healing can happen.

Where to get help:

Pennsylvania rape crisis centers serve all adults and children. Services include:

- Free and confidential crisis counseling 24 hours a day.
- Services for a survivor's family, friends, partners or spouses.
- Information and referrals to other services in your area and prevention education programs.

Call **1-888-772-7227** or visit the link below to reach your local rape crisis center.

Pennsylvania Coalition Against Rape
pcar.org

Early Intervention Services

While all children grow and develop in unique ways, some children experience delays in their development. Children with developmental delays and disabilities can benefit from the Early Intervention Program.

The Early Intervention Program provides support and services to families with children, from birth to the age of 5, who have developmental delays or disabilities. Services are provided in natural settings, which are settings where a child would be if the child did not have a developmental delay or disability.

Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family. These services and supports address the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

Parents who have questions about their child's development may contact the CONNECT Helpline at 1-800-692-7288 or visit **papromiseforchildren.com**.

The CONNECT Helpline assists families in locating resources and providing information regarding child development for children from birth to age 5. In addition, CONNECT can help parents with contacting their county Early Intervention Program or local preschool Early Intervention Program.

Section 5 –

Special Needs

Special Needs Unit

Highmark Wholecare wants to make sure all of our members get the care they need. We have trained case managers in the Highmark Wholecare Special Needs Unit that help our members with special needs have access to the care they need. The case managers of the unit help members with physical or behavioral disabilities, complex or chronic illnesses, and other special needs. Highmark Wholecare understands that you and your family may need help with issues that may not be directly related to your health care needs. The Special Needs Unit is able to assist you with finding programs and agencies in the community that can help you and your family address these needs.

If you think you or someone in your family has a special need, and you would like the Special Needs Unit to help you, please contact them by calling 1-800-392-1147 (TTY: 711 or 1-800-654-5984). Select the option for the Special Needs Unit. The Special Needs Unit staff members are available Monday through Friday, 8:30 am to 4:30 pm. If you need assistance when the Special Needs Unit staff are not available, you may call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Coordination of Care

The Highmark Wholecare Special Needs Unit will help you coordinate care for you and your family who are members of Highmark Wholecare. In addition, Highmark Wholecare can assist in connecting you with other state and local programs.

If you need help with any part of your care, your child's care, or coordinating that care with another state, county, or local program, please contact the Highmark Wholecare Special Needs Unit for assistance.

The Highmark Wholecare Special Needs Unit will also assist members in transitioning care from services received in a hospital or temporary medical setting to care received at home. We want our members to be able to move back home as soon as possible. Please contact the Highmark Wholecare Special Needs Unit for assistance in help receiving care in your home.

Care Management

Our Care Management program includes continuity of care and member care coordination and is essential to our mission of delivering high quality and customized health care to all members within our Integrated Care Model (ICM). The Clinical Operations ICM, is comprised of different teams that assist members with needed care coordination. These integrated care teams include: Special Needs Unit Coordinator (SNUC), Special Needs Pediatric Shift Care, Transition management, Outreach/Navigators, Embedded Care Management, Disease Management, MOM's Matter, EPSDT Program and Behavioral Health MCOs. Our Prospective Care Management (PCM®) model keeps each member directly at the center of care

planning, thus minimizing the impact of transitions between delivery systems. We coordinate member care prospectively and holistically, taking into account not only immediate care needs, but also the social determinants of health and the need to coordinate between our members, providers and community resources.

Special Needs Care coordination services include, but are not limited to:

- Assist member with timely access to services and benefits/care coordination/care transitions
- Assistance with locating referrals to community-based services as these impact Social Determinants of Health
- Collaboration with physicians, caregivers and other supports to assist members in coordinating their care. This includes assisting the member in scheduling appointments with health care providers
- Home & Community based services
- Disease specific member education, including instructions on improving self-care
- Interagency Meetings
- Coordinate with other Physical Health and Behavioral Health MCOs

We review your case to develop strategies and interventions for care coordination. One of these interventions may include a referral for Complex Care Management.

Home and Community-Based Waivers and Long-Term Services and Supports

The Office of Developmental Programs (ODP) administers the Consolidated Waiver, Community Living Waiver, Person/Family Directed Supports Waiver, Adult Autism Waiver, and the Adult Community Autism Program (ACAP) for individuals with intellectual disabilities or autism. If you have questions regarding any of these programs, you may contact ODP's Customer Service Hotline at 1-888-565-9435, or request assistance from the Special Needs Unit at Highmark Wholecare.

The Office of Long-Term Living (OLTL) administers programs for seniors and individuals with physical disabilities. This includes the Community HealthChoices Program (CHC). The CHC Program is a Medical Assistance managed care program for individuals who also have Medicare coverage or who need the services of a nursing facility or home-and community-based wavier.

If you have questions regarding what services are available and how to apply, you may contact OLTL's Participant Helpline at 1-800-757-5042, the CHC Helpline at 1-844-824-3655 or request assistance from the Highmark Wholecare Special Needs Unit at 1-800-392-1147 (TTY: 711 or 1-800-654-5984). Select the option for the Special Needs Unit.

Medical Foster Care

The Office of Children, Youth, and Families has oversight of medical foster care for children under the authority of county children and youth programs. If you have questions about this program, please contact the Special Needs Unit at 1-800-392-1147 (TTY: 711 or 1-800-654-5984). Select the option for the Special Needs Unit.

Section 6 –

Advance Directives

Advance Directives

There are 2 types of advance directives: Living Wills and Health Care Powers of Attorney. These allow for your wishes to be respected if you are unable to decide or speak for yourself. If you have either a Living Will or a Health Care Power of Attorney, you should give it to your PCP, other providers, and a trusted family member or friend so that they know your wishes.

If the laws regarding advance directives are changed, Highmark Wholecare will tell you in writing what the change is within 90 days of the change. For information on Highmark Wholecare's policies on advance directives, call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) or visit Highmark Wholecare's website at **HighmarkWholecare.com**.

Living Wills

A Living Will is a document that you create. It states what medical care you do, and do not, want to get if you cannot tell your doctor or other providers the type of care you want. Your doctor must have a copy and must decide that you are unable to make decisions for yourself for a Living Will to be used. You may revoke or change a Living Will at any time.

Health Care Power of Attorney

A Health Care Power of Attorney is also called a Durable Power of Attorney. A Health Care or Durable Power of Attorney is a document in which you give someone else the power to make medical treatment decisions for you if you are physically or mentally unable to make them yourself. It also states what must happen for the Power of Attorney to take effect. To create a Health Care Power of Attorney, you may but do not have to get legal help. You may contact Highmark Wholecare for more information or direction to resources near you.

What to Do if a Provider Does Not Follow Your Advance Directive

Providers do not have to follow your advance directive if they disagree with it as a matter of conscience. If your PCP or other provider does not want to follow your advance directive, Highmark Wholecare will help you find a provider that will carry out your wishes. Call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) if you need help finding a new provider.

If a provider does not follow your advance directive, you may file a Complaint. See page 86 in Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint; or call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984).

Section 7 –

Behavioral Health Services

Behavioral Health Care

Behavioral health services include both, mental health services and substance use disorder services. These services are provided through behavioral health managed care organizations (BH-MCOs) that are overseen by the Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS). Contact information for the BH-MCO is listed below. You can also call Member Services at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) to get contact information for your BH-MCO.

You can call your BH-MCO toll-free 24 hours a day, 7 days a week.

You do not need a referral from your PCP to get behavioral health services, but your PCP will work with your BH-MCO and behavioral health providers to help get you the care that best meets your needs. You should let your PCP know if you, or someone in your family, is having a mental health or drug and alcohol problem.

The following services are covered:

- Behavioral health rehabilitation services (BHRS) (children and adolescent)
- Clozapine (Clozaril) support services
- Drug and alcohol inpatient hospital-based detoxification services (adolescent and adult)
- Drug and alcohol inpatient hospital-based rehabilitation services (adolescent and adult)
- Drug and alcohol outpatient services
- Drug and alcohol methadone maintenance services
- Family based mental health services
- Laboratory (when related to a behavioral health diagnosis and prescribed by a behavioral health practitioner)
- Mental health crisis intervention services
- Mental health inpatient hospitalization
- Mental health outpatient services
- Mental health partial hospitalization services
- Peer support services
- Residential treatment facilities (children and adolescent)
- Targeted case management services

If you have questions about transportation to appointments for any of these services, contact your BH-MCO.

Mental Health, Drug, and Alcohol Services

COUNTY	BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS	SINGLE COUNTRY AUTHORITY FOR SUBSTANCE TREATMENT
Adams	Community Care Behavioral Health 1-866-738-9849	York Adams Drug and Alcohol Commission 717-771-9222
Allegheny	Community Care Behavioral Health 1-800-553-7499	Allegheny County Department of Human Services - Office of Behavioral Health - Bureau of Drug and Alcohol Services 412-350-3328
Armstrong	Carelon Health of PA 1-877-688-5969	Armstrong/Indiana/Clarion Drug and Alcohol Commission, Inc. 724-354-2746
Beaver	Carelon Health of PA 1-877-688-5970	Beaver County Behavioral Health Drug and Alcohol Program 724-847-6225
Bedford	Community Care Behavioral Health 1-866-483-2908	Personal Solutions Inc (Bedford) 814-623-5009
Berks	Community Care Behavioral Health 1-866-292-7886	Berks County Council on Chemical Abuse 610-376-8669
Blair	Community Care Behavioral Health 1-855-520-9715	Blair County Drug and Alcohol Program, Inc 814-381-0921
Butler	Carelon Health of PA 1-877-688-5971	The Butler County Drug and Alcohol Program 724-284-5114
Cambria	Magellan 1-800-424-0485	Cambria County Drug and Alcohol Program 814-536-5388

COUNTY	BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS	SINGLE COUNTRY AUTHORITY FOR SUBSTANCE TREATMENT
Cumberland	Performcare 1-888-722-8646	Cumberland/Perry Drug and Alcohol Commission 717-240-6300
Dauphin	Performcare 1-888-722-8646	Dauphin County Department of Drug and Alcohol Services 717-635-2254
Fayette	Carelon Health of PA 1-877-688-5972	Fayette County Drug and Alcohol Commission Inc. 724-438-3576
Franklin	Performcare 1-866-773-7917	Franklin/Fulton County Drug and Alcohol Program 717-263-1256
Fulton	Performcare 1-866-773-7917	Franklin/Fulton County Drug and Alcohol Program 717-263-1256
Greene	Community Care Behavioral Health 1-866-878-6046	Greene County Human Services Program 724-852-5276
Huntingdon	Community Care Behavioral Health 1-866-878-6046	Juniata Valley Tri-County Drug and Alcohol Abuse Commission 717-242-1446
Indiana	Carelon Health of PA 1-877-688-5969	Armstrong/Indiana/Clarion Drug and Alcohol Commission, Inc. 724-354-2746
Lancaster	Performcare 1-888-722-8646	Lancaster County Drug and Alcohol Commission 717-299-8023

COUNTY	BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS	SINGLE COUNTRY AUTHORITY FOR SUBSTANCE TREATMENT
Lawrence	Carelon Health of PA 1-877-688-5975	Lawrence County Drug and Alcohol Commission Inc. 724-658-5580
Lebanon	Performcare 1-888-722-8646	Lebanon County Commission on Drug and Alcohol Abuse 717-274-0427
Lehigh	Magellan 1-866-238-2311	Lehigh County Drug & Alcohol Services 610-782-3555
Northampton	Magellan 1-866-238-2312	Northampton County D&A Division 610-829-4725
Perry	Performcare 1-888-722-8646	Cumberland/Perry Drug and Alcohol Commission 717-240-6300
Somerset	Community Care Behavioral Health 1-866-483-2908	Somerset County Drug and Alcohol 814-445-1530
Washington	Carelon Health of PA 1-877-688-5976	Washington D&A Commission, Inc. 724-223-1181
Westmoreland	Carelon Health of PA 1-877-688-5977	Westmoreland Drug and Alcohol Commission, Inc. 724-243-2220
York	Community Care Behavioral Health 1-866-542-0299	York Adams Drug and Alcohol Commission 717-771-9222

Section 8 –

Complaints, Grievances, and Fair Hearings

Complaints, Grievances, and Fair Hearings

If a provider or Highmark Wholecare does something that you are unhappy about or do not agree with, you can tell Highmark Wholecare or the Department of Human Services what you are unhappy about or that you disagree with what the provider or Highmark Wholecare has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell Highmark Wholecare you are unhappy with Highmark Wholecare or your provider or do not agree with a decision by Highmark Wholecare.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Highmark Wholecare has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call Highmark Wholecare at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and tell Highmark Wholecare your Complaint, or
- Write down your Complaint and send it to Highmark Wholecare by mail or fax, or
- If you received a notice from Highmark Wholecare telling you Highmark Wholecare's decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that:

- Highmark Wholecare has decided that you cannot get a service or item you want because it is not a covered service or item.
- Highmark Wholecare will not pay a provider for a service or item you got.
- Highmark Wholecare did not tell you its decision about a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.
- Highmark Wholecare has denied your request to disagree with Highmark Wholecare's decision that you have to pay your provider.

You must file a Complaint within **60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New member appointment for your first examination…	**We will make an appointment for you…**
members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in Highmark Wholecare unless you are already being treated by a PCP or specialist.
members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a member in Highmark Wholecare unless you are already being treated by a PCP or specialist.
members under the age of 21	with PCP for an EPSDT exam no later than 45 days after you become a member in Highmark Wholecare unless you are already being treated by a PCP or specialist.

all other members	with PCP no later than 3 weeks after you become a member in Highmark Wholecare.
Members who are pregnant:	**We will make an appointment for you**
pregnant women in their first trimester	with OB/GYN provider within 10 business days of Highmark Wholecare learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of Highmark Wholecare learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of Highmark Wholecare learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of Highmark Wholecare learning you are pregnant.
Appointment with…	**An appointment must be scheduled**
PCP	
urgent medical condition	within 24 hours.
routine appointment	within 10 business days.
health assessment/general physical examination	within 3 weeks.
Specialists (when referred by PCP)	
urgent medical condition	within 24 hours of referral.

routine appointment with one of the following specialists: Otolaryngology Dermatology Pediatric Endocrinology Pediatric General Surgery Pediatric Infectious Disease Pediatric Neurology Pediatric Pulmonology Pediatric Rheumatology Dentist Orthopedic Surgery Pediatric Allergy & Immunology Pediatric Gastroenterology Pediatric Hematology Pediatric Nephrology Pediatric Oncology Pediatric Rehab Medicine Pediatric Urology Pediatric Dentistry	within 15 business days of referral
routine appointment with all other specialists	within 10 business days of referral.

You may file **all other Complaints at any time.**

What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Complaint, and about the First Level Complaint review process.

You may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Highmark Wholecare.

You may attend the Complaint review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more Highmark Wholecare staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor or licensed dentist will be on the committee. Highmark Wholecare will mail you a notice within 30 days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 87.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint that is postmarked or received by Highmark Wholecare within 15 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like Highmark Wholecare's Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- Highmark Wholecare's decision that you cannot get a service or item you want because it is not a covered service or item.
- Highmark Wholecare's decision to not pay a provider for a service or item you got.
- Highmark Wholecare's failure to decide a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.
- You not getting a service or item within the time by which you should have received it.
- Highmark Wholecare's decision to deny your request to disagree with Highmark Wholecare's decision that you have to pay your provider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing within **120 days from the mail date on the notice telling you the Complaint decision**.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice**.

For information about Fair Hearings, see page 101.
For information about external Complaint review, see page 93.
If you need more information about help during the Complaint process, see page 87.

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call Highmark Wholecare at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and tell Highmark Wholecare your Second Level Complaint, or
- Write down your Second Level Complaint and send it to Highmark Wholecare by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare's address and fax number for Second Level Complaints
Highmark Wholecare
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Complaint, and about the Second Level Complaint review process.

You may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Highmark Wholecare.

You may attend the Complaint review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for Highmark Wholecare, will meet to decide your Second Level Complaint. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor or licensed dentist will be on the committee.
Highmark Wholecare will mail you a notice within 45 days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 87.

What if I Do Not Like Highmark Wholecare's Decision on My Second Level Complaint?

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care.

You must ask for an external review within **15 days of the date you got the Second Level Complaint decision notice**.

External Complaint Review

How Do I Ask for an External Complaint Review?

Send your written request for an external review of your Complaint to the following:
Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

You can also go to the "File a Complaint Page" at:
www.insurance.pa.gov/Consumers

If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

What Happens After I Ask for an External Complaint Review?

The Insurance Department will get your file from Highmark Wholecare. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or received by the Pennsylvania Insurance Department within 15 days of the date on the notice telling you Highmark Wholecare's First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you must request both the external Complaint review and the Fair Hearing within 15 days of the date on the notice telling you Highmark Wholecare's First Level Complaint decision. If you wait to request a Fair Hearing until after receiving a decision on your external Complaint, services will not continue.

Grievances

What is a Grievance?

When Highmark Wholecare denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you Highmark Wholecare's decision.

A Grievance is when you tell Highmark Wholecare you disagree with Highmark Wholecare's decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call Highmark Wholecare at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and tell Highmark Wholecare your Grievance, or

- Write down your Grievance and send it to Highmark Wholecare by mail or fax, or

- Fill out the Complaint/Grievance Request Form included in the denial notice you got from Highmark Wholecare and send it to Highmark Wholecare by mail or fax.

Highmark Wholecare
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from Highmark Wholecare telling you that Highmark Wholecare has received your Grievance, and about the Grievance review process.

You may ask Highmark Wholecare to see any information that Highmark Wholecare used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to Highmark Wholecare.

You may attend the Grievance review if you want to attend it. Highmark Wholecare will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor or licensed dentist, will meet to decide your Grievance. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. Highmark Wholecare will mail you a notice within

30 days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page 94.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance that is postmarked or received by Highmark Wholecare within 15 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like Highmark Wholecare's Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for Highmark Wholecare.

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice telling you the Grievance decision**.

For information about Fair Hearings, see page 101.
For information about external Grievance reviews, see below.
If you need more information about help during the Grievance process, see page 94.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call Highmark Wholecare at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and tell Highmark Wholecare your Grievance, or

- Write down your Grievance and send it to Highmark Wholecare by mail to:

Highmark Wholecare
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

Highmark Wholecare will send your request for external Grievance review to the Pennsylvania Insurance Department.

What Happens After I Ask for an External Grievance Review?

Highmark Wholecare will notify you of the external Grievance reviewer's name, address, email address, fax number, and phone number. You will also be given information about the external Grievance review process.

Highmark Wholecare will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 20 days of being notified of the external Grievance reviewer's name.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a written request that is postmarked or received by the Pennsylvania Insurance Department within 15 days of the date on the notice telling you Highmark Wholecare's Grievance decision, the services or items will continue until a decision is made. If you will be asking for both an external Grievance review and a Fair Hearing, you must request both the external Grievance review and the Fair Hearing within 15 days of the date on the notice telling you Highmark Wholecare's Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, services will not continue.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **30** days to get a decision about your Complaint or Grievance, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask Highmark Wholecare for an early decision by calling Highmark Wholecare at 1-800-392-1147 (TTY: 711 or 1-800-654-5984), faxing a letter or

the Complaint/Grievance Request Form to 412-255-4503, or sending an email to **MedicaidCommitteeReviews@HighmarkWholecare.com**.

- Your doctor or dentist should fax a signed letter to 412-255-4503 within 72 hours of your request for an early decision that explains why Highmark Wholecare taking 30 days to tell you the decision about your Complaint or Grievance could harm your health.

If Highmark Wholecare does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, Highmark Wholecare will decide your Complaint or Grievance in the usual time frame of **30** days from when Highmark Wholecare first got your Complaint or Grievance.

Expedited Complaint and Expedited External Complaint

A committee of 3 or more people, including a licensed doctor or licensed dentist, will meet to decide your Complaint. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by video conference because Highmark Wholecare has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

Highmark Wholecare will tell you the decision about your Complaint within 48 hours of when Highmark Wholecare gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when Highmark Wholecare gets your request for an early decision, whichever is sooner, unless you ask Highmark Wholecare to take more time to decide your Complaint. You can ask Highmark Wholecare to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Pennsylvania Insurance Department within **2 business days from the date you get the expedited Complaint decision notice**. To ask for an expedited external review of a Complaint:

- Call Highmark Wholecare at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and tell Highmark Wholecare your Complaint, or

- Send an email to Highmark Wholecare at **MedicaidCommitteeReviews@HighmarkWholecare.com**, or

- Write down your Complaint and send it to Highmark Wholecare by mail or fax:

Highmark Wholecare
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

Highmark Wholecare will send your request for expedited review to the Pennsylvania Insurance Department within 24 hours of receiving it.

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor or licensed dentist, will meet to decide your Grievance. The Highmark Wholecare staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person but may have to appear by phone or by video conference because Highmark Wholecare has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

Highmark Wholecare will tell you the decision about your Grievance within 48 hours of when Highmark Wholecare gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when Highmark Wholecare gets your request for an early decision, whichever is sooner, unless you ask Highmark Wholecare to take more time to decide your Grievance. You can ask Highmark Wholecare to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review within **2 business days from the date you get the expedited Grievance decision notice**. To ask for expedited external review of a Grievance:

- Call Highmark Wholecare at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) and tell Highmark Wholecare your Grievance, or

- Send an email to Highmark Wholecare at **MedicaidCommitteeReviews@HighmarkWholecare.com**, or

- Write down your Grievance and send it to Highmark Wholecare by mail or fax:

Highmark Wholecare
Attn: Complaint and Grievance Department
P.O. Box 22278
Pittsburgh, PA 15222
Fax: 412-255-4503

Highmark Wholecare will send your request to the Pennsylvania Insurance Department within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice telling you the expedited Grievance decision**.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of Highmark Wholecare will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell Highmark Wholecare, in writing, the name of that person and how Highmark Wholecare can reach him or her.

You or the person you choose to represent you may ask Highmark Wholecare to see any information Highmark Wholecare has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call Highmark Wholecare's toll-free telephone number at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

Persons Whose Primary Language Is Not English

If you ask for language services, Highmark Wholecare will provide the services at no cost to you.

Persons with Disabilities

Highmark Wholecare will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by Highmark Wholecare at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something Highmark Wholecare did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after Highmark Wholecare decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked, faxed, or submitted via email* within **120 days from the date on the notice** telling you Highmark Wholecare's decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- Highmark Wholecare's failure to decide a First Level Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.
- The denial of your request to disagree with Highmark Wholecare's decision that you have to pay your provider.

- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.

- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that Highmark Wholecare failed to decide a First Level Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter or email*, it needs to include the following information:

- Your (the member's) name and date of birth;

- A telephone number where you can be reached during the day;

- Whether you want to have the Fair Hearing in person or by telephone;

- The reason(s) you are asking for a Fair Hearing; and

- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair Hearings
PO Box 2675
Harrisburg, PA 17105-2675
Fax: 1-717-772-6328
Email: **RA-PWCGFHteam@pa.gov***

*Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email. You may send a request for a Fair Hearing through email and provide your personal identifying information in a letter mailed to the above address.

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

Highmark Wholecare will also go to your Fair Hearing to explain why Highmark Wholecare made the decision or explain what happened.

You may ask Highmark Wholecare to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Highmark Wholecare, not including the number of days between the date on the written notice of the Highmark Wholecare's First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because Highmark Wholecare did not tell you its decision about a Complaint or Grievance you told Highmark Wholecare about within 30 days from when Highmark Wholecare got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Highmark Wholecare, not including the number of days between the date on the notice telling you that Highmark Wholecare failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 15 days of the date on the notice telling you Highmark Wholecare's First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339, by faxing a letter or the Fair Hearing Request Form to 717-772-6328 or submitting a written request electronically via email* to **RA-PWCGFHteam@pa.gov**. Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled, and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

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You may call Highmark Wholecare's toll-free telephone number at 1-800-392-1147 (TTY: 711 or 1-800-654-5984) if you need help or have questions about Fair Hearings, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

Medical Assistance Transportation

COUNTY	LOCAL TELEPHONE	TOLL-FREE	COUNTY	LOCAL TELEPHONE	TOLL-FREE
Adams	717-846-7433	1-800-632-9063	Lancaster	717-291-1243	1-800-892-1122
Allegheny	412-350-4476	1-888-547-6287	Lawrence	724-658-7258	1-888-252-5104
Armstrong	724-548-3408	1-800-468-7771	Lebanon	same as Toll-	717-273-9328
Beaver	724-375-2895	1-800-262-0343	Lehigh	610-253-8333	1-888-253-8333
Bedford	814-623-9129	1-800-323-9997	Northampton	610-253-8333	1-888-253-8333
Berks	610-921-2361	1-800-383-2278	Perry	717-846-7433	1-800-632-9063
Blair	814-695-3500	1-800-458-5552	Somerset	814-701-3691	1-800-452-0241
Butler	724-431-3663	1-866-638-0598	Washington	724-223-8747	1-800-331-5058
Cambria	814-535-4630	1-888-647-4814	Westmoreland	724-832-2706	1-800-242-2706
Cumberland	717-846-7433	1-800-632-9063	York	717-846-7433	1-800-632-9063
Dauphin	717-232-7009	1-800-309-8905			
Fayette	724-628-7433	1-800-321-7433			
Franklin	717-846-7433	1-800-632-9063			
Fulton	717-485-6767	1-888-329-2376			
Greene	724-627-6778	1-877-360-7433			
Huntingdon	814-641-6408	1-800-817-3383			
Indiana	724-465-2140	1-800-524-2766			

County Assistance Office

COUNTY	LOCAL TELEPHONE	TOLL-FREE	COUNTY	LOCAL TELEPHONE	TOLL- FREE
Adams	717-334-6241	800-638-6816	Lancaster	717-299-7411	not available
Allegheny	412-565-2146	not available	Lawrence	724-656-3000	1-800-847-4522
Armstrong	724-543-1651	800-424-5235	Lebanon	717-270-3600	1-800-229-3926
Beaver	724-773-7300	800-653-3129	Lehigh	610-821-6509	1-877-223-5956
Bedford	814-623-6127	800-542-8584	Northampton	610-250-1700	1-800-349-5122
Berks	610-736-4211	866-215-3912	Perry	717-582-2127	1-800-991-1929
Blair	not available	866-812-3341	Somerset	814-443-3681	1-800-248-1607
Butler	724-284-8844	866-256-0093	Washington	724-223-4300	1-800-835-9720
Cambria	814-533-2491	877-315-0389	Westmoreland	724-832-5200	1-800-905-5413
Cumberland	717-240-2700	800-269-0173	York	717-771-1100	1-800-991-0929
Dauphin	717-787-2324	800-788-5616			
Fayette	724-439-7015	877-832-7545			
Franklin	717-264-6121	877-289-9177			
Fulton	717-485-3151	800-222-8563			
Greene	724-627-8171	888-410-5658			
Huntingdon	814-643-1170	800-237-7674			
Indiana	724-357-2900	800-742-0679			


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