



2012 Guide to Basic Health *Plus* and the Maternity Benefits Program

Questions?

Go to <http://hrsa.dshs.wa.gov/contact/default.aspx>, or call the Medicaid helpline at 1-800-562-3022.
The TTY/TDD number is 1-800-848-5429 (for people who have difficulties with hearing or speech).

Health Plan phone numbers and websites

Health Plan Name	Customer Service Hours	Customer Service Phone Numbers	Website Address
Columbia United Providers, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-315-7862 or 360-891-1520 TDD: 1-866-287-9962	www.cuphealth.com
Community Health Plan of Washington	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-440-1561 TTY: 7-1-1	www.chpw.org
Group Health Cooperative	Mon. – Fri. 8 a.m. – 5 p.m.	1-888-901-4636 TTY: 1-800-833-6388	www.ghc.org
Molina Healthcare of Washington, Inc.	Mon. – Fri. 7:30 a.m. – 5:30 p.m.	1-800-869-7165 TTY: 1-877-665-4629	www.molinahealthcare.com

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2714. TTY users may call this number through the Washington Relay Service by dialing 711.

If this information is not in English, please call 1-800-660-9840. The TTY/TDD line is 1-888-923-5622 (only for people who have difficulties with hearing or speech; your phone must be equipped to use this line).

ENGLISH

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AMHARIC

បើព័ត៌មាននេះមិនមែនជាភាសាខ្មែរទេ សូមទូរស័ព្ទលេខ 1-800-660-9840 ។ ទូរស័ព្ទ TTY/TDD លេខ 1-888-923-5622 (សំរាប់គ្រូជនដែលមានបញ្ហាខាងស្តាប់ឬខាងនិយាយគ្រប់ប្រភេទ ទូរស័ព្ទ របស់អ្នក ត្រូវតែមានសម្ភារៈដែលអាចប្រើលេខទូរស័ព្ទនេះបាន) ។

CAMBODIAN

若此資訊不是中文，請電 1-800-660-9840。聾啞人士 TTY/TDD 專線，號碼是 1-888-923-5622（僅供有聽力和語言障礙的人士使用；要使用這一專線，您的電話機必須有專門的設備）。

CHINESE

اگر این اطلاعات به زبان فارسی نیست، لطفاً با شماره 1-800-660-9840 تماس بگیرید. شماره تلفن 1-888-923-5622 برای استفاده خط TTY/TDD میباشد (تنها برای افرادی که مشکل شنوایی یا تکلم دارند، تلفن شما باید با دستگاه مخصوص مجهز باشد)

FARSI

Yog cov ntaub ntauv no tsis muaj ntauv Hmoob, thov hu xovtooj rau 1-800-660-9840. Tus xovtooj rau TTY/TDD yog 1-888-923-5622 (tus xovtooj no yog rau cov uas nws muaj teeb meem tsis hnov lus lossis muaj teeb meem txog ntawm kev hais lus; koj yuav tsum siv lub xovtooj uas ntaus tau rau yam no).

HMONG

No daytoy nga Impormasyon wenno pakaammo ket saan a naisurat ti llokano, pangngaasim ta awagam ti numero 1-800-660-9840. Ti makunkuna a TTY/TDD a linya ti telepono ket 1-888-923-5622 (para kadagiti tattao nga marigatan wenno nakapsut ti pinagdengngeg da wenno pinagsao da; dayta teleponom ket masapul nga maaddaan ti aparato nga kasta tapno mausar dayta a linya.)

ILOCANO

해당 정보가 한국어로 제공되지 않았으면 1-800-660-9840 로 전화주십시오. TTY/TDD라인은 1-888-923-5622입니다(이 라인은 청각 및 언어장애자 전용임으로 그에 필요한 설비가 갖추어 있어야지만 사용할 수 있습니다).

KOREAN

ຖ້າຂໍ້ມູນນີ້ບໍ່ແມ່ນພາສາລາວ, ໃຫ້ໂທ 1-800-660-9840. ສາຍໂທເສັ້ນສຽງຄະຫຼາດາແມ່ນ 1-888-923-5622 (ສະເພາະ ແຕ່ຜູ້ມີຄວາມຫຍຸ້ງຍາກດ້ານການໄດ້ຍິນ ຫລື ປາກເວົ້າ; ໂທສະສັບຂອງທ່ານຈະຕ້ອງປະກອບເຄື່ອງສໍາຮັບໂທສາຍນີ້ໂດຍສະເພາະ).

LAOTIAN

Yoo Odeeffannoon kun Afaan Oromootin miti ta'e lakkofsa 1-800-660-9840 bilbila. Lakkofsi bilbila [TTY/TDD] 1-888-923-5622 dha (kun kan fayyadu warra dhibee dhagahuf dubbachu qaban qofa; itti bilbilufis bilbilli keessan meesha addaa isa barbaachisa).

ROMO

ਜੇ ਇਹ ਜਾਣਕਾਰੀ ਪੰਜਾਬੀ ਵਿਚ ਨਹੀਂ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-660-9840 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। TTY/TDD ਲਾਈਨ ਦਾ ਨੰਬਰ 1-888-923-5622 ਹੈ (ਇਹ ਲਾਈਨ ਕੇਵਲ ਉਹਨਾਂ ਲੋਕਾਂ ਲਈ ਹੈ ਜਿਨ੍ਹਾਂ ਨੂੰ ਸੁਣਨ ਜਾਂ ਬੋਲਣ ਵਿਚ ਕਠਨਾਈ ਹੁੰਦੀ ਹੈ; ਇਸ ਲਾਈਨ ਦੀ ਵਰਤੋਂ ਲਈ ਤੁਹਾਡੇ ਫੋਨ ਵਿਚ ਖਾਸ ਸਾਜ-ਸਮਾਨ ਲੱਗਿਆ ਹੋਣਾ ਜ਼ਰੂਰੀ ਹੈ)।

PUNJABI

Dacă aceste informații nu sunt în limba română, vă rugăm să telefonați la 1-800-660-9840. Numărul de telefon pentru persoanele cu deficiențe de vorbire sau de auz este 1-888-923-5622 (pentru a folosi această linie telefonică, telefonul dvs. trebuie să fie dotat cu un dispozitiv special).

ROMANIAN

Если данная информация не представлена на русском языке, пожалуйста, позвоните по телефону 1-800-660-9840. Телефонная линия службы TTY/TDD: 1-888-923-5622 (только для лиц с нарушениями слуха или речи; чтобы работать с этой линией, ваш телефон должен быть оснащен специальным оборудованием).

RUSSIAN

Afai e le fa'aSamoaina ia upu fa'ailoa, fa'amolemole vala'au ile 1-800-660-9840. Ole TTY/TDD laini e 1-888-923-5622 (mo tagata e leaga latou fa'alogo po'o le tautala, o lau telefoni e tatau ona aoga mo lea ituaiga laini).

SAMOAN

Ako ove informacije nisu na srpskohrvatskom, nazovite 1-800-660-9840. TTY/TDD linija je 1-888-923-5622 (samo za ljude koji imaju poteškoće sa sluhom ili govorom; vaš telefon mora biti opremljen za korištenje ove linije).

SERBO-CROATIAN

Haddii warkanu uusan ku qorneyn af Soomaali, fadlan wac 1-800-660-9840. Khadka TTY/TDD waa 1-888-923-5622 (waxaana loogu talagalay oo keliya dadka xagga maqalka iyo hadalka dhibaataada ka qaba; telefoonkaagu waa inuu u qalabaysan yahay si aad u isticmaasho khadkan).

SOMALI

Si esta información no está en español, llame al 1-800-660-9840. La línea TTY/TDD es 1-888-923-5622 (solamente para personas con dificultades auditivas o del habla; su teléfono debe estar equipado para el uso de esta línea).

SPANISH

Kung ang impormasyon na ito ay hindi nasa Tagalog, mangyaring tumawag sa 1-800-660-9840. Ang linya ng TTY/TDD ay 1-888-923-5622 (para lamang sa mga taong may kahirapan sa pandinig o pagsasalita; ang inyong telepono ay kailangang naangkop upang magamit itong linyang ito).

TAGALOG

እዚ መረጃታ ብትግርኛ ተጻሒፉ እንተዘይረኹብኩዮ፣ 1-800-660-9840 ደውል። ናይ TTY/TDD መስመር 1-888-923-5622 እዩ (ናይ ምስማዕ ወይ ምዝራብ ጸገም ንዘለዎም ሰባት ጥራሕ እዩ። በዚ መስመር ንክትጥቀም፣ ቴሌፎንካ ፍሉይ ዝኾነ መሳርሒ ክህልዎ ይግባእ)።

TIGRIGNA

Якщо ця інформація не на українській мові, будь ласка телефонуйте за номером 1-800-660-9840. Телефон лінії TTY/TDD: 1-888-923-5622 (тільки для тих людей, які мають послаблений слух чи дефекти мовлення). Для того, щоб ви могли користуватися цією лінією, до вашого телефона мусить бути підключене спеціальне обладнання).

UKRAINIAN

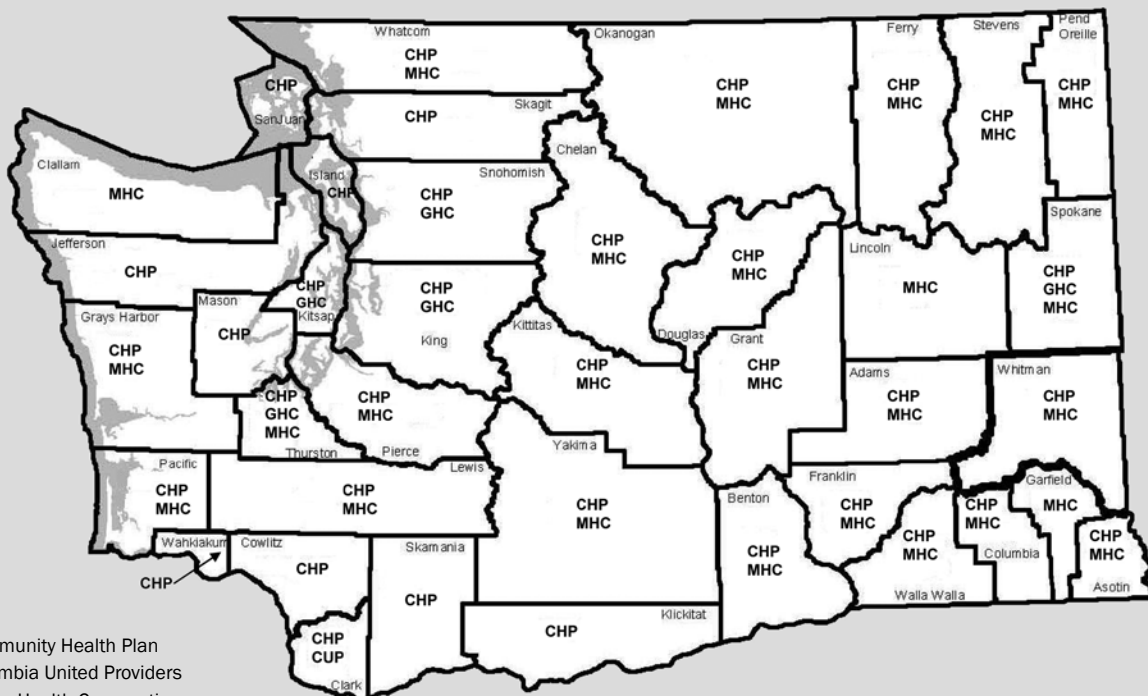
Nếu những tin tức này không phải bằng tiếng Việt, xin gọi số 1-800-660-9840. Đường dây dành cho TTY/TDD là 1-888-923-5622 (chỉ dành cho người bị lảng tai hoặc bị trở ngại về nói; điện thoại của quý vị phải được trang bị để có thể dùng đường dây này).

VIETNAMESE

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2011 Basic Health *Plus* Service Areas



CHP – Community Health Plan
 CUP – Columbia United Providers
 GHC – Group Health Cooperative
 MHC – Molina Healthcare of Washington

Effective January 1, 2012 - December 31, 2012

What is Basic Health *Plus*?

Basic Health *Plus* is a Medicaid program for children who are under age 19, and live in households that meet the eligibility guidelines for Medicaid. This program allows children extra services, such as dental and eyeglasses, not covered by Basic Health with no copays, no premiums, and no waiting for pre-existing conditions. The Health Care Authority (HCA) determines eligibility for Basic Health *Plus*. Children enrolled in the Basic Health *Plus* program will get letters and a Services card from HCA to cover the extra services. Basic Health will send you information about your child's managed care health plan.

What is the Maternity Benefits Program?

The Maternity Benefits Program is a Medicaid program for pregnant women who are Basic Health members and meet the Medicaid income guidelines. This program allows pregnant women extra services not covered by Basic Health with no copays, no premiums, and no waiting for pre-existing conditions. If you are pregnant, call Basic Health at 1-800-660-9840 for a Maternity Benefits Program application. HCA determines eligibility for this program. If you are eligible for the Maternity Benefits Program, you will get letters and a Services card from HCA. If you do not apply for the Maternity Benefits Program, you may not be eligible to receive coverage for your maternity services.

How do you get your health care?

In most cases you will get your care from a Basic Health managed care health plan. This may take some time. Until you are enrolled in a managed care health plan, you will get medical care by using your Services card. Once you are enrolled in a managed care health plan, you will officially be a Basic Health *Plus* or Maternity Benefits Program member and get your medical care through your health plan.

Do you have to be in a health plan?

Yes. As a Basic Health *Plus* or Maternity Benefits Program member, you must enroll in a Basic Health managed care health plan.

Visit the Medicaid website for more information about our medical programs and services at: <http://hrsa.dshs.wa.gov/>, or the Basic Health website at: <http://www.basichealth.hca.wa.gov/>.

Information about managed care health plans

Does everyone in my family have to be in the same health plan?

Yes. If enrolled in Basic Health, Basic Health *Plus*, or the Maternity Benefits Program, all family members must be in the same health plan. There are a few exceptions. These include children with special health care needs, and families with members who are American Indian or Alaska Native. Please call HCA at 1-800-562-3022 for specific information about these exceptions.

When I'm in a health plan, can I go to any doctor or hospital that I want?

No. Each health plan has certain doctors and other medical providers you must use. Most of the plans also have certain hospitals and pharmacies you must use. When you are in a health plan, the hospitals you can use also depend on which hospitals your doctor uses. Call your health plan's customer service line (found on page 2) for more information about their doctors, hospitals, and pharmacies. They can give you a list of providers which includes:

- Name, location, and phone number.
- Languages spoken.
- Specialty and medical degree.
- Limits of the provider and if they are accepting new patients.

Will one health care provider take care of most of my health care needs?

Yes. For most of your care, you will go to a doctor, nurse practitioner, or physician assistant (under the supervision of a physician), called a primary care provider (PCP). If you need care from a specialist, your PCP will help you find the right specialist and give you a referral.

Can I and others in my family have different PCPs?

Yes. While you and your family must be in the same health plan, you can have different PCPs. Of course, all of the PCPs must work with your health plan.

Can I and others in my family change PCPs?

Yes. You and other family members can change your PCP by calling your health plan's customer service number. Most PCP changes will take place the first day of the next month.

What is fee-for-service?

Fee-for-service means you can see any doctor or medical provider who will bill HCA for your care. HCA also pays for some of your extra services such as dental care and eyeglasses, which your health plan does not cover. You can find a list of covered services in this book. Remember—it is not always easy to find providers who will bill HCA for your care. It's a good idea to call the doctor or other medical providers you want to use to be sure they will see you as a fee-for-service patient and bill HCA for your care.

What if I do not speak English?

If you need an interpreter, call your PCP's office ahead of time. They will get an interpreter for your medical visit at no cost to you.

Do you have to pay for health care services?

Usually not. You may have no copays, but if you get a service that is not a covered benefit you might have to pay.

To make sure you are not billed:

- Always carry both your Services card and your health plan identification (ID) card with you.
- Know the name of your health plan, primary care provider (PCP), and/or primary care case management (PCCM) provider.
- Know your health plan and PCCM's rules for getting care. There are times when you can be billed if you don't follow the rules of your health plan or PCCM, such as going to a specialist without getting a referral first.

You may have to pay if:

- A service you get is not a covered benefit.
- A service you get is not medically necessary.
- You get care from a provider who does not work with your health plan (unless it is an emergency or is pre-approved by your health plan).
- You sign an agreement to pay and
 - You get specialty care or equipment without a referral from your PCP, or
 - You get care that requires prior authorization before it is approved.

If you are not in a health plan but are getting care covered by Medicaid fee-for-service, call the provider ahead of time to make sure they will bill HCA for the service.

If you get a bill for a service you believe is covered, call your health plan first. If you still need help, call the Medicaid helpline at 1-800-562-3022.

What is your Services card?

Each family member on medical assistance gets a Services card. Your Services card is a permanent card that is activated while you are eligible for medical assistance. This card only includes your name and identification number. You may also need to show a picture ID to prevent unauthorized use of your card. Your providers will verify your eligibility for medical services. If you lose your Services card, call the Medical Assistance helpline at 1-800-562-3022 and follow the voice response prompts to ask for a new Services card.

What is your health plan ID card?

When you are enrolled in a health plan, you will get an identification (ID) card from the health plan. You should have both a Services card and your health plan ID card to:

- Get medical services
- Make, cancel, or check appointments
- Order or pick up prescriptions

Please call your plan's customer service number (found on page 2) if any information on the card is wrong, or the card is lost, stolen, or needs to be replaced.

What are your medical benefits?

Medicaid covers many benefits and services when medically necessary whether you get health care through a managed care health plan, a PCCM clinic, or a fee-for-service provider. Some of the benefits covered by the health plans are listed below. For some services you need to get approval from your health plan. Check with your provider or your health plan if a service you need is not listed as a benefit.

For some services, you may need to get a referral from your PCP and/or approval from your health plan before you get the service. Otherwise, your health plan might not pay for the service. Some services are limited by number of visits or supply/equipment items. Each health plan has a process to review your provider's request for a *Limitation Extension*.

Call your health plan's customer service number (found on page 2) before you get medical services or ask your PCP to help you get the care you need.

Benefits and Services covered by your health plan or PCCM:

Note: This list is provided for general information only and does not guarantee that the service will actually be covered.

Benefit/Service	Comments
Ambulance service	For emergencies only or when transporting between facilities.
Antigen (allergy serum)	Allergy shots
Audiology tests	Hearing tests
Biofeedback therapy	Limited to plan requirements
Birth control	See family planning services
Birth defects	See cosmetic surgery
Blood products	Includes blood, blood components, human blood products and their administration
Breast pumps	
Chemotherapy	
Chiropractic care for children	Benefit is for children only (age 20 and under) with referral from PCP after being seen for an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening (well-child care). See Spinal Manipulations.
Contraceptives	See family planning services
Cosmetic surgery	ONLY WHEN the surgery and related services and supplies are provided to correct physiological defects from birth, illness, physical trauma, or for mastectomy reconstruction for post-cancer treatment
Diabetic supplies	
Dialysis	
Emergency services	Available 24 hours per day, 7 days per week anywhere in the United States. An emergency is a sudden or severe health problem that needs treatment right away. If you think you have an emergency, no matter where you are, call 911 or go to the nearest emergency room.

(continued)

Benefit/Service	Comments
EPSDT (Early Periodic Screening, Diagnosis, and Treatment)	EPSDT includes regular checkups to make sure people ages 20 and under get the preventive care they need to catch and treat health problems at an early stage. These EPSDT screenings (well-child care) include: <ul style="list-style-type: none"> • A complete physical exam with health, mental health screening, and developmental history. • Immunizations (shots) and lab tests. • Screens for vision, hearing, dental care, mental health, and substance abuse.
Eye exams	You must use the health plan's provider network. Limited to one exam every 12 months for children age 20 and under and every 24 months for adults 21 and over. Can be more frequent if determined to be medically necessary by the health plan. Note: For children, eyeglasses, contact lenses, and hardware fittings are covered by HCA separately.
Family planning services	You have a choice of either going to a family planning clinic or using the health plan's network of providers.
Fluoride treatment prescription (liquid or tablets)	When prescribed by a physician (PCP) after a well-child or EPSDT screening
Healthcare services (office visits, preventive care, specialty care)	Must use participating health plan providers. Health plans may require approved referrals. Call your health plan with specific questions.
Health education and counseling	Examples: Health education for conditions such as diabetes and heart disease
Hearing exams	Hearing exams are covered by health plan's network of providers. Note: For children, hearing aids are covered separately by HCA.
HIV/AIDS screening	You have a choice of going to a family planning clinic, the local health department, or your PCP for the screening.
Home health care	Must be approved by health plan
Hospital, inpatient and outpatient services	Must be approved by health plan for all non-emergent care
Immunizations/vaccinations	Vaccines for international travel purposes only are not covered.
Lab and x-ray services	
Mammograms	See Women's Health Care
Maternity & prenatal care	See Women's Health Care
Medical equipment	Call the health plan for specific details
Medical supplies	Call the health plan for specific details
Mental health, outpatient treatment	Limited benefit based on medical need. The benefit through the health plan covers: <ul style="list-style-type: none"> • Up to 12 hours of treatment per calendar year for adults. • Up to 20 hours of treatment per calendar year for children. • Mental Health medication management by your PCP or mental health provider. • Children under 5 years of age being prescribed mental health medication must have a second opinion from a psychiatrist to approve the medication. • Psychological testing and evaluation once every 12 months for adults 21 and over, or as needed if identified by an EPSDT (well-child care) screening for children 20 years old and under.

(continued)

Benefit/Service	Comments
Nutritional counseling	See Health education and counseling
Organ transplants	Call your health plan for specific details
Outpatient Rehabilitation	Physical, speech, and occupational therapies
Oxygen and respiratory services	
Pharmacy services	Must use participating pharmacies. The health plans have their own drug formulary (list). Call your health plan for specific information and list of pharmacies.
Pregnancy terminations, involuntary (miscarriage)	
Private duty nursing	
Radiology and medical imaging services	
Reconstructive surgery after mastectomy	
Sexually transmitted diseases (STD) treatment	You have a choice of going to your PCP, the local health department, or family planning clinic.
Skilled nursing facility (SNF)	
Smoking cessation	Smoking cessation is covered for all clients based on the health plan's policies.
Spinal manipulations	Limited Benefit - Ten (10) spinal manipulations per calendar year are covered by the health plan, only when performed by a plan Doctor of Osteopathy (D.O.).
Sterilizations (age 21 and over)	Must complete sterilization form 30 days prior to procedure or meet waiver requirements. Reversals are not covered.
Tuberculosis (TB) screening and follow-up treatment	You have a choice of going to your PCP or to the local health department.
Women's health care	Services must be obtained from the health plan's network of providers and includes follow-up treatment for any problems discovered.

You have a choice to get some services from you PCP/PCCM clinic or go directly to a local health department or family planning clinic. You do not need a referral (permission) from your health plan for:

- Family planning services and birth control
- HIV and AIDS testing
- Immunizations
- Sexually transmitted disease treatment and follow-up care
- TB screening and follow-up care

Benefits and services covered by HCA fee-for-service:

The following benefits and services are covered by fee-for-service. Your health plan and PCP can help coordinate your care with other community-based services and programs. If you have a question about a benefit or service not listed here, call your health plan's customer service number (found on page 2) or the Medicaid helpline at 1-800-562-3022.

Benefit/Service	Comments
Alcohol and substance abuse services, inpatient, outpatient, and detoxification	DSHS-certified agencies must provide services Call 1-877-301-4557 for specific information
Community and home-based services for older and physically disabled persons such as Community Options Program Entry System (COPEs) and Personal Care Services	These services must be approved by DSHS Aging and Disability Services Administration (ADSA). Call 1-800-422-3263
Dental services	You must find a dental provider who will bill HCA
Eyeglasses and fitting services*	You must find a provider who will bill HCA
Hearing aid devices*	You must find a provider who will bill HCA
Early Support for Infants and Toddlers (ESIT) from birth to age 3.	Call 1-800-322-2588 for information
Maternity support services	Part of the First Steps Program - Call 1-800-322-2588
Mental health, inpatient psychiatric care, and crisis services	Inpatient care must be authorized by a mental health professional from the local community mental health agency. For specific information call 1-800-446-0259.
Prenatal genetic counseling	
Pregnancy terminations, voluntary	Includes termination and follow-up care for any complications
Sterilizations (under age 21)	Must complete sterilization form 30 days prior to procedure or meet waiver requirements. Reversals not covered.
Transportation for medical appointments	HCA pays for transportation services to get you to and from needed non-emergency health care appointments. If you have a current Services card, you may be eligible for transportation. Call the transportation service provider (broker) in your area. A list of brokers can be found at http://maa.dshs.wa.gov/transportation/phone.htm . Your regional broker will arrange the most appropriate, least costly transportation for you.

***Note:** Eyeglasses and fittings, and hearing aids are no longer covered for adults 21 years and older.

Some services are excluded and NOT paid for:

The examples in the list below are called exclusions, meaning these services are not covered even if *medically necessary*. These services are not covered by your health plan, PCCM, or fee-for-service. If you get any of these services, you may have to pay for them yourself.

When a service is not a covered benefit, each health plan has a process to review your or your provider's request as an *Exception to Rule*. If you have a question about a benefit or service, call your health plan's customer service number (found on page 2).

Services Excluded	Comments
Alternative Medicines	Acupuncture, Christian Science practice, faith healing, herbal therapy, homeopathy, massage, massage therapy, or naturopathy
Chiropractic care for adults	
Cosmetic or plastic surgery	Such as tattoo removal; face lifts; ear or body piercing; or hair transplants
Diagnosis and treatment of infertility, impotence, and sexual dysfunction	
Gender reassignment surgery	
Marriage counseling and sex therapy	
Personal comfort items	
Physical exams needed for employment, insurance, or licensing	
Nonmedical equipment	
Services not allowed by federal or state law	
Weight reduction and control services	This includes weight loss drugs, products, gym memberships, or equipment for the purpose of weight reduction

Emergencies and medical care away from home

Emergency care: An emergency is a sudden or severe health problem that needs treatment right away. If you think you have an emergency, no matter where you are, call 911 or go to the nearest emergency room.

Medical care away from home: If you need to see a doctor while you are away from home, call your PCP or your health plan. They will help you get the care you need.

Advance directives

An advance directive puts your choices for health care into writing. It may also name someone to speak for you if you are not able to speak for yourself. Having an advance directive means your loved ones or your doctor will not have to make medical choices for you without your guidance.

Washington State law has two kinds of advance directives:

- (1) **Durable power of attorney for health care.** This names another person to make medical decisions for you if you are not able to make them for yourself.
- (2) **A health care directive (living will).** This is a written statement that tells people whether or not you want treatments to prolong your life. If you want to be allowed to die naturally, you can put it in writing with this document.

You can cancel an advance directive at any time. Talk to your doctor, family, friends, and those close to you. Put decisions about your medical care in writing now. Your health plan or your doctor can give you more information about advance directives.

Women's Health Care Act

Under Washington State law you do not need a referral from your primary care provider if the women's health care provider you see works with your health plan. Follow your health plan's rule about women's health care. Call your health plan's customer service number (found on page 2) to find out more information on how to get women's health care.

What is EPSDT?

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a preventive health care benefit for children and youth. This program provides complete, periodic health screenings to clients ages 20 and under. Screenings can help identify potential physical and/or behavioral health conditions. Diagnostic testing and medically necessary treatment to correct or improve physical and mental illnesses or conditions are also available through the EPSDT program. EPSDT encourages early and continuing health care access for children and youth.

Screening: When requested, screenings are done according to a recommended schedule to fully assess each child's health status and find possible health problems.

A screening includes:

- Complete health and developmental history
- A full physical examination
- Appropriate behavioral health and substance abuse screening
- Health education and counseling based on age and health history
- Appropriate vision testing
- Appropriate hearing testing
- Appropriate laboratory testing
- Dental screening services
- Immunizations (shots)

All EPSDT screening elements must be performed or ordered for the visit to be considered an EPSDT screening.

Diagnosis: When a health care risk is identified in an EPSDT screening, additional tests may be done to determine if further evaluation or treatment is needed.

Treatment: When a health care condition is diagnosed as a result of an EPSDT screening, the provider(s) will:

- Treat the client if it is within the provider's scope of practice; or
- Refer the client to an appropriate provider for treatment which may include:
 - Additional testing or specialty evaluations, such as developmental assessment, comprehensive mental health, substance abuse evaluation, or nutritional counseling.

The provider who treats the patient will share the results with the provider who referred the patient for the EPSDT screening. If there is a need for a more complete evaluation of the client's health or condition, that evaluation, diagnosis, and medically necessary treatment is provided to the client.

Children may receive medically necessary covered health care services with or without an EPSDT screening. Certain covered health care services may require prior authorization. A current EPSDT screening is required before medically necessary non-covered services may be requested and authorized. All non-covered services require prior authorization.

Your rights and responsibilities

You have the right to:

- Help make decisions about your health care, including refusing treatment.
- Be informed about all treatment options available regardless of cost.
- Get services without having to wait too long.
- Be treated with respect. Discrimination is not allowed. No one can be treated differently or unfairly because of their race, color, national origin, sex, sexual preference, age, religion, creed, or disability.
- Speak freely about your health care and concerns without any bad results.
- Have your records and information about your care kept confidential (private).
- Ask for and get copies of your medical records.
- Ask for and have corrections made to your medical records when needed.
- Ask for and get information about:
 - Your health care.
 - Your doctor and how referrals are made to specialists and other providers.
 - How the health plan pays for care—call your health plan to ask for this information.
 - All options for care and why you are getting certain kinds of care.
 - Your health plan.
 - Your covered services.
- A second opinion from another provider. Call your health plan to find out how to get a second opinion.

You have the responsibility to:

- Help make decisions about your health care, including refusing treatment.
- Keep appointments and be on time. Call the office if you are going to be late or if you have to cancel the appointment.
- Give your doctors the information they need to get paid for providing services to you.
- Bring your Services card and health plan ID card to all of your appointments.
- Learn about your health plan and how services are covered.
- Use health services when you need them.
- Show your doctors the same respect you want from them.
- Give your doctors complete information about your health so you can get the care you need.
- Follow your doctor's instructions.
- Use health services appropriately or you may be enrolled in the Patient Review and Coordination Program.
 - In this program, you are assigned to one primary care provider, one pharmacy, one prescriber for controlled substances, and one hospital for non-emergent care.
 - You also stay in your health plan for at least 12 months.

What if you are *not* happy with your health care coverage?

If you are not happy with the care you receive, you have a right to talk with your doctor about your concern. And if you are still unhappy, call your health plan to file a grievance or complaint (your health plan will help you do this).

Grievances are complaints about services such as:

- A problem with your doctor's office.
- Getting a bill from your doctor.
- Any other problems you may have getting health care.

Your health plan has up to 45 days to answer your complaint.

Things to know if a medical service is denied...there are time limits.

A **denial** is when your health plan does not approve or pay for a service that either you or your doctor asked for. When a plan denies a service, it is called an **action**.

An **action** is when your health plan sends you a letter about the denied service or ends a medical service you or your doctor asked for. It will also let you know about your rights if you or your doctors do not agree with the plan's decision. Once you get a denial letter, you have **90 days** to ask for an appeal.

Is it urgent? For urgent medical conditions, you or your doctor can ask for an expedited (quick) review or hearing. If approved, a decision will be made about your medical care within 72 hours.

An **appeal** is when you or your doctor asks the health plan to review your case because you disagree with the action. You only have **10 days** to ask for an appeal if you want to keep getting a service that you are already getting while the plan reviews its denial. Your health plan must send you a letter giving its final decision within **45 days**.

If you still disagree with the appeal decision, you have the right to ask for a state hearing within **90 days**. A **hearing** is when you ask the state to review your case after your plan denied your appeal. To ask for a hearing:

- Call the Office of Administrative Hearings (www.oah.wa.gov) at 1-800-583-8271, or write to them at: PO Box 42489, Olympia, WA 98504-2489.
- Tell the Office of Administrative Hearings the reason for the hearing, what service was denied, the date it was denied, and the date that the appeal was denied. Also, be sure to give them your name, address, and phone number.
- You may talk with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer call the NW Justice CLEAR line at 1-888-201-1014, weekdays from 9:15 a.m. until 12:15 p.m., and Tuesdays from 3:30 p.m. until 6:15 p.m., or visit their website at www.nwjustice.org.

After the hearing, the state will send you a letter with its decision within **45 days**. If you disagree with the hearing decision, you have the right to ask your health plan for a review by an Independent Review Organization (IRO). An IRO is a group of doctors, who do not work for your plan, who will review your case. You have **180 days** to call your plan and ask for a review by an IRO.

If you are not happy with the decision of the IRO, you can ask a review judge to review your case. You only have **21 days** to ask for this review after getting your IRO decision letter. The decision of the review judge is final. You can ask for a review by:

- Calling 1-877-351-0002, or
- Writing to the Review Judge at P.O. Box 45803, Olympia, WA 98504-5803.

Note: If you keep getting a service during any of the review steps and the service is still denied, you may have to pay for the service.

Changing how you get your health care

As a Basic Health *Plus* or Maternity Benefits Program member you get your care through a Basic Health managed care plan in the county where you live. However, for some members, getting health care through Basic Health's managed care health plan, may not be the best way.

When you are a Basic Health *Plus* or Maternity Benefits Program member, you are also a Medicaid client.

As a Medicaid client, you may want to get your health care through another state Medicaid program. Depending on the availability of health plans in your county, you may choose a Healthy Options health plan or the fee-for-service program.

You may decide not to be in a Basic Health or Healthy Options managed care health plan if a family member or you:

- **Are American Indian or Alaska Native**—you are *not required* to be in a health plan.
- **Have other health insurance coverage**—you may not have to be in a health plan. Call the Medicaid helpline at 1-800-562-3022, ext. 16134 with your other private insurance information.
- **Are a Child with Special Health Care Needs**— and getting services through your county's *Children with Special Health Care Needs Program*.
- **Are homeless** and you think you will live in a shelter or temporary address for a short time (less than four months), you may not have to be in a health plan.
- **Are seeing a doctor or other medical provider who is not with your health plan** and this doctor tells HCA the medical reasons why you need to keep getting your care from him or her.
- **Are hearing impaired** and want to see a doctor or other medical provider who knows American Sign Language, and this doctor *is not* with your health plan, *and* the health plan does not have an American Sign Language provider, *and* an interpreter is not available.
- **Don't speak English well** and you want to see a doctor or other medical provider who speaks your language *and* this doctor is *not* with your health plan, *and* the health plan does not have a provider available who can communicate in your language, *and* an interpreter is not available.
- **Are a child placed in foster care**—call the Medicaid helpline at 1-800-562-3022.

Remember, you must call the Medicaid helpline at 1-800-562-3022, ext. 16136 if you need to change how you get your health care coverage.

American Indian and Alaska Native health care choices

If you or a family member are an American Indian or Alaska Native, you can choose a:

1. **Basic Health or a Healthy Options managed care health plan.** You will get your health care from the doctors and other providers who are part of that health plan.
2. **Tribal clinic or an urban Indian clinic that is part of Primary Care Case Management (PCCM) program.** The PCCM program may be run by a tribal program, an Indian Health Service clinic, or an urban Indian organization. (See chart below.)
 - If you choose PCCM as the way to get your medical care, the tribal clinic (or urban Indian clinic in Seattle and Spokane) will help coordinate your medical care and get you referrals for services that aren't provided at the clinic. Services are provided by people who know your culture. The clinic can help you get rides to medical appointments and interpreter services if you need them.
3. **Fee-for-service.** This means you can go to any doctor or other provider who will bill HCA for your care. It's a good idea to call the doctors and other medical providers you want to use to be sure they will see you as a fee-for-service patient and bill HCA.

Tribe	Name of Clinic	Phone Number
Any tribe	Seattle Indian Health Board – Seattle	206-324-9360
Any tribe	NATIVE Health Clinic – Spokane	509-483-7535
Colville	Inchelium & Sanpoil Valley Health Center – Inchelium and Keller	509-722-7006
Colville	Colville Indian Health Center* - Nespelem and Omak	509-634-2900
Lower Elwha Klallam	Lower Elwha Health Center – Port Angeles	360-452-6252
Lummi	Lummi Tribal Health Center - Bellingham	360-384-0464
Nooksack	Nooksack Community Clinic - Everson	360-966-2106
Puyallup	Takopid Health Center – Tacoma	253-593-0232
Quileute	Quileute Health Center – LaPush	360-374-9035
Quinault	Roger Saux Health Center – Taholah	360-276-4405
Shoalwater Bay	Shoalwater Bay Wellness Center – Tokeland	360-267-0119
Spokane	David C. Wynecoop Memorial Clinic* - Wellpinit	509-258-4517
Tulalip	Tulalip Tribes Health Center – Tulalip	360-651-4511
Yakama	Yakama Indian Health Center* - Toppenish & White Swan	509-865-2102

*Federally recognized tribal status must be verified to receive services at this site.



Basic HealthTM

Washington State Health Care Authority

PO Box 42683

Olympia, WA 98504

HCA 22-407 (1/12)



Basic Health Is Going “Green”

To save paper, Basic Health will not mail 2012 Member Handbooks. You may either access this at www.basichealth.hca.wa.gov now or request a printed copy by calling 1-800-660-9840.