Member Handbook

Nevada

Anthem

Member Handbook

Nevada

844-396-2329 (TTY 711)

anthem.com/nvmedicaid

Find a doctor on your smartphone or tablet at **anthem.com/nvmedicaid**.

December 2024

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Welcome to Anthem Blue Cross and Blue Shield Healthcare Solutions. We're glad to have you as a member. This handbook tells you how Anthem works and how to help keep your family healthy.

You've probably already received your Anthem member ID card. If not, you should receive it in a few days. Your ID card tells you when your Anthem membership starts. The name of your primary care provider (PCP) is on the card, too. Please check your ID card right away. If the name of your doctor or any other information isn't right, please call us at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time. We'll send you a new ID card with the correct information. If you have a new doctor, make an appointment with him or her soon to discuss your health needs.

Benefits beyond what you'd expect.
With Anthem, you receive your regular Medicaid and Nevada Check Up benefits, plus extras designed to make a difference in your life:

- Do you have a child between the ages of 5 and 14? They can get a free Boys & Girls Club membership. The clubs provide many fun and educational activities for children. It's a great place to go after school.
- We also offer free sports physicals every 12 months for children ages 6 to 18.

We're just a call or a click away.
When you have questions or need help, our team is ready and willing to assist. Our website has many of the answers you need. Visit **anthem.com/nvmedicaid** to:

- Learn more about your benefits.
- Choose or change your PCP.
- Use our **Find a Doctor** tool to search for a doctor by name, type or location.
- And a lot more.

You can also call Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time. If you have health questions and want to talk with a registered nurse, call 24/7 NurseLine at the phone number above. Our nurses are available anytime, day or night.

You want to visit us in person to learn more about your benefits? Come see us at one of our Wellness Centers

Las Vegas Wellness Center address: 2348 E. Bonanza Rd., Las Vegas, NV 89129
Monday through Friday, 9 a.m. to 5 p.m.

Reno Wellness Centers address: 294 E. Moana Lane, Suite 25, Reno, Nevada 89502 (Walk-

Ins Monday through Friday, 10 a.m. to 2 p.m.)

Sincerely,

Anthem Blue Cross and Blue Shield Healthcare Solutions

To update your address or phone number, please call Nevada Medicaid at:

- Carson City: **775-684-3651**
- Elko: **775-753-1191**
- Las Vegas: **702-668-4200**
- Reno: **775-687-1900**

Frequently asked questions

1. How do I change my primary care provider?
   See the **How to change your primary care provider** section.

2. Where can I find a list of behavioral health providers?
   See the **Where to find a list of Anthem network providers** section or go to **anthem.com/nvmedicaid**.

3. My child needs something to do after school and in the summer. Can Anthem help?
   See the **Special Anthem services for healthy living** section.

4. As an adult member, does Anthem cover my care?
   See the **Wellness care for adults** section.

5. What if I don't have transportation to my doctor appointment? See the **Transportation** section.

6. I don't have a phone. How can I communicate with Anthem or my doctors?
   See the **Extra Anthem benefits** section.

7. How do I find out if my medication has been approved or requires authorization?
   See the **Medication** section.

8. How can I receive another copy of my ID card?
   - See the **Go online** section; **Download the Sydney Health app** section or the **Your Anthem identification card** section.
   - Call **844-396-2329 (TTY 711**), Monday through Friday from 7 a.m. to 7 p.m. Pacific time
   - You can also download your member ID from your secure account at **anthem.com/nvmedicaid**

Welcome to Anthem Blue Cross and Blue Shield Healthcare Solutions. You'll receive most of your Medicaid and Nevada Check Up benefits through Anthem. This member handbook will tell you how to receive the most from your benefits.

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WELCOME TO ANTHEM BLUE CROSS AND BLUE SHIELD HEALTHCARE SOLUTIONS!

Your new health plan

Anthem Blue Cross and Blue Shield Healthcare Solutions provides your Medicaid and/or Nevada Check Up benefits. We're the health plan that will help you make the most of them! Working with you and your doctors, we will help you feel your best and stay healthy.

We offer healthcare coverage to individuals living in urban Clark and Washoe counties.

The state requires us to give you the information below.

Please note that all monthly payments from Medicaid to Anthem may be recovered by Medicaid as a claim against your estate if we cover services included under Nevada's plan for estate recovery* and you are one of the following:

- Age 55 or older
- An inpatient of a medical facility

Medicaid can't recover payments from estates of deceased Medicaid members if there is a:

- Surviving spouse.
- Child under 21 years old.
- Child of any age with a disability or blindness.

Medicare Parts A and B copays paid after January 1, 2010, also can't be recovered. For more information, visit dwss.nv.gov or call toll free **800-992-0900**.

*Per the Centers for Medicare & Medicaid's State Medicaid Manual, section 3810.

How to find help

Call Member Services

We're here to help you. Call us at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time if you:

- Have any questions about our health plan or your benefits.
- Need help receiving care or finding a plan provider.
- Need an interpreter to help you communicate with your doctor in your native language or are deaf or hard of hearing.
- Want to suggest how we can make your health plan better.
- Want to participate in a committee to help improve healthcare services and community education.

Call Anthem 24/7 NurseLine

Call 24/7 NurseLine at **844-396-2329 (TTY 711)** anytime, day or night. Our nurses can help if you have health-related questions or need advice on:

- What to do to take care of yourself before you see the doctor.

- How soon you need to receive care for an illness.
- When to go to the emergency room or urgent care center.
- How you can receive the care you need.

Go online

Visit our website at **anthem.com/nvmedicaid**. We've made some updates and improvements. You can:

- Choose or find a primary care provider (PCP) in the Anthem network.
- Change your PCP.
- Request an ID card.
- Update your address or phone number. Please also call Nevada Medicaid at:
  - Carson City: **775-684-3651**
  - Elko: **775-753-1191**
  - Las Vegas: **702-668-4200**
  - Reno: **775-687-1900**
- Download or request a member handbook or provider directory.
- Learn about community programs and services.
- Ask questions or make comments to help improve Anthem.
- Learn about your rights and responsibilities as a member.
- Report waste, fraud and abuse.
- Read what we are doing to keep your private information safe and receive a copy of the Anthem Notice of Privacy Practices. This Notice describes how your medical information may be used and shared, and how you can access it.
- Learn about pharmaceutical management procedures.

Download the Sydney℠ Health app

Now you can access your Anthem member identification (ID) card and find doctors in our network from your smartphone or tablet. Just download the Sydney Health app. With Sydney, you can show, email, or fax your member ID card to your doctor, pharmacy or hospital. You can also use our interactive symptom checker and explore health and wellness information. It's fast. It's free. And best of all, it's safe. You just need your ZIP code and Anthem ID number, printed on your ID card, to use these services.

To download the app, go to the App Store®, Google Play™, or visit our website at **anthem.com/nvmedicaid**.

Need help in person? Come to one of our Wellness Centers:

Las Vegas Wellness Center address: 2348 E. Bonanza Rd., Las Vegas, NV 89129
Monday through Friday, 9 a.m. to 5 p.m.

Reno Wellness Centers address: 294 E. Moana Lane, Suite 25, Reno, Nevada 89502 (Walk-Ins Monday through Friday, 10 a.m. to 2 p.m.

Important phone numbers

Name	Description	Phone number
Emergencies	Call or go to the nearest hospital emergency room.	**911**
24/7 NurseLine	Receive medical advice or talk with a registered nurse about any nonemergency health-related questions or concerns.	**844-396-2329 (TTY 711)**
Anthem Member Services	Receive a member handbook, update your member identification card, find a new provider, schedule an appointment and much more.	**844-396-2329 (TTY 711)**
Behavioral Health Care Crisis Line	If you have a behavioral or mental health issue or substance abuse issue, we can help. Call our 24/7 Behavioral Health Crisis Line. You can also call Member Services to find information about behavioral healthcare.	**844-396-2331 (TTY 711)**
Case Management	Call Member Services to be connected with a case manager.	**844-396-2329 (TTY 711)**
Disease Management programs	Speak with a Disease Management case manager if you have a chronic condition.	**888-830-4300 (TTY 711)**
EyeQuest®	Find out information about your vision benefits.	**888-300-9025 (TTY 800-466-7566)**
Member Pharmacy Help Line		**833-207-3116 (TTY 711)**
MTM	Arrange for transportation to medically needed appointments and treatments (not available for Nevada Check Up members).	Toll free at **844-879-7341**
Nevada Check Up	Receive information about Nevada Check Up program eligibility and premium requirements.	Toll free in-state at **877-543-7669** (KIDS NOW) Toll free out-of-state at **800-992-0900**

Nevada Medicaid	Find out more about Medicaid program eligibility and other information.	**775-684-7200** (North) **702-486-1646** (South) Toll free at **800-992-0900**

About this member handbook

This handbook will help you understand your healthcare plan. The other side of this handbook is in Spanish. If you have questions, need help understanding or reading something in here, or want this in a different language, call Member Services at **844-396-2329 (TTY 711)**. Anthem members have the right to request and obtain a copy of the member handbook at least once per year or upon request. You will receive your Member handbook in paper format at no cost within 5 business days of your request. You can also request this member handbook in:

- A large-print version
- An audio version
- A braille version

When there are benefit changes or other changes that impact your care and services, we'll let you know at least 30 days before the intended effective date of the change. Here's how you will be notified :

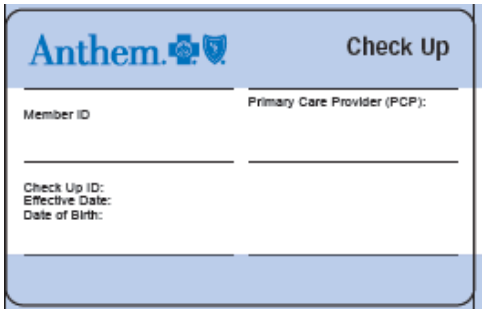
- We'll send you a letter or notice to keep with your member handbook.
- We'll update our member website at **anthem.com/nvmedicaid**.

Your Anthem identification card

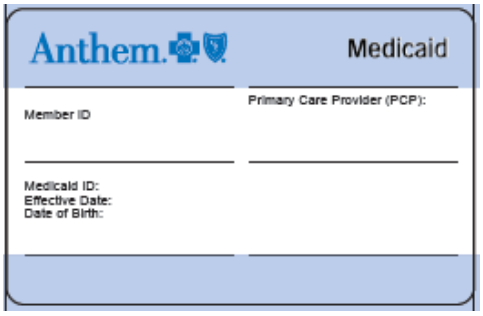
If you don't have your Anthem identification (ID) card yet, you'll receive it soon.

- Please carry it with you at all times.
- Show it to any doctor, hospital, or pharmacy you

visit. This card identifies you as an Anthem member.



Nevada Check Up ID card



Nevada Medicaid ID card

Your Anthem ID card shows:

- The name and phone number of your PCP.
- Your Medicaid or Nevada Check Up number.

- The date you became an Anthem member.
- Important phone numbers.

If your Anthem ID card is lost or stolen, call us right away at **844-396-2329 (TTY 711)**. We'll send you a new one.

For members who don't speak English:

- We can help in many different languages and dialects.
- We'll provide an interpreter to help you talk to your doctors during your appointments. Please call Member Services at least 24 hours before your appointment.

For members who are deaf or hard of hearing:

- Call **711** to reach Member Services.
- If you need a sign language interpreter for a doctor visit, please call us at least five business days before your appointment. We'll set up and pay for the service.

YOUR PROVIDERS

Picking a primary care provider

All our members must have a primary care provider (PCP) in the Anthem plan. Your PCP is your regular doctor who you'll see for all your basic healthcare needs — such as yearly checkups, minor illnesses, or referrals to specialists. They will:

- Learn about you and your health history.
- Provide all your basic health services and send you to other doctors or hospitals when you need special care.
- Help you receive the right care.

Each Anthem member must elect a PCP within five (5) business days of the effective date or enrollment. If you didn't choose one, we assigned one to you. We picked one close to your home. The name and phone number of your PCP is on your Anthem ID card. You may also choose a primary care site (PCS), such as a Federally Qualified Health Center (FQHC) and receive medical care from any doctor in the PCS. It is important to schedule an appointment with your PCP within the first 90 days of enrollment with Anthem. You need to discuss your health history and medications with him or her as soon as possible.

If you are not happy with the PCP we assigned, you can pick another one at any time. Just look in the provider directory that came with your new member package or go online to **anthem.com/nvmedicaid**. Our search tool lets you search for providers by name, location, and specialty. Need help? Call Member Services and our Concierge team would be happy to help find providers and schedule appointments at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time. No matter how you make the change — online or on the phone — we'll send you a new member ID card.

If you are already seeing a PCP, you can look in the provider directory to see if that provider is in our network. If so, you can tell us you want to keep him or her by calling Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time. Your PCP can be any of the following, as long as he or she is in the Anthem network:

- Family or general practitioner
- Internist
- Pediatrician
- Specialist (for those with a disability, chronic, or complex
- Physician assistant
- Certified nurse practitioner
- Obstetricians/gynecologists (during pregnancy)

You can also pick a Federally Qualified Health Center (FQHC) as your PCP if you would like.

You and your children don't have to have the same PCP. If you are pregnant, your newborn will be assigned to the same PCP as the other covered children in the family.

You may be able to have a specialist or a state-operated clinic as your PCP if you have a:

- Disability
- Chronic condition
- Complex condition

Your specialist must agree to take on PCP responsibilities for your care. Members with disabilities have an additional thirty (30) calendar days to select a PCP. If you don't select a PCP, we will automatically assign one to you. You can ask us to change your PCP at any time.

Where to find a list of Anthem network providers

In addition to this member handbook, we will give you a provider directory. The provider directory is included in your new member package. The provider directory lists primary care providers (PCPs), behavioral health providers, specialists, optometrists, chiropractors, drug stores, and hospitals that participate with Anthem. The directory shows if the provider is accepting new patients and if they are board-certified.

The directory also lists:

- Office addresses
- Office phone numbers
- Office hours
- Languages spoken at the office

If you did not receive a provider directory, please contact Member Services at **844-396-2329 (TTY 711)**. We'll send you a new directory. You can also search for a provider online by going to **anthem.com/nvmedicaid** and selecting **Find a Doctor**.

Seeing an out-of-plan provider

There may be times when you will need to see a provider who is not part of the Anthem network. If you were ill or injured before joining Anthem and were seeing a PCP who is not in our network, please let us know about the care you were receiving. In some cases, you may be able to keep seeing this PCP while you pick a new one in our network. Call Member Services at **844-396-2329 (TTY 711)** to find out more. Anthem will work with you and your PCP to provide a smooth transition to your new PCP.

It is important to schedule an appointment with your doctor within the first 90 days of enrollment with us. You need to discuss your health history and medications with your PCP as soon as possible.

If you require medically needed care that is not available from a plan provider and your PCP requests the services, Anthem will provide those services at no cost to you for as long as the service you need is required and not available from a plan provider.

To see an out-of-plan provider, you or your doctor will need to ask for approval from us first.

If your primary care provider's office moves, closes, or leaves the Anthem plan

Your PCP's office may move, close, or leave our plan. If this happens, we will:

- Notify you in writing within 15 calendar days of receiving the provider termination notice; in some cases, you may continue seeing this PCP while you pick a new one.
- Work with you and your PCP to provide a smooth transition to your new PCP.
- Help you pick a new PCP if you call Member Services for help.
- Send you a new ID card within five business days after you pick a new PCP.

How to change your primary care provider

If you need to change your PCP, you may pick another PCP from the network at any time. To change your PCP, do one of the following:

- Look in the Anthem provider directory that came with your new member package.
- Go to **anthem.com/nvmedicaid** to search for a new PCP or view the provider directory online.
- Call Member Services for help at **844-396-2329 (TTY 711)**.

When you ask to change your PCP:

- We can make the change the same day you ask for it.
- The change will be effective the next day.
- You'll receive a new ID card in the mail within five business days after your PCP has been changed.

If your PCP asks for you to be changed to another PCP

Your PCP may ask for you to be changed to another one. They may do this if:

- Your PCP does not have the right experience to treat you.
- The assignment to your PCP was made in error (like an adult assigned to a child's PCP).
- You fail to keep your appointments without calling the PCP to let them know or schedule a new appointment.
- You and your PCP have not been able to align on a treatment plan that works for you.
- Your PCP agrees a change is best for you and your medical needs.

If your PCP asks you to change to another PCP for any of these reasons, please contact Member Services for help finding a new PCP or check the provider directory. You may also use the **Find a Doctor** tool online at **anthem.com/nvmedicaid**.

If you want to see a provider who is not your PCP

If you want to see a provider who isn't your PCP, talk to your PCP first. They may give you a referral to see another provider.

Please read the section about **Specialists** to learn more about referrals. Also, read the section **Services That Do Not Need a Referral** for more details.

Second opinions

Anthem members have the right to ask for a second opinion about any treatment or diagnosis at no cost. You can seek a second opinion from a network provider or a non-

network provider if a network provider is not available. Ask your PCP to submit a request for you to have a second opinion. Call Member Services if you need assistance finding a provider for a second opinion at **844-396-2329 (TTY 711)**.

Picking an OB-GYN

- Members can see a network OB-GYN. These services are no additional cost to members and include:
- Wellness visits
- Prenatal care
- Family planning

You do not need a referral to see any qualified family planning provider, even if this provider is not part of the Anthem network.

Your PCP may be able to treat you for OB-GYN care. If not, you will need to see a network OB-GYN. To find an OB-GYN from the list of network providers:

- Look in the Anthem provider directory that came with your new member packet.
- Go to our online provider directory at **anthem.com/nvmedicaid**.
- Call Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

While you are pregnant, your OB-GYN can be your PCP. 24/7 NurseLine nurses can help you decide if you should see your PCP or an OB-GYN.

If you are pregnant when you enroll in Anthem and your current provider is not part of the Anthem plan, you may be able to continue receiving OB-GYN care from your current provider. This is called continuity of care. Call Member Services for more information.

Going to a specialist

Your PCP can take care of most of your healthcare needs, but sometimes you may also need care from other kinds of providers. There are many different kinds of providers in our plan who give other medically needed care. These providers are called specialists because they have training in special areas of medicine.

Examples of specialists are:

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

If you need to see a specialist, your PCP will give you a referral. The referral form tells you and the specialist what kind of healthcare you need. Be sure to take the referral form with you when you go to the specialist.

In a few cases, a referral isn't needed. Read the section in this handbook, **Services That Do Not Need a Referral**, for more details.

Sometimes, a specialist can serve as your PCP. This may happen if you have a special healthcare need that requires specialist care. If you believe you have special healthcare

needs, you can:

- Talk to your PCP.
- Call Member Services at **844-396-2329 (TTY 711)**.

If you're receiving care from a specialist who is not part of our plan when you join Anthem, please let us know. In some cases, you may continue seeing them until you can switch to an Anthem plan specialist. Call Member Services to find out more.

If you are currently receiving care from a specialist whose office is moving, closing, or who will no longer participate in our plan, we will:

- Call or send you a letter within 15 calendar days of receiving the provider termination notice. In some cases, you may continue seeing this specialist for care while you pick a new one. Call Member Services to find out more about this.
- Work with you and your PCP to ensure a smooth transition to your new specialist.
- Help you pick a new specialist if you need help.

Out-of-Network Services

Sometimes an in-network provider or service is not available. When you need a provider or service out-of-network, Anthem will attempt to find you care as close to home as possible, searching first within 25 miles of your home before expanding beyond that radius.

All out-of-network or non-covered services require a prior authorization for review of medical necessity.

Receiving Healthcare

How to make an appointment with your PCP

It is important to visit your PCP for regular checkups, called wellness visits, and for care when you are ill. Call your PCP's office whenever you need care. The phone number is on your Anthem ID card.
If you were assigned a new PCP when you enrolled in Anthem, it is important to schedule a wellness visit within 90 calendar days. If your PCP did not change when you enrolled, call them to see if it is time for a checkup. If so, set up a visit with your PCP as soon as you can.

Wellness visits can help you stay healthy and let your PCP take better care of you when you are sick. When you are not feeling well, call your PCP's office. Let them know your symptoms, and they will tell you how soon you need to be seen. If you need help making an appointment, or you have lost your Anthem ID card and are unsure of your assigned PCP's phone number, call Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

Wait times for appointments	
Emergencies (Call 911 or go to the nearest hospital)	Immediately
PCP visits	
Emergent appointment	Same day
Urgent appointment	Within two (2) calendar days
Routine appointment	Within two (2) weeks
Specialist visits	
Emergent appointments	Within twenty-four (24) hours of referral
Urgent appointment	Within three (3) calendar days of referral
Routine appointment	Within thirty (30) calendar days of referral
Behavioral Health	
Non-life-threatening emergency	Within six (6) hours
Urgent care	Within forty-eight (48) hours
Initial visit for routine appointments	Within ten (10) business days

Wait times for appointments	
Prenatal care visits	
First trimester	Within seven (7) calendar days
Second trimester	Within seven (7) calendar days
Third trimester	Within three (3) calendar days
High-risk pregnancies	Within three (3) calendar days or immediately if an emergency exists
Home health, private duty nursing, and personal care services	*(initiation of ongoing services)*
Urgent needs	Same day
Non-urgent needs	Within fourteen (14) calendar days

After-hours callbacks

We want you to be able to receive care at any time. When your PCP's office is closed, your PCP must have an answering machine or an answering service to take your call. The answering service will forward your call to your PCP or on-call physician or instruct you that the provider will contact you back by the next business day. When an answering machine is used after hours, the answering machine will provide you with a process for reaching a provider after hours. For emergent issues, both the answering service and answering machine will direct you to call **911** or go to the nearest emergency room. Talk to your PCP and setup an appointment.

What to bring to an appointment

When you visit your provider, be sure you have:

- Your Anthem ID card
- Any medicines you are taking
- Any questions you may want to ask

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

- Identification (ID) cards
- Shot records
- Any medicine they are taking

How to cancel an appointment

If you make an appointment and then cannot go, it is important to:

- Cancel the appointment at least 24 hours in advance. You can call the doctor's office or call Member Services and ask us to cancel for you. This will let someone else make an appointment at that time.
- Make a new appointment when you call to cancel.

Your PCP may ask us to switch you to a new PCP if you frequently miss appointments without cancelling.

Transportation

If you need a ride to and from your medical appointments for routine visits, call MTM toll-free at **844-879-7341**. You can call to schedule a ride Monday through Saturday from 7 a.m. to 6 p.m. Please call MTM as soon as possible and at least three business days before your scheduled appointment. MTM will work with you to find the right transportation for you and may consult your healthcare provider. Nonemergency transportation service is only available to Medicaid recipients. Nevada Check Up members are not eligible for this service.

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

- Be sure to tell the hospital staff you are an Anthem member.
- Contact your PCP as soon as you can. Your PCP can:
  - Arrange your ongoing treatment.
  - Help you receive needed hospital care.

Access for members with special needs

Anthem plan providers and hospitals should help members with disabilities receive the care they need. If you use a wheelchair, walker, or other aid and need help entering an office:

- Make sure your provider's office knows this before you go to your appointment. This will help them be ready for your visit.
- Call Member Services if you want help talking to your doctor about your special needs.

What does medically necessary mean?

Your PCP will help you receive medically necessary services. **Medically necessary health services** are:

- Necessary to diagnose, treat or prevent illness, injury, or disease.
- Necessary to regain or improve the ability to perform the activities and tasks of daily living.
- Consistent with the symptoms or diagnosis of the illness or injury being treated.
- Consistent with generally accepted professional medical standards, including:

- Guidelines and standards that are endorsed by professional healthcare or government agencies.

- Not experimental (not new or untried), unless identified as an exception.
- Safe and effective for the member (Medicaid and Nevada Check Up will only cover items and services that are needed for the diagnosis or treatment of an illness or an injury, or to improve the working of a malformed body part). This does not include cosmetic procedures.
- Not mainly for the convenience of the member, the member's caregiver, or the provider.
- Not for cosmetic purposes.

As an Anthem member, you and your doctor together will decide what treatment plan is best for you. If the services you receive are not helping you then they might be stopped or changed to best meet your needs. Services are also stopped when they are not medically necessary.

HEALTHCARE BENEFITS AND PREMIUMS

Anthem benefits

See Anthem Covered Services table for a summary of the healthcare services and benefits Anthem offers. Your PCP will either give you the care you need or refer you to another provider.

For some benefits, you must be a certain age or have a certain kind of health problem. In some cases, your PCP may need to receive prior approval from Anthem before you can receive a benefit. Your PCP will work with us to receive approval. If we do not approve a service, your PCP may provide you with another service.

There are no copays or deductibles required for any covered services.

If you have a question or are not sure if Anthem offers a certain benefit, call Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

Prior authorization (preapproval)

Some Anthem services and benefits need prior authorization (preapproval). This means your PCP must ask Anthem to approve the services or benefits. Emergency services, post-stabilization services, and urgent care do not need prior approval.

Anthem has a Utilization Review team that looks at prior authorization requests. The team will decide:

- If the service is needed and if it is covered by Anthem.
- Within 14 calendar days after receiving the request and clinical information from your PCP. We will share our decision with you by mail, and with your PCP by fax, mail, or phone.

Your PCP can ask for an expedited review if a delay could cause serious harm to your health. We will notify you by mail and your doctor of our decision within 72 hours of receiving the request.

Sometimes, additional time is needed to allow providers to submit more information needed before we can make a decision. In those instances, an additional 14 calendar days will be provided.

If we say we will not pay for the care, or the approved services are less than the amount or type requested, you or your doctor can ask for a reconsideration or an appeal. To learn more about the appeal process, see the **Grievances and Medical Appeals** section. If you appeal, we will notify you of our decision within 30 days. If you have a question or aren't sure if we offer a certain benefit, you can call Member Services for help. For a list of the services we cover, go to the Anthem **Covered services** section.

HOW WE MAKE DECISIONS ABOUT YOUR CARE

Sometimes we need to review care and services to make sure they are medically necessary. This is called Utilization Management (UM). Our UM process follows National Committee for Quality Assurance (NCQA) standards. All UM decisions are based on members' medical needs and current benefits.

We do not encourage providers to underuse services. In addition, we do not create barriers to receiving healthcare. Clinicians are not rewarded for limiting or denying care. Anthem clinical reviewers use clinical practice guidelines to determine necessary treatments and services.

Listed below are some of the benefits we cover. If a service is not listed, please check with your provider or contact us.

Some services are limited by the number of provider visits or by the number of supplies and equipment items. We have a process to review requests from you or your provider for extra visits or extra supplies. We also have a process to review requests for non-covered services, when they are medically necessary.

Remember to call us before you receive medical services or ask your PCP to help you. You might need a referral from your PCP or approval from us before you can receive some services. If you do not get a required referral form or pre-approval, then some services might not get covered and paid. When you ask or your provider asks for certain care that needs a pre-approval, our Utilization Review team decides if the service is medically necessary and covered by Anthem.

Anthem associates are available during normal business hours for inbound, collect, or toll-free calls regarding general UM issues.

An Anthem associate will identify themselves by name, title, and organization name when initiating or returning calls regarding general UM issues.

If you are unable to contact Anthem during business hours, you can use Sydney App 24/7 to view any UM information.

Additionally, some of the services listed below may need pre-approval; please ask your provider for more information or contact us Monday through Friday from 7 a.m. to 7 p.m. Pacific time. To speak to a representative, please call 844-396-2329 (TTY 711). An Anthem member services representative can also assist with language assistance services as needed.

***Anthem does not cover testing, medication, or treatment that is experimental,** such as a new treatment that is being tested or has not been shown to work, unless identified as an exception.

Anthem covered services

As an Anthem member, you will receive all medically necessary Medicaid-covered services at no cost to you.

COVERED SERVICE	ADDITIONAL INFORMATION
ALLERGY SERVICES	Covered services include: • Treatment — Immunotherapy (commonly called allergy shots) is a useful treatment for patients with allergies. It is based on the belief that people who receive injections of a specific allergen will no longer be sensitive to it. • Testing — Allergy tests are used to determine what a person is allergic to. There are many methods of allergy testing. Common types include: – Skin tests – Elimination-type tests
APPLIED BEHAVIORAL ANALYSIS (ABA)	Applied Behavior Analysis (ABA) is a behavior intervention model to treat children with autism spectrum disorder (ASD). ABA is offered to Medicaid-eligible individuals under age 21 in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT). ABA services include: • Assessment • Evaluation/reevaluation • Treatment intervention plan with measurable objective goals • Targeted goals (data driven) • Functional communication training • Self-monitoring skills • Adaptive living skills • Cognitive skills • Speech, occupational, physical therapy • Durable Medical Equipment (DME) • Speech Generating Device (SGD) • Verbal skills • Language skills • Peer play • Social skills

	• Pre-vocational and vocational skills • Parent training • Family education • Family counseling • Case management A referral is needed for ABA services. One of the following are necessary for authorization of ABA services: • MD prescription recommending applied behavioral analysis (ABA) • Recent comprehensive diagnostic evaluation completed by a physician or licensed psychologist • Signed coordination of care letter recommending ABA by physician or licensed psychologist Our providers are familiar with the request form requirements for ABA, and can also reach out to Provider Services for needed support.
ASSISTANT SURGEON	An assistant surgeon aids the performing surgeon during a surgical procedure. These services are covered for qualifying procedures.
ASSISTIVE/AUGMENTATIVE COMMUNICATION DEVICES	Devices, such as speech synthesizers, that help members with limited vocal or verbal communication skills convey their thoughts.
AUDIOLOGY SERVICES	These services help decide whether a person can hear within the normal range and, if not, which parts of hearing have changed and to what degree. If an audiologist diagnoses a hearing loss, he or she will advise what options may help a patient (e.g., hearing aids, cochlear implants, surgery). Anthem covers: • Medically needed hearing aids • Hearing aids and supplies made during a Healthy Kids checkup, for members under age 21 in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

	Certain limits apply.
BARIATRIC SURGERY/OBESITY SURGERY	Bariatrics is a branch of medicine to help prevent, control, and treat obesity. Obesity surgery/bariatric surgery is a weight-loss method limited to people who meet the eligibility and medical necessity requirements. Anthem will cover services up to limits as outlined in the Medicaid and Nevada Check Up program.

COVERED SERVICE	ADDITIONAL INFORMATION

BEHAVIORAL HEALTH	Covered services up to limits outlined in the Nevada Medicaid and Nevada Check Up program include:
	• Crisis Intervention for members who go through a psychiatric crisis to:
	  • Reduce symptoms.
	  • Help stabilize and restore a person to their former level of function.
	• Crisis stabilization to help a person in crisis return to their prior level of function.
	• Prescribed Electroconvulsive Therapy (ECT) to treat some behavioral health conditions that are treatment resistant.
	• Hospital-based Detoxification/Chemical Dependency. Services:
	  • Aimed to restore the mental and physical well-being of those who struggle with drugs or alcohol.
	*Certain limits apply as determined by the Nevada Medicaid and Nevada Check Up program.
	• Inpatient Professional Services given within an inpatient setting by:
	  • Psychiatrists
	  • Psychologists
	  • Clinical social workers
	  • Psychotherapists
	  • Medical doctors or specialists
	  • Certified Nurse Practitioners
	• Intensive Outpatient Program for psychiatric and chemical dependency that:

	• Meets several times a week for at least three hours of mental health or substance/alcohol disorder services. • Aims to improve a person's level of function to prevent a relapse or hospital admission. • Medication Assisted Treatment (MAT) such as a Methadone Maintenance Program for the treatment of heroin / opioid addiction. • Hospital observation services • Outpatient/ambulatory detox and/or rehab services: • Aimed to restore the mental and physical well-being of those who struggle with drugs or alcohol. • Outpatient mental health/substance use disorder services include: • Basic medical and therapeutic services • Crisis services • Review and diagnosis of care • Individual, family and/or group therapy, unless part of an EPSDT screening • Medication management You may receive these services from authorized physicians, psychologists, or other mental health professionals. • Partial Hospital, Psychiatric and Chemical Dependency Treatment programs that: • Are offered Monday through Friday for at least six hours each day.
COVERED SERVICE	**ADDITIONAL INFORMATION**

BEHAVIORAL HEALTH (Cont.)	• Medication management • Medical treatment • Lab testing • Room and board • Active treatment • Psychiatric services • Psychological services • Therapeutic and behavioral modification services • Individual, group, family, recreation, and milieu therapies • Nursing services • Medication management • Quarterly RTC-sponsored family visits • Psycho-educational services and supervised work projects Medicaid and Nevada Check Up covers the admission, daily room rate, and ancillary services.
COVERED SERVICE	**ADDITIONAL INFORMATION**
BLOOD ADMINISTRATION AND OTHER BLOOD PRODUCTS	Anthem covers injecting of blood or blood products into a vein or artery.
BOTOX INJECTIONS	Covered services include treatment for migraines, jerkiness of limbs as a result of a brain, or spinal cord injury, including cerebral palsy. Treatment for cosmetic purposes is not covered.

COVERED SERVICE	ADDITIONAL INFORMATION

CASE MANAGEMENT	Care management is designed to respond to a member's needs when the member's condition or diagnoses require assistance for care coordination.
	
	When a member is in a care management program:
	• An Anthem care manager helps identify settings in which care may be given.
	• A provider, on behalf of the member, may request the member take part in the program. The care manager will work with the member and the member's providers to decide:
	  • The level and types of services needed.
	  • Other settings where care may be given.
	  • Equipment and/or supplies needed.
	  • Nearby community-based services.
	  Communication needed between the member and the member's care team, such as the PCP and specialists.
	Care managers will complete member screening and assessment tools to help identify holistic care needs, and gaps in care including behavioral, physical, and/or social determinants of health needs.
	
	The Comprehensive Health Assessment includes:
	• A range of questions to identify and assess the member's:
	  • Immediate care needs and current services in place.

	• Physical Health Conditions. • Behavioral Health Conditions, including substance use status and/or disorders. • Physical, intellectual, or developmental disabilities. • Cultural preferences and considerations. • Community resource needs. • Available informal, caregiver, or social supports, including peer support. • Any ongoing special conditions that request a course of treatment or regular care monitoring. • Exposure to adverse childhood experiences (ACEs) or other trauma.

COVERED SERVICE	ADDITIONAL INFORMATION

CASE MANAGEMENT (Cont.)	• Special health needs.
	• Current treatment plan.
	• Phone interviews, video interviews, or home visits to collect and assess information received from members or their representatives to complete the assessment. Care managers will also receive information from:
	  • The member's PCP and specialists.
	  • Other key treatment team members such as State agencies or community-based organizations.
	  • The member's family if applicable, such as a legal representative of the member.
	Individualized plan of care
	Case managers will use information from the assessment to help the members and their care team decide the proper care management services needed.
	The case manager will:
	• Work with the member, their family and/or representative (when applicable), and the member's providers to develop and set up the proper care plan.
	• Help identify member's needs for social, educational, therapeutic, and other nonmedical support services as well as the strengths and needs of the member and their family.

COVERED SERVICE	ADDITIONAL INFORMATION
CASE MANAGEMENT (Cont.)	When nonmedical needs are complex, case managers will work with other care management team members, including but not limited to: • Social workers • Patient navigators • Community health workers • Community based organizations • Peer support specialists Member advocates or outreach specialists may attempt to contact members for Care Management Services. If a member is receiving case management services from other sources (e.g., a community services organization), the care plan will define: • The process for managing medical, behavioral health, and/or substance abuse, and social aspects of care. • The roles of each person on the care team. A signed member release may be needed in certain situations to openly discuss specific health concerns with the member's care team, including their PCP.

COVERED SERVICE	ADDITIONAL INFORMATION
CHEMOTHERAPY AND RADIATION	**Chemotherapy** is the use of drugs to kill bacteria, viruses, fungi, and — most often — cancer cells. • It can destroy cancer cells at sites great distances from the original cancer. • More than half of all people diagnosed with cancer receive chemotherapy. A **chemotherapy regimen** is a treatment plan and schedule that includes drugs to fight cancer, plus drugs to help support finishing the cancer treatment at the full dose or schedule. **Radiation therapy** is the use of a certain type of energy, called ionizing radiation, to kill cancer cells and shrink tumors. • In some cases, the goal of radiation treatment is to destroy an entire tumor. • In other cases, the goal is to shrink a tumor and relieve symptoms. In both cases, doctors plan treatment to spare as much healthy tissue as possible. Prior authorization is required.

COVERED SERVICE	ADDITIONAL INFORMATION
CHIROPRACTIC SERVICES	For Medicaid members under age 21 and Nevada Check Up members through their 19th birthday. Covered services include: Medically needed chiropractic services when referred to a chiropractor as part of a Healthy Kids checkup, and when a diagnosis of spinal subluxation is made by the referring doctor.
CIRCUMCISION	Circumcision is a covered benefit. Prior authorization is not needed for one year of age or less. Over one year of age requires a prior authorization.
CLINICS	**Federally qualified health centers (FQHCs)** provide preventive services, or services to treat an illness or chronic disease.

COVERED SERVICE	ADDITIONAL INFORMATION
Clinics (cont.)	**Rural health clinics (RHCs)** provide preventive services. Members can receive covered services at these facilities from the following providers: • Physicians • Nurse practitioners • Clinical social • Physician assistants • Visiting nurses • Community Health Workers • Dental Hygienist • Doulas • Opticians • Optometrists • Licensed Martial and Family Therapists • Podiatrists • Radiologists • Clinical psychologists • Clinical social workers • Certified dietitians • Registered nurses • Midwives • Nutritional professionals **You can receive these services without a referral from your PCP.**

COVERED SERVICE	ADDITIONAL INFORMATION
COSMETIC/PLASTIC/RECONSTRUCTIVE SURGERY PROCEDURES	**Cosmetic surgery**, performed to reshape normal structures of the body to improve a person's appearance and self-esteem, is not a covered benefit. **Reconstructive surgery,** performed on abnormal structures of the body caused by birth defects, developmental abnormalities, trauma or injury, infection, tumors, or diseases, may be covered. Reconstructive surgery is usually done to improve function, but in some cases may also be done to help come close to a normal appearance. This may include cleft palate repair, breast reconstruction, etc. Covered reconstructive surgery services include: • Surgery for the prompt repair of an injury caused by an accident. • Surgery to improve a malformed body part in order to improve function.
DENTAL SERVICES	Call LIBERTY Dental at **866-609-0418** or visit LibertyDentalplan.com/nvmedicaid for information about receiving dental services.
DERMATOLOGY	Dermatology is the science that treats the skin and its structure, function, and diseases, including the hair and nails. Anthem covers this service.

DIABETIC SERVICES	Services include: • Screenings, which consist of lab tests for members who have certain risk factors for diabetes or who are diagnosed with prediabetes. • Training to teach members to self- manage their diabetes; the program includes: • Instructions on how to self-monitor blood glucose.

COVERED SERVICE	ADDITIONAL INFORMATION
DIABETIC SERVICES (Cont.)	• Training on diet and exercise. • An insulin treatment plan specifically for the person who is insulin-dependent. • Reasons for patients to use skills for self-management. • Supplies to self-test glucose levels of the blood to monitor and control diabetes including: • Glucometers • Syringes • Lancets • Needles Prior authorization may be required for certain services or devices.

DIAGNOSTIC TESTING	Diagnostic testing includes:
	• Laboratory and radiology services including, but not limited to:
	  • Blood chemistry
	  • Pathology testing: microbiology and other testing using physical specimens such as tissue, urine or blood
	  • Bone mass/density studies
	  • Testing for human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS)
	  • Lead blood screenings
	  • Prostate-specific antigen testing (PSA)
	  • Sleep studies
	  • Portable X-ray services
	  • Preadmission tests
	  • Colorectal cancer screening procedures
	  • Positron emission tomography (PET) scans

COVERED SERVICE	ADDITIONAL INFORMATION

DIAGNOSTIC TESTING (Cont.)	• Nuclear medicine services include procedures and tests performed by a radioisotope lab using radioactive materials such as:
	  • Computed tomography (CT)
	  • Magnetic resonance imaging (MRI)
	  • Cardiac testing
	
	Prior authorization may be required for certain testing.

DIALYSIS SERVICES	Dialysis services are given to remove toxic materials and maintain fluid balances in cases of poor kidney function. Covered services include: • Home dialysis managed by the patient or a patient's representative under the guidance of a freestanding clinic • Services received in an inpatient or outpatient hospital setting
DISPOSABLE MEDICAL EQUIPMENT	Anthem covers medically needed disposable supplies that would not generally be useful to a person without an illness or an injury. Members should ask their PCP if they need disposable medical equipment.
DOULA SERVICES	A Doula is a non-medical trained professional who provides education, emotional and physical support during pregnancy, labor/ delivery, and postpartum periods. They may provide services within the home, office, hospital or freestanding birthing center settings. These services are covered with certain limitations.

DRUGS/INJECTABLES/BIOLOGICALS	A **drug** is a substance (medication) that can be used to change chemical processes in the body.

COVERED SERVICE	ADDITIONAL INFORMATION
DRUGS/INJECTABLES/BIOLOGICALS (Cont.)	**Injectable** drugs are those drugs that are managed by a health professional or self-managed. These may be drugs such as insulin, growth hormones, etc. **Over-the-counter** drugs are those that are purchased without a prescription from a physician. **Biologicals** in medicine refer to substances made from a living organism or its products. Biologicals are used to prevent, diagnose, treat or relieve symptoms of a disease (for example, vaccines). Anthem does not cover: • Agents used for weight loss • Agents used to promote fertility • Agents used for cosmetic reasons or hair growth • Less than effective drugs • Experimental drugs unless as an exception • Agents used for impotence/erectile dysfunction Anthem has a list of commonly prescribed drugs. You or your child's PCP or specialist can choose drugs from this list to help you feel well. This list is called a preferred drug list (PDL). It is part of the Anthem formulary. Drugs must be approved by the Food and Drug Administration (FDA). Drugs must have a Medicaid rebate agreement with Centers for Medicare and Medicaid

	Services (CMS). • The covered medicines on the PDL include prescriptions and certain over-the-counter medicines. • All Anthem network providers have access to this drug list. • You or your child's PCP or specialist should use this list when he or she writes a prescription.

DRUGS/INJECTABLES/BIOLOGICALS (Cont.)	• Certain medicines on the Anthem PDL need prior approval. • All medicines that are not listed on the Anthem PDL need prior approval. • See the Medications section under the heading **Special Kinds of Healthcare**. • Here's a list of things to remember: - Anthem covers up to a 30-day supply of prescriptions at retail pharmacies. - You can have prescriptions filled at any in-network pharmacy. - If you want to switch to home-delivery pharmacy, you can contact Alto Pharmacy online at alto.com or through their app at app.alto.com/login. You can also call Alto Pharmacy at 800-874-5881 (TTY 711), Monday through Friday from 9 a.m. to 6 p.m., and Saturday through Sunday from 9 a.m. to 3 p.m. Pacific time. In-network pharmacies include most major pharmacy chains, and many independent community pharmacies. - CVS, Walmart, Raley's Pharmacy, Smith's Pharmacy, Save Mart Pharmacy and Rite Aid are part of our plan and will accept your AnthemID card. - Walgreens is not in the Anthem plan. - You can find a list of in-network pharmacies in the provider directory you received with your

	new member package. **If you need help finding a pharmacy, call Member Services toll free or visit our website at anthem.com/nvmedicaid.**

COVERED SERVICE	ADDITIONAL INFORMATION
DURABLE MEDICAL EQUIPMENT (DME)	Durable medical equipment is equipment: • Used to serve a medical purpose. • Fitted for use in the home. • Able to withstand repeated use. Covered services as determined by the Nevada Medicaid and Nevada Check Up program include: • Certain medically needed equipment (e.g., crutches, wheelchairs, ventilators, etc.) • Items that would not generally be useful to a person without an illness or an injury Members should ask their PCP if they need durable medical equipment. Anthem does not cover: • Physical fitness or personal recreation equipment • Personal care or hygiene products • Household items such as air conditioners and ceiling fans • Environmental products • TDD devices
EARLY CHILDHOOD INTERVENTION (ECI) SERVICES	These services assist families with children ranging from birth to school age that have developmental disabilities and delays. The program provides screening and resource referral methods that support families in helping effected children reach their potential through developmental services.

COVERED SERVICE	ADDITIONAL INFORMATION

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES (MEDICAID)/ WELL-BABY/WELL-CHILD SCREENINGS (NEVADA CHECK UP)	The EPSDT program covers screening and diagnostic services to decide healthcare needs and other measures to correct or improve:
	• Physical or mental abnormalities.
	• Chronic conditions found in Medicaid members under age 21 and Nevada Check Up members through their 19th birthday.
	
	This program is known as "Healthy Kids" in Nevada.
	
	Covered services for Medicaid Members under age 21 and Nevada Check Up Members through their 19th birthday include:
	• Complete medical screenings, including:
	  • Complete health and development history with assessment for both physical and mental health development
	  • Complete physical exam
	  • Proper immunizations (shots) according to age and health history
	  • Lab tests, including lead blood level assessment
	  • Health education
	  • Vision screening
	  • Hearing screening
	
	EPSDT is not covered for Pregnant members under the age of 21 whose coverage is for pregnancy-related services only.

EMERGENCY SERVICES	Emergency services include inpatient and outpatient services by a qualified provider to assess or stabilize an emergency medical condition. See the section **Different Types of Healthcare** under the heading **Emergency Care** for more details.

COVERED SERVICE	ADDITIONAL INFORMATION
ENTERAL NUTRITION	Enteral nutrition, also called tube feeding, is a way to provide food through a tube placed in the nose, stomach, or small intestines. Enteral nutrition is covered for certain conditions. Prior authorization and medical necessity review are required.
FAMILY PLANNING	Anthem covers family planning services for members of childbearing age. Members can receive family planning services from plan or non-plan providers. Services include: • Education • Counseling • Physical exams • Birth control devices, implants, medication, and supplies Members do not need a referral for family planning services. See the **Family Planning Services** section under the heading **Special Kinds of Healthcare** for more details. The following services are not covered: • Tubal ligations and vasectomies for people who are: • Under age 21

	• Mentally incompetent • Institutionalized • Sterilization reversals • Abortions (These services are excluded from family planning but may be covered under certain conditions; for example, to save the life of the mother, for rape or incest, or if medically necessary. Your provider will explain these services and ask you to sign a consent form.)
GASTROENTEROLOGY SERVICES	Gastroenterology is a branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines. Gastroenterology services may be covered with or without a prior authorization depending on the service needed. Call Member Services for assistance.

COVERED SERVICE	ADDITIONAL INFORMATION
GENDER REASSIGNMENT SERVICES	Transgender healthcare services cover treatment for gender dysphoria. Treatment includes both hormonal and surgical modalities, and psychotherapy based on medical necessity. Genital reconstruction surgery is covered for recipients who meet eligibility criteria under Nevada and federal laws. Prior authorization may be required.
GENETIC AND DNA TESTING	Genetic and DNA testing is considered medically needed to establish a diagnosis of inherited diseases when certain conditions are met. Covered services include: • Assessing if there is a genetic disorder. • Diagnosing such disorders. • Counseling and following up with members with known or supposed disorders. Anthem does not cover: • Prenatal diagnosis to find out the sex of the baby unless there is reason for genetic disease. • Self-testing home kits. • Genetic testing for cleft disorders. • Experimental genetic testing, unless identified as an exception. • Blood typing for paternity testing.

HIV/AIDS CARE	Anthem covers: • Standard diagnostic tests to diagnose HIV infection. • Medications to treat HIV infection. Anthem does not cover experimental or investigational studies or treatments, unless identified as an exception.

COVERED SERVICE	ADDITIONAL INFORMATION
HOME HEALTH SERVICES	Anthem covers medically needed home healthcare services provided at a member's home if services are clearly defined as part of an approved plan of care. Covered services include: • Personal care services • Home environment evaluation • Skilled nursing services • Home health aide services • Dietitian services • Respiratory therapy • Physical therapy (limit restrictions apply) • Occupational therapy (limit restrictions apply) • Speech therapy (limit restrictions apply) Prior authorization and functional assessment testing may be required for certain services.
HOME INFUSION/TOTAL PARENTERAL NUTRITION (TPN)	Services provided by a licensed nurse to administer drugs, intravenous fluids, or total parenteral nutrition (TPN) through an intravenous catheter. TPN is given to people who are not able to absorb nutrients through the intestinal tract.

HOSPITAL INPATIENT MEDICAL AND SURGICAL	Anthem covers inpatient hospital care for medically necessary conditions. Inpatient hospital services include: • Room and board • Nursing and provider services • Diagnostic or therapeutic services • Medical or surgical treatments and supplies • Medication given while in the hospital
HOSPITAL OUTPATIENT	Anthem covers medically necessary outpatient hospital services.
HYPERBARIC OXYGEN (HBO) THERAPY	Anthem covers certain chronic and acute conditions such as: • Carbon monoxide poisoning • Air or gas embolism

COVERED SERVICE	ADDITIONAL INFORMATION
HYPERBARIC OXYGEN (HBO) THERAPY (CONT.)	• Smoke inhalation • Acute cyanide poisoning • Decompression sickness • Certain cases of blood loss or anemia where increased oxygen may help balance the blood deficiency • Complicated wounds Topical HBO therapy is not covered.
HYSTERECTOMY	Anthem covers medically necessary hysterectomies. Your provider will require you to sign a consent form. A hysterectomy performed for the sole purpose of sterilization is not covered.
NUTRITION/DIETICIAN SERVICES	Anthem covers medically necessary services to address nutrition related issues for Medicaid recipients. To receive nutrition/dietician related services, members must have written orders of a physician, physician assistant (PA) or advanced practice registered nurse (APRN). A registered dietician must design and approve the treatment. Certain limitations apply.
MEDICAL REHABILITATION CENTER OR SPECIALTY HOSPITAL	Anthem covers medically needed services provided at freestanding rehab hospitals, or a rehab unit of a general hospital. Anthem also covers care provided in a freestanding long-term acute care hospital, or a long-term acute care unit of a general hospital.

COVERED SERVICE	ADDITIONAL INFORMATION
OPHTHALMOLOGY/OPTOMETRY SERVICES (VISION SERVICES)	Covered services include: • One complete eye exam every 12 months • Refractive exams • Frames • Lenses • Fitting, dispensing, and adjustment of glasses • Follow-up exams • Contact lenses (in certain circumstances) • Fitting, dispensing, and adjustment of glasses. • Follow-up exams • Contact lenses (in certain circumstances)
OUTPATIENT SURGERY	Anthem covers medically needed outpatient surgery.

PERSONAL CARE SERVICES	Anthem covers personal care services given to members who need help with daily living and meet the eligibility requirements. These services are given at certain times and as described in the Nevada Medicaid program. Covered services include: • Help with bathing, grooming, or dressing • Help with toileting needs • Help with transferring and positioning people who cannot walk • Help with walking • Help with eating • Help with taking medicines The following services are not covered: • Tasks a person is able to perform • Services given by legally responsible caregivers • Tasks that aren't on the approved service plan • Services to maintain a household

COVERED SERVICE	ADDITIONAL INFORMATION
PERSONAL CARE SERVICES (CONT.)	• Services given to a person other than the planned receiver • Care is required to be given by a healthcare professional approved by the state Prior authorization and functional assessment are required.
PHYSICIAN SERVICES	Anthem covers medically needed care provided by a: • Certified nurse-midwife • Certified registered nurse practitioner • Nurse anesthetist • Physician/osteopath • Physician assistant Ask your PCP if you think you need to see one of these providers.
PODIATRY SERVICES	Anthem covers medically needed podiatry care for all Medicaid eligible individuals.
POST-STABILIZATION CARE	Post-stabilization care services are Medicaid-covered services you receive after emergency medical care. You receive these services to help keep your condition stable after you have an emergency. Anthem covers post-stabilization services obtained within or outside the Network that are pre-approved. Post-stabilization services that are not pre-approved, but are administered to maintain, improve, or resolve the stabilized condition are reviewed for medical necessity.

REHABILITATIVE THERAPY (PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY)	Anthem covers therapy to treat illness or injury that keep people from doing their daily activities. Therapy is provided only for problems that are expected to improve in a reasonable period of time. Therapy is not covered just for exercise or fitness.

COVERED SERVICE	ADDITIONAL INFORMATION
SKILLED NURSING CARE	Anthem covers the first 180 consecutive days of medically needed care in a nursing facility. On the 181st day, you — the member — will be disenrolled from Anthem. The rest of your stay will be covered by Nevada Check Up or Nevada Medicaid.
SMOKING CESSATION PROGRAMS/SUPPLIES	Anthem covers products to help you stop smoking, including: • Over-the-counter (OTC) patches • Gums • Lozenges • Inhalers • Tablets These products are available with a prescription from your PCP. These products do not require Prior Authorization. Certain limitations apply.

SPECIAL HEALTHCARE NEEDS CASE MANAGEMENT ***including SED or SMI Determinations**	Anthem covers special health care management services for the following groups: • Adults with special healthcare needs • Children with special healthcare needs • Children and adolescents who carry a diagnoses of a Severe Emotional Disturbance nature (SED)* • Adults diagnosed with serious mental illness (SMI)* • Infants and toddlers with developmental delays A care manager will help: • Assess and evaluate health care needs. • Develop a plan of care. • Receive referrals and needed services. • Coordinate services between PCPs and specialists. • Monitor care and follow-up. • Periodically check-in with members after active care management is completed to ensure no new concerns arise.

COVERED SERVICE	ADDITIONAL INFORMATION
SPECIAL HEALTHCARE NEEDS CASE MANAGEMENT (CONT.) ***SED or SMI Determinations**	**SED or SMI determination must be completed by a qualified Anthem provider.** **Upon determination, Medicaid members** who are diagnosed as being SED or SMI can choose to disenroll from Anthem and continue to receive benefits through Medicaid. **Nevada Check Up members** diagnosed as SED or SMI do not have the option to disenroll and will continue to receive covered services through Anthem. Annually, Medicaid and Nevada Check Up members diagnosed as SED or SMI will be evaluated, and a new determination will be made. If the evaluation does not result in a redetermination as SED or SMI, the Medicaid member who chose to disenroll from Anthem will be re-enrolled as of the first day of the next possible month.
SWING BEDS	A swing bed is a bed in a rural or critical access hospital that can be used to provide either standard hospital care or skilled nursing care. Anthem covers the first 45 days of care from a swing bed in an acute hospital, when medically needed. Once the stay goes over 45 days, the member will be disenrolled from Anthem. The rest of the stay will be covered by Nevada Check Up or Medicaid Fee for Service.

TELEHEALTH	Telehealth allows you to see a doctor through a video chat session on your smartphone, tablet, or computer with a webcam. Your video chats are private and secure. It's a convenient way to see the doctor when you cannot make it to the doctor's office, or you need an appointment fast.

COVERED SERVICE	ADDITIONAL INFORMATION
TMJ TEMPOROMANDIBULAR DISORDERS	Covered for recipients ages 21 and younger. TMJ services may be provided by a dentist or medical doctor. Surgery to correct a wide range of diseases, injuries, and defects to the head, neck, face, jaw, and hard and soft tissues of the lower jaw and face region is covered.
TRANSPLANTS	Anthem covers the following transplants for Medicaid-eligible adults (21 and older) when medically needed and not experimental: • Cornea • Kidney • Liver • Bone marrow Anthem covers any medically needed transplant that is not experimental for: • Medicaid members under age 21 • Nevada Check Up members through their 19th birthday

Extra Anthem benefits

We provide extra benefits just for our members. These extra benefits are called value-added services and include:

- FREE Costco Gold Star membership
- $100 for eligible members towards childcare for kids ages 5–11
- FREE Boys & Girls Club memberships for ages 5–14
- $100 extra vision benefit for glasses
- FREE sports physicals for ages 6–18
- FREE online fitness resources for all ages
- FREE WW® (formerly called Weight Watchers®) voucher for initiation fee and 13 weeks of classes for ages 18+
- $50 gift card towards gym membership for eligible members ages 18+
- $100 gift card for eligible members to purchase products for pain management

- FREE virtual tutoring for eligible members ages 8–17
- FREE GED/HiSET (High School Equivalency Test) gift card
- FREE industry certification assistance for ages 18+
- $50 gift card for college application fees for ages 17+
- FREE life transition kit with supplies and a Subway gift card for eligible members
- $100 Healthy Grocery card for eligible members to purchase fresh produce
- FREE Grooming Pass and hair product voucher for members in foster care
- FREE meditation app for ages 26 and younger
- FREE Emotional Well-Being resource for ages 13+
- FREE Community Resource Link for local programs and services
- FREE dental hygiene kits
- Transitional care assistance from hospital to home
- $75 gift card for feminine hygiene products for females ages 10–18 or experiencing homelessness
- $120 gift card for swim lessons for eligible members up to age 18
- FREE therapy light box for members with seasonal affective disorder or depression.
- Community Resource Link — an online resource to help you find all available local community-based programs, benefits and services

Flu Pandemic Kit
The kits will contain:

- Masks - 10 ct.
- Sanitizer
- Sani-Hands Wipe, Alcohol, Individually Packed, 8" x 5.3"

One kit per member. A non-covered parent may request a kit for their child if Anthem covers the child. One kit per year. Member must complete a Wellness visit.

Non-Pharmacologic Pain Management

Non-pharmacological pain therapy refers to interventions that do not involve the use of medications to treat pain. Catalogue items can include items such as: handheld massagers, TENS units, Theracane, Epsom salts, massage oils and lotions, lidocaine cream, cold/hot packs, yoga bd mats, etc.

Members can purchase up to $100 of therapeutic devices to help them manage their pain.

Eligible members include those who have a clinical diagnosis related to chronic pain. Limit one package per household per lifetime.

Maternal Health – Meal Program

Members who qualify or are identified by can receive up to 2 meals per day for 14 days providing 28 meals per member total. Meals are customized to enhance recuperation for each member. We offer low-sodium and low-fat options, diabetic-friendly, gluten-free, vegetarian, renal-friendly, and pureed meals. Pregnant mothers with diabetes qualify for 10 weeks meal delivery.

Anthem will provide home-delivered, medically tailored meals to pregnant members who are on bed rest or post-partum members or who were recently discharged. The meals will be home delivered. We are not able to deliver meals to members who are not housed at this time.

Youth Behavioral Health – Meditation App Subscription

To help youth improve their mental health state, Anthem will give a year subscription to the meditation app. Members can access age-appropriate meditations and sleep aids to help calm the mind and body, aiding to reduce stress and anxiety. This resource gives our youth and adolescent members' tools to practice leading happier lives. Offered in Spanish, German, French, Portuguese, Japanese and Korean. Eligible members age 26 and younger may receive a yearly subscription for the meditation app.

Emotional Well Being

Members ages 13+ receive access to our Emotional Well-Being Resource is a web and mobile online community designed to help members cope with emotional health issues such depression, anxiety, and stress, chronic pain, insomnia, and managing drugs or alcohol.

Pyx Health

Pyx Health – Anthem Nevada has partnered with Pyx Health to support our members in addressing their feelings of loneliness. The Pyx Health App is available 24/7 to assist our members in finding resources to support your physical and behavioral health needs, connect with compassionate human beings through live calls for a friendly chat or help with needed resources, and to feel better each day with companionship and humor.

Chess Health

Chess Health is a supportive online application focused to support our members who are experiencing Substance Use Disorder needs. Our members have 24/7 access to a supportive, safe online peer community, can practice coping skills, set reminders, track your recovery progress, and more. This extra layer of support is there between treatment sessions and ensures that you are never alone and always have this additional resource in hand, through our digital app.

Baby Essentials Bundle Package

Pregnant moms, new moms, and/or babies up to 12 months may receive a $200 gift card to use toward the purchase of baby essential products such as:

- Bottles and nursing supplies
- Formula and baby food
- Diapers, wipes, and creams
- Bathtubs
- Car seat
- Strollers
- Portable crib

Healthy Grocery Card

Members receive a $100 Healthy Grocery card to purchase fresh produce in stores or online. *One card per household per year. Members diagnosed with obesity, diabetes, or prediabetes.*

Grooming Kit for Foster Care Youth

Eligible members receive a Grooming Pass to a hair salon or barber shop. Eligible members also receive a voucher to use toward styling education, supplies, and hair grooming products.

All youth/young adults in Foster Care are eligible up to age 26.

Maternal Health Transportation Benefit

Anthem will provide a Bus Pass for one month to help them with their transportation needs. Members who don't have access to the bus can opt to choose between a $50 Uber card or a $50 gas card. New moms or babies and children up to 5 years old can obtain the benefit. One time per year.

Industry Certification

Eligible members receive a $100 gift card to help cover the costs of industry certifications. Limited to members who are recent high school graduate (or GED/HiSET recipients), recent vocational/college graduates, and members reentering society from incarceration. One per year.

Internet Essentials Package

Members will receive up to a $300 allowance to help cover the cost of internet services.

To help ensure members have access to the internet for educational pursuits or employment opportunities, eligible members can receive up to $300 towards the cost of internet services. Funds can be used to purchase modems, routers, and any additional equipment that is essential to obtain (or strengthen) an internet connection, as well as to help cover monthly service charges. For members without current internet access, the funds can be used for installation and set-up fees as well.

Members must have been previously incarcerated within the 12 months. Eligible for members in re- entry program and are seeking employment or furthering education. One per lifetime. Must complete a Wellness Visit.

Free Laptop Program
Eligible for members transitioning from incarceration and pursuing education/employment. Members will be able to receive a free laptop to help with employment and educational pursuits. Members must have been previously incarcerated within the past 12 months. One per lifetime. Must complete a Wellness Visit.

Life Transition Kit
To support members transitioning for an institutional setting into housing. We will provide a kit to help the member get settled. Must complete a Wellness visit.

The kits include:
- First aid supplies such as bandages and ointment
- Soap, Shampoo, Toothpaste, travel toothbrush, mouthwash, dental floss
- Emergency blanket

College Application Fee Support
Members ages 17+ will receive $50 to use for application fee of college applications.

Gym Membership
Eligible members ages 18+ with a primary or secondary clinical diagnosis of obesity or diabetes/prediabetes will receive up to a $50 allowance to help cover costs for a gym membership.

We give you these benefits to help keep you and your family healthy and to thank you for choosing Anthem as your health insurance plan.

Daycare Benefit
Eligible members receive a $100 gift card to use toward childcare services with local YMCAs, Boys and Girls Clubs, and licensed childcare providers.

Member Wellness Incentives
Anthem rewards its members for making healthy choices. Healthy Rewards is a no-cost, optional program for eligible Anthem members. It encourages you to complete healthy activities and screenings to help you get and stay healthy.

Register for Healthy Rewards by logging in to the Benefit Reward Hub at https://mss.anthem.com/nevada-medicaid/benefits/medicaid-benefits.html or call Healthy Rewards toll free at 888-990-8681 (TTY 711) Monday through Friday from 6 a.m. to 5 p.m. Pacific time.

Housing Supports Anthem NV Medicaid offers some limited housing supports as value-added

services for members experiencing homelessness or who are at immediate risk of homelessness. Value-added housing supports may include homeless prevention, emergency shelter, and supportive housing programs for members that meet specific homelessness and medical/behavioral health criteria.

Screening is required by the housing team to determine eligibility. The availability of the housing supports may be limited by program capacity and the availability of discretionary funding.

To inquire about Anthem Housing Supports please visit: Anthem NV Housing Assistance Referral Tool or email NVhousing@anthem.com

Nevada Check Up premiums

A premium is a quarterly payment you pay for healthcare coverage for your child. Only Nevada Check Up members have premiums. Native Americans and Alaska Natives don't pay premiums.

Remember, if you have a quarterly premium and do not pay it, your child will be disenrolled. This premium will go toward your family cost-share. Your family cost-share is based on your total family income. To find out more about premiums, call the Nevada Check Up program a**t the following locations below**, or you may also call toll-free at **800-992-0900**.

Carson City	1000 E Williams St., Suite 118 Carson City, NV 89701	Phone: 775-684-3660
Elko	1010 Ruby Vista Dr., Suite 103 Elko, NV 89801	Phone: 775-753-1191
Las Vegas	1210 S. Valley View Blvd. Las Vegas, NV 89102	Phone: 702-668-4200
Reno	745 W. Moana Ln., Suite 200 Reno, NV 89509	Phone: 775-687-1900

You can also go to the Division of Health Care Financing and Policy website at http://dhcfp.nv.gov/Pgms/CPT/NevadaCheckUp/NCUMAIN/.

SERVICES COVERED BY NEVADA CHECK UP OR NEVADA MEDICAID

Some services are covered by Nevada Check Up or Medicaid instead of Anthem. You do not

need a referral for these services.

Members who receive carve-out services (as listed below) are submitted to Check Up or Nevada Medicaid for authorization determination and are not covered by Anthem.

- Adult day healthcare
- Habitational Services
- Children in out-of-home placement
- Indian health service facilities and tribal clinics
- Ground Emergency Medical Transportation (GEMT)
- Non-Emergency Secure Behavioral Health Transport
- School Health Services (Anthem covers when provided by federally qualified health centers or rural health clinics)
- Targeted case management (TCM)
- Orthodontic Services
- Pharmacy Drug Limitations

Members who receive carve-out services (as listed below) will be disenrolled from Anthem and will receive healthcare benefits directly from fee-for-service Medicaid or Nevada Check Up.

- Home- and community-based waiver services
- Hospice
- Intermediate care facilities for members with intellectual disabilities
- Nursing facility stays beginning on the 181st calendar day. The first 180 calendar days are covered by Anthem.
- Swing Bed Stays in Acute Hospitals beginning on the 46th calendar day
- Evaluations/screening for appropriate level of care before admission to a facility residential treatment center for Medicaid members

Nonemergency transportation is available for only Medicaid recipients through the state's transportation vendor, MTM. As of August 24, 2011, nonemergency transportation service is no longer available to Nevada Check Up recipients.

If you have questions about how to obtain these services, please contact Anthem Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time. We can help you.

SERVICES THAT DO NOT NEED A REFERRAL

It is always best to ask your primary care provider (PCP) for a referral for any Anthem covered service. You can receive the following services without a referral:

- Behavioral healthcare (Applied Behavior Analysis does require a referral)
- Crisis Intervention
- Tobacco Cessation Treatment
- Care provided by your plan PCP's nurse or doctor's assistant
- Emergency care
- Eye exams from a plan eye care provider (optometrist)

- Family planning services from any qualified family planning provider
- Healthy Kids visits to a plan provider
- Prenatal care from a plan obstetrician or certified nurse-midwife
- Yearly exams from a plan OB-GYN
- First mental health or substance abuse assessment in a 12 month period

SERVICES OFFERED BY ANTHEM WHEN TRANSFERRING TO/FROM ANOTHER MANAGED CARE ORGANIZATION OR FEE-FOR-SERVICE MEDICAID

When transferring from another managed care organization (MCO) or from fee-for-service Medicaid:

- We will honor services and prescriptions approved by your prior Medicaid provider as your care is transitioned.
- We will assess and transition continuing services to plan providers if needed.
- We will make arrangements with your prior providers if care cannot be transitioned.

When transferring to another MCO or to fee-for-service Medicaid:

- We will communicate services we approved to your new Medicaid provider.
- Our nursing staff will communicate current treatments and care to your new Medicaid provider.

Please contact Anthem Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time to notify us of your transitional needs. We will assign a nurse to help coordinate your care as you join Anthem.

SERVICES NOT COVERED BY ANTHEM, NEVADA CHECK UP OR FEE-FOR-SERVICE MEDICAID

The following are not covered (but not limited to):

- Anything experimental, such as a new treatment that is being tested or has not been proven to work, unless an exception has been granted with medical necessity review
- Anything that is not medically needed
- Sterilization for members under age 21, or members who are institutionalized or mentally incompetent
- Non-emergency, out-of-network services (unless prior authorization is obtained)
- Elective abortions

If you choose to receive a service that is not covered, you will have to pay for it. Your provider may ask you to sign a form. This form tells your provider you understand and agree to pay for the service.

NEW TECHNOLOGY

Advances in medical technology bring new treatments to the market all the time. We want to make sure you have access to medical and behavioral health treatments that are safe and effective. So, we review them to make sure they are safe and effective, and they work the way they are supposed to.

We use the following in our review process:

- Scientific literature
- Peer-reviewed medical journals
- Nationally recognized guidelines by accredited medical specialty societies
- Current medical community standards
- Government regulatory bodies, such as the Food and Drug Administration (FDA)
- Medical experts in the condition the new treatment is for

DIFFERENT TYPES OF HEALTHCARE

Routine, urgent, and emergency care: what is the difference?

Routine care

In most cases, when you need medical care, you visit your PCP. This type of care is known as **routine care**. Some examples are most minor illnesses and injuries and regular checkups. You should be able to see your PCP within two weeks for routine care.

Your PCP also provides care that can prevent you from getting sick. This is called wellness care, and includes checkups, shots, and screenings. See the section in this handbook **Wellness Care for Children and Adults**.

Urgent care

Some injuries and illnesses are not emergencies, but can turn into emergencies if not treated within 24 hours. This type of care is called **urgent care**. Some examples are:

- Throwing up and diarrhea
- Minor burns or cuts
- Earaches
- Headaches
- Sore throat
- Fever over 101 degrees
- Muscle sprains/strains and joint pain
- Backaches
- Pain with urination
- Coughs, colds, and flu

If you need urgent care:

- Call your PCP. Your PCP will tell you what to do.

- Follow your PCP's instructions. Your PCP may tell you to go to:
  - His or her office right away.
  - Some other office to receive immediate care.
  - An urgent care location. You can find urgent care locations by using the Find Care tool at **findcare.anthem.com/search-providers**.
  - Mobile urgent care that can come to you. Call Member Services at **844-396-2329 (TTY 711)** for assistance verifying an available provider, or you can find mobile urgent care providers using the Find Care tool at **findcare.anthem.com/search-providers**.

You can also call 24/7 NurseLine at **844-396-2329 (TTY 711)** if you need advice about urgent care. You should be able to see your PCP within two days for an urgent care appointment.

Emergency care

What is an emergency? An emergency is anything that could cause very serious harm or death if not treated immediately. This means someone with an average knowledge of health and medicine can tell the problem may threaten your life or cause serious harm to you or your unborn child if you are pregnant. Here are some examples of problems that are most likely emergencies:

- Trouble breathing
- Chest pains
- Loss of consciousness
- Very bad bleeding that does not stop
- Very bad burns
- Shakes called convulsions or seizures
- Unable to walk or talk
- Mental health crisis or feeling like hurting yourself or hurting someone else

If you have an emergency, do one of the following:

- Call 911.
- Go to the nearest hospital emergency room. The hospital does not need to be a part of the Anthem plan for you to receive emergency care. You will be able to continue to receive care until your health has stabilized.

If you are unsure if you are having a medical emergency and would like advice on next steps, call your PCP or you can contact 24/7 NurseLine at **844-396-2329 (TTY 711)** .

You should be able to see a physician right away. You do not need a referral from your PCP or another provider to receive emergency care. Treatment for medical emergencies does not need pre-approval by Anthem.

After you visit the emergency room, it is important to call your PCP to schedule a follow-up appointment as soon as possible.

It may be necessary for you to receive additional care to keep your condition stable after an

emergency. This type of care is referred to as post-stabilization care. Post-stabilization care is a covered service, unless you are out-of-state and/or out-of-network.

How to receive healthcare when your doctor's office is closed

Except in the case of an emergency or when you need care that does not need a referral, you should always call your PCP **first** before you receive medical care. If you call your PCP's office when it is closed, leave a message with your name and a phone number for a return call. If it is not an emergency, someone should call you back soon to tell you what to do. You may also:

- Call 24/7 NurseLine to speak to a nurse 24 hours a day, seven days a week.
- Call mobile urgent care for a same-day visit to your home; call Member Services at **844-396-2329** for information on which providers are available in your area
- Call our 24/7 Behavioral Health Crisis Line 24 hours a day, seven days a week at **844-396-2331**.
- If you think you need emergency services, call 911 or go to the nearest emergency room right away.

How to receive healthcare when you are out of town

- If you need emergency services when you are out of town, go to the nearest hospital emergency room or call 911.
- If you need urgent care:
  - Call your PCP. If your PCP's office is closed, leave a phone number where you can be reached. Someone should call you back within the next business day.
  - Follow your PCP's instructions. You may be told to receive care right away.
  - Call 24/7 NurseLine.
  - Call our 24/7 Behavioral Health Crisis Line.
- If you need routine care like a checkup or a prescription refill:
  - Call your PCP.
  - Call 24/7 NurseLine.

***If you are outside of the United States and receive healthcare services, they will not be covered by Anthem, Nevada Check Up or fee-for-service Medicaid.**

How to receive healthcare when you can't leave your home

If you cannot leave your home, we will find a way to help take care of you. Call Member Services to help find a provider or connect with the 24/7 Nurseline. If you need help coordinating your health care needs, we can refer to a care manager that will help you meet your health care goals.

WELLNESS CARE FOR CHILDREN AND ADULTS

All Anthem members need to have regular wellness visits, including checkups and screenings, with their primary care provider (PCP). Your PCP will provide care based on nationally accepted guidelines.

During a wellness visit, your PCP may detect problems before they worsen. When you become an Anthem member, make an appointment with your PCP within 90 days.

When you or your child misses one of your wellness visits

If you or your child does not go to a wellness visit on time:

- Make an appointment with the PCP as soon as you can.
- Call Member Services Monday through Friday from 7 a.m. to 7 p.m. Pacific time at **844-396-2329 (TTY 711)** if you need help setting up the appointment.

If your child has not visited his or her PCP on time, we will send you a postcard and/or text message reminding you to make your child's well-child appointment.

Wellness care for children, the Healthy Kids program

All services provided under the Healthy Kids program, *Nevada's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program*, is provided at no cost to members.

Why well-child visits are important for children

Children need more wellness visits than adults. These wellness visits for children are called Healthy Kids visits. Healthy Kids is a program for:

- Medicaid members until their 21st birthday
- Nevada Check Up members until their 19th birthday

Babies need to see their PCP at least seven times in their first year, and more times if they are sick. If your child has special needs or a condition like asthma or diabetes, one of our care coordinators can help your child receive checkups, tests, and shots.

Your child can receive Healthy Kids checkups from his or her PCP or any plan provider. These Healthy Kids visits include:

- A comprehensive review of your child's physical, developmental, and mental growth
- A complete unclothed physical exam
- Immunizations (shots) for your child that will help protect them from illnesses
- Laboratory tests (blood lead screening, urinalysis, tuberculin skin test, sickle cell, hemoglobin/hematocrit, etc.)
- Health education and help with preventive care
- Vision and hearing screenings

Your child does not need a referral for these visits.

When your child should have Healthy Kids visits

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

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

- 3 to 5 days old
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old

Well-child visits in your baby's second year of life
Starting in your baby's second year of life, they should see the doctor at least four more times:

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

Well-child visits for children ages 3 through 20
Your child should see the doctor again at ages 3, 4, and 5. Be sure to set up these visits. It is important to take your child to their PCP when scheduled.

Starting at age 6, your child should go to the doctor every year for a checkup until they reach:

- Age 21 for Medicaid members
- Age 19 for Nevada Check Up members

Lead screening

Your child's PCP will screen your child for lead poisoning at 12 months and 24 months of age. Your child's PCP will take a blood sample by pricking your child's finger or heel or taking blood from his or her vein. The test will tell if your child has lead in their blood. If your child is at risk of lead exposure, they may receive a blood test once each year until age 6.

Vision screening

Your child's PCP should check your child's vision at every well-child visit. Please see the section **Eye care** under the heading **Special Kinds of Healthcare** for more details.

Hearing screening

Your child's PCP should check your child's hearing at every well-child visit.

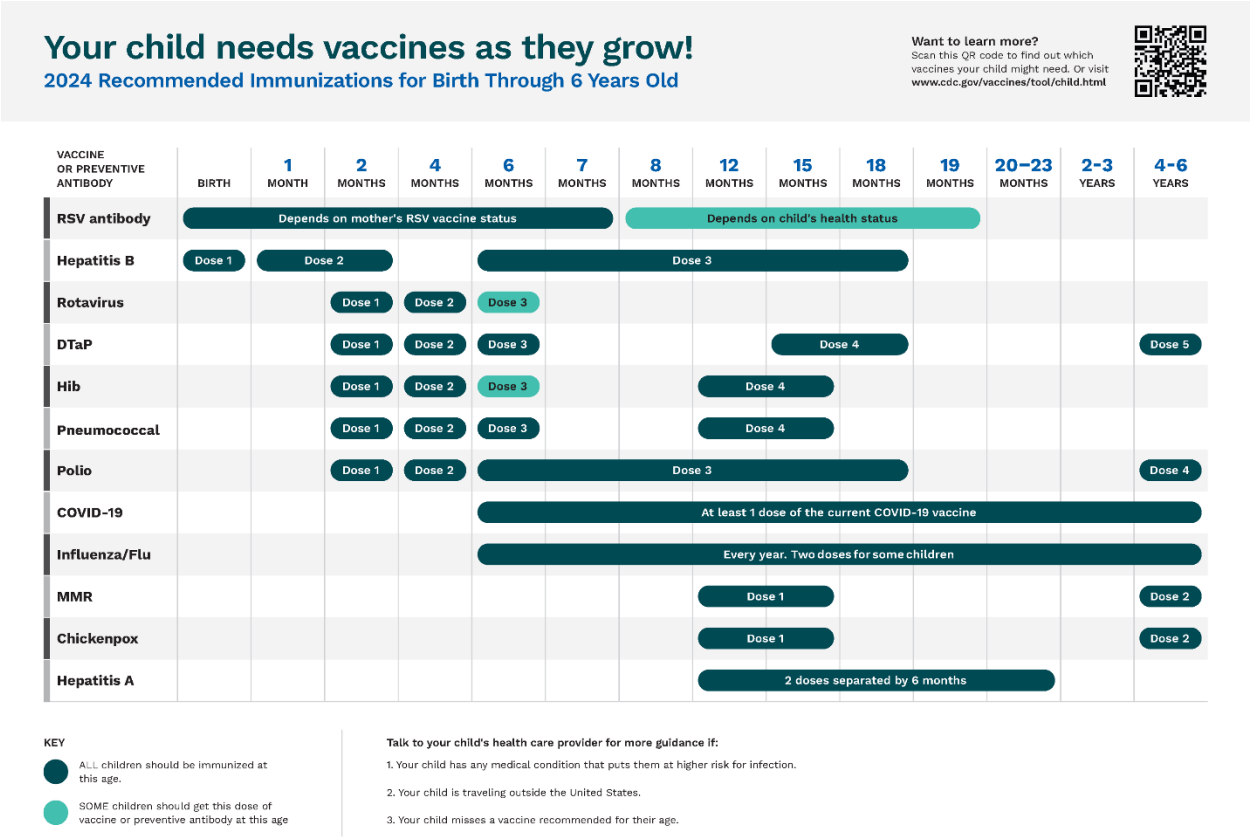
Immunizations (shots)

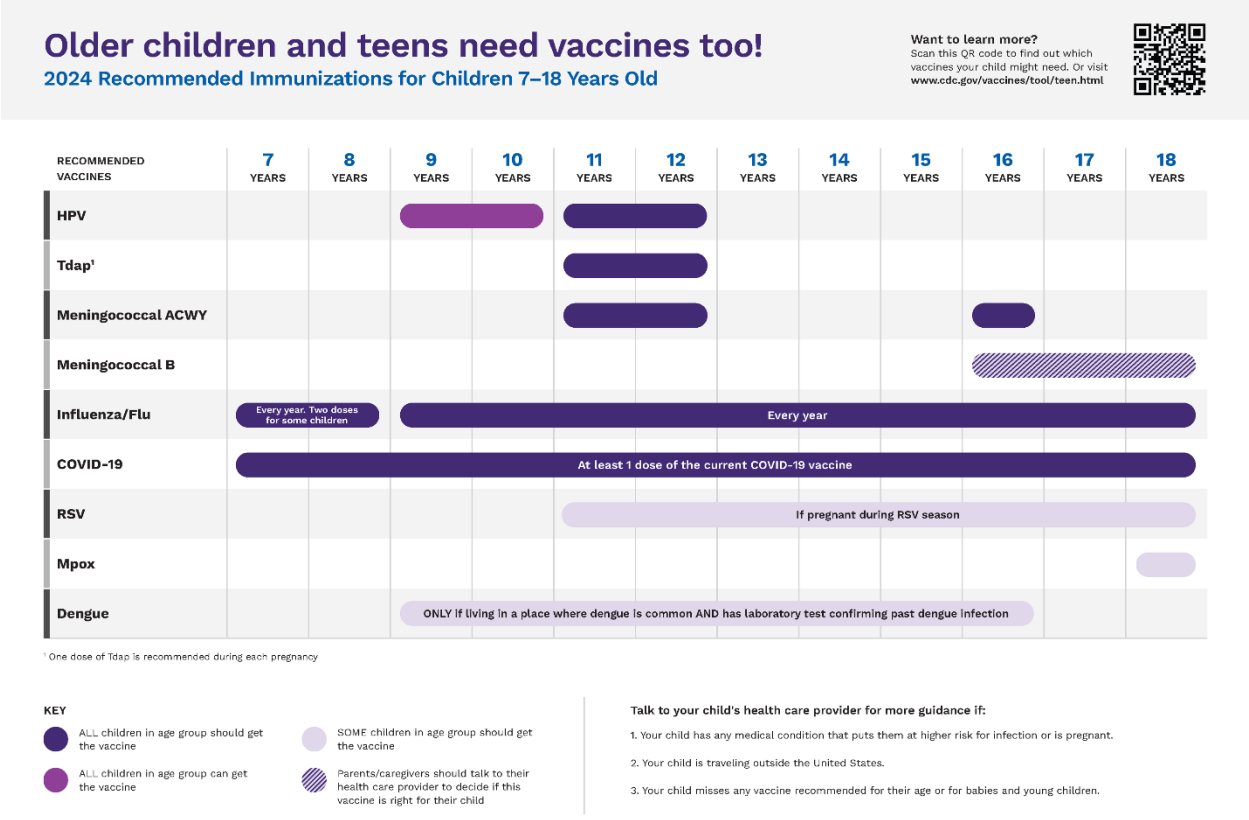
It is important for your child to have shots on time. Follow these steps:

1) Take your child to the PCP when they need shots.
2) Use the chart below to help keep track of the shots your child needs.

Additional immunization information and schedules can be found on the CDC website.

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger:





Wellness care for adults

Staying healthy means seeing your PCP regularly for checkups. Use this chart to make sure you are up to date with your yearly wellness exams. Please note, these recommendations are for adults of average risk for cancer. If you are high risk, your doctor may recommend more frequent testing.

WELLNESS VISITS SCHEDULE FOR ADULT MEMBERS		
EXAM TYPE	**WHO NEEDS IT?**	**HOW OFTEN?**
Clinical breast exam		
	Women age 40 and over	Every year
Stool based test	Men and women age 45 and over	Every year
Mammograms (Breast X-ray)	Women age 45 and over	Every year
Pap smear and pelvic exam	All women over 21, and women under age 21 who are sexually active	Every three years
Colonoscopy	Men and women age 45 and over	Every 10 years

PSA and digital rectal exam (DRE)	Men age 45 and over	Every year
Wellness visit	Men and women age 20 and over	Every year

SPECIAL KINDS OF HEALTHCARE

Eye care

Anthem members do not need a referral from their PCP for eye care benefits. Members can receive:

- One complete eye exam every 12 months
- One complete eye exam every 12 months
- Refractive exams
- Fittings, dispensing, and adjustment of glasses

Frames and lenses.

- Frames and lenses
- Follow-up exams
- Contact lenses (in certain circumstances)

Members age 20 and under receive eyeglasses as often as medically needed* (or for broken or lost glasses) as part of the Healthy Kids program.

*Medically needed is when an eye exam shows a significant change in vision.

See **Ophthalmology/Optometry Services** under the section Anthem **covered services** for more details. If you need help finding a plan eye doctor (optometrist) in your area, call EyeQuest toll-free at **888-300-9025 (TTY 800-466-7566)**.

Behavioral health (mental health/substance use disorder)

We encourage our members to take care of themselves and their families, both physically and emotionally. Stress can lead to mood concerns, including depression and anxiety. It can also lead to problems with marriage, family, and parenting. Stress can lead to concerning alcohol and drug use, too.

If you or a family member are having these kinds of concerns, you can receive help. Call Anthem Member Services at **844-396-2329 (TTY 711)**. You can also be given the name of a behavioral health specialist who will see you if you need one.

Your benefits include many medically needed services, such as:

- Inpatient mental healthcare
- Outpatient mental healthcare (counseling/therapy)
- Behavior modification (Applied Behavior Analysis)
- Psychiatric services/medication management
- Crisis services
- Alcohol and substance abuse treatment, including intensive outpatient treatment and residential treatment
- Case management services
- Mental health rehabilitative treatment services

You do not need a referral from your PCP to receive these services or to see a behavioral health specialist in your network. ABA services do require a referral.

If you think a behavioral health specialist does not meet your needs, talk to your PCP. They can help you find a different kind of specialist and can support if you need a referral for ABA services.

There are some treatments and services your PCP or behavioral health specialist must ask Anthem to approve before you can receive them. Your doctor will be able to tell you what they are.

If you have questions about referrals and when you need one, contact Member Services at **844-396-2329 (TTY 711)**.

Applied Behavior Analysis

Anthem has a benefit to help families with children 21 years and younger touched by Autism Spectrum Disorder. This benefit is called Applied Behavior Analysis or ABA. When a child is diagnosed with Autism Spectrum Disorder (ASD), families need as much support as possible. The Behavioral Health team can help you find a provider certified in ABA services and determine if ABA is suitable for your child. They will also help you and your family with other referrals in order to offer you well-rounded support.

We offer you and your family Utilization Management and Case Management services from licensed behavioral health clinicians, which includes:

- Authorization and review of ABA services
- Connecting your family with community resources
- Providing on-going support and answering your questions about coverage, authorizations and providers, as well as assisting all members of the family
- Helping you fit your new support systems into daily life

A referral is needed for ABA services. One of the following are necessary for authorization of ABA services:

- MD prescription recommending applied behavioral analysis (ABA)
- Recent comprehensive diagnostic evaluation completed by a physician or licensed psychologist
- Signed coordination of care letter recommending ABA by physician or licensed psychologist

Our PCPs and providers are familiar with the request form requirements for ABA, and can also reach out to Provider Services for needed support.

Our Behavioral Health team can guide your family through this process. They will coordinate care and help you understand the healthcare system. Our goal is to help families make good use of their benefits. To learn more about the ABA benefit, call the Behavioral Health team at **844-396-2331 (TTY 711)**.

Lock-In Program

The availability and access to controlled medications and opioids used for the treatment of acute and chronic health conditions is at an all-time high. This access to healthcare is helping patients live longer and healthier lives. However, it can also lead to safety concerns when members are on multiple controlled medications that are prescribed by multiple healthcare providers. To address this growing epidemic, Anthem has implemented the Lock-In Program to allow for better administration of drug benefits through increased communication and coordination amongst doctors and pharmacies.

The Lock-In Program helps reduce potential overutilization of prescription medications by identifying individuals who may benefit from oversight by managing their access to controlled medications through a single pharmacy. Identification for enrollment into the program is determined by the Division of Healthcare Financing and Policy's retrospective Drug Utilization Review (DUR) of the member's prescription claims history. If a member is believed to be at an increased safety risk due to the utilization of multiple medications, providers and/or pharmacies; and meets enrollment criteria, they may be included in this program.

The program is designed to limit a qualifying patient to the use of one specific in-network pharmacy for a consecutive 36-month period. The assigned pharmacy (i.e., Pharmacy Home) will fill all of the patient's controlled substance medications throughout the term of their enrollment in this program.

The Lock-In Program includes:

- Reimbursement of claims when filled at the member's assigned pharmacy also

described as the patient's Pharmacy Home. All controlled substance pharmacy claims are denied if filled at any pharmacy other than the member's assigned Pharmacy Home.

- Temporary overrides for urgent prescriptions will be permitted when 'good cause' criteria have been met.
- Access to specialty pharmacies in addition to the assigned Pharmacy Home.

Criteria

A covered Member whose prescription claims history shows they meet the state defined identification criteria may be enrolled in the Lock-In Program for a period defined by the state:

What type of communications will members receive?

Members who are locked into one pharmacy are issued a written Notice of Decision (NOD) 15-days prior to the implementation of the pharmacy restriction. The Pharmacy Home assigned may be selected based on the pharmacy most frequently used by the Member for access of controlled substance prescriptions. The NOD includes the individual's right to request a fair hearing within 90-days if he/she disagrees with the findings. If the decision is not overturned, both the Member and the pharmacy will be notified of their assignment in writing. After enrollment is completed, Members may change their Pharmacy Home by contacting their Medicaid District Office.

Anthem is more committed than ever to equipping Providers with the tools and support necessary to help curb these trends and save more lives than are lost. If you have any questions or comments regarding enrollment, please contact the Member Services number located on the back of the covered member's ID card.

Family planning services

Family planning services and supplies are covered by Anthem for all individuals of childbearing age. Anthem will arrange for counseling and education about planning or preventing a pregnancy if you are interested. You can also talk to your PCP to learn about planning or preventing pregnancy. You may visit any family planning provider, even if the provider is not part of the Anthem network. You do not need a referral from your PCP.

For assistance finding a provider, scheduling an appointment, or requesting a care manager, call Members Services at **844-396-2329 (TTY 711)**

Prescription and Nonprescription Drugs

Anthem has a list of commonly prescribed drugs. This list is called a Preferred Drug List (PDL). It is part of the Anthem formulary. Your or your child's PCP or specialist can choose from this list of drugs to help you be well. There are no copays for prescriptions on the preferred drug list.

We will pay for FDA-approved drugs that require a prescription, that are authorized by a professional licensed to write prescriptions, and that appear in the Anthem Formulary called a Preferred Drug List (PDL). We will pay for nonprescription drugs that are authorized by a

professional licensed to write prescriptions and that also appear in the Anthem Formulary called a Preferred Drug List (PDL).

The following are examples of the covered items:

- Prescription drugs
- Certain non-prescription or over-the-counter (OTC) medicines
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine and glucose/acetone testing agents
- Lancets and lancet devices
- Smoking Cessation products
- Compounded medication of which at least one ingredient is a legend drug and listed on the Anthem PDL
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Anthem PDL

Exclusions and Limitations

- Under this section we will not pay for the following:
- Administration or injection of any drugs
- Prescribed drugs used for cosmetic purposes only, unless medically necessary
- Experimental or investigational drugs, unless recommended by an external appeal agent
- Nutritional supplements taken electively
- Non-FDA approved drugs except that we will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which FDA approval was obtained. However, the drug must be recognized for treatment of the type of cancer it has been prescribed for by one of these publications: – AMA Drug Evaluations – American Hospital Formulary Service – U.S. Pharmacopoeia Drug Information – A review article or editorial comment in a major peer-reviewed professional journal
- Devices and supplies of any kind except glucometers, lancets, and glucometer test strips
- Prescribed drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide,

euthanasia or mercy killing of a person

- Prescribed drugs used for the purpose of treating erectile dysfunction
- Patients who are prescribed home infusion medications may need additional covered services as part of their care, even if the medications do not require precertification. For durable medical equipment (DME), outpatient home care, home infusion or hyperbaric treatment, and wound care, please call the Pharmacy department at 1-844-396-2330 or fax to 1-866-920-8362.

Things to remember about the Preferred Drug List:

- The Preferred Drug List (PDL) is a smaller version of the complete formulary.
- The PDL lists preferred drugs commonly prescribed in certain categories.
- All Anthem network providers have access to this drug list.
- Your or your child's primary care provider (PCP) or specialist should use this list when he or she writes a prescription.
- The Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) PDL includes all medicines covered by Medicaid. You may need to get approval from us for certain drugs. This is known as prior authorization (PA). Your request should include why a specific drug is needed and how much is needed. You must get approval from us before a prescription can be filled. When there is a generic drug available, it will be covered.
- Requests for brand name drugs when generics are available will need a PA.
- To understand how to use the PDL and guide your doctor please use this website: https://mss.anthem.com/nevada-medicaid/benefits/pharmacy-benefits.html
- Certain medicines on the PDL need prior approval including brand name drugs that have a generic available. For those medicines, your doctor must receive approval from Anthem before you can fill your prescription. Call Pharmacy Member Services at 833-207-3116 (TTY 711) to find out about the prior approval process for your medicine. Providers can also send a request for a prescription coverage determination via electronic prior authorization (ePA) rather than fax or phone.
- Go to anthem.com/nvmedicaid to receive a copy of the PDL or call Pharmacy Member Services at 833-207-3116 (TTY 711) to request one.

You can have prescriptions filled at any plan pharmacy. Plan pharmacies include most major pharmacy chains, and many independent community pharmacies.

Here's a list of some of the pharmacies currently in our plan:

- CVS
- Walmart
- Raley's Drug Pharmacy
- Smith's Pharmacy
- Save Mart Pharmacy
- Rite Aid

Walgreens is **not** a plan pharmacy.

For a complete list of plan pharmacies:

- See the provider directory that came with your new member packet.
- Go to **anthem.com/nvmedicaid** and click **Find a Doctor.**

If you are not sure if a pharmacy is in our plan, ask the pharmacist. You can also call Pharmacy Member Services for help at **833-207-3116 (TTY 711)**.

To have a prescription filled, follow these steps:

1) Take the written prescription from your provider to the pharmacy. Or your provider can call in the prescription to the pharmacy.
2) If you use a new pharmacy, tell the pharmacist about all of the medicines you are taking, including over-the-counter (OTC) medicines.
3) Show your Anthem ID card and your Medicaid ID card to the pharmacy.

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

- Will know all the medicines you are taking.
- Can watch for problems that may occur when you are taking more than one prescription.
- CarelonRx makes sure people know quickly if there's a problem with their medicine. If a medicine is really dangerous (Class I Recall), they tell people and doctors in 25 days. If the recall is not as urgent (Class II Recall), they let people know in 30 days. If a medicine is taken off the market for safety, they notify everyone in 30 days too. But they don't have to tell people if the issue isn't about safety, if it's only for drug manufacturers, or if they can't figure out who got the affected medicine.

Special care for pregnant members

New Baby, New Life℠ is the Anthem program for all pregnant and postpartum members and their newborns. It is very important to see your primary care provider (PCP) or obstetric (OB) healthcare provider for care when you are pregnant. This kind of care is called **prenatal care**. It can help you to have a healthy baby. It is important that you seek prenatal care each time you are pregnant. With our program, you have access to health information and may receive incentives for going to your appointments.

Our program also helps pregnant members with complicated healthcare needs. Nurse care managers work closely with members with high risk pregnancies to provide:

- Prenatal and postpartum education
- Emotional support
- Help in following the OB provider's care plan
- Information on services and community resources

Our care managers also work with OB providers and help with other services you may need. The goal is to promote better health for pregnant members and delivery of healthy babies.

Quality care for you and your baby

At Anthem, we want to give you the very best care during your pregnancy. That's why you also have access to a digital maternity program which is offered at no cost as part of our New Baby, New Life program. The digital maternity program gives you the information and support you need to stay

healthy during your pregnancy and after you deliver.

Get to know our Digital Maternity Program
The digital maternity program delivers maternal health education by smartphone app that is helpful and fun. You can count on:

- Prenatal and postpartum education you can use
- Communication with the care management team via chat
- Information delivery on a time schedule that works for you
- No cost to you

Helping you and your baby stay healthy
The Anthem digital maternity program can give you answers to your questions, plus clinical support, if you need it. There is an important pregnancy screener that you'll complete shortly after you download the app and register, followed by ongoing educational outreach and fun activities via the smartphone app. All you need to do is download the app to learn, have fun, and answer a few questions. You can also chat with the care management team if a question comes up that isn't answered in the app.

If you think you are pregnant:

- Call your PCP or OB provider right away. You do not need a referral from your PCP to see an OB provider.
- Call Member Services if you need help finding an OB healthcare provider in the Anthem network.

When you become pregnant
When you find out you are pregnant, you must call Member Services to notify Anthem of the pregnancy. You should also:

- Call your welfare caseworker; tell him or her you are pregnant. This is to make sure your baby receives the care he or she needs.
- Make an appointment as soon as possible.
- Call Member Services and request an OB Care Manager if you would like to work with our OB Care Management team for additional support and education.

Visit our Pregnancy page at **mss.anthem.com/nevada-medicaid/care/pregnancy-womens-health.html** for information and resources on how to keep you and your baby healthy. If you would like to receive pregnancy information by mail, please call Member Services.

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from Women, Infants and Children program (WIC). You can learn more about WIC and find a location close to you online at https://www.fns.usda.gov/wic

When you are pregnant, you must go to your PCP or OB provider at least:

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

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

When you have a new baby
When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery
- 72 hours after a Cesarean section (C-section)

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

After you have your baby
If you are a Nevada Check Up member:

- Call Nevada Check Up at **800-992-0900** within 14 calendar days of delivery. If you do not call Nevada Check Up within 14 calendar days of the birth, your baby will not be covered until the month after you call Nevada Check Up.

If you are a Medicaid member:

- Call Anthem Member Service as soon as you can.
  - Let your care manager know you had your baby. We will need to be given information about your baby, too.
  - If you did not pick a PCP for your baby before he or she was born, let the Member Services representative know. We can help you pick a PCP for your baby.
- Call your welfare caseworker to let the caseworker know your baby's name and date of birth. This is to make sure your baby receives the care he or she needs.

After your baby is born, the digital maternity program will provide you access to postpartum education as well as valuable education about your baby.

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

- The visit should be done between 7 to 84 days after you deliver
- If you delivered by C-section or had complications with your pregnancy or delivery, your PCP or OB provider may ask you to come back for a one or two week checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within 7 to 84 days after your delivery for your postpartum checkup.

Anthem may cover the cost of a breast pump. Contact Member Services to learn about how you can get a breast pump.

You can learn more about the New Baby, New Life program and our digital maternity program

online at **mss.anthem.com/nevada-medicaid/care/pregnancy-womens-health.html** or by calling Member Services and asking to speak to an OB Care Manager.

Navigating the neonatal intensive care unit (NICU)

If your baby was born premature or with a serious health condition, they may have been admitted to the NICU. We believe the more you know, the better you will be able to care for your infant. To support you, we have a NICU Case Management program.

We extend our support by helping you to prepare yourself and your home for when your baby is released from the hospital. After your baby is home, our case managers continue to provide education and assistance in improving your baby's health, preventing unnecessary hospital readmissions, and guiding you to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns you may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping you engage with hospital-based support programs.
- Facilitating screenings for potential PTSD.
- Connecting you with behavioral health program resources and community support as needed.
- Actively asking for your feedback on the provided resources and how an increased awareness of PTSD has helped you.

You can learn more about the NICU Care Management program online at **mss.anthem.com/nevada-medicaid/care/pregnancy-womens-health.html** or by calling Member Services and asking to speak to a NICU Care Manager.

CARE MANAGEMENT

To see if you can have a care manager, or if you want to participate in Care Management, you or your provider, or someone on your behalf can call Anthem **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time. A Care Management program can help you live your best life. As part of your Anthem benefits, we're here to help you learn more about your health, keeping you and your health care needs in mind at every step.

Care Management may include referrals to community resources, help identifying and connecting to health plan services, coordinating services with member's healthcare team, support improved health outcomes through goal setting, addressing barriers to goals, and providing education/resources to help manage social determinants of health drivers and physical and behavioral health conditions.

Our team includes a variety of care managers including but not limited to registered nurses, licensed mental health clinicians, community health workers (CHWs), social workers, and peer support specialists.. They will help you learn how to better manage your condition or health issue. You can choose to join a Care Management program for free.

What programs do we offer?
You can join a Care Management program to receive healthcare and support services for a variety of healthcare needs. Some of our programs are shorter duration to meet urgent needs identified. Other programs may last 6 months or longer to ensure more chronic or complex health needs are addressed. Some programs may even last the duration of your eligibility with Anthem with your consent.

We may contact you through a variety of methods including telephone, text messages, letters or even in- person. For our members with urgent or complex health needs we may outreach to you multiple times to engage you in a Care Management program during a time of day that works for you. If you do not know who called or are wanting to refer yourself to a Care Management program, please call Members Services at **844-396-2329 (TTY 711)**.

Disease Management, a type of care management program, may be able to assist if you have any of these conditions:

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

For members with the conditions listed above wishing to talk to a case manager in Disease Management, you can call us **888-830-4300 (TTY 711)** or you can also email us at dmself-referral@anthem.com. Please be aware that emails sent over the internet are usually safe, but there is some risk that third parties may access these emails without you knowing. By sending your information in an email, you acknowledge (or know, understand) third parties may access these emails without you knowing.

How it works

When you join one of our Care Management programs, a care manager will:

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

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

How to join

One of our Care Management teams may call or text you or send you a letter if eligible for one of our programs. You can also call us toll free at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. local time to request care management services.

When you call, we'll:

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

You can choose to opt out of any care management program (we'll take you out of the program) at any time. Please call your care manager directly, or call Member Services toll-free at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. local time and let the representative know you would like to opt out.

Useful phone numbers
In an emergency, call **911**.

Member Services
Toll-free: **844-396-2329 (TTY 711)**
Monday through Friday
7 a.m. to 7 p.m. Pacific time

Disease Management
Toll-free: **888-830-4300 (TTY 711)**
Monday through Friday
8:30 a.m. to 5:30 p.m. local time
Leave a private message for your case manager 24 hours a day.
After-hours:
Call 24/7 NurseLine
24 hours a day, seven days a week
844-396-2329 (TTY 711)

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

- Receive details about us, such as:
    - Programs and services we offer
    - Our staff and their qualifications (skills or education)
    - Any contractual relationships (deals we have with other companies)
- Opt out of care management services.
- Know which care manager is handling your services, and how to ask for a change.
- Receive support from us to make healthcare choices with your healthcare providers.
- Ask about all care management-related treatment options (choices of ways to feel better) mentioned in clinical guidelines (even if a treatment is not part of your health plan), and talk about options with treating healthcare providers.
- Have personal date and medical information kept private.
- Know who has access to your information and how we make sure your information stays secure, private, and confidential.
- Receive polite, respectful treatment from our staff.
- Receive information that is clear and easy to understand.
- File complaints to Anthem by calling **844-396-2329 (TTY 711)** toll-free Monday through Friday from 7 a.m. to 7 p.m. local time and:
    - Receive help on how to use the complaint process.
    - Know how much time Anthem has to respond to — and resolve issues of — quality and complaints.
    - Give us feedback about the care management program.

You also have the responsibility to:

- Notify Member Services if you have been working with Care Management upon enrollment and report any on-going care related to your care plan.
- Follow the care plan that you and your care manager agree on.
- Give us information needed to carry out our services.
- Tell us and your healthcare providers if you choose to opt-out (leave the program).

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

SPECIAL ANTHEM SERVICES FOR HEALTHY LIVING

Health information

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

- Ask your primary care provider (PCP).
- Call us. 24/7 NurseLine is available 24 hours a day, seven days a week to answer your questions. They can tell you:
  - If you need to see your PCP.
  - Next steps on health care questions.

Health A to Z

Anthem wants to help you make better health choices with Health A to Z. This is an online resource that is easy to use and includes a symptom checker, tests, tools, and information on many health topics.

Health A to Z is your one-stop for questions about your health. Access Health A to Z on our website at **anthem.com/nvmedicaid** and choose *Programs and Info in Your Community*.

Health education classes

Anthem can help you find classes near your home. You can call Member Services to find out where and when these classes are held.

Some of the classes include:

- Childbirth
- Infant care
- Parenting
- Pregnancy
- Quitting cigarette smoking
- Protecting yourself from violence
- Other classes about health topics

Some of the larger medical offices in our network show health videos. They talk about immunizations (shots), prenatal care, and other important health topics. We hope you will learn more about staying healthy by watching these videos.

We will also mail a member newsletter to you twice a year. This gives you health news about well care and taking care of illnesses. It gives you tips on how to be a better parent and other topics.

Community events

Anthem sponsors — and participates in — special community events and family-fun days where you can receive health information and have a good time.

You can learn about topics like:

- Healthy eating
- Maternity support
- Women's health
- Asthma
- Stress management

People from Anthem will be there to answer your questions about your benefits, too. Call Member Services to find out when and where these events will be.

You can also learn about upcoming events in person at one of our Wellness Centers:

Las Vegas Wellness Center address: 2348 E Bonanza Rd., Las Vegas, NV 89129
Monday through Friday, 9 a.m. to 5 p.m.

Reno Wellness Centers address: 294 E. Moana Lane, Suite 25, Reno, Nevada 89502 (Walk-Ins Monday through Friday, 10 a.m. to 2 p.m.)

Domestic violence

Domestic violence is abuse. Abuse is unhealthy. Abuse is unsafe. It is never OK for someone to hurt you. It is never OK for someone to make you afraid. Domestic violence causes harm and hurt on purpose.

Domestic violence in the home can affect your children, and it can affect you. If you feel you may be a victim of abuse, call or talk to your PCP. Your PCP can talk to you about domestic violence. He or she can help you understand you have done nothing wrong and don't deserve abuse.

Safety tips for your protection:

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

- Pack a small bag and give it to a friend to keep until you need it.

If you have questions or need help:

- Call the National Domestic Violence hotline number at **800-799-7233 (TTY 711)**.
- Call Member Services and request a care manager who can help connect you with resources within the community, and/or coordinate with your doctor.

MINORS

Our network doctors and hospitals cannot give care to most Anthem members under age 18 without a parent's or legal guardian's consent. This does not apply if emergency care is needed.

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

These rules do not apply to emancipated minors. Emancipated minors may make their own decisions about their medical care and the medical care of their children. Parents no longer have the right to see the medical records of emancipated minors.

Members under age 18 may be emancipated minors if they:

- Are married.
- Are pregnant.
- Have a child.
- Are emancipated by court order.

ADVANCE DIRECTIVES (LIVING WILLS OR DURABLE POWERS OF ATTORNEY)

Emancipated minors and members over 18 years old have rights under the state's advance directive law. An advance directive is a written statement by you, telling how you want medical decisions made if you become unable to decide for yourself. There are a few types of advance directives:

1. **Living will or declaration** — a living will tells your healthcare providers and family about the type of life-sustaining actions you want, and do not want, if you suffer from a terminal illness or an irreversible condition. A living will does not apply unless you cannot make decisions for yourself; until then, you'll be able to say what treatments you want or don't want.
2. **Durable power of attorney for healthcare** — a durable power of attorney for healthcare will let you pick a person to make decisions for you when you can't make them yourself. You can also include information about any treatment you want or do not want. Ask your PCP or specialist about these forms.

You can have either a living will or a durable power of attorney for health, or you can have both documents. A living will is your personal statement regarding the types of life-sustaining treatment you want if you are not able to share your desires. A durable power of attorney for

healthcare covers more than the living will. It covers any medical decisions, not just decisions concerning life-sustaining treatment.

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

- Ask your PCP for a living will form, or call Member Services to receive one.
- Fill out the form.
- Take or mail the completed form to your PCP or specialist; your PCP or specialist will then know what kind of care you want to receive.

You can change your mind any time after you have signed a living will:

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

Your PCP will require you to sign the Acknowledgement of Patient Information on Advance Directives form. Your signed form, along with your advance directive, will be kept on file with your medical record.

Right to object

Nevada law says your PCP and other providers, individually and/or institutionally, have the right to object to the request you make in your advance directive. You can find the law in the Nevada Revised Statutes Annotated Section 449.628.

Individual and institutional objection

An individual objection is when your individual PCP or other providers treating you will not honor your advance directive on the basis of their conscience (beliefs).

An institutional objection is when an entire institution, like a hospital or health system, will not honor your advance directive for reasons of conscience (beliefs). The range of medical conditions that may be objected to by individual and institutional providers could be different from provider to provider. Be sure to ask your PCP and other providers if they have objections to the requests you have included in your advance directive.

If your PCP or other provider objects to the request for care you make in your advance directive, you have the right to select another PCP or provider who will honor your request. Please call Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time for help.

If you have a grievance about your advance directive, contact Member Services or file your grievance with DHCFP at:

Division of Health Care Financing and Policy

1100 E. William St., Suite 101
Carson City, NV 89701
775-684-3676

GRIEVANCES AND MEDICAL APPEALS

Grievances

If you, or your authorized representative have a problem with our services or network providers, we would like you to tell us about it. You or your authorized representative may file a grievance either orally or in writing. Please call Member Services and we will try to solve your problem on the phone.

If we cannot take care of the problem when you call us, you can file a grievance. You can:

- Call Member Service and file a grievance on the phone
- Ask Member Services for help with writing a letter; include information such as the date the problem happened, the people involved, and details about the problem.
- Write a letter to us and include information, such as:
  - The date the problem happened
  - The names of people involved
  - Details about the problem
- Send your letter to:

  Grievance and Appeals Department
  Anthem Blue Cross and Blue Shield Healthcare Solutions

  Member Appeals
  PO Box 62429
  Virginia Beach, VA 23466

When we receive your call or letter, we will:

1. Send you an acknowledgment letter within five calendar days to let you know we received your grievance.
2. Look into your grievance in a timely manner.
3. Send you a resolution letter within 45 calendar days of when you first told us about your grievance; the letter will tell you what we decide and the date when it was completed. If urgent, we will send you a letter and will try to call you to provide oral notice of the resolution of the grievance. In addition, to the written resolution letter, we will make reasonable efforts to provide you with oral notice of the resolution of the grievance.

Upon state approval of your request, we may extend the grievance process up to 14 calendar days if it is in your best interest. If the state approves our extension request, we will let you — or the person you asked to file the grievance for you — know in writing within 2 calendar days the reason for the delay. A reasonable attempt to provide prompt oral notice will also be made, in addition to the written notice. If you are not happy with the extra time we need to complete the review, you can file a grievance about the delay.

Appeals

Medical appeals

There may be times when Anthem says we will deny, end, or reduce a service we approved. We may also say we will not pay for all or part of the care your provider asked for. If we decide to deny the care a provider asked for, or to end or reduce a service you are currently approved to receive, we will send you a letter called a Notice of Adverse Benefit Determination.

For standard approval requests, Anthem has 14 calendar days to respond and either approve or deny the service request. For expedited (rushed) approval requests, when you need a quick response, Anthem has 72 hours or less to respond and either approve or deny the service request. If Anthem is reducing or ending a previously authorized service, we must send you a Notice of Adverse Benefit Determination at least 10 days before the date we plan to reduce or end the covered service.

If Anthem sends you a Notice of Adverse Benefit Determination, you can appeal the decision. Your provider can appeal our decision for you if he or she has your written permission.

A medical appeal is when you ask us to look again at the care we said we would not pay for. You must file for a medical appeal within 60 calendar days from the date on the Notice of Adverse Benefit Determination letter. A medical appeal can be filed by:

- You
- A person helping you
- Your PCP or the provider taking care of you at the time

If you want your representative, PCP or provider to file an appeal for you, he or she must have your written permission.

To continue receiving services we have already approved and are now denying, you or your provider must complete a Request to Continue Benefits during an Appeal or Fair Hearing form and return it to us on or before the later of:

- 10 calendar days after we mail the denial notice
- The date the notice says your service will end

You can appeal our decision in two ways:

1. Call us
    - Call Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time and ask to appeal.
    - Let us know if you want someone else to help you with the appeal process, such as a family member, friend, your PCP, or the provider taking care of you at the time.

We will send you an acknowledgment letter within 5 calendar days from when we receive your appeal request to let you know we got your request for an appeal unless you asked for an expedited appeal. See the section called **Expedited Appeals** for details.

2. Write us
    - Send us a letter letting us know the care you are looking for and the people involved.

- Have your doctor send us your medical information about this service to:

  Medical Appeals
  Anthem Blue Cross and Blue Shield Healthcare Solutions

  Member Appeals
  PO Box 62429
  Virginia Beach, VA 23466

During the appeal process, you or the person filing the appeal on your behalf, have the right to present evidence, information, and allegations of fact or law about your appeal either in writing or in person.

After we receive your appeal:

- A different medical director than the one who made the first decision will look at your appeal.
- We will send you and your provider a Notice of Resolution of an Appeal letter telling you our decision within 30 calendar days from when we receive your appeal or within 72 hours if you asked for an expedited appeal. See the section called **Expedited Appeals** for details.
- We will also try to call you to provide oral notice of the decision of the appeal. We will tell you and your provider how to find out more about the decision. We will tell you your rights to request a state fair hearing if you aren't happy with our decision. You may also request a copy (free of charge) of the documents used to make the appeal decision, including your medical records, actual benefit provision, guideline, protocol or criteria we based our decision on.

If we need more information about your appeal:

- We may ask your doctor for medical records to help us make a decision. You, your PCP, or the provider giving you care must forward the records to us within seven calendar days or within 24 hours, if expedited.
- Upon state approval or your request, we may extend the appeal process up to 14 calendar days if it is in your best interest.
- If the state approves our extension request, we will let you — or the person you asked to file the appeal for you — know in writing within 2 calendar days the reason for the delay. A reasonable attempt to provide prompt oral notice will also be made, in addition to the written notice. If you are not happy with the extra time we need to complete the review, you can file a grievance about the delay.

You may also ask us to extend the process if you have more information that we should consider. After you have completed the Anthem appeal process, you may ask for a state fair hearing. See the section **Fair Hearings** for more details.

Expedited appeals

You or the person you ask to file an appeal for you can request an expedited appeal. You can request an expedited appeal if you or your provider feels that taking the time for the standard

appeals process could seriously harm your life or your health.

You or your provider can request an expedited appeal in two ways:

1. Call Member Services toll-free at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time.
2. Mail a letter to:
   Member Appeals
   Anthem Blue Cross and Blue Shield Healthcare Solutions
   Member Appeals
   PO Box 62429
   Virginia Beach, VA 23466

When we receive your letter or call, we will send you an acknowledgment letter with our decision within 72 hours.

If you have more information you'd like us to look at, you must give it to us right away (within one or two days). If we need more information about your appeal:

- Upon state approval, we may extend the appeals process up to 14 calendar days.
- If the state approves our extension request, we will let you know in writing within 2 calendar days of the reason for the delay. A reasonable attempt to provide prompt oral notice will also be made, in addition to the written notice. If you are not happy with the extra time we need to complete the review, you can file a grievance about the delay.

You may also ask us to extend the process if you have more details that we should review. If we don't agree that your request for an appeal should be expedited, we'll:

- Call you right away to let you know of the decision.
- We will also send you a letter within two calendar days to let you know how the decision was made, and that your appeal will be reviewed through the standard review process of 30 calendar days.
- If you are not happy with the extra time we need to complete the review, you can file a grievance about the delay.

If the decision on your expedited appeal upholds (agrees with) our first decision and we will not pay for the care your doctor asked for, we will call you and send you a letter. This letter will:

- Let you know how the decision was made.
- Tell you about your rights to request an expedited state fair hearing.

Provider payment appeals

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

- The date you received the service.
- The type of service.
- The reason we can't pay for the service.

If you receive an EOB, you don't need to call or do anything at that time, unless you want to appeal the decision.

A payment appeal is when your provider asks Anthem to look again at the service we said we would not pay for. Your provider must ask for a payment appeal within 60 calendar days of receiving the EOB.

Payment appeals must be submitted in writing by your provider.

Fair hearings

You have the right to ask for a fair hearing from the state after the Anthem appeal process has been exhausted. If we fail to review your appeal within 30 calendar days for a standard request or within 72 hours for an expedited request, you are deemed to have exhausted Anthem's appeal process and may ask for a Fair Hearing.

You may ask for a fair hearing within 90 calendar days from the date of the notice of our appeal denial letter.

You can ask for a fair hearing by completing and sending the Member State Fair Hearing form we sent you with the appeal denial notice. Or, you may write and mail a letter asking for a State Fair Hearing with the Anthem denial notice to:

Nevada Division of Health Care Financing and Policy Hearings 1100 E. William St., Suite 102 Carson City, NV 89701

If you have any questions about your rights to request a fair hearing, call Anthem Member Services at **844-396-2329 (TTY 711)**, Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

If you have questions regarding the fair hearing, you may call the hearings supervisor in the Las Vegas area at **702-486-3000, ext. 43604**; or the Carson City area at **775-684-3604**. You may also call toll-free **800-992-0900, ext. 43604**.

If you ask for a fair hearing, you will receive a letter from the state telling you the date and time of the hearing preparation meeting. The hearing preparation meeting will be held by phone, and you can explain why you disagree with the decision made by Anthem. If you proceed to a fair hearing, you must attend the fair hearing in person unless you receive the hearing officer's consent to attend by phone. You do not have to pay any costs to take part in the hearing.

Continuation of benefits

You may ask Anthem to continue to cover your benefits during the appeal or fair hearing process. Call Member Services or send us the form you got with your Notice of Decision. The request to continue benefits applies to inpatient stays, outpatient services, or pharmacy

benefits approved by Anthem that you still receive now.

Your first request to continue benefits may be verbal. But you must also ask in writing. If you want to keep receiving benefits, please fill out the Request to Continue Benefits during an Appeal or a Fair Hearing form and return it to:
Appeals Department
Anthem Blue Cross and Blue Shield Healthcare Solutions
Provider Appeals or Disputes
PO Box 61599
Virginia Beach, VA 23466

To continue services during the appeal or fair hearing:

- You must request to continue benefits within 10 calendar days of the Notice of Adverse Benefit Determination or by the intended effective date of the reduction, suspension or termination of the service.
- You must file the appeal within 60 calendar days following the date on the Notice of Adverse Benefit Determination.
- Any previously authorized course of treatment must have ended or been suspended or reduced.
- Services must have been ordered by an authorized provider.
- The coverage period of the original approval must still be in effect.

We must continue coverage of your benefits until:

- You withdraw the appeal.
- 10 days from the date of our first decision if you have not requested an appeal or a fair hearing.
- An appeal or fair hearing decision is reached and is not in your favor.

Anthem will pay for services you receive during the time your benefits were continued until a final decision is made. **You may have to pay for the cost of any continued benefit if the final decision is not in your favor.**

If a decision is made in your favor as a result of your Appeal or Fair Hearing, we will approve and pay for the services we denied coverage of before as soon as possible but no later than 72 hours from the date we are told of the decision.

OTHER INFORMATION

If you move

If you are a Medicaid member, you must contact your welfare caseworker as soon as you move to report your new address or if your family size changes. Please find the number to call under the section **Important phone numbers**.

If you are a Nevada Check Up member, you should call Nevada Check Up when you move to a new address. Please find the number to call under the section **Important Phone Numbers**.

Once you call the state, you should then call Anthem Member Services. If you move out of the service area, you will continue to receive healthcare services through us until you are disenrolled. You must call Anthem before you can receive any services in your new area unless it is an emergency.

How to renew your Medicaid or Nevada Check Up benefits on time

Keep the right care. You need to renew your benefits every twelve (12) months. If you do not, you could lose your Medicaid or Nevada Check Up benefits, even if you still qualify.

If you are a Nevada Medicaid member, the Nevada Division of Welfare and Supportive Services (DWSS) will send you a letter telling you it is time to renew your Medicaid benefits. You will receive a renewal package about two months before the date you need to renew your benefits. You can return the packet via mail or renew online at dwss.nv.gov.

If you are a Nevada Check Up member, the Nevada Division of Health Care Financing and Policy (DHCFP) will send you a letter telling you it is time to renew your Nevada Check Up benefits. You will receive a renewal package about two months before the date you need to renew your benefits.

If you do not renew your eligibility by the date in the letter, you will lose your healthcare benefits. Your DWSS or welfare caseworker can answer your questions about renewing your benefits. We want you to keep receiving your healthcare benefits from us as long as you still qualify. Your health is very important to us.

We can help you renew at one our Wellness Centers.

Las Vegas Wellness Center address: 2348 E Bonanza Rd., Las Vegas, NV 89129 (Walk-Ins Monday through Friday, 10 a.m. to 2 p.m.)

Reno Wellness Centers address: 294 E. Moana Lane, Suite 25, Reno, Nevada 89502 (Walk-Ins Monday through Friday, 10 a.m. to 2 p.m.)

If you are no longer eligible for Medicaid or Nevada Check Up

You will be disenrolled from Anthem if you are no longer eligible for Medicaid or Nevada Check Up benefits. If you are ineligible for Medicaid or Nevada Check Up for two months or less and then become eligible again, you will be re-enrolled in Anthem. If possible, you will be given the same PCP you had when you were with Anthem before. You will be assigned to the same PCP as your other family members where appropriate.

How to disenroll from Anthem

If you live in urban Clark or Washoe counties, you must be enrolled with a Managed Care Organization (MCO). In most cases, you will not be able to go back to the Fee-For-Service program unless you have a special medical condition that may qualify under the state's rules.

- If you do not like something about Anthem, please call Member Services. We will work with you to try to fix the problem. If you are still not happy, you may change to another health

plan at any time during the first 90 days of enrolling with Anthem. If you are a new Medicaid or Nevada Check Up member, you may mail your request to:

Nevada Medicaid Attn: MCO Changes
P.O. Box 30042, Reno, NV 89520

Please include your Medicaid number, your address, and your phone number.

- Change health plans after the first 90 days of enrollment with good cause. Good cause reasons to disenroll are:
  - You move out of the service area.
  - Anthem does not, because of moral or religious objections, cover the service you seek.
  - You need related services, not available in our network, to be performed at the same time, and your PCP or other provider believes receiving the services separately would subject you to unnecessary risk.
  - You experience a disruption in your residence or employment due to having to switch your LTSS provider.
  - Poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with your healthcare needs, or if DHCFP imposes sanctions against Anthem.
- Change health plans without cause during the annual open enrollment period.
  - If you choose Anthem or a new managed care organization during open enrollment, you will be enrolled in the plan for the following calendar year. You can choose to switch back to your old managed care organization within the first 90 days. On the 91st day, you can only change health plans during the next 9 months if you can show good cause–wanting to go to a provider that is not in the Anthem network is not considered "good cause."

If you would like to be disenrolled from Anthem to enroll in a different health plan, you can do one of the following:

- Complete and submit a disenrollment request form online
- Email your request to managedcare@dhcfp.nv.gov
- Contact the Division of Health Care Financing and Policy (DHCFP) District Office
  - Southern Nevada: 702-668-4200
  - Northern Nevada: 775-687-1900 or TTY 7-1-1
- Call Anthem Member Services toll-free to:
  - Make an oral request to disenroll and Anthem will submit the request to DHCFP using the disenrollment form on your behalf.
  - Request a disenrollment form, and send the completed the completed disenrollment form to:
    Attn: DHCFP MCQA Unit
    1100 E. William St., Suite 101
    Carson City, NV 89701
- Send us a letter that includes:
  - Your name
  - Anthem ID number

- A phone number where you can be reached
- A complete description of your request to disenroll including specific supporting documentation of a good cause reason listed above

Send the completed letter to:

Disenrollment Department
Anthem Blue Cross and Blue Shield Healthcare Solutions
Desert Canyon, Building 9
9133 W. Russell Road
Las Vegas, NV 89148

If the State decides there is a good reason to disenroll you, it will send you a written notice approving the disenrollment. The State will make this decision as quickly as your health needs.

Reasons you can be disenrolled from Anthem

There are several reasons you could be disenrolled from Anthem without asking to be. Some of these are listed below. If you have done something that may lead to disenrollment, we will contact you. We will ask you to tell us what happened.

You could be disenrolled if:

- The member's enrollment makes it hard for us to give proper services to them or other members.
- The member has moved to a place outside our service area.
- The member was sent to our Member Services but:
  - Refused to follow the advice given, or
  - Did not try to fix the issue in a cooperative way.

If you have any questions about your enrollment, call Member Services.

Reasons you cannot be disenrolled from Anthem

Anthem may not request you be disenrolled for any of the following reasons:

- Your health status changes.
- You have pre-existing medical conditions.
- Your mental ability decreases.
- You use medical services.
- You have special needs that do not affect your ability to receive medical services.
- You file a grievance or appeal.
- Your age, national origin, creed, color, sex, or religion.

If you receive a bill or your primary care provider charges you a fee

When going to a provider, always verify that he or she is in the Anthem network. Always show

your Anthem ID card when you visit a provider, go for tests, or to the hospital. Showing your member ID card tells the provider to bill the covered medical services to Anthem.

Under the Nevada Medicaid and Nevada Check Up program, your PCP cannot bill you or charge you a fee for any of the following:

- You cancel or do not go to your appointment.
  - If you refuse to sign a form saying you will pay for missed appointments, your provider is not allowed to withhold treatment or refuse to let you return.
- You ask for the **first** copy of your medical records.
  - You will be charged a reasonable fee for extra copies.
- Your PCP does not submit your claim for services to Anthem within a certain period of time.
- Your PCP's claim for services has been rejected by Anthem and your provider has not submitted a corrected claim within a certain period of time.

If you are charged for any of these reasons, please call Member Services to report the issue. Anthem will contact your PCP and notify them they are not allowed to send you a bill.

If you do receive a bill for medical services your PCP provided to you, send it to Anthem with a letter saying you have been sent a bill. Anthem will contact your PCP. Send the letter to:

Claims
Anthem Blue Cross and Blue Shield Healthcare Solutions
P.O. Box 61010
Virginia Beach, VA 23466-1010
You can also call Member Services for help.

You *will* receive a bill when your PCP performs a service that was denied as not medically needed or is not an Anthem covered benefit, **only** if both of the following conditions are met:

- You request the specific service or item.
- Your PCP obtains and keeps a written acknowledgement statement in your medical chart, signed by you and your provider, stating the following:

  "I understand that, in the opinion of (Provider's Name), the services or items I have requested to be provided to me on (Dates of Service) may not be covered under Anthem as being reasonable and medically necessary for my care or be an Anthem-covered benefit. I understand that Anthem has established the medical necessity standards for the services or items that I request and receive. I also understand that I'm responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Anthem medically necessary standards for my care or are not covered benefits."

  Signature:_____ Date: _____

If you have other health insurance (coordination of benefits)

Please call your welfare caseworker and Anthem Member Services if you or your children have other insurance. The other insurance plan needs to be billed for your healthcare services before Anthem can be billed. Anthem will work with the other insurance plan on payment for these

services.

Changes in your Anthem coverage

Sometimes, Anthem may have to make changes in the way we work, our covered services, or our network providers and hospitals. We will mail you a letter when we make changes in the services we cover. Your PCP's office may move, close, or leave our network. If this happens, we will call or send you a letter to tell you about this.

We can also help you pick a new PCP. You can call Member Services if you have any questions. Member Services can also send you a current list of our network PCPs.

How to tell Anthem about changes you think we should make

We want to know what you like and do not like about Anthem. Your ideas will help make us better. Please call Member Services to tell us your ideas. You can also send a letter to:

Anthem Blue Cross and Blue Shield Healthcare Solutions
P.O. Box 62509
Virginia Beach, VA 23466

Members can also serve on the Consumer Advocacy Committee, which meets quarterly. This offers members a time to find out more about us, ask questions, and give us suggestions for improvement. If you would like to be part of this group, call Member Services.

Each year, we send surveys to some members. The surveys ask questions about how you like Anthem. If we send you a survey, please fill it out and send it back. Our staff may also call to ask how you like Anthem. Please tell them what you think. Your ideas can help us make us better. We want to give you the quality care you deserve.

How Anthem measures the quality of your care

To help providers and health plan employees choose the best care for specific health issues, we have a process to create, change, and distribute nationally known Clinical Practice Guidelines (CPGs) and health service delivery standards to all our providers. Members can also request a copy of the guidelines by contacting Member Services.

CPGs are based on scientific evidence and focus on a broad range of healthcare, including:

- Preventive health (keeping you healthy)
- Maternity care to help ensure healthy moms and babies
- Diabetes
- Cardiac care
- Mental health
- Other conditions

Anthem measures how often you need care and the quality of care you receive through a set of standard performance measures related to these guidelines, including:

- Frequency of childhood wellness visits

- Childhood immunizations
- Lead screenings
- Mammograms and Pap smears
- Pregnancy care
- Diabetes screenings and tests

These measures are tracked with other health plans. These measures also give us the chance to help improve your health by:

- Providing educational tools to you and your PCP through newsletters and community events.
- Mailing reminder cards to you and your family members to help you receive routine preventive care and shots on time.

Why does Anthem measure quality of care?
These results tell us how healthy you are. Some of the measures have tests that show good health or the right types of care. Some tests tell us when we need to watch your health to keep you from being sick.

What does this mean to you?

Anthem wants to help you stay healthy. You are the most important decision maker when it comes to making healthcare choices. Anthem reviews the care and services available to you, what we have provided, and your feedback. This helps us learn how we can make our services better.

What can you do about your own health?
You can also help your PCP know what kind of care is right for you by following these important steps:

- Receive tests and healthcare services on time.
- Keep appointments for routine checkups to help keep you healthy.
- Read and follow the instructions on any reminders you receive from Anthem.

If you have a question about your health or the kind of care you might need, please call 24/7 NurseLine at **844-396-2329 (TTY 711)**. Nurses are available anytime, day or night.

How Anthem pays providers

Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time he or she treats you (Fee-For-Service). Or your provider may be paid a set fee each month — for each member — whether or not the member actually receives services (capitation). Your provider may also participate in the Anthem Provider Quality Incentive Program (PQIP).

These kinds of payments may include ways to earn more money. This kind of pay is based on different things, like how happy a member is with the care or quality of care. It is also based on how easy it is to find and receive care.

If you want more details about how our contracted providers or any other providers in our

network are paid, please call the Anthem Member Services department or write to us at:

Anthem Blue Cross and Blue Shield Healthcare Solutions
P.O. Box 62509
Virginia Beach, VA 23466

YOUR RIGHTS AND RESPONSIBILITIES AS AN ANTHEM MEMBER

Your rights

As an Anthem member, you have the right to:

- Anthem members have the right to request and obtain a copy of the member handbook at least once per year or upon request, including notice that the member handbook is available in paper format without charge within five business days of request.
- Be treated with respect and recognition of your dignity and your right to privacy:
  - Knowing your medical records and discussions with your primary care providers (PCPs) will be kept private and confidential.
  - Being treated fairly.
- A right to receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities. Know their case manager and know how to request a change in case manager.
- Choose a PCP who is part of the Anthem network and to refuse care from specific PCPs and providers; this includes:
  - Knowing how to choose and change your health plan and PCP.
  - Choosing any health plan you want that is available in your area and choosing your PCP from that plan.
  - Changing your PCP.
  - Selecting a specialist to serve as your PCP if you have a chronic condition.
  - Changing your health plan without penalty.
  - Participate with practitioners in making decisions about your health care; working as part of a team with your PCP to decide what healthcare is best for you.
  - Taking part in an honest discussion on the proper or medically needed treatment options for your condition, without concern about the cost or benefit coverage.
  - Deciding on care recommended by your PCP.
  - Being told and understanding the results of the decision.
  - Refusing treatment.
- Have a candid discussion of appropriate or medically necessary treatment options for your condition(s), regardless of the cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Express and expect resolution of grievances and appeals about:
  - Anthem
  - Our network PCPs and providers.
  - The care you're provided.
- Create an advance directive to tell your doctor the kind of care you want if you are not able to communicate your decisions.
- Have access to your medical records in agreement with all Federal and state laws and be able to request the records be changed or corrected in agreement with Federal and state laws.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline,

convenience, or retaliation.

- Receive information on available treatment options and alternatives in a way you are able to understand.
- Exercise your rights without Anthem or network providers treating you unfairly.
- Make suggestions about the Anthem Member Rights and Responsibilities policy.

Your responsibilities

As an Anthem member, you have the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care: telling your PCP about your health.
- Talking to your PCP about your healthcare needs and asking questions about your treatment options.
- Help providing your PCP with your medical records.
- Providing your PCP with the right information.
- To follow plans and instructions for care that you have agreed to with your practitioner(s), understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible; working as a team with your PCP to decide what healthcare is best for you.
- Understanding how what you do can affect your health.
- Doing the best you can to stay healthy.
- Treating providers and staff with respect.
- Being on time for scheduled appointments and canceling appointments in a timely manner.

- Notify Anthem if you have other health insurance.
- Carry your ID card at all times.
- Reporting fraud, waste, and/or abuse.

Call Anthem Member Services if you have a problem and need help.

Anthem provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, race, age, religion, national origin, physical or mental disability, or type of illness or condition.

HOW TO REPORT SOMEONE WHO IS MISUSING THE MEDICAID OR NEVADA CHECK UP PROGRAM

Important terms

- **Fraud**: This is when someone lies or tricks others on purpose to get a benefit or advantage that they shouldn't have. It can be something that breaks Federal or State law.
- **Waste:** This happens when services are overused or resources are misused, which leads to high costs. Waste isn't usually done on purpose but happens when things are not used wisely.
- **Abuse:** This means using financial, business, or medical resources in a way that causes unnecessary costs. It includes actions that lead to services that aren't needed or don't meet proper health care standards.

It also includes any practices by Medicaid and Check Up members that result in unnecessary costs to the Medicaid or Check Up programs. **An overpayment is a payment made to a provider that is over the amount due for the service provided.**

If you know someone who is misusing (through fraud, abuse and/or overpayment) the Medicaid or Check Up programs, you can report him or her.

Reporting Fraud, Waste and Abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting our fighthealthcarefraud.com education site; at the top of the page click Report it and complete the **Report Waste, Fraud and Abuse** form
- Calling Customer Service
- Call our SIU fraud hotline: 800-377-2227
- Emailing us at medicaidfraudinvestigations@anthem.com
- Send report by mail to:

Anthem Special Investigations Unit
21215 Burbank Blvd.
Woodland Hills, CA 91367

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Provider Fraud, Waste and Abuse (FWA):

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

When reporting concerns involving a PROVIDER (a doctor, dentist, counselor, medical supply company, etc.) include:

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

Examples of Enrollee Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Relocating to out-of-service Plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a MEMBER include:

- The member's name
- The member's date of birth, Member ID, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Consumers can also report an allegation of fraud to Nevada Health and Human Services Surveillance and Utilization Review Unit:

Report Provider Fraud and Abuse
775-687-8405 (Northern or Southern Nevada)

Report Member Fraud and Abuse
Northern Nevada 775-684-7200 or 775-448-5298
Southern Nevada 702-486-1646 or 702-486-1875

More information is available on the Nevada Department of Health and Human Services website: dhcfp.nv.gov/Resources/PI/SURMain/

WE HOPE THIS BOOK HAS ANSWERED MOST OF YOUR QUESTIONS ABOUT ANTHEM. FOR MORE INFORMATION, CALL MEMBER SERVICES AT 844-396-2329 (TTY 711).

THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN ANTHEM AND THE MEMBER.

TERM OR ACRONYM	*DEFINITION*
Access	A Member's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the Member, the location of health care facilities, transportation methods, hours of operation, and cost of care.
Actuarially Sound or Actuarial Soundness	Refers to Capitation Payments/Capitation Rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered, and the services to be furnished under the Contract; and have been certified as meeting the requirements of 42 CFR 438.4(b) by an Actuary.
Actuary	An individual, acting on the State's behalf in the development and certification of Capitation Rates, who meeting the qualification standards established by the American Academy of Actuaries for an Actuary and follows the best practice standards established by the Actuarial Standards Board.
Administrative Cut-Off Date	A date each month selected by the State. Changes made to the Medicaid Recipient eligibility system prior to this date are effective the next month. Changes made to the computer system after this date become effective the first day of the second month after the change was made.
Advance Directive	An Advance Directive refers to a written statement, completed in advance of a serious illness or condition, which allows the Member to direct health care decisions when the Member is unable to do so. The Advance Directive allows the Member to make decisions regarding the use or refusal of life sustaining treatments. An Advance Directive consists of Declarations (Living Wills) and Durable Powers of Attorney for Health Care Decisions, recognized under Nevada State law, which relate to the provision of care when an individual 18 years of age and older has an incurable or irreversible condition, and is unable to communicate health care decisions verbally.
Adverse Benefit Determination	The following decisions by the Contractor are appealable by the Member: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an Adverse Benefit Determination; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure to

	process Grievances, Appeals or expedited Appeals within the required timeframes, including resolution and notification; or (6) For a resident of rural area with only one Contractor, the denial of a Member's request to exercise his or her right, to obtain services outside the network (note the geographic service area for this program does not include rural areas); and (7) The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities (note is no financial liability for Members under the managed care program).
AFDC	Aid to Families with Dependent Children. Refer to definition for TANF.
AFDC-UP	Aid to Families with Dependent Children – Unemployed Parent Program. Refer to definition for two parent TANF
AFDC-RMO	Aid to families with dependent children related to Medicaid only.
ADSD	Aging and Disability Services Division.
Appeal	A Member's request for review of an Adverse Benefit Determination.
Authorized Representative	An authorized representative is an individual who has been designated by an applicant or Member having authority to act on behalf of the applicant or Member.
Behavioral Health Services	Services covered under the Medicaid and CHIP State Plans that promote mental health, resilience and wellbeing, treat mental and substance use disorders, and support Members who experience and/or are in recovery from these conditions.
Benefit	A Service authorized by the Contractor.
Business Day	Any Monday thru Friday except for state observed holidays.
Calendar Day	All seven (7) days of the week, including State of Nevada holidays.
Credible Allegation of Fraud (CAF)	Credible allegation of Fraud (CAF) is an allegation from any source *when it has an* "indicia of reliability."
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.
Capitation Payment or Capitation Rate	A payment the State makes periodically to a Contractor on behalf of each Member enrolled under the Contract for the provision of medical services under the Medicaid State Plan and in accordance with 42 CFR 438.3(c). The State agency makes the payment regardless of whether the particular Member receives services during the period covered by the payment.

Cardholder	Means the person named on the face of a Medicaid or Nevada Check Up card.
Care Coordination	Care coordination links persons who have complex personal or social circumstances or health needs, which place them at risk of not receiving appropriate services. It also ensures coordination of these services. The requirements for Care Coordination are specified in Section 7.5.6.6.
Care Management	Care Management is a process by which an individual's needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Care Management is comprised of Care Coordination and Case Management as described in Section 7.5
Case Management	Case Management is the Care Management process for Members identified as high-risk as specified in Section 7.5.6.7.
Case Manager	A professional, whose background is most frequently anchored in the disciplines of social work and/or nursing, who assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health needs.
Children with Special Health Care Needs (CSHCN)	Children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions; and also require health and related services of a type and amount beyond that required by children in general; and are receiving services through family-centered, community-based, coordinated care systems receiving grant funds, under Section 501 (a)(1)(D) of Title V of the SSA (known as Nevada Early Intervention Program).
Children's Health Insurance Program (CHIP)	Children's Health Insurance Program (CHIP) provided under Title XXI of the Social Security Act to children whose families exceed Medicaid limits, but is equal to or less than 205% of the federal poverty level. Nevada's CHIP managed care program is referred to as the Nevada Check Up program (NCU).
Claim	Means (1) a bill for services; (2) a line item of services; or (3) all services for one Member within a bill. "Claim" is further defined as communication, whether oral, written, electronic or magnetic, which is used to identify specific goods, items or services as reimbursable pursuant to the Medicaid or CHIP State Plan, or which states income or expense and is or may be used to determine a rate of payment pursuant to the Medicaid or CHIP State Plan.
Clean Claim	Means a claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

Clinic Services	As amended by the Deficit Reduction Act of 1984, section 1905(a)(9) describes clinic services as "services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician." Regulations at 42 CFR 440.90 define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that: (1) Are provided to outpatients; Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and Except in the case of nurse-midwife services as specified in 42 CFR 440.165, are furnished by or under the direction of a physician.
Centers for Medicare and Medicaid Services (CMS)	Medicaid and CHIP programs are administered by the states with the Centers for Medicare and Medicaid Services, Department of Health and Human Services. CMS has responsibility for monitoring State compliance with federal requirements and providing federal financial participation (FFP). CMS monitors State programs to assure minimum levels of service are provided, as mandated in the Code of Federal Regulations (CFR).
Code of Federal Regulations (CFR)	Code of Federal Regulations
Cold Call Marketing	Any unsolicited personal contact by the Contractor with the Potential Member for the purpose of Marketing.
Certified Community Behavioral Health Centers (CCBHCs)	Certified Community Behavioral Health Centers (CCBHCs) are responsible for directly providing or contracting with partner organizations to provide a continuum of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, Care Coordination and integration with physical health care. CCBHCs must provide crisis mental health services; screening, assessment and diagnosis; patient-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; Targeted Case Management; psychiatric rehabilitation services: peer support, counseling and family support services; and services for veterans. Prior authorization to access CCBHC services is not required.
Competent	Properly or well qualified and capable.
Compliance Review	Any investigation, audit, focused data analysis, or other assessment of whether improper payments have been made.
Concierge Service	A service that personally assists Members to find a Provider.
Confidentiality	Confidentiality pertains to all safeguards required to protect all information which concerns Medicaid and CHIP applicants and Members, Medicaid Providers, and any other information which

	may not be disclosed by any party pursuant to federal and State law, and Medicaid Regulations, including, but not limited to NRS Chapter 422, and 42 CFR 431.
Contract Year	A calendar year period within the Contract Term as described in Section 7.1.1.
Contractor	The company or organization that has an approved contract with the State of Nevada for services identified in this RFP. The Contractor has full responsibility for coordinating and controlling all aspects of the contract, including support to be provided by any Subcontractor(s). The Contractor will be the sole point of contact with the State relative to contract performance.
Coordination of Benefits (COB)	Coordination of Benefits means an individual has personal medical health insurance coverage that is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State Medicaid Plan. COB includes cost avoidance and recovery when other medical health insurance exists.
Co-payment	A co-payment is a fixed dollar amount that an individual pays for health care services, in addition to what their health plan covers.
Covered Services	Covered services are those services for which Nevada Medicaid and Check Up may reimburse Providers.
Cross Reference	A reference from one document/section to another document/section containing related material.
Cultural Competency	An awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual to increase the quality and appropriateness of health care services and outcomes.
Culture	The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age.
DCFS	The Division of Child and Family Services.
Denied Service	Any medical service requested by a Provider for a Medicaid or CHIP Member for whom the Contractor denies approval for payment.
DHCFP	Nevada Division of Health Care Financing and Policy. Primarily referred to as "State" in this RFP.
DHHS	Nevada Department of Health and Human Services (NV DHHS) and United States Department of Health and Human Services (US

	DHHS).
Disenrollment	Process of terminating individuals from enrollment with a Contractor. Except where expressly required by federal or Nevada regulations, disenrollment may not occur mid-month. Under most circumstances, requests for disenrollment are effective the first day of the month following receipt of the request, providing that the request is within policy/contract guidelines and is submitted before the Administrative Cut-Off Date.
Division/Agency	The Division/Agency requesting services as identified in this RFP.
Durable Medical Equipment (DME)	Durable medical equipment is defined as equipment, devices, and gases, which can withstand repeated use and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury.
DPBH	Division of Public and Behavioral Health
Eligibility	Term that references a person's status to receive Medicaid or CHIP program benefits. The determination of Medicaid or CHIP eligibility is the sole responsibility of the Nevada Division of Welfare and Supportive Services (DWSS).
Emergency Medical Condition	Medical condition (including labor and delivery) manifesting itself by the sudden onset of acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect that the absence of immediate medical attention could reasonably be expected to result in either placing an individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulting in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious physical harm to another.
Emergency Medical Transportation	Emergency medical transportation is use of a ground or air ambulance, as Medically Necessary, to transport a Member with an Emergency Medical Condition. A ground or air ambulance resulting from a "911" communication is considered emergency medical transportation, as specified in Medicaid Services Manual, Chapter 1900.
Emergency Services	Emergency services means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services and are needed to evaluate or stabilize an Emergency Medical Condition. The Contractor must not require the services to be prior or post-authorized.
Encounter	A Covered Service or group of services delivered by a Provider to a Member during a visit, or as a result of a visit (e.g., pharmacy)

	between the Member and Provider.
Encounter Data	Data documenting a contact of service delivered to a Member by a Provider.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A preventive health care program, the goal of which is to provide to Medicaid eligible children under the age of 21 the most effective, preventive health care through the use of periodic examinations, standard immunizations, diagnostic services, and treatment services which are Medically Necessary and designed to correct or ameliorate defects in physical or mental illnesses or conditions. *See* section 1905(r) of the SSA and 42 CFR part 441, subpart B. In Nevada, EPSDT is also referred to as Healthy Kids.
External Quality Review (EQR)	The review and evaluation by an External Quality Review Organization of information on quality, timeliness, and access to the health care and services that a Contractor, or their Subcontractor(s), furnish to Medicaid Members.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, and other EQR-related activities as set forth in 42 CFR 438.358, or both.
Essential Community Providers (ECP)	A healthcare Provider that (a) has historically provided services to underserved populations and demonstrates a commitment to serve low- income, underserved populations who make up a significant portion of its patient population or, in the case of a sole community Provider, serves underserved patients within its clinical capability; and (b) waives charges or charges for services on a modified sliding fee scale based on income and does not restrict access or services because of a client's financial limitations. In addition, the State has identified Essential Community Providers in Section 7.3.6.8 that may not meet the aforementioned requirements but are critical to ensuring access to Covered Services in the Contractor's Provider Network and are deemed ECPs.
Electronic Verification System (EVS)	A means to verify an individual's eligibility for services covered by the State of Nevada's Medicaid program via the Internet.
Exception	A formal objection taken to any statement/requirement identified within the RFP.
Excluded Services	Excluded services are benefits that are not covered under the Medicaid Nevada Check Up managed care program. Excluded services are as follows: • All services provided at Indian Health Service Facilities and Tribal Clinics. • Non-Emergency Transportation • Non-Emergency Secure Behavioral Health Transport

	• Ground Emergency Medical Transportation • School Health Services • Adult Day Health Care • Home and Community Based Waiver Services • Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments • Targeted Case Management • Day Habilitation and Residential Habilitation Services • All Nursing Facility Stays Over One Hundred Eighty (180) Days • Swing Bed Stays in Acute Hospitals Over Forty-Five (45) Days • Hospice • Dental Services Not Covered under Medical Benefits • Orthodontic Services • Pharmacy Drug Limitations
External Quality Review Protocols	A series of procedures or rules to monitor, measure, and document information on quality, timeliness, and access to the health care and services that a Contractor or their Subcontractors furnish to Medicaid and Nevada Check Up Members.
Family Planning Services	Section 1905(a)(4)(C) of the SSA requires states to provide family planning services and supplies (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the Medicaid State Plan and who desire such services and supplies. Section 1902(a)(10)(A) of the SSA specifies family planning services be made available to categorically needy Medicaid Members while section 1902(a)(10)(C) of the SSA indicates the services may be provided to medically needy Medicaid Recipients at the State's option. The term "family planning services" is not defined in the law or in regulations. However, Congress intended that emphasis be placed on the provision of services to "aid those who voluntarily choose not to risk an initial pregnancy," as well as those families with children who desire to control family size. In keeping with congressional intent, these services may be defined as narrowly as services, which either prevent or delay pregnancy, or they may be more broadly defined to also include services for the treatment of infertility. However, the Medicaid definition must be consistent with overall State policy and regulation regarding the provision of family planning services.

Federal Financial Participation (FFP)	Usually expressed as a percentage or fraction of certain expenditures for which the State is entitled to reimbursement by the federal government in accordance with applicable laws and regulations.
Fee-for-service Reimbursement (FFS)	Fee-for-service Reimbursement is a health care delivery program whereby the State's medical assistance program Recipients are served by health care Providers reimbursed on a per service or point of service basis.
First Step Program	The Division of Child and Family Services (DCFS) early intervention services for families and their children, ages birth through two (2) years (to third birthday), with suspected or confirmed developmental delays.
Fiscal Agent	The program's fiscal agent is an entity under contract to the State with responsibility for the prompt and proper processing of all claims for payment of Covered Services in accordance with policies and procedures established by Nevada Medicaid. In addition, the fiscal agent may: (1) Provide the auditing function for Providers under cost reimbursement; (2) Perform a cursory pre-payment review on all claims; (3) Trace, identify and apply any and all Prior Resources, including third-party liability and subrogation; (4) Supply Provider education and Provider services; and, (5) Other administrative service.
Family Medical Coverage (FMC)	Applications for Medicaid are treated as application for Family Medical Coverage. This includes parents, caretakers, and children in the MAGI medical groups of: AM, AM1, CH, CHI, CH5, TR, PM; Nevada Check Up (NC); and Childless Adults (CA).
Fraud	Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2)
Federally Qualified Health Center (FQHC)	An entity as defined in 42 CFR 405.2401(b). An FQHC is located in a rural or urban area designated as either a shortage area, or an area that has a medically underserved population and has a current provider agreement with the State.
Geographic Service Area	The geographic service area included in the contract will be urban Clark and Washoe Counties. Other geographic areas may become mandatory managed care during the course of this contract and are to be considered as covered for this RFP. Members not residing in the areas included in the geographic service areas will be provided Medicaid Covered Services

	through fee-for-service provided by the State.
Grievance	Means any oral or written communications made by a Member, or a Provider acting on behalf of the Member with the Member's written consent, to the Contractor expressing dissatisfaction or making a complaint with any aspect of the Contractor's or Provider's operations, activities or behavior, regardless of whether the communication requests any remedial actions.
Goods	The term "goods" as used in this RFP has the meaning ascribed to it in NRS 104.2105(1) and includes, without limitation, "supplies", "materials", "equipment", and "commodities", as those terms are used in NRS Chapter 333.
Habilitation	Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a home and community-based setting. The repetitive services required to maintain function generally do not involve complex and sophisticated therapy procedures, and consequently the judgment and skill of a qualified therapist are not required for safety and effectiveness. As such, "maintenance" programs do not meet the requirement of being restorative or rehabilitative and are not a covered benefit by Nevada Medicaid. In certain instances, the specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program. Habilitation services are provided through Nevada's FFS delivery system.
Home and Community Based Services (HCBS)	Comprehensive services delivered in home and community based (HCB) settings depending upon the needs and preferences of the individual. The goal of services offered in HCB settings is to help support individuals so they may safely remain in the community. Many services are offered under Medicaid State Plan authority and are included in this Contract. These include Personal Care Services, Home Health Services, and private duty nursing.
Health Care Services	Any services included in the furnishing to any natural person of medical care or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person any other services for the purpose of preventing, alleviating, curing or healing human illness or injury.
Healthy Kids	The State refers to the EPSDT program as Healthy Kids.
Hearing	A hearing is an orderly, readily available proceeding before a hearing officer, which provides for an impartial process to determine the correctness of an agency action (See MSM Chapter 3100). Members and Medicaid Providers are afforded an opportunity for hearing in certain circumstances and when requested in a timely manner. An agency or Contractor Adverse Benefit Determination made against a Member's request for service or payment as well as a determination against a Provider that terminates or denies a Provider application may provide

	opportunity for a hearing.
Healthcare Effectiveness Data and Information Set (HEDIS)	The performance measurement tool of choice for more than 90 percent of the nation's managed care organizations. It is a set of standardized measures that specifies how health plans collect, audit, and report on their performance in important areas ranging from breast cancer screening, to helping patients control their cholesterol to customer satisfaction. Purchasers and others use HEDIS data to compare plan performance.
HEDIS Compliance Audit	A comprehensive assessment by a HEDIS Certified Auditor using findings from the HEDIS Baseline Assessment Tool (BAT), from audits in prior years (if applicable) and the HEDIS logical measure groups to select a core set of measures from all Contractor-reported measures. The auditor evaluates the core set of measures across all applicable domains described in the HEDIS specifications and extrapolates findings from the core set to all measures reported by the Contractor.
Health Insurance Exchange (HIX)	Nevada Health Link, the State-designated Health Insurance Exchange.
Home Health Services	Home health services are a mandatory benefit for individuals entitled to NF services under the state's Medicaid plan. In order to qualify for Home Health Services, the Recipient must have a face-to-face visit with qualified medical professional. Home health services must include nursing services, as defined in the state's Nurse Practice Act, that are provided on a part-time or intermittent basis by a HHA, home health aide services provided by a HHA, and medical supplies, equipment, and appliances suitable for use in the home. Physical therapy, occupational therapy, speech pathology, and audiology services are optional services States may choose to provide. To participate in the Medicaid program, a HHA must meet the conditions appliances suitable for use in the home. Physical therapy, occupational therapy, speech pathology, and audiology services are optional services States may choose to provide. To participate in the Medicaid program, a HHA must meet the conditions of participation for Medicare.
Hospice Services	Hospice care means a comprehensive set of services identified and coordinated by an Interdisciplinary Group (IDG) to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill Recipient and/or family members, as delineated in a specific Recipient plan of care.
Hospital	Hospital means an inpatient medical facility licensed to provide services at an acute level of care for the diagnosis, care and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a "hospital" must meet the requirements for participation in Medicare as a hospital. It is not an Institution for Mental Diseases (IMD), a Nursing Facility (NF), or an Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/IID) regardless of

	name or licensure.
Improper Payment	A payment made for any Medicaid service that was not authorized, performed, documented, billed, and paid in accordance with Nevada Medicaid policy and all applicable federal and state laws. The term encompasses fraud, waste, and abuse, but also includes errors on the part of the Provider or the payer.
Incentive Bonus Payment	A payment made under the Incentive Bonus Payment Program that is in addition to the approved Capitation Payments paid to the Contractor for services in the corresponding Contract Year. Incentive Bonus Payments must be based on the Contractor's performance under specified metrics or activities outlined in the Contract for the corresponding Contract Year. Any Incentive Bonus Payments may not in total exceed 105 percent of the Capitation Payments made to the Contractor for services in the corresponding Contract Year.
Incentive Bonus Payment Program	A performance-based program that may be established by the State in accordance with 42 CFR 438.6(b)(2) for a Contract Year to promote improvement in initiatives that align with the State's Quality Strategy or other State goals for Contractors under the Contract Period.
Indian Health Programs	These are services that the United States Government provides to federally recognized American Indian Tribes and Alaska Native Villages ("Indian tribes") based on a special government-to- government relationship. This relationship is the result of treaties between the federal government and Indian tribes and federal legislation. The Indian Health Services (IHS) is the primary source of medical and other health services for American Indian and Alaska Native people living on federal Indian reservations and other communities serviced by the IHS. The IHS delivery system includes over 500 health care facilities, including 51 hospitals, operated directly by the IHS or by Indian tribes or tribal organizations under agreements (contracts, grants, or compacts) authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended).
In Lieu of Services	These are services or settings that a Contractor may cover that are not covered in the Medicaid State Plan but the State has determined such services or settings to be a medically appropriate and cost effective substitute for a covered service or setting. Services or settings may only be considered "in lieu of" to the extent the State has defined and approved the service or setting.
Inpatient Hospital Services	"Inpatient hospital services" means services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that (a) is maintained primarily for the care and treatment of patients with disorders other than tuberculosis; (b) is licensed as

	a hospital by an officially designated authority for State standard-setting; (c) meets the requirements for participation in Medicare; and (d) has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30, 42 CFR 456.50-456.145 and 42 CFR 440.10 Inpatient hospital services do not include Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF) services furnished by a hospital with swing bed approval.
Institutions for Mental Diseases (IMD)	Section 1905(i) of the SSA and 42 CFR 435.1009 defines an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The regulation also indicates that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.
IQAP	Internal Quality Assurance Programs (IQAPs)
I&R Unit	Investigation and Recovery Unit at DWSS
Key Personnel	Contractor staff responsible for oversight of work during the life of the project and for deliverables.
LCB	Legislative Counsel Bureau
Limited English Proficiency (LEP)	The inability to read, write or understand the English language at a level that permits one to interact effectively with health care Providers or the Contractor.
Licensure	The act or practice of granting licenses as to practice a profession.
Managed Care Organization (MCO)	Managed Care is a system of health care delivery that influences utilization, cost of services and measures performance. The delivery system is generally administered by an MCO, which may also be known as a Health Maintenance Organization (HMO). An MCO is an entity that must provide its Medicaid or Check Up Members inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, home health services, Emergency Services, and additional contracted Medicaid and CHIP State Plan benefits. The MCO provides these services for a capitation fee, regardless of whether the Member receives services. The MCOs awarded a contract resulting from this RFP are referred to as "Contractors."
Marketing	Any communication from the Contractor, including its employees, affiliated Providers, agents or subcontractor, to a Medicaid or Nevada Check Up Recipient who is not enrolled with the Contractor that can reasonably be interpreted as intended to influence the Recipient to enroll with the Contractor or either not

	to enroll in or to disenroll from another Contractor's plan.
Marketing Materials	Materials that are produced in any medium, by or on behalf of Contractor that can reasonably be interpreted as intended to market to Potential Members.
Maternity Kick Payment (SOBRA)	The Maternity Kick Payment is payment made to the Contractor, which is intended to reimburse the Contractor for costs associated specifically with covered delivery costs and postpartum care.
May	Indicates something that is recommended but not mandatory.
Medicaid	Title XIX of the Social Security Act is a federal program, which pays for medical benefits to eligible low-income persons needing health care. In Nevada, the Department of Health and Human Services, Division of Health Care Financing and Policy administers the program, subject to oversight by CMS. The federal and State governments share the program costs.
Medicaid or Nevada Check Up Billing Number	The Medicaid and Nevada Check Up identification is an eleven digit number format. Providers use the Medicaid identification number when submitting claims for payment on services provided to eligible program Members.
Medicaid and Nevada Check Up Card	An instrument or device evidencing eligibility for receipt of Medicaid or Nevada Check Up Covered Services. The card is issued by the Fiscal Agent for the use of the Cardholder in obtaining the types of medical and remedial care for which assistance may be provided under the Medicaid and CHIP State Plans.
Medicaid Fraud Control Unit (MFCU)	The MFCU is a federally funded and mandated State fraud unit, independent of the State Medicaid agency and authorized by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. The purpose of MFCU is to investigate and prosecute Provider fraud in the Medicaid program. In Nevada, MFCU was established by the 1991 Legislature within the Office of the Attorney General.
Medicaid State Plan (aka "State Plan")	The Medicaid State Plan is a comprehensive statement submitted by the state Medicaid agency describing the nature and scope of its program and giving assurance that it will be administered in conformity with the specific requirements stipulated in the pertinent title of the Act, and other applicable official issuances of the Department of Health and Human Services (HHS). The Medicaid State Plan contains all information necessary for HHS to determine whether the State Plan can be approved as a basis for Federal Financial Participation (FFP) in Nevada's Medicaid program. The Medicaid State Plan consists of written documents furnished by the State to cover each of its programs under the Act

	including the medical assistance program (Title XIX, Title XXI). After approval of the original plan by HHS, all relevant changes required by new statutes, rules, regulations, interpretations, and court decisions, are required to be submitted so HHS may determine whether the State Plan continues to meet federal requirements and policies.
Medical Assistance to the Aged, Blind and Disabled (MAABD)	MAABD is a Medicaid eligibility category which provides medical coverage for certain persons who are eligible for and/or may be receiving Supplemental Security Income (SSI), persons who qualify for Home and Community Based Services (HCBS) 1915(c) waivers, certain persons who qualify for Medicare coverage, and certain disabled children who would be eligible for nursing facility placement but who are being cared for in their home for less cost than what would be incurred in such placement. The MAABD population is currently excluded from the Medicaid managed care program.
Medical Care Advisory Committee (MCAC)	MCAC is a federally mandated advisory committee whose purpose is to act in an advisory capacity to the State Medicaid Administrator.
Medical Necessity	A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability. The determination of Medical Necessity is made on the basis of the individual case and takes into account: (1) Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies. (2) Level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available. (3) Services are delivered in the setting that is clinically appropriate to the specific physical and mental/Behavioral Health care needs of the Member. (4) Services are provided for medical or mental/behavioral reasons rather than for the convenience of the Recipient, the Recipient's caregiver, or the health care Provider. Medical Necessity shall take into account the ability of the service to allow Recipients to remain in a community based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting.

Member	A Medicaid or Nevada Check Up Recipient who is enrolled in the managed care program. May also be referred to as enrollee, recipient, or beneficiary.
Mid-Level Practitioner	Includes physician assistants and nurse practitioners (advanced practice nurses).
Medicaid Services Manual (MSM)	The Medicaid Services Manual is a compilation of regulations adopted under NRS 422.2368 and 422.2369. It sets guidelines and limitations regarding how the Division operates and what services are covered. Changes to the MSM are approved at public hearings.
Medical Expenditures	Total amount of spending by the Contractor on Covered Services under the Contract net of any recoveries, rebates, third-party obligations, and Provider contract discounts. This includes spending by the Contractor on approved In Lieu of Services under the Contract and any incentives, rate increases, or bonuses provided by the Contractor to Providers for Covered Services and APMs. Medical Expenditures exclude spending by the Contractor on items or services that do not qualify as Covered Services under the Contract, such as Value-Added Services, administrative services, quality- or APM- related administrative activities, any non-covered benefits and services, and any other services and benefits that the Contractor is not at risk for under the Contract.
Must	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the State's imposition of a corrective action plan (also referred to as "Plan of Correction"), sanctions, liquidated damages, termination of the contract, or any remedies permitted under state or federal law.
National Committee for Quality Assurance (NCQA)	National Committee for Quality Assurance is an organization that develops health care measures that assess the quality of care and services that commercial and Medicaid Members receive.
NCPDP	National Council for Prescription Drug Programs
Network	A Network is a directory of doctors, health care professionals, hospitals, and health care facilities that a Contractor has written agreements with to provide medical care to its Members.
Nevada Administrative Code (NAC)	All applicable NAC documentation may be reviewed via the internet at: www.leg.state.nv.us.
Nevada Check Up (NCU)	Children's Health Insurance Program (CHIP) provided under Title XXI of the Social Security Act to children whose families exceed Medicaid limits, but is equal to or less than 200% of the federal poverty level.

Nevada Division of Welfare and Supportive Services (DWSS)	The Nevada Division of Welfare and Supportive Services (DWSS) determine eligibility for Medical Assistance, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF).
Nevada Early Intervention Services (NEIS)	Clinics operating to serve children, from birth to their third (3rd) birthday, providing early intervention services for children with known or suspected developmental delays. These clinics receive Title V funding.
Nevada Revised Statutes (NRS)	All applicable NRS documentation may be reviewed via the internet at: www.leg.state.nv.us.
Non-Emergency Transportation (NET) Broker	A NET Broker contracts with individual transportation companies who provide transportation for eligible Recipients of the State's medical assistance programs. The NET Broker manages, authorizes, and coordinates NET services for these Recipients. The NET Broker also provides various utilization management reports to Nevada Medicaid for quality assurance purposes. The NET Broker may perform the transportation services with limitations.
Open Enrollment Period	The annual opportunity for Members to change Contractors as described in Section 7.3.10.1.1.
Orthodontics	The branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function. Nevada Medicaid authorizes payment for orthodontics for qualified Medicaid Recipients less than 21 years of age and for qualified Nevada Check Up Recipients up to the birth month of their 19th year of age.
Other Health Care Coverage (OHC)	As defined by Nevada Medicaid, OHC means any private health coverage plan or policy, which provides or pays for health care services. Exclusions to OHC include but are not limited to Medicaid managed care, automobile insurance, and life insurance.
Out-of-Network Provider	These are certain types of Providers with whom formal contracts may not be in place with the Contractor. However, the Contractor's benefit package includes Medicaid services for which the Contractor will reimburse for specific services. The Contractor must negotiate a contract, often referred to as a "single case agreement", to determine the rate prior to services being rendered or pay no more than the FFS rate established by the State unless otherwise specified in the Contract.
Outpatient Services	Outpatient services are those Medically Necessary services provided for the diagnosis and/or treatment of an illness or disease for which the patient will not require care in a facility for more than 24 hours. Services are provided in variety of settings that include, but are not limited to the office/clinic, home, institution and outpatient hospital.

Patient Protection and Affordable Care Act (PPACA) or Affordable Care Act (ACA)	The Patient Protection and Affordable Care Act (PPACA) is a United States federal statute signed into law by on March 23, 2010. It represents the most significant regulatory overhaul of the health care system. Under the ACA, hospitals and primary physicians would transform their practices financially, technologically, and clinically to drive better health outcomes, lower costs, and improve their methods of distribution and accessibility. The ACA was enacted to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government.
Patient Liability (PL)	Patient Liability is that portion of a Recipient's income that must be paid toward the cost of care.
Performance Improvement Project (PIP)	Activities conducted by managed care organizations designed to improve the quality of care or services received by Members.
Performance Indicators	Performance indicators are preset criteria, which involve the Member or Provider and show the outcomes and impact level of Contract performance on specified sets of the population.
Personal Care Services (PCS)	Services performed in accordance with a written service plan developed in conjunction with the Member, or the representative, and based on the needs of the Member being served as determined by a functional assessment. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task, and relates to the performance ADLs and IADLs. Personal Care Services may be provided in the home, or locations outside the home, including employment sites, or wherever the need for Personal Care Services occurs. The time authorized for services is documented in the approved service plan, regardless of the location of services.
Personal Representative	A personal representative is: (1) A parent, including a parent who is an emancipated minor; (2) A guardian of the person as defined in NRS Chapter 159, an executor or administrator; (3) A person who has authority to make health care decisions under a power of attorney for health care; or A person who is designated, in writing, as a personal representative for a Medicaid or Nevada Check Up Member (this authority may be granted only by the Member or, in the case of a minor child or adult who is adjudicated incompetent, his/her parent or guardian).
Plan of Correction (POC)	A detailed written plan describing the actions and/or procedures to remedy deviation from the stated standard(s) or contractual

	and/or legal mandates.
Post-Stabilization Services	Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the Member's condition.
Potential Member	A Medicaid or Check Up Recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a Member of a specific Contractor. (Potential Member definition is applicable to the Information Requirements in 42 CFR 438.10, not to the Marketing requirements in 42 CFR 438.104.)
Preauthorization	A decision by your plan or the State that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. Sometimes called prior authorization, prior approval or precertification.
Prescription Drug Coverage	Prescription drug coverage is a policy of health insurance which provides coverage for prescription drugs in accordance with NRS 689A.405 and Sec. 1860D-4 of the Social Security Act.
Prescription Drugs	Prescription drug means (1) a controlled substance or dangerous drug that may be dispensed to an ultimate user only pursuant to a lawful prescription; and (2) any other substance or drug substituted for such a controlled substance or dangerous drug. See NRS 453.3628.
Primary Care Provider (PCP)	Physicians who practice general medicine, family medicine, general internal medicine, general pediatrics, or osteopathic medicine. Physicians who practice obstetrics and gynecology may function as PCPs for the duration of the Member's pregnancy.
Primary Care Site	A location, usually a clinic, where a Member chooses to access primary health care. The Member's medical record is maintained at this location, and a rotating staff of physicians manages and coordinates the Member's medical needs.
Primary Care Services	Services covered under the Medicaid and Check Up State Plans rendered by Physicians who practice general medicine, family medicine, internal medicine, general pediatrics, and osteopathic medicine, obstetrics and gynecology. Primary Care Services also include services covered under the Medicaid and Check Up States Plans rendered by Advanced Practice Registered Nurses, Physician Assistants, Federally Qualified Health Centers, Psychologists, Rural Health Centers, Social Workers as defined by State, Community Health Workers, Doulas, Nurse Midwives, Behavioral Health Outpatient Centers, CCBHCs, and School-Based Health Centers.

Prior Resources	Prior resources are any non-Medicaid coverage, public or private, which can be used to pay for medical services. These resources and benefits are payable before Medicaid benefits are paid.
Private Duty Nursing Services (PDN)	42 CFR 440.80 defines PDN services as nursing services for Members who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or NF, and are provided through an agency: (1) by a Registered Nurse or a Licensed Practical Nurse; under the direction of the Recipient's physician; and at the State's option, to a Recipient in one or more of the following locations: his or her own home, a hospital, or a nursing facility.
Provider	Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services. This includes a person who has applied to participate or who participates with the Contractor as a Provider of goods or services; or a private insurance carrier, health care cooperative or alliance, health maintenance organization, insurer, organization, entity, association, affiliation, or person, who contracts to provide or provides goods or services that are reimbursed by or area required benefit of the Contractor. For the fee-for-service program any individual or entity furnishing Medicaid services under an agreement with the Division is a Provider. For the managed care program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services is a Provider.
Provider Dispute	The term Provider Dispute encompasses both grievances and appeals. An appeal is a request to review an action as an "action" is described herein. A grievance is an expression of dissatisfaction with any aspect of the Medicaid managed care health plan's operations, activities or behavior, regardless of whether the communication requests any remedial actions.
Provider Exclusion	Refers to an action taken by the federal Office of the Inspector General (OIG) of the United States Department of Health and Human Services, which prohibits individual practitioners and/or providers from participating in providing services under and submitting claims for such services for reimbursement from all federally funded health care programs. An exclusionary action by the OIG is immediate grounds for termination of a State Medicaid Provider agreement and Contractor's provider contract and offers no opportunity for hearing with Nevada Medicaid.
Provider Type	Provider type means a category of provider as defined by DHCFP. Provider types and specialties are listed in the Provider Enrollment Information Booklet available on the Nevada Medicaid Provider Portal at https://www.medicaid.nv.gov/providers/enroll.aspx.

Prudent Layperson	A person who possesses an average knowledge of health and medicine, who could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
Public Record	All books and public records of a governmental entity, the contents of which are not otherwise declared by law to be confidential must be open to inspection by any person and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. (Refer to NRS 333.333 and NRS 600A.030 [5]).
Qualified Clinical Staff	Those who are appropriately licensed or certified to perform Medically Necessary services or render clinical expertise, evaluation, and judgment in accordance with State and federal laws.
Qualified Health Maintenance Organization	As defined by 42 USC 300e-9(c)(1) a health maintenance organization which has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by section 300e(b) of title 42 of the USC and that itis organized and operated in the manner prescribed by section 300e(c) of title 42 of the USC, and (2) an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by section 300e(b) of title 42 of the USC and will be organized and operated in the manner prescribed by section 300e(c) of title 42 of the USC.
Quality Assurance (QA)	A formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.
Quality Improvement	A continuous process that identifies problems in organizational systems, including health care delivery systems which tests solutions to those problems and constantly monitors the solutions for improvement.
Quality Improvement Organization (QIO)	Titles XI and XVIII of the Social Security Act (the Act) provide the statutory authority for the broad objectives and operations of the Utilization and Quality Control Quality Improvement Organization (QIO) program. The Peer Review Improvement Act of the Tax Equity and Fiscal Responsibility Act of 1982 established utilization and quality control Quality Improvement Organizations (QIOs). QIOs operate under contract with the Secretary of Health and Human Services to review Medicare services, once so certified by CMS. They may also contract with State Medicaid agencies and private insurers. The utilization

	review/control requirements of 42 CFR 456, are deemed met if a State Medicaid agency contracts with a Medicare certified QIO, designated under Part 475, to perform review/control services (42 CFR 431.630).
Qualified Mental Health Associates (QMHA)	A person who meets the minimum qualifications outlined in MSM Chapter 400, Section 403.3A.
Qualified Mental Health Professional (QMHP)	A Physician, Physician's Assistant or a person who meets the definition of a Qualified Mental Health Associate (QMHA) and meets the documented minimum qualification outlined in MSM Chapter 400, Section 403.3B.
Rate Cell or Cohort	A set of mutually exclusive categories of Members that is defined by one or more characteristics for the purpose of determining the Capitation Rate and making a Capitation Payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each Member should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the Contract.
Recipient	Means a natural person who receives benefits pursuant to the Medicaid or CHIP State Plan.
Records	Means medical, professional or business records relating to the treatment or care of a Member, or to goods or services provided to a Member, or to rates paid for such goods or services, and records required to be kept by the Contractor.
Redacted	The process of removing confidential or Proprietary Information from a document prior to release of information to others.
Referral	The recommendation by a physician, dentist and/or Contractor, and in certain instances, the recommendation by a parent, legal guardian and/or Authorized Representative, for a Member to receive Medically Necessary care from a different Provider.
Regulation	A U.S. Department of Health and Human Services statement of general applicability designed to implement or interpret federal law, policy or procedure; or a statement of Nevada Medicaid of general applicability designed to implement or interpret State or federal law, policy or procedure.
Rehabilitation Services and Devices	Rehabilitation services are an optional Medicaid benefit that must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functional level. Nevada Medicaid provides for physical rehabilitation services and mental health rehabilitation services under separate programs within the Medicaid State Plan.
Reinsurance	Insurance purchased by a Contractor, insurance company, or

	self- funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its Network Providers, policyholders, or employees and covered dependents.
Request for Hearing	A clear, written request from either a Provider or Medicaid or Nevada Check Up Member to the State or the Contractor for a hearing relating to a sanction and/or Adverse Benefit Determination. In the case of a Provider sanction or Adverse Benefit Determination, it is a request made after all Contractor and State remedies have been exhausted by the Provider.
Risk Contract	Means under which the Contractor assumes risk for the costs of the services covered under the Contract and incurs loss if the cost of furnishing the services exceeds the payments under the Contract.
Rural Health Clinic (RHC)	Rural Health Clinic, defined in 42 CFR 491.2, means a clinic that is located in a rural area designated as a shortage area. It is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.
Sanction	A sanction refers to an action taken by either the State or the HHS Office of Inspector General (OIG) against a Provider or Provider applicant. The term also includes sanctions imposed by the State on the Contractor pursuant to 42 CFR part 438, subpart I.
Secretary	The Secretary of the United States Department of Health and Human Services.
Seriously Emotionally Disturbed (SED)	For children, only a qualified Provider can make a determination of SED.
Serious Mental Illness (SMI)	For adults, only a qualified provider can make a determination of SMI.
Service	Means any procedure, intervention, or item reimbursable under Medicaid or CHIP.
Service Area	The geographic area served by the Contractor as approved by State regulatory agencies and/or as detailed in the certificate of authority.
Service Levels	Service levels are various measurable requirements that pertain to the delivery system structure of the Contract and are used for evaluating Contract performance and compliance.
SFY	State Fiscal Year, July 1st through June 30th.
Shall	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a Vendor's

	Proposal as non-responsive or result in imposition of sanctions or other remedies under the Contract on a Contractor.
Skilled Nursing Care	Skilled Nursing care means assessments, judgments, interventions and evaluations of intervention, which require the training and experience of a licensed nurse. Skilled Nursing care includes, but is not limited to: (1) Performing assessments to determine the basis for action or the need for action; (2) Monitoring fluid and electrolyte balance; (3) Suctioning of the airway; (4) Central venous catheter care; Mechanical ventilation; and Tracheotomy care.
Social Security Act (the Act)	The Social Security Act (the Act), Pub. L. 74–271, 49 Stat. 620, enacted August 14, 1935, now codified as 42 U.S.C. Ch. 7, was a social welfare legislative act which created the Social Security system in the United States and governs the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Specialist	A specialist is a doctor who has completed advanced education and training in a specific field of medicine.
State	The State of Nevada and any agency identified herein, generally used in the Contract to refer to the DHCFP.
Statement of Work	A statement of the work or services, which the Contractor is to perform under any contract awarded as, specified in Section 7 of this RFP and any attachments thereto. Also referred to as the "Contract").
State Quality Assessment and Performance Improvement Strategy	A written document that describes methods the State uses to assess and improve the quality of managed care services offered by all Contractors.
Subcontractor	A third party, not directly employed by the Contractor, who will provide delegated services or administrative functions identified in this RFP. This does not include third parties who provide support or incidental services to the Contractor.
Subrogation	Subrogation is the principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.
Supplemental Omnibus Budget Reconciliation Act of 1996 (SOBRA)	Legislation of the Omnibus Budget Reconciliation Act (OBRA) of 1986.
Surveillance and Utilization	The statewide surveillance and utilization program that

Review (SUR) Unit	safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; assesses the quality of those services; provides for the control of the utilization of, including inpatient services provided in accordance with 42 CFR 456 Subpart B.
Targeted Case Management (TCM)	Targeted case management is a service that refers to the identification of a "target" group of Recipients for whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition, or another identifiable characteristic or combination thereof. These services are defined as "services which assist an individual, eligible under the plan, in gaining access to needed medical, social, educational and other service." The intent of these services is to allow States to reach beyond the usual bounds of the Medicaid program to coordinate a broad range of activities and services necessary to the optimal functioning of the Medicaid Recipient. Targeted Case Management has a specific meaning for Nevada Medicaid & Nevada Check Up. TCM, as defined by Chapter 2500 of the Medicaid Services Manual, is carved out of the managed care contract. Care Management activities required of the Contractors determined to be duplicative of Targeted Case Management will not be provided to Members. All other Care Management activities will be required of Contractors.
Temporary Assistance for Needy Families (TANF)	Medicaid eligibility category, which became effective January 1, 1997as a result of the Personal Responsibility and Work Opportunity Act of 1996. TANF eligibility allows for cash payments. In addition, States have the option of including Medicaid eligibility as a program benefit. Nevada has elected to include Medicaid coverage under this eligibility option.
Third Party Liability (TPL)	Third parties including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, MCOs, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. TPL includes COB cost avoidance and recovery.
Trade Secret	Information, including, without limitation, a formula, pattern, compilation, program, device, method, technique, product, system, process, design, prototype, procedure, computer programming instruction or code that: derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by the public or any other person who can obtain commercial or economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

Urgent Care	Urgent care is medical care that is not life threatening, but could result in serious injury or disability if medical attention is not received.
USC	United States Code
Utilization	The extent to which the Members of a covered group use a program or obtain a particular service, or category of procedures, over a given period. It is usually expressed as the number of services used per year or per 100 or one 1,000 persons eligible for the service.
Utilization Control	Utilization Control refers to the federally mandated methods and procedures to safeguard against unnecessary or inappropriate utilization of care and services to Medicare and Medicaid Members. (42 CFR 456.50-456.145).
Utilization Review	A formal assessment of Medical Necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
Vaccines for Children (VFC)	The VFC program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay.
Value Added Service	A benefit offered to all Members in specific population groups covered by the Contractor for which the Contractor receives no direct Capitation Payment from the State.
Will	Indicates a mandatory requirement.

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in October 2022.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

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

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

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

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

- **For your medical care (treatment)**
  - To help doctors, hospitals and others get you the care you need
- **For payment reasons**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for healthcare or services before you get them
  - To support you and help you get available benefits.
- **For healthcare business reasons (operations)**
  - To help with audits, fraud, and abuse prevention programs, planning and everyday work
  - To find ways to make our programs better

We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations and treatment. If you don't want this, please visit **anthem.com/nvmedicaid** for more information.

- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you

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

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

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

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

What are your rights?

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.

- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of healthcare, payment, everyday healthcare business or some other reasons we didn't list here. We will have 60 days to send it to you. If we need more time, we have to let you know.

- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

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

Contacting you

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

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at **844-396-2329**. If you're deaf or hard of hearing, call **TTY 711**.

To see more information

To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy web page at **anthem.com/privacy**.

What if you have a complaint?

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

Write to or call the Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services 90 Seventh St., Suite 4-100
San Francisco, CA 94103 Phone: **800-368-1019**

TDD: **800-537-7697**
Fax: 415-437-8329

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

Race, ethnicity, language, sexual orientation, and gender identity

We may get race, ethnicity, language, sexual orientation, and gender identity information about you. We protect this information as described in this notice.

We may use this information to:

- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:

- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information

We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact our Member Services number at 844-396-2329 (TTY 711), Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Revised October 2022.

Anthem Blue Cross and Blue Shield Healthcare Solutions follows Federal civil rights laws. We don't discriminate against people because of their:

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

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

Communicating with you is important

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

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

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 844-396-2329 (TTY 711).

Your rights

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

Grievance
Member Appeals
P.O. Box 624429
Virginia Beach, VA
23466

Phone: 844-396-2329 (TTY 711)
Fax: 888-235-9334
Email: NV1-qualitymanagement@anthem.com

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

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

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

We can translate this at no cost.
Call the customer service number on your member ID card.

Podemos traducir esto gratuitamente. Llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación (ID Card).	*Spanish*
نستطيع ترجمة هذه المواد مجاناً. اتصل بخدمات الاعضاء، بأستخدام رقم الهاتف المدون على بطاقة الاعضاء لديك.	*Arabic*
Մենք կարող ենք անվճար թարգմանել սա: Զանգահարեք հաճախորդների սպասարկման բաժին ձեր անդամաքարտում (ID card) նշված հեռախոսահամարով:	*Armenian*
ဤအရာကို ကျွန်ုပ်တို့ အခမဲ့ ဘာသာပြန်ပေးနိုင်ပါသည်။ သင့် ID ကတ်ပါ ဝယ်ယူသုံးစွဲသူ ဝန်ဆောင်မှုနံပါတ်ကို ဖုန်းဆက်ပါ။	*Burmese*
我們可以免費為您提供翻譯版本。請撥打您 ID 卡上所列的電話號碼洽詢客戶服務中心。	*Chinese*
ما می توانیم این را به رایگان برایتان ترجمه کنیم. به شماره خدمات مراجعین ما که پشت کارت شناسایی تان (ID) درج شده، تلفن بزنید.	*Farsi*
Nous pouvons traduire ceci gratuitement. Appelez le numéro du service après-vente sur votre carte d'identification.	*French*
Nou ka tradwi sa la pou okenn pri. Pélé nimero sèvis kliyentèl la sou tô kat didantité.	*Fr. Creole*
Wir können das gerne kostenlos übersetzen. Bitte wenden Sie sich an die Kundenservice-Hotline auf Ihrer ID-Karte.	*German*
Μπορούμε να σας μεταφράσουμε το παρακάτω χωρίς χρέωση. Καλέστε τον αριθμό του Τμήματος Εξυπηρέτησης Πελατών που θα βρείτε στην κάρτα ταυτοποίησής σας.	*Greek*
અમે આનું ભાષાંતર કોઈપણ ખર્ચ લીધા વિના કરી શકીએ છીએ. તમારા ID કાર્ડ પર આપેલ ગ્રાહક સેવા નંબર પર ફોન કરો.	*Gujarati*
אנחנו יכולים לתרגם את זה ללא עלות. התקשר למספר של שירות הלקוחות הנמצא על גבי כרטיס הזיהוי שלך.	*Hebrew*
हम इसका अनुवाद निशुल्क कर सकते हैं। अपने ID कार्ड पर दिए गए ग्राहक सेवा नंबर पर फोन करें।	*Hindi*
Peb txhais tau qhov ntawm no dawb. Hu rau lub chaw haujlwm pab cov neeg siv peb cov kev pab tus xovtooj uas nyob ntawm koj daim npav ID rau tus tswv cuab.	*Hmong*

Possiamo effettuare la traduzione gratuitamente. Contatti il numero dell'assistenza clienti riportato sulla Sua tessera identificativa.	*Italian*
私たちは、この文章を無料で翻訳することができます。ご自身のIDカードにあるカスタマーサービス番号へお電話ください。	*Japanese*
យើងអាចបកប្រែជូនដោយឥតគិតថ្លៃអ្វីទេ ។ សូមទូរស័ព្ទទៅផ្នែកសេវាអតិថិជន តាមលេខមាននៅលើប័ណ្ណ ID របស់អ្នក ។	*Khmer*
지희는 이것을 무료로 번역해 드릴 수 있습니다. 가입자 ID 카드에 있는 고객 서비스부 번호로 연락하십시오.	*Korean*
ພວກເຮົາສາມາດແປອັນນີ້ໃຫ້ທ່ານໄດ້ຟຣີ. ໃຫ້ໂທຫາຝ່າຍບໍລິການລູກຄ້າ ທີ່ມີເບີຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.	*Laotian*
Możemy to przetłumaczyć bez żadnych kosztów. Zadzwoń pod numer obsługi klienta za pomocą karty ID.	*Polish*
Podemos traduzir isto gratuitamente. Ligue para o serviço de atendimento ao cliente que consta no seu cartão de identificação.	*Portuguese*
Мы можем это бесплатно перевести. Позвоните в отдел обслуживания по телефону, приведенному на вашей идентификационной карточке участника плана.	*Russian*
Možemo to prevesti besplatno. Pozovite na broj korisničkog servisa s Vaše identifikacione kartice (ID).	*Serbian*
Maaari namin ito isalin-wika nang walang bayad. Mangyaring tawagan ang numero ng customer service sa inyong ID card na pang miyembro.	*Tagalog*
เราสามารถแปลได้โดยไม่มีค่าใช้จ่ายใดๆ ติดต่อหมายเลขโทรศัพท์ของฝ่ายบริการลูกค้าบนบัตรประจำตัวของคุณ	*Thai*
ہم اس کا ترجمہ مُفت کر سکتے ہیں۔ اپنے ID کارڈ پر دیے گئے کسٹمر سروس کے نمبر پر کال کریں۔	*Urdu*
Chúng tôi có thể phiên dịch tài liệu này miễn phí. Xin gọi dịch vụ khách hàng qua số điện thoại ghi trên thẻ ID hội viên của quý vị.	*Vietnamese*
מיר קענען דאס איבערזעצן פריי פון אפצאל. רופט דעם קאסטומער סערוויס נומער אויף אייער אידענטיטעט קארטל.	*Yiddish*

NEVADA MEDICAID AND NEVADA CHECK UP - MANAGED CARE ORGANIZATION (MCO) GOOD CAUSE DISENROLLMENT FORM

Federal regulations allow Medicaid members to change their MCO through a process called, "Disenrollment for Cause". This process is for members who want to change their current MCO and are not within their 90-day window to change. If you request good cause disenrollment, you must continue to receive all medical care from your current MCO until the effective date of disenrollment. Contact the **Division of Health Care Financing and Policy (DHCFP) District Office Southern Nevada: (702) 668-4200 or Northern Nevada: (775) 687-1900 or TTY 7-1-1** to verify your disenrollment before you seek medical services outside of your MCO's network or for any other questions.

Head of Household Information

Name:

Address:

Medicaid ID: Date of Birth:

Phone #:

Reason for Disenrollment Per 42 CFR 438.56(d)(2) (Check all that apply):

1. The recipient moves out of the MCO service area.
   Note: Contact the Division of Welfare and Supportive Services (DWSS) for Southern Nevada: (702) 486-1646 or Northern Nevada: (775) 684-7200 or Toll Free: 1(800) 992-0900 or TTY 7-1-1 or log into the Access NV web portal to update your address at https://accessnevada.dwss.nv.gov/public/landing-page. You may also submit an address change at the following link https://dhcfp.nv.gov/UpdateMyaddress/.
2. The MCO does not, because of moral or religious objections, cover the service the recipient seeks.
3. The recipient needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the recipient's primary care provider or another provider determines that receiving the services separately would subject the recipient to unnecessary risk.
4. Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the recipients care needs.
   (Explain)_____

Please include the name of your Primary Care Physician, Specialist and/or the Hospital you use.

Primary Care Physician _____ Phone# _____
Specialist _____ Phone # _____
Hospital _____ Phone # _____

Current MCO: (please only check one)	**New MCO Choice**: (please only check one)
☐ **Anthem Blue Cross and Blue Shield Healthcare Solutions (844) 396-2329** **Health Plan of Nevada (800) 962-8074** **Molina Healthcare of Nevada (833) 685-2109** **SilverSummit Healthplan (844) 366-2880**	☐ **Anthem Blue Cross and Blue Shield Healthcare Solutions (844) 396-2329** **Health Plan of Nevada (800) 962-8074** **Molina Healthcare of Nevada (833) 685-2109** **SilverSummit Healthplan (844) 366-2880**

Fax completed form to (775) 684-3773 or mail to Attn: DHCFP MCQA Unit, 1100 E William St Suite 101, Carson City NV 89701. You may also drop off the form at your local Medicaid District office.

You may also submit the completed form via email managedcare@dhcfp.nv.gov or by clicking the "**SUBMIT**" button below. After clicking "SUBMIT" check the Default email application (Microsoft Outlook) circle in the Send Email box that displays, then click Continue and it will direct you to an email to send the form.

SUBMIT

Atención: si habla español, dispone de servicios gratuitos de asistencia lingüística, llame al 1(866) 569-1746 (TTY: 7-1-1)

NMO-5008 (08/22)

844-396-2329 (TTY 711) | anthem.com/nvmedicaid

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