Summary Plan Description

July 2015 – June 2016

2 Hale Street, Suite 101
Charleston, WV 25301

I'm sick or hurt...
Where do I go?

(Or, where do I take my child?)

Need medical care and feel safe to wait a day.

EXAMPLES ARE:
- Runny nose
- Simple backache
- Sore throat
- Earache

Need medical care today and feel safe to wait a few hours.

EXAMPLES ARE:
- Tried but could not reach my doctor
- Reached the doctor and told to go to an Urgent Care Center

Need medical care now and do not feel safe to wait.

EXAMPLES ARE:
- Trouble breathing or chest pain
- Fainting
- Sudden numbness or weakness
- Uncontrolled bleeding
- Severe pain or serious injury

WVCHIP BENEFITS AT A GLANCE

SERVICE	COVERED SERVICE	BENEFIT LIMITS
Allergy Services	Yes	
*Applied Behavior Analysis Services	Yes	$30,000 /year for 3 yrs/then $2,000/month until age 19, primary autism/PDD diagnosis
Ambulance Services (air/ground)	Yes	Non-emergency transport not covered
Birth To Three	Yes	
*Chiropractic	Yes	Prior authorization for under 16 required
Dental Services	Yes	
Diabetic Supplies	Yes	
*Diagnostic Services (Lab, X-ray, imaging, etc.)	Yes	
*Durable Medical Equipment (Orthotics/Prosthetics)	Yes	
Emergency Room Services	Yes	
Family Planning Services	Yes	
EPSDT (including Well Child Services)	Yes	
*Hearing Exams/Aids	Yes	
*Home Health Services	Yes	
*Hospice Care	Yes	
Immunizations	Yes	Only in WV and through Vaccines For Children providers
*Inpatient/Outpatient Hospital Services	Yes	
*Inpatient/Outpatient Mental Health & Substance Abuse Services	Yes	General behavioral therapy not covered under CHIP, except ABA
*Occupational/Physical/Speech/Vision Therapies	Yes	More than 20 visits reviewed for medical necessity
*Organ Transplant	Yes	
*Orthodontia Services	Yes	Cosmetic Services not covered
*Out-of-State Coverage	Yes	Out-of-state coverage limited to primary care/emergency services, unless otherwise unavailable in-state
Physician/Nurse Practitioner/RHC/FQHC Services	Yes	
Prescription Drug Services (including *Specialty Drugs)	Yes	
Skilled Nursing Care	Yes	
*Sleep Management Services	Yes	
Urgent Care Visits	Yes	
Vision Services	Yes	

***There is a prior authorization requirement which applies:**

- See WVCHIP Summary Plan Description (SPD) for more details regarding prior authorization requirements, cost-sharing, and benefit limitations. Information on prescription drug coverage is included on pages 32-37.
- **To see WVCHIP/WV Medicaid benefit comparison, go to www.chip.wv.gov**

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What Is WVCHIP?

In 1997 Congress amended the Social Security Act to create Title XXI "State Children's Health Insurance Program." The West Virginia Legislature established the insurance governance and legal framework in legislation that was enacted in April 1998. Children first began enrolling in the West Virginia Children's Health Insurance Program (WVCHIP) in July 1998.

WVCHIP covers children from birth through age 18. It pays for a full range of health care services for children including: doctor visits, check-ups, vision and dental visits, immunizations, prescriptions, hospital stays, mental health and special needs services.

WVCHIP reports to a financial governing board made up of citizen members, legislators, and state agency members who are responsible for the Program's annual financial plan. The West Virginia Children's Health Insurance Board meets at least four times each year and meetings are open to the public. WVCHIP's administrative office is located at 2 Hale Street, Suite 101, Charleston, West Virginia 25301.

WVCHIP has contracts with agencies known as third-party administrators to provide benefits management and payment of claims for all medical, dental and pharmacy services. They are:

Prior Authorizations

HealthSmart
PO Box 2451
Charleston, WV 25329-2451
1-800-356-2392
www.healthsmart.com

Pharmacy

Express Scripts, Inc. ™
PO Box 390873
Bloomington, MN 55439-0873
1-877-256-4689
www.express-scripts.com.

Medical & Dental Claims Processing

Molina Medicaid Solutions
PO Box 2673
Charleston, WV 25032-2673
1-800-479-3310
www.wvmmis.com

Important Terms

The following terms are used throughout this Summary Plan Description (SPD) and are defined below as they pertain to WVCHIP:

Allowed Amounts: The lesser of the actual charge amount or the maximum fee for that service as set by WVCHIP.

Alternate Facility: A facility other than an inpatient or acute care hospital.

Applied Behavior Analysis (ABA): This entails the application of the principles, methods, and procedures of the experimental analysis of behavior (including principles of operant and respondent learning) to assess and improve socially important human behaviors. It includes, but is not limited to, applications of those principles, methods, and procedures to those children who have been properly diagnosed with Autism Spectrum Disorder (ASD) by any one of the following licensed physicians: such as neurologist; pediatric neurologist; developmental pediatrician;, psychiatrist; or a licensed psychologist; (a) the design, implementation, evaluation, and modification of treatment programs to change behavior of individuals; (b) the design, implementation, evaluation and modification of treatment programs to change behavior of groups; and (c) consultation to individuals and organizations. The practice of behavior analysis expressly excludes psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities.

Autism/Autism Spectrum Disorder (ASD): A group of related neuropsychiatric disorders which is characterized by deficits in social interaction, communication, and unusual and repetitive behavior. The term applies to any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

Benefit Year: A 12-month period beginning January 1 and ending December 31. This period is used to calculate any benefit and out-of-pocket limits.

Birth-To-Three (BTT): This statewide system can assess early child development and provide services and support for the families of children three and under who have a delay in their development, or may be at risk of having a delay. See pages 24-25 for more details.

Claims Administrator: Molina processes all medical dental and vision claims.

Coordination of Benefits: WVCHIP members are otherwise not insured, therefore, this would not apply to our members. WVCHIP does not pay claims that indicate payment by any other insurance.

Copayment: A set dollar amount a member pays when using particular services, such as office visits, brand name drugs, and some dental services.

Durable Medical Equipment: Medical equipment that is prescribed by a physician which can withstand repeated use, is not disposable, is used for medical purposes, and is generally not useful to a person who is not sick or injured.

Eligible Expense: A necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by the Plan covering the person for whom the claim is made. Allowable expenses under this Plan are calculated according to WVCHIP fee schedules, rates and payment policies in effect at the time of service.

Emergency: An acute medical condition resulting from injury, sickness, pregnancy, or mental illness that arises suddenly and which a reasonably prudent layperson would believe requires immediate care and treatment to prevent the death, severe disability, or impairment of bodily function.

Exclusions: Services, treatments, supplies, conditions, or circumstances not covered by the Plan.

Experimental, Investigational, or Unproven Procedures: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the plan

(at the time it makes a determination regarding coverage in a particular case) to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Medical Association Drug Evaluations as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of Phase 1, 2, 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Explanation of Benefits (EOB): A form sent to the member's guardian which explains the action taken by WVCHIP on the claim submitted by the provider. This explanation might include the amount paid, benefits available, reasons for denying payment, etc.

Express Scripts, Inc. (ESI): The pharmacy benefits manager that processes and pays claims for prescription drugs, provides drug information and drug utilization management functions for the Plan.

Molina Medicaid Solutions: The third party administrator that handles medical and dental claims processing and customer service for WVCHIP.

Help Me Grow: A free program which helps physicians and parents address childhood development issues from birth to age 5. The program includes the Ages and Stages Questionnaire (ASQ-3), an expertly staffed hotline, and serves as information and referral service to help connect parents and healthcare providers with specialized services and therapies as well as support services.

Inpatient: Someone admitted to the hospital as a bed patient for medical services.

Medical Case Management: A process by which HealthSmart assures appropriate available resources for the care of serious long-term illness or injury. HealthSmart's case management program can assist in providing alternative care plans.

Medical Home: A West Virginia provider who is a general practice doctor, family practice doctor, internist, or pediatrician who has enrolled with Molina as a medical home provider and who is listed in WVCHIP's medical home directory. The medical home directory can be found on the Molina website at www.wvmmis.com.

Medically Necessary Care (or Medical Necessity or Medically Necessary): Medically necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider to treat an injury, illness or medical condition; are consistent with the patient's condition, symptoms, diagnosis or accepted standards of good medical and dental practice; conform to generally accepted medical practice standards**; not solely for the convenience of the patient, family or health care provider**; not for custodial, comfort or maintenance purposes; rendered in the most cost-efficient setting and level appropriate for the condition; and not otherwise excluded from coverage under the Plan. **The fact that a physician recommends or approves certain care does not mean it is a covered benefit; all the aforementioned criteria must be met.** WVCHIP reserves the right to make the final determination of medical necessity based on diagnosis and supporting medical data.

Member: A child enrolled in WVCHIP.

Outpatient: Someone who receives services in a hospital, alternative care facility, freestanding facility, or physician's office, but is not admitted as a bed patient.

Plan: The plan of benefits offered by the West Virginia Children's Health Insurance Program.

Plan Year: A twelve (12) month period beginning July 1 and ending June 30. Please note that the Plan Year is different from the Benefit Year.

Policyholder: The child who is enrolled for health care coverage under the Plan as determined eligible by the Department of Health and Human Resources, Bureau for Children and Families.

Important Terms (Cont.)

Preferred Provider Organization (PPO): A group or network of health care providers that is under agreement to provide services for discounted amounts for Plan participants.

Premium: A monthly payment required for continued enrollment in the Plan for WVCHIP Premium Plan members.

Primary Care Provider: A general practice doctor, family practice doctor, internist, pediatrician, obstetrician/gynecologist, nurse practitioner or physician assistant working in collaboration with such a physician, who, generally, provides basic diagnosis and non-surgical treatment of common illnesses and medical conditions.

Prior Authorization: WVCHIP requires **ALL** services outside the state of West Virginia, **except office visits to primary care doctors in counties bordering West Virginia in surrounding states**, **and emergency services, and out-of-state providers who have accepted in-state rates,** to be prior authorized (PA).

Provider: A hospital, physician, or other health care professional who provides care. A health care professional must be licensed and qualified under the laws of the jurisdiction in which the care is received and must provide treatment within the scope of his or her professional license. If the service is provided by a medical facility such as a hospital or treatment center, the facility must be approved by Medicare or the Joint Commission on Accreditation of Health Organizations (JCAHO).

Provider Discount: A previously determined percentage that is deducted from a provider's charge or payment amount that is not billable to the member when WVCHIP is the payer and the service is provided in West Virginia or by an out-of-state prior-authorized and approved provider or facility.

Rational Drug Therapy Program (RDTP): The Rational Drug Therapy Program of the WVU School of Pharmacy provides clinical review of requests for drugs that require prior authorization under the Plan.

Reasonable and Customary: The prevailing range of fees charged by providers of similar training and experience, located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully.

Regular WVCHIP: The WVCHIP Gold and WVCHIP Blue plans are referred to as "regular" WVCHIP.

Specialty Drugs: These are high-cost injectable, infused, oral, or inhaled prescription medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions and are prior-authorized by HealthSmart.

Subrogation: The right of WVCHIP to succeed to a member's right of recovery against a third party for benefits paid by WVCHIP, or on behalf of, a member for services incurred for which a third party is, or may be, legally liable. Basically, this is a repayment to WVCHIP for medical costs WVCHIP paid for due to an illness or injury wrongfully caused by someone else (as in an auto accident, for example). This usually occurs after repayment by another insurer or court settlement. Health Management Systems (HMS) is the vendor that provides subrogation services to WVCHIP.

Third Party Administrator (TPA): Company or service agent with whom WVCHIP has contracted to provide customer service, utilization management and claims processing services to children insured under the Plan.

Timely Filing: Claims must be filed within six months for both dental and medical services. Claims not submitted within this period will not be paid, and WVCHIP will not be responsible for payment. *It is the obligation of the parent or guardian of the member to present the WVCHIP member card to the provider, i.e. physician's office hospital, etc., at the time of service or within 30 days from the date of service. If the member card with correct billing identification is not provided in a timely manner which causes delays of the provider's submission of the claim to WVCHIP within the timely filing limits, the provider may hold the guardian or member responsible for payment of the claim. Parent or guardian may also be held responsible for any service provided that is not a covered benefit under the WVCHIP program.*

Utilization Management: A process by which WVCHIP controls health care costs. Components of utilization management include pre-admission and concurrent review of all inpatient hospital stays, known as prior authorization; **prior** review of certain outpatient surgeries and services; and medical case management. Utilization management is handled by HealthSmart.

WVCHIP (West Virginia Children's Health Insurance Program): The health care program provided to eligible children through an expansion of the Social Security Act, Title XXI. Each state has designed its own program by defining the benefit

Important Terms (Cont.)

plans and eligibility levels. In West Virginia, eligible children from birth through age 18 receive benefits through a state-designed program.

WVCHIP Gold: WVCHIP enrollment group for children in families with incomes at/or below 150% of the Federal Poverty Level (FPL).

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

WVCHIP Premium: The enrollment group for children in families with incomes over 211% of the FPL that requires monthly premium payments to continue enrollment.

WVCHIP EXEMPT: The enrollment group for children who are Native American/Alaskan natives that are members of a federally recognized tribe, who are exempt from copayments and other cost-sharing.

Copayments

Under the WVCHIP Plan, you do not pay deductibles or coinsurance, but there are copayments for some services and premium payments for WVCHIP Premium members. The monthly premium payment for families with one child is $35 and for two or more children is $71.

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

Note: **Copayments are waived for all office visits to a child's medical home**. In order to save money on copayments for office visits, please choose and use a medical home provider for your child.

Medical Services and Prescription Benefits	WVCHIP Gold	WVCHIP Blue	WVCHIP PREMIUM
Generic Prescriptions	No Copay	No Copay	No Copay
Listed Brand Prescriptions	$5	$10	$15
Non-listed Brand Prescriptions	Full Retail Cost	Full Retail Cost	Full Retail Cost
Multisource Prescriptions	No Copay	$10	$15
Medical Home Physician Visit	No Copay	No Copay	No Copay
Physician Visit (Non-medical home)	$5	$15	$20
Preventive Services	No Copay	No Copay	No Copay
Immunizations	No Copay	No Copay	No Copay
Inpatient Hospital Admissions	No Copay	$25	$25
Outpatient Surgical Services	No Copay	$25	$25
Emergency Department (is waived if admitted)	No Copay	$35	$35
Vision Services	No Copay	No Copay	No Copay
Dental Benefit	No Copay	No Copay	$25 Copay for some non-preventive services

Copayment Limits

Copayment Maximums: The maximum copayment amounts required during a benefit year are as follows:

# of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP PREMIUM
1 Child Medical Maximum	$150	$150	$200
1 Child Prescription Maximum	$100	$100	$150
2 Children Medical Maximum	$300	$300	$400
2 Children Prescription Maximum	$200	$200	$250
3 or more Children Medical Maximum	$450	$450	$600
3 or more Children Prescription Maximum	$300	$300	$350
Dental Services	Does not apply	Does not apply	$150 per family

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

Starting & Ending Coverage

To Enroll or Renew Enrollment Each Year: Applications to enroll or renew coverage can be downloaded from our website at www.chip.wv.gov; or you can apply electronically at www.wvinroads.org. You can also go to a local community partner agency to apply in person. A list of community partner agencies can be found at www.chip.wv.gov or by calling the WVCHIP Helpline at 1-877-982-2447.

Who Is Eligible for WVCHIP?

- Children under age 19 who live in the State of West Virginia; and
- Are United States citizens and immigrant children who entered the U.S. as lawful permanent residents having continuous U.S. residency for five years; and
- Live-in families that meet the income guidelines (See income guidelines at www.chip.wv.gov or call the WVCHIP Helpline at 1-877-982-2447); and
- Are not eligible for West Virginia Medicaid; and
- Are not eligible for other group insurance (See "good cause" exceptions below); and
- Do not have "creditable" health insurance now unless they meet "good cause" exceptions for terminating "creditable" health insurance.
- Public Employees Insurance Agency (PEIA) – Eligible public employees' children who meet the CHIP eligibility requirements during PEIA open enrollment
- **Newborn Eligible's** - For CHIP deemed newborns (a child born to a mother that is currently enrolled in CHIP), the family must report the birth. The child and mother are evaluated first for Medicaid. If the newborn does not qualify for Medicaid, the newborn will be in CHIP. The effective date of coverage for the newborn will be the child's birth date. WVCHIP does not cover labor and delivery charges.

What are "good cause" exceptions for terminating current non-excepted "creditable" health insurance coverage: An applicant with "creditable" insurance may be eligible for WVCHIP, if he/she meets one of the following good cause exceptions and the other insurance is terminated:

- Annual premium cost of family coverage is equal to or greater than 10% of family gross income; or
- Other insurance is geographically non-accessible; or
    - Children whose insurance coverage is through a non-custodial parent may be eligible when services under that plan can only be assessed in another state or geographic area, such that it is considered non-accessible. Non-accessibility measures are as follows:

- Routinely used delivery sites (including primary care physicians' offices and frequently used specialists) are 60 minutes travel time from the child's residence to site;
- Basic hospital services are 90 minutes of travel time from the child's residence to the site;
- Other medical services (including specialists not routinely used) are 90 minutes of travel time from the child's residence to the site.

- Employer terminates health insurance coverage; or
- Job is involuntarily terminated and family loses benefits; or
- Loss of coverage for child due to change in employment; or
- Loss of coverage outside control of an employee; or
- Death of the policy holder.

Types of insurance that are "excepted": Insurance that is "excepted" is not considered "creditable" and does not affect eligibility for WVCHIP. Creditable coverage does not include:

- Coverage only for accidents (including accidental death or dismemberment) or disability income insurance
- Liability insurance
- Supplements to liability insurance
- Worker's compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance (for example, mortgage insurance)
- Coverage for on-site medical clinics
- Limited excepted benefits (excepted if they are provided under separate policy, certificate, or contract of insurance)
  - Limited scope dental (See note below)
  - Limited scope vision (See note below)
  - Long-term care benefits
- Non-coordinated benefits (excepted if they are provided under separate policy, certificate, or contract of insurance and there is no coordination of benefits, such as benefits paid without regard to whether benefits are provided under another health plan)
  - Policy that covers only a specified disease or illness, i.e. cancer-only policy
  - Hospital indemnity or other fixed dollar indemnity insurance policy
- Supplemental benefits (excepted if they are provided under a separate policy, certificate or contract of insurance)
  - Medicare supplemental benefits
  - Coverage supplemental to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other health benefit plans for the uniformed services of the United States
  - Similar supplemental coverage provided to coverage under a group health plan

Note: Because federal regulations require prevention of duplicative payments, WVCHIP pays nothing for medical, dental or pharmacy claims where payment from other insurance is indicated, including payments from excepted insurance listed above.

When Can Families of Public Agencies Be Eligible For WVCHIP: A child may be eligible in the following situations:

- If the public agency that employs a parent is a non-profit agency that exists for charitable purposes as shown by a 501(c)3 exemption from the IRS and as such is not taxed under law. (For example, senior service centers and mental health centers.)
- When a public agency has offered employee-only coverage (or no coverage to child dependents) since November 8, 1999.
- When the public agency makes no more than a nominal contribution to the cost of the health benefits plan available from the public agency or would have been available on November 8, 1999.
- When the employed parent of the agency is classified such that they are not eligible for the insurance offered. (For example, part-time or contractual employees.)
- **NOTE:** Applicants must obtain a signed statement certifying any of the above from the agency's director or other authorized officers. Coverage should not be dropped until notification from either a local DHHR office or WVCHIP administrative offices has stated child has met all other eligibility requirements. The list of non-state agencies (PEIA buy-in) is on the web site under the Materials tab at www.chip.wv.gov.

Starting & Ending Coverage (Cont.)

- Children of public employees may be determined eligible and enrolled in WVCHIP during PEIA's open enrollment period. Coverage starts once the child is disenrolled from the PEIA. This rule is for all PEIA children and not just the exceptions listed above.

When Does Coverage Start for WVCHIP Gold, WVCHIP Blue or WVCHIP Premium: The child's application for WVCHIP coverage must be approved by your local county DHHR. The child's health care coverage will be effective on the first day of the month in which you applied. For example, if the child applies for WVCHIP on January 15, upon approval of eligibility, he or she will receive health care coverage beginning on January 1. Families eligible for WVCHIP Premium will receive an initial letter and will be invoiced monthly thereafter.

Participation in WVCHIP PREMIUM requires monthly premium payments. Premiums are due by the 1st of the month to continue coverage for that month. To pay online: Go to www.chip.wv.gov and select, "Make a Payment Online" and follow the instructions or families can mail a check or money order with the account number/PIN number to WVCHIP, Post Office Box 40237, Charleston, WV 25364.

Continuing Your Coverage (Re-enrollment): WVCHIP members are required to re-determine eligibility every 12 months. After ten months of coverage with the Plan, the child's parent or guardian will receive a letter from their local DHHR office to redetermine eligibility. Promptly returning the application will help assure that your child will not have a gap in coverage.

When Coverage Ends: The child becomes ineligible to receive benefits through the Plan for the following reasons:

1) The 12 month period of enrollment ends and the child's parent/guardian does not reapply for benefits; or
2) The child reaches the maximum age of 19; the child's coverage will end on the last day of the month of the child's 19th birthday. For example, if a child covered by the Plan turns 19 on March 2nd, the child will be eligible to receive benefits through March 31st (**Note:** If the child is receiving inpatient hospital services on the date he/she would lose eligibility due to the attainment of maximum age, coverage continues until the end of the inpatient stay.); or
3) The child moves out-of-state; or
4) The child dies; or
5) The child is covered by Medicaid when the parent/guardian chooses Medicaid over WVCHIP; or
6) The child obtains individual or group health insurance coverage; or
7) The child was approved in error and is not currently eligible; or
8) The child was approved in error and is not currently eligible; or
9) The parent/guardian of a child enrolled in WVCHIP PREMIUM fails to pay the monthly premium by the due date.

Amending the Benefit Plan

WVCHIP reserves the right to amend all or any portion of this Summary Plan Description in order to reflect changes required by court decisions, legislative actions, by the WVCHIP Board, or for any other matters as are deemed to be appropriate. The SPD will be amended within a reasonable time of any such actions.

Your Member Card

A member card is issued within 15 days of the child's enrollment in WVCHIP or after any change in coverage. This card is used for medical, dental and prescription drug coverage and is effective the full 12 months that a child is enrolled and covered by the WVCHIP unless coverage ends. Duplicate cards are issued when a member card is reported lost, stolen or damaged. A new card will **NOT** be issued to a child upon re-enrollment if the child remains in the same coverage group.

All children insured under the Plan participate in some level of cost share (copayments and premiums), except for those children registered under the federal exception for Native Americans or Alaskan Natives. Members must present the WVCHIP card at the time medical, dental or prescription drug services are provided. Cost share participation is at three levels referred to as enrollment groups: The enrollment group is marked on the member card. Each card shows the insured child's name and identification number, and relationship code.

WVCHIP GOLD: Copayments for non-medical home office visits and brand drugs.

WVCHIP BLUE: Copayments for non-medical home office visits, hospital inpatient and outpatient services, emergency room visits, and brand drugs.

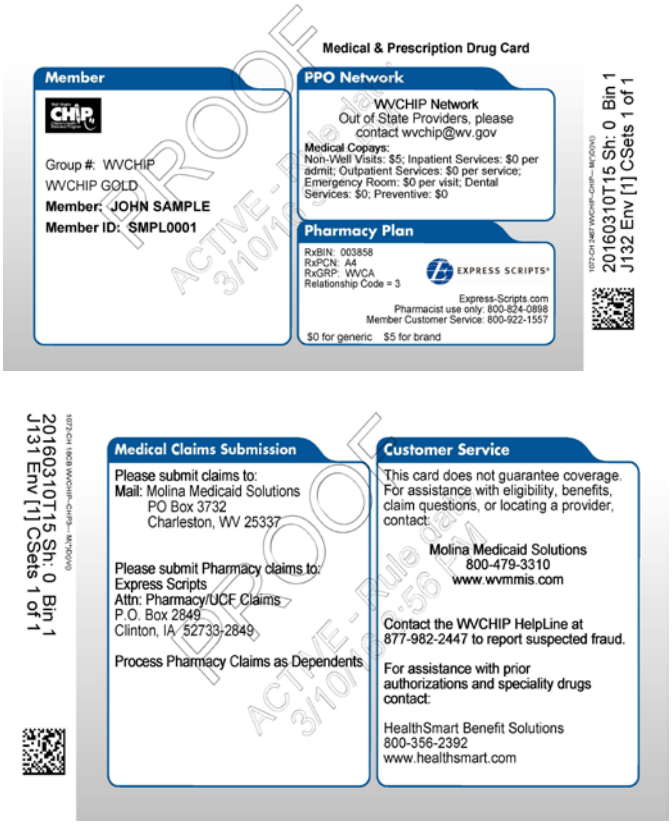
WVCHIP PREMIUM: Copayments for non-medical home office visits, some dental services, hospital inpatient and outpatient services, emergency room visits, and brand drugs. In addition, monthly premium payments are required for continued participation.

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

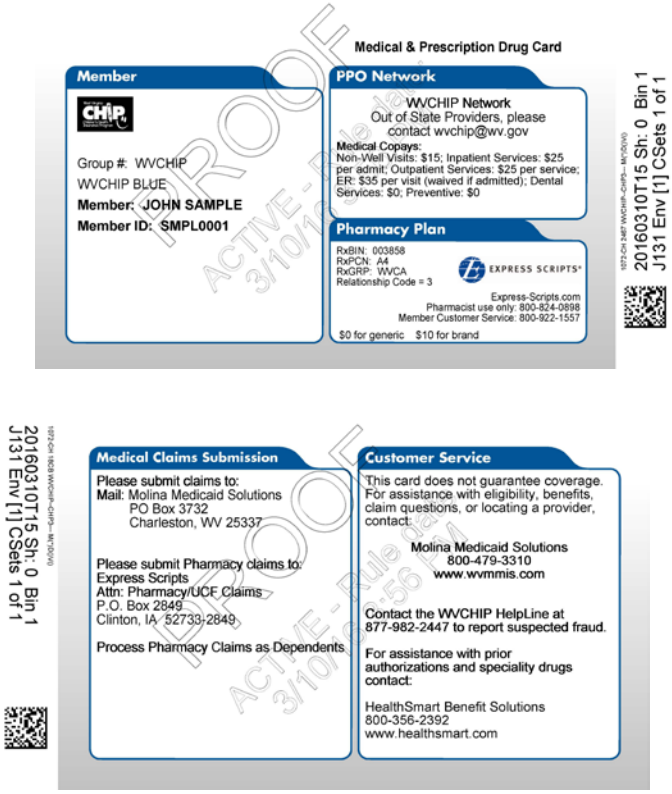
Please contact Molina at 1-800-479-3310, if you do not receive your Card within 15 days of enrollment.

Note: See page 14 for sample of cards.

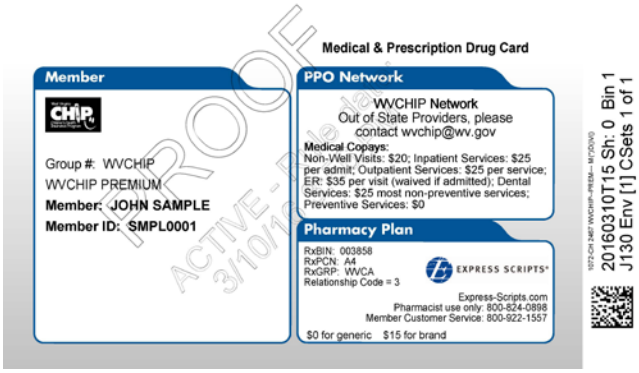
Sample Member Cards

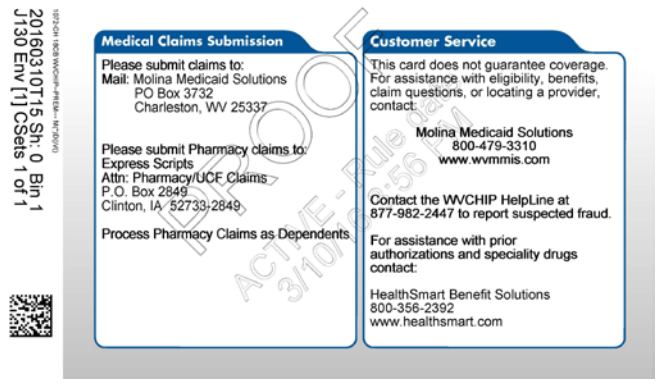


WVCHIP GOLD PLAN



WVCHIP BLUE PLAN





WVCHIP PREMIUM PLAN

Provider Network

West Virginia Providers: All West Virginia providers that are enrolled with Molina Medicaid Solutions are included in WVCHIP's network of providers. Enrolled providers agree to accept WVCHIP's fee schedules and payment as payment in full. They cannot bill you for the difference between WVCHIP's payment and the full charges on the claim. To find a participating WVCHIP provider, call the provider of your choice and ask if they take WVCHIP or check the provider directory on Molina's website at www.wvmmis.com.

Out-of-State/In-Network Providers: WVCHIP will cover services from Out-of-State providers that accept the WVCHIP in-state network fees. Participating providers are located on the provider directory on Molina's website at www.wvmmis.com or you can verify by calling Molina at 1-800-479-3310.

Please note: **routine childhood vaccines from out-of-state providers, including border providers, are not covered – routine childhood vaccines are covered when received from in-state Vaccine for Children's Program (VFC) providers – refer to page 20 for more details.**

Out-of-State/Non-Network Providers: Non-network providers are not covered by the WVCHIP program. There are exceptions for Out-of-State providers that do not accept the WVCHIP in-state network. To meet the criteria as a covered benefit, the service must be medically necessary, and the type of care must not be available within the State of West Virginia, as determined **PRIOR** to the service. If you seek care outside West Virginia, please call HealthSmart at 1-800-356-2392 to have the services prior authorized for payment. Failure to have the service prior authorized may make the child's guardian responsible for payment of the claim. The provider will be required to enroll with Molina Medicaid Solutions and request approval from WVCHIP before reimbursement will be made.

> **NOTE: For members that have received covered services from an out-of-state facility and require Durable Medical Equipment (DME)/medical supplies, Orthotics & Prosthetics devices and appliances, and other related services or items that are medically necessary at discharge, a written prescription by the respective out-of-state attending physician must be presented to a West Virginia provider for provision of services requested. This is required to assure the warranty is valid and to ensure that repairs and maintenance are provided in the most efficient and cost-effective means for WVCHIP members. Other DME policies apply.**

Prior Authorization (Mandatory)

WVCHIP requires **ALL** services outside the state of West Virginia, **except office visits to primary care doctors in counties bordering West Virginia in surrounding states**, **and emergency services,** to be prior authorized (PA). This requirement applies to all non-network providers. **Prior authorization for Out-of-State (Mandatory) is 15 days in advance for planned services, within 48 hours for emergency.**

Contact HealthSmart at 1-800-356-2392 for prior authorization

IMPORTANT! -- Failure to obtain prior authorization for out-of-state services may result in the member or member's family being responsible for the entire cost of the claim.

Prior Authorization (Mandatory) (Cont.)

Specialized services	Outpatient Services	Outpatient Services
All air ambulance transportation	Abortion (see details on web site SPD)	Any potentially experimental – investigational procedure
All inpatient hospital admissions	All out-of-state non CHIP-network hospitals/facilities	Artificial Intervertebral Disc Surgery
Applied Behavioral Analysis Therapy	Chelation Therapy	Colonoscopy – Routine Only
Chiropractic Services for children under age 16	Cosmetic/Reconstructive surgery as a result of accident or birth defects	CTA (Ct angiography)
Continuous Glucose Monitors	CT scan of sinuses or brain	Dental Ridge reconstruction
Dialysis Services	Discectomy with spinal fusion surgery	Dual Energy X-ray Absorptiometry (DEXA Scans)
Durable Medical Equipment over $1000 or three months rental	Endoscopic procedures for treatment of Gastro-esohageal Reflux Disease (GERDS)	Heart Perfusion Imaging
Hearing Aids and Cochlear Implants	Hysterectomy	Hyperbaric Oxygen therapy (HBOT)
Home Health Care Services	Insertion of implantable devices (see examples on web site SPD)	IMRT (Intensity Modulated Radiation Therapy
Hospice Care	Laminectomy with or without spinal fusion	MRA and PET scan
Orthotics/Prosthetics over $1000	MRI scan of knee, spine, cervical, thoracic, lumbar and breast	Medical Case Management Services
Oral Surgeries including Frenectomy and Orthognathic surgeries	Septoplasty or Submucous Resection	Single-photon emission computed tomographic (SPECT) of brain and lung
Sleep Apnea Services	Spinal fusion	Stereotactic Body Radiation
Transplants	Surgeries – (Cataract Surgery; Total Joint Replacement; Knee arthroscopy)	Transplants
	TTE (Transthoracic Echocardiogram)	Uvulopalatropharyngoplasty

Note: Prior authorization DOES NOT assure eligibility or payment of benefits under this Plan.

Visits above the limits listed below require prior authorization.

Type of Service	Number of Visits
Occupational Therapy Services	20
Physical Therapy Services	20
Speech Therapy Services	20
Vision Therapy Services	20
Primary Care Visits	26
Specialty Care Visits	26
Mental Health Visits	26

Medical Case Management

When Medical Case Management is Offered:

If the member is experiencing a serious or long-term illness or injury, such as asthma, cerebral palsy, a developmental disability, sickle cell anemia, juvenile diabetes, spina bifida, leukemia, cancer, cardiac issues, a seizure disorder, psychiatric or emotional disorder, HealthSmart's medical case management program can help you learn about and access the most appropriate resources, treatment and family support. Through medical case management, HealthSmart can:

1. arrange in-home care to avoid admission to a hospital; and
2. arrange in-home services to assist in early hospital release; and
3. obtain discounts for special medical equipment; and
4. locate appropriate services to meet the child's health care needs; and
5. for catastrophic cases, when medically proven as a part of a comprehensive plan of care, allow additional visits for outpatient mental health or outpatient therapy services; and
6. under very limited circumstances allow additional visits for short-term outpatient physical therapy services for treatment of a separate condition which is also a new incident or illness – not an exacerbation of a chronic illness. For example, a member who receives physical therapy following a broken leg and later in the Plan Year has a separate new condition, such as a broken ankle, may receive coverage for additional physical therapy visits.

Should you believe your child has special needs and could benefit from this service, please call HealthSmart at 1-800-356-2392.

For catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, the HealthSmart case manager may, based on medical documentation, recommend additional treatment for certain therapy services. For details of these benefits, see "What is Covered Under the Plan" later in this section beginning page 18.

When Medical Case Management is Required:

HealthSmart must provide medical case management for the following services:

- treatment of Autism Spectrum Disorder (ABA services related to Autism)
- home health care, including but not limited to:
  - skilled nursing of more than twelve (12) visits;
  - I.V. therapy in the home;
  - physical therapy, occupational therapy or speech therapy done in the home;
  - inpatient hospice care; and
  - medication provided or administered by a home health agency
  - mental health services subsequent to inpatient mental health stay
- skilled nursing facility services; and
- rehabilitation services.

Sleep Studies, Services and Equipment

WVCHIP covers services for the treatment of sleep apnea and other related conditions that can affect your child's health.
All sleep-testing services require prior authorization to ensure that the services are medically necessary and appropriate. If your child's physician says your child needs a sleep test, ask him/her to call HealthSmart for prior authorization at 1-800-356-2392.

What is Covered Under the Plan?

Medically Necessary Services

To be covered, services must be medically necessary and listed as covered.

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

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

- licensed or certified under the law of the jurisdiction in which the care is rendered; and
- enrolled in WVCHIP; and
- providing treatment within the scope or limitation of the license or certification; and
- not sanctioned by Medicare, Medicaid or both. Services of providers under sanction will be denied for the duration of the sanction; and
- not excluded by WVCHIP or PEIA due to adverse audit findings; and
- not excluded by other State's Medicaid or CHIP Programs.

Covered Services: a full range of health care services. Some major categories are listed below. These services are covered in full unless otherwise noted. Copayments are listed on page 10. If you have questions about covered services, call Molina at 1-800-479-3310. ***All services marked with a star (*) must be prior authorized***

* **Abortion:** covered only in cases of rape, incest, or endangerment to a mother's life.

Allergy Services: includes testing and related treatment.

* **Applied Behavior Analysis (ABA):** for members with a primary diagnosis of ASD and prior authorized by HealthSmart, and case managed by HealthSmart. Additional benefits include screening and developmental testing, speech language therapy, and occupational therapy. Please see ABA coverage policy posted on WVCHIP's website at www.chip.wv.gov .

* **Ambulance Services:** emergency ground or air ambulance transport to the nearest facility able to provide needed treatment when medically necessary. Non-emergency transportation is not covered. All air ambulances require prior-authorization. **Note: Ambulance transport for transfer from facility to facility is subject to retroactive review for medical necessity.**

* **Autism/Autism Spectrum Disorder (ASD) Services:** provided to members with a primary diagnosis of Autism or Autism Spectrum Disorder (ASD). Please refer to ASD service guidelines posted at www.chip.wv.gov for more information regarding coverage guidelines.

Cardiac or Pulmonary Rehabilitation: limited to 3 sessions per week for 12 weeks or 36 sessions per year for the following conditions: heart attack occurring in the 12 months preceding treatment, heart failure, coronary bypass surgery, or stabilized angina pectoris.

* **Chelation Therapy: for reduction of lead and other metals;** services are limited.

* **Chiropractic Services:** for acute treatment of a neuromuscular-skeletal condition, including office visits and x-rays. ***Coverage is limited to 20 visits per child per benefit year***. Maintenance chiropractic services are not covered. ***Note:*** **The provider must submit a treatment plan to HealthSmart for services requested for any member under 16 years old before prior authorization will be given for any visits. Initial office visit for evaluation and treatment plan will be covered prior to the request for prior authorization.**

* **Cosmetic/Reconstructive Surgery:** when required as the result of accidental injury or disease, or when performed to correct birth defects.

* **Durable Medical Equipment and Related Supplies:** for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at WVCHIP's discretion) of standard

durable medical equipment, when prescribed by a physician. Prosthetics and durable medical equipment purchases of $1,000 or more, or rental for more than three (3) months must be prior authorized by HealthSmart. Omni pod and other disposable insulin delivery systems are not covered.

Emergency Outpatient Services and Supplies: includes acute medical or accidental care provided in an outpatient facility, urgent care facility, or a provider's office.

Family Planning Services: include but are not limited to:

- Patient visits for the purpose of family planning
- Family planning counseling services provided during a regular patient visit
- Contraceptive drugs or devices, including:
  - IUD and IUCD insertions, or any other invasive contraceptive procedures/devices – e.g. Mirena Skyla; covered as appropriate per FDA guidelines for age or other restrictions
  - Implantable medications – e.g. Implanon
  - Hormonal contraceptive methods; oral, transdermal, intravaginal, injectable hormonal contraceptives
  - Barrier contraceptive methods – e.g. diaphragms/cervical caps; covered as appropriate per FDA guidelines for age or other restrictions
  - Emergency contraceptive method RX and Over the Counter (OTC) – e.g. Plan B and Ella
  - OTC contraceptive medications – e.g. anything with a spermicide
- Laboratory procedures, radiology and drugs associated with family planning procedures

Note: OTC and Emergency Contraceptives require a prescription in order to be covered.

Foot Care: includes medically necessary foot care performed by a health care provider practicing within the scope of his/her license, including such services as:

- Treatment of bunions, neuromas, hammertoe, hallux valgus, calcaneal spurs or exostosis;
- Removal of nail matrix or root;
- Treatment of mycotic infections; and,
- Diabetic foot care (may include routine foot care)

* **Hearing Services:** includes annual examinations and medically necessary external hearing aids with prior authorization.

HealthCheck: HealthCheck is the name of West Virginia's Early and Periodic Screening, Diagnosis and Treatment Program (E.P.S.D.T.). This program provides periodic, comprehensive health examinations; developmental delay, vision, dental and hearing assessments; immunizations; and treatment for follow-up of conditions found through the health examination as covered by WVCHIP. HealthCheck requires standard health screening forms to be completed by providers at well-child exams. WVCHIP recommends that all providers use the HealthCheck form or an equivalent form at well-child exam visits. See our website, www.chip.wv.gov under the Healthy Kids site for more information.

Hemophilia Disease Management: WVCHIP along with PEIA have partnered with Charleston Area Medical Center (CAMC) to provide a Hemophilia Care Program. Members who participate in the program will be eligible for the following:

1. An annual evaluation by specialists in the Hemophilia Treatment Center at CAMC with no copay or coinsurance.
2. Reimbursement for a) travel and lodging will be paid for the child and one to two parents, b) adult and an accompanying adult, c) lodging will be at the CAMC travel lodge for a maximum of 2 nights, d); gas will be reimbursed at the federal rates; reimbursement for food up to $30 per day per person for the child and parents or for the two adults (receipts for food are required for reimbursement).
3. Lodging will be covered at 100% of the charge at CAMC's travel lodge in Kanawha City. Other hotel/motel expenses will be covered, not to exceed the cost at CAMC's travel lodge. The current rate is $57.12 per night.
4. Gas receipts are required for reimbursement.

Members who are already in treatment at another facility may continue at that facility, or if new to treatment, they may choose to use another facility at the above stated reimbursements for food, lodging, and gas. **All claims must be submitted within the six-month filing period, including the submission of all lodging and**

travel expenses. (For more information about this program please contact: CAMC Hemophilia Treatment Center at 304-388-8896 or HealthSmart Care Management Solutions at 888-440-7342.)

* **Home Health Services:** Intermittent health services of a home health agency when prescribed by a physician. Services must be provided in the home, by or under the supervision of a registered nurse, for care and treatment that would otherwise require confinement in a hospital or skilled nursing facility. **This benefit requires prior authorization when more than twelve visits are prescribed.**

* **Hospice Care:** when ordered by a physician.

Hyperlipidemia (High Cholesterol) Screening: WVCHIP, along with HealthCheck, has adopted the American Heart Association's (AHA) guidelines regarding blood cholesterol screening for all children and adolescents. Beginning at age 2, WVCHIP recommends, but does not require, that all children and adolescents have a hyperlipidemia risk screening to determine their risk of developing high cholesterol. When one or more risk factors indicate the child is high risk, then an initial measurement of total cholesterol can be obtained. Additional testing and follow-up should be based on total cholesterol levels, following the American Academy of Pediatrics' recommendations for cholesterol management.

Immunizations: All age-appropriate vaccines through age 18 are covered as recommended by the Centers for Disease Control (CDC) Advisory Committee on Immunizations. WVCHIP covers immunizations as part of an associated office visit to a doctor enrolled in the Vaccine for Children's program. See Well Child Care on page 22, or the Immunization Schedules located on our web site at www.chip.wv.gov for more details.

WVCHIP purchases vaccines from the State's Vaccines for Children (VFC) program. This program allows physicians to provide free vaccines to children. Members should receive vaccinations from providers that participate in this program. **Since providers outside of West Virginia cannot participate in the State VFC program, vaccinations from out-of-state providers will not be covered.** If your doctor does not participate in VFC, then vaccinations can be obtained at your local health department.

* **Inpatient Hospital and Related Services:** Confinement in a hospital including semiprivate room, special care units, confinement for detoxification, and related services and supplies during confinement.

* **Inpatient Rehabilitation Services:** when ordered by a physician.

Iron-Deficiency Anemia Screening: WVCHIP, along with HealthCheck, requires that all infants are tested (hemoglobin and/or hematocrit) for iron-deficiency anemia at 12 months of age. Providers are encouraged to screen all infants and children at each well-child exam visit to determine those who are at risk for anemia. Those at high risk or those with known risk factors should be tested at more frequent intervals as recommended by the CDC.

Laboratory Services: includes iron deficiency anemia, lead testing, complete blood count, chemistry panel, glucose, urinalysis, total cholesterol, tuberculosis, etc. Certain laboratory tests are required or recommended by the American Academy of Pediatrics at well-child exams.

Lead Risk Screen: A lead risk **screen** must be completed on all children between the ages of 6 months and 6 years at each initial and periodic visit. A child is considered HIGH risk if there are one or more checked responses on the Lead Risk Screen and LOW risk if no responses are checked. Serum blood testing is required at 12 and 24 months and up to 72 months if the child has never been screened.

Medical Home: the WVCHIP Plan encourages its members to select a medical home from a list of enrolled providers. Enrolled providers must be primary care practitioners in the areas of pediatrics, general or family medicine, or internal medicine. By selecting a Medical Home WVCHIP members will reduce their costs by eliminating copays for sick visits (***there are no copays for preventive visits)***. See pages 30-32 for more information about medical home and selecting a Medical Home Provider.

* **Mental Health Services:** ***Inpatient hospitalization for mental health,*** **chemical dependency and substance abuse services.** Chronic or extreme medical conditions will be assigned to a nurse case manager,

and based on the medical condition the nurse case manager may recommend additional treatment. Prior authorization is required.

Mental Health Services: ***Outpatient mental health, outpatient partial hospitalization day programs, chemical dependency, and substance abuse services***. These may include evaluation, referral, diagnostic, therapeutic and crisis intervention services performed on an outpatient basis (including a physician's office). Coverage for service beyond 26 visits is not provided without medical necessity review and prior authorization. Chronic or extreme medical conditions will be assigned to a nurse case manager, and based on the condition; the nurse case manager may recommend continued visits.

* **MRA and PET SCAN:** Magnetic Resonance Angiography (MRA) and Photo Emission Topography (PET) services covered only on an outpatient basis.

* **MRI:** Magnetic Resonance Imaging (MRI) services performed on an outpatient basis.

* **Neuromuscular stimulators, bone growth stimulators, vagal nerve stimulators and brain nerve stimulators:** when criteria is met for prior authorization.

Nutritional Counseling: services are covered with the appropriate office visit copayment. Coverage is limited to two visits per year when prescribed by a physician for children with the following conditions:

- ☐ Diabetes, Type 1 and 2
- ☐ Overweight and obesity with documentation of Body Mass Index (BMI)
- ☐ High cholesterol or other blood lipids
- ☐ High Blood Pressure
- ☐ Gastrointestinal disorders such as GERD or short gut syndrome
- ☐ Celiac disease
- ☐ Food allergies
- ☐ Failure to thrive or poor growth

Occupational Therapy (Outpatient): when ordered by a physician; coverage for service beyond 20 visits requires prior authorization.

* **Oral Surgery:** only covered for extracting impacted teeth, medically necessary orthognathism (straightening of the jaw) and medically necessary ridge reconstruction.

* **Organ Transplants:** see Organ Transplant Benefits on page 23 for more details.

* **Orthodontia Services:** see Dental Services on pages 25-27, and also the Dental Provider Guide on the WVCHIP website at www.chip.wv.gov. Services must be prior authorized through WVCHIP.

* **Orthotics/Prosthetics:** prior authorization required when rental or purchase of equipment is over $1,000 or rental requested for more than 3 months.

Outpatient Diagnostic and Therapeutic Services: pre-scheduled laboratory and diagnostic tests and therapeutic treatments, when ordered by a physician.

* **Outpatient Hospital and related Services (Out-of-State and some In-State services require prior approval/prior authorization):** performed in a hospital, alternative facility, or physician's office. All out-of-state procedures requires prior authorization and may be required for some in-state outpatient procedures. See page 15-16 for more details.

Pap Smear: annual Pap smear and the associated office visit to screen for cervical abnormalities.

Periodic Physicals: through Well Child Care (see page 22).

Physical Therapy (Outpatient): when ordered by a physician; coverage for service beyond 20 visits requires prior authorization.

Prescription Benefit Services: with mandatory generic substitution, including oral contraceptives.

Professional Services: physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services such as surgery, anesthesia, radiology, office visits, and urgent care visits; coverage for services beyond 26 visits requires prior authorization.

* **Skilled Nursing Facility Services:** confinement in a skilled nursing facility including a semiprivate room, related services and supplies. Confinement must be prescribed by a physician in lieu of hospitalization.

* **Sleep Apnea:** all sleep testing, equipment and supplies are covered through a network of West Virginia providers and require prior authorization through HealthSmart.

* **Specialty Drugs:** acute and chronic diseases such as rheumatoid arthritis, anemia, cerebral palsy, hemophilia, osteoporosis, hepatitis, cancer, multiple sclerosis and growth hormone therapy are examples of conditions that may need specialty medications. All specialty medications require **Prior Authorization**. The process begins with a call to HealthSmart at 1-800-356-2392, Option 7.

Speech Therapy (Outpatient): when ordered by a physician; coverage for service beyond 20 visits requires prior authorization.

Urgent Care and After Hours Clinic Visits: a visit to an urgent care or after hour's clinic is treated as a physician visit for illness. These visits are counted in the 26 visits listed on page 16. **Note:** Copayments are required for all non-medical home visits, including urgent care and after hour clinic visits.

Well Child Care: Routine office visits for preventive care as recommended by the American Academy of Pediatrics (AAP). A complete preventive care checkup includes, but is not limited to:

- height and weight measurement
- BMI calculation
- blood pressure check
- objective vision and hearing screening
- developmental/behavioral assessment
- lead risk screen
- physical examination
- age appropriate immunizations as indicated by physician

For children three years old and under, wellness visits are covered more often at:

- 3-5 days after birth
- 1 month
- 2 months
- 4 months
- Every 3 months from 6 to 18 months
- 24 months
- 30 months
- 3 years old
- 4 years
- Annually after age 4 to 18 years old

➢ **Objective, developmental screening tool is to be administered to child at the 9, 18, and 30 month well visits.**

➢ **Objective, autism screening tool is to be administered to the child at the 18 and 24 month well child visits.**

X-ray Services: when ordered by a physician.

Vision Therapy: service beyond 20 visits requires prior authorization.

Organ Transplants

Organ transplants are covered when deemed medically necessary and non-experimental. Transplants require prior authorization for medical necessity, and case management by HealthSmart. When it is determined by the child's physician that he or she is a potential candidate for any type of transplant, HealthSmart should be contacted immediately at 1-800-356-2392.

You should advise your physician that HealthSmart needs to coordinate the care from the initial phase when considering a transplant procedure to the initial work-up for transplant through the performance of the procedure, as well as the care following the actual transplant.

Fees/Expenses: WVCHIP will pay all covered expenses related to pre-transplant, transplant, and follow-up services while the child is enrolled in WVCHIP. Testing for persons other than the chosen donor is not covered.

Travel Allowance: Because transplant facilities may be located some distance from the patient's home, benefits include up to $5,000 per transplant for patient travel, lodging and meals related to visits to the transplant facility or physician. A portion of this benefit is available to cover the travel, lodging and meals for a member of the patient's family or a friend providing support. Receipts are required for payment of this benefit. No alcoholic beverages will be reimbursed. Mileage will be reimbursed at the federal mileage rate for medical expenses. The travel allowance benefit applies only to transplant services.

Medical Case Management: HealthSmart offers support and assistance in evaluating treatment options, locating facilities, and referrals to the prescription drug administrator. Case Management begins early when the potential need for a transplant is identified, and continues through the surgery and follow-up.

Transplant-Related Prescription Drugs: Transplant-related immunosuppressant prescription drugs are covered if they are filled at a Network pharmacy. These are covered through the Prescription Drug Plan.

Other Resources

Maternity Benefits

WVCHIP **does not cover** any pregnancy related conditions other than a pregnancy test. We are committed to the concept of prenatal care and good outcomes for all mothers and their newborns. We strongly urge you to start prenatal care as early as possible by calling the **Office of Maternal Child and Family Health toll-free at 1-800-642-8522**. They will provide information on financial and medical coverage available through their programs. They can also assist you with referrals to one of over 130 physician offices and primary care center sites throughout the state for care during pregnancy and delivery. They also can refer for free pregnancy testing and family planning, if this is the patient's primary need. All calls and referrals are confidential. Please see "Starting and Ending Coverage" section on pages 11-12 for information about adding newborns to existing WVCHIP coverage.

WIC (Women, Infants and Children)

Breastfeeding is the best nutrition for your baby. It provides everything needed for brain growth, helps prevent allergies, and is easily digested, therefore less colic and constipation. There are advantages for the Mother as well. Breastfeeding helps mom to lose weight sooner, they don't have to heat or mix breast milk nor clean and store bottles by putting baby to the breast and it is free.

WIC (Women, Infants and Children) can help mothers and babies get started with breastfeeding in order to have the best experience possible. WIC Breastfeeding Peer Counselors offer support during moms' pregnancy and continue helping after the baby is born. Talk to your local WIC agency or the WIC helpline at 1-800-953-4002 about getting started with breastfeeding.

Help Me Grow

HELP ME GROW – A Resource for both Parents and Primary Care Providers to Check Development. Checking a child's development as they grow and change is a key part of what primary care providers (PCP's) do at Well Child Visits. To check development more objectively and in all spheres of child's growth, PCP's often use an objective measuring tool. Many PCP's now send copies out for parents to complete at home or ask the parent to complete one in the waiting room. The Ages and Stages Screen, 3rd version- called the ASQ3 for short – is often used. Completing the ASQ3 gives the parent and PCP a common basis to discuss the child's development in full and check for developmental milestones. HELP ME GROW supports both parents and PCP's - both in scoring this tool and answering questions about its use. Screenings are different for each age and stage a child passes to adulthood, but focus on the early years is critical for early detection when the most benefit can be gained.

HELP ME GROW- Plays an Important Information and Linking Role. When PCP's give guidance to parents, they may discuss together many kinds of child needs, that are not easy for parent to address. Parents may share issues they have such as getting a recommended service or activity due to lack of transportation, what supervised activities are available locally, finding child care, where to go for counseling, a specialized service or therapy, navigating the way to a DHHR special needs program, how to assist child nutrition through programs available in the community. There are so many resources that could help, but where to turn? Now HELP ME GROW builds and maintains a statewide information network to help parents and primary practices find this information.

For specialized care or support services, call HELP ME GROW at 1-800-642-8522.

HELP ME GROW is available for children of all ages and any income level and WVCHIP is pleased to work with it in partnership and for support of CHIP families!

Birth to Three

Specialized Services for Infants and Toddlers with Developmental Delays

WVCHIP covers a special set of services targeted only to very young children up to and including their third birthday. These specialized services are meant to lessen or remove effects of conditions that if not detected early, could result in more severe or long lasting disability or learning problems, when not addressed at the earliest life stages; they are also called early intervention services. Most states have an Early Intervention program, and in our state it is called **"Birth to Three" (BTT),** and it is administered by Office of Maternal, Child and Family Health, a division of the Public Health Bureau in DHHR.

Checking On Delays

If you, or your family primary care provider, notice signs which make you question whether your child is developing normally, you can refer your child to this program (or ask your physician if they would advise a BTT referral). Before your child's next well-child visit, you can check your child's development by filling out an Ages and Stages Questionnaire (ASQ) to see how they are doing. It can help you to have a more meaningful discussion with your child's pediatrician.

What Is a Delay?

The BTT program experts are experienced in working with little ones and they can help assess whether or not a child has one or more delays or is considered at risk for a future delay. They will assess and check for slower than usual growth or ability in these areas:

1) **cognitive** for thinking and learning ability;
2) **physical** for moving, seeing, and hearing ability;
3) **social/emotional** for feeling, coping, and getting along with others;
4) **adaptive** ability – how well they can do things for themselves; and
5) **communication** – their ability to understand and be understood by others.

Birth to Three (Cont)

Qualifying for Services

Assessed children found to have one or more delays (or being at risk for future delays) may then qualify for program services to be delivered in a child's natural learning environment, typically the home. Children needing further services after three years of age will be referred by BTT to preschool or other services available in their county. Schools also get funds as part of the Individuals with Disabilities Education Act (IDEA) to provide services for children with special challenges, and IDEA also helps fund the BTT program.

Making a Referral

Either a parent or a physician may refer a child to the Birth to Three program for further assessment by calling 1-866-321-4728 to get an appointment with BTT providers nearest your location.

Dental Services

WVCHIP Premium Members: There is an out-of-pocket maximum of $150.00 per family per benefit year for dental services. Please note the copayment is per visit.

If the request for prior authorization is denied, WVCHIP will not cover the cost of the procedure. If requested treatment is denied, follow the appeal process.

Comprehensive orthodontic treatment is payable only once in the member's lifetime.

Note: Prior authorization DOES NOT assure eligibility or payment of benefits under this plan.

If you are looking for an in-state dentist, you can find one that is in your area by going to the following website: http://www.insurekidsnow.gov/state.

Dental Services (Cont.)

Benefit	Prior Authorization Required	Copayment Amount for Premium Members	Services Not Covered
Dental Examination/ every six months	No		Temporaomandibular Joint (TMJ) Disorders
Cleaning and fluoride/ every six months	No		Intraoral prosthetic devices
Bitewings/every six months	No		Antibiotic injections
Full mouth x-rays (Panorex)/ every 36 mo.	No		Tests/Lab Exams
Sealants (one sealant per tooth per 3 years)	No		Onlays/Inlays
Treatment of abscesses	No		Gold Restorations
Analgesia	No		Precision Attachments
IV/Conscious Sedation	No		Replacement of teeth extracted prior to coverage
Palliative Treatment	No		Replacement of crowns (covered after five years)
Other x-rays (if done with another service)	No		Cosmetic Dentistry
Consultations	No		Dental implants
Space Maintainers	No		Experimental Procedures
Fillings as needed	No	$25.00	Splinting
Pulpotomy	No	$25.00	Out of State without PA
Root Canals	No	$25.00	
Simple Extractions	No	$25.00	
Extractions - Impacted	PA required if performed in hospital setting	$25.00	
Extractions	No	$25.00	
Frenulectomy (frenectomy or frenotomy)	Yes	$25.00	
Removal of dental related cysts under a tooth or on gym	No	$25.00	
Biopsy of oral tissue	No	$25.00	
Restorative/Periodontics	No	$25	
Prosthodontics	No	$25	
Accident Related Dental Services	No		
Emergency Dental Services	No		
Orthodontic Services	Yes	$25	

Note: Retrospective review is available for WVCHIP members in instances where it is in the dental practitioner's opinion that a procedure that requires prior authorization is medically necessary per recommended dental practices and that delaying the procedure may subject the member to unnecessary or duplicative service, or will negatively impact the member's condition. In these instances, a request for prior authorization **MUST** be made by the provider within 10 business days of the date the service is performed. If the procedure does **NOT** meet medical necessity criteria upon review by WVCHIP then the prior authorization request will be **DENIED** and the provider cannot be reimbursed for the service.

Dental Services (Cont.)

- Accident Related Dental Services: The Least Expensive Professional Acceptable Alternative Treatment (LEPAAT) for accident-related dental services is covered when provided within six (6) months of an accident and required to restore damaged tooth structures. The initial treatment must be provided within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered. **Note:** For children under the age of 16, the six-month limitation may be extended if a treatment plan is provided within the initial six months and approved by WVCHIP.
- Emergency Dental Services: Medically necessary adjunctive services that directly support the delivery of dental procedures, which, in the judgment of the dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care to patients with medical, physical or behavioral conditions. These services include but are not limited to sedation, general anesthesia, and utilization of outpatient or inpatient surgical facilities. Contact WVCHIP for more information.
- Orthodontic Services: Orthodontic services are covered if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development. Treatment is routinely accomplished through fixed appliance therapy and maintenance visits. All requests for treatment are subject to prior authorization by WVCHIP Dental Consultants. Prior authorization is dependent on diagnosis, degree of impairment and medical documentation submitted. Failure to obtain prior authorization before service is performed will result in the family being responsible for amounts above and beyond their copayment requirements.

Vision Services

Covered benefits include annual exams and eyewear. Lenses/frames or contacts are limited to a maximum benefit of $125 per year. The year starts on the date of service. The eyewear maximum benefit may exceed $125 when medically necessary. Contact HealthSmart for prior authorization. The office visit and examination are covered in addition to the $125 eyewear limit. ***Families are responsible to pay the difference between the total charge for eyewear and the $125 allowance for lenses and frames that do not meet medical necessity and are not prior authorized.***

What is Not Covered under the Plan?

Some services are not covered by the Plan regardless of medical necessity. Specific exclusions are listed below. If you have questions, please contact **Molina at 1-800-479-3310.** The following services are not covered:

- Acupuncture, unless for anesthesia associated with a covered procedure
- Aqua therapy
- Behavioral therapy except for ABA therapy
- Biofeedback
- Christian Science treatments
- Chemical dependency treatments when a patient leaves a hospital or facility against medical advice
- Cosmetic or reconstructive surgery unless required as a result of accidental injury or disease, or unless the surgery is performed to correct birth defects. Services resulting from or related to these excluded services also are not covered.
- Court-ordered services not otherwise available under the plan
- Custodial care, intermediate care (such as residential treatment centers), domiciliary care, respite care, rest cures
- Dental services other than those listed as covered on pages 25-27
- Duplicate testing, interpretation or handling fees
- Education, training and/or cognitive services, unless specifically listed as covered services

What is Not Covered under the Plan? (Cont.)

- Elective abortions
- Electroconvulsive therapy
- Electronically controlled thermal therapy
- Expenses for which you are not responsible, such as patient discounts and contractual discounts
- Expenses incurred as a result of illegal action, while incarcerated or while under the control of the court system
- Experimental, investigational or unproven services, unless prior authorized by HealthSmart
- Fertility drugs and services
- Foot care (routine) (except for diabetic patients), including:
  - Removal in whole or in part: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin)
  - Cutting, trimming, or partial removal of toenails
  - Treatment of flat feet, fallen arches, or weak feet
  - Strapping or taping of the feet
- Genetic testing for screening purposes is generally not covered; however, it may be covered for diagnostic purposes after medical necessity review
- Glucose monitoring devices, except Bayer models covered under the prescription drug benefit
- Hearing Aids Implanted: External hearing aids are covered when prior authorized as medically necessary
- Homeopathic medicine
- Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
- Hypertension screening, unless medically indicated
- Hypnosis
- Immunizations from an out-of-state provider
- Incidental surgery performed during medically necessary surgery
- Infertility services of in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen, semen storage
- Maintenance outpatient therapy services, including, but not limited to:
  - Chiropractic
  - Occupational Therapy
  - Osteopathic Manipulations
  - Outpatient Physical Therapy
  - Outpatient Speech Therapy
  - Vision Therapy
- Massage therapy
- Maternity Services - labor and delivery are not covered (see Maternity Benefits on page 23; also Newborn Admissions on page 11)
- Medical equipment, appliances or supplies of the following types:
  - augmentative communication devices
  - bathroom scales
  - equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; and adjustable beds
  - exercise equipment, such as exercycles; parallel bars; walking, climbing or skiing machines
  - educational equipment
  - environmental control equipment, such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors
  - equipment which is widely available over-the-counter, such as wrist stabilizers and knee supports
  - hygienic equipment, such as bed baths, commodes, and toilet seats
  - motorized scooters
  - nutritional supplements, over-the-counter (OTC) formula, food liquidizers or food processors
  - Omni pod, V-go, Finesse and other disposable insulin delivery systems
  - professional medical equipment, such as blood pressure kits or stethoscopes
  - replacement of lost or stolen items
  - supplies, such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
  - traction devices

  - vibrators
  - whirlpool pumps or equipment
  - wigs or wig styling
- Medical rehabilitation and any other services which are primarily educational or cognitive in nature except as provided for under State Code
- Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning
- Non-listed brand name drugs determined not medically necessary by the RDTP.
- Optical services: Any services not listed on page 27 as covered benefits under Vision Services
- Oral appliances, including, but not limited to, those treating sleep apnea
- Out-of-State/Out-of-Network Providers (see page 15)
- Personal comfort and convenience items or services (whether on an inpatient or outpatient basis), such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician
- Physical conditioning. Expenses related to physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation
- Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered by WVCHIP, when such services are:
  - related to employment
  - to obtain or maintain insurance
  - needed for marriage or adoption proceedings
  - related to judicial or administrative proceedings or orders
  - conducted for purposes of medical research
  - to obtain or maintain a license or official document of any type
  - for participation in athletics
- Pregnancy-related conditions
- Prostate screening, unless medically indicated
- Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations, form completion
- Radial keratotomy and other surgery to correct vision
- Safety devices used specifically for safety or to affect performance, primarily in sports-related activities
- Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family, including spouse, brother, sister, parent, or child
- Services rendered outside the scope of a provider's license
- Sex transformation operations and associated services and expenses
- Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit
- Sensory Stimulation therapy (SS)
- Take-home drugs provided at discharge from a hospital
- TMJ. Treatment of temporomandibular joint (TMJ) disorders, including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma
- The difference between private and semiprivate room charges
- Therapy and related services for a patient showing no progress
- Therapies rendered outside the United States that are not medically recognized within the United States
- Transportation, unless medically necessary ambulance services, or as approved under the organ transplant benefit
- Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, bariatric surgery, and services of a similar nature
- Work-related injury or illness

The Importance of a Medical Home

What is a "Patient Centered" Medical Home?: A Medical Home is a primary care physician or mid-level provider you have chosen to act as your usual source for health care (or in some cases such as a clinic or large practice setting, it may be a team of physicians or mid-level providers). A good Medical Home is organized to create the best health care value in a caring atmosphere for you as the patient, as well as an atmosphere of mutual respect and responsibility. This is what is called "patient-centered" care.

NOTE: **The American Academy of Pediatrics specifically recommends that hospital emergency departments should not be the place for a child's usual source for getting care** (except for emergencies, which are not usual!). An emergency room, an urgent care center or clinic, a specialty clinic, or even a specialist seen regularly (an allergist, for example) cannot be considered a Medical Home since they cannot take on the central role of primary care for a child or an adult.

Benefits of a Medical Home: A "Patient Centered Medical Home (PC-MH)" means **high value health care** delivered in a setting of mutual respect and responsibility.

1. Your PC-MH knows you individually and your medical history each time you visit once your care has started there. You have developed a sense of trust with your PC-MH due to an atmosphere of caring and mutual respect.
2. The medical records at your PC-MH are well organized and used to schedule routine visits needed to meet preventive care guidelines; this is particularly important for children and parents to assure necessary preventive visits and immunizations are given.
3. Your PC-MH medical record includes all information from referral visits or services that you get outside the Medical Home so it has the most complete, up-to-date picture of your child's health possible.
4. Your PC-MH assures your comprehensive service needs are met. They do this by coordinating care with any specialists (an allergist, for example) outside the Medical Home. They also guide you to specialists or services outside the Medical Home to make certain all your medical needs are met.
5. Your PC-MH has set up ways for you to make contacts after regular office hours on a 24 hour/seven days a week basis. This may be done with an answering service, paging service, 24 hour nurse line, or other way to help you know how to handle after hours situations that may or may not require immediate attention. ***NOTE:*** For afterhours care, any Medical Home that automatically refers you to an emergency room without offering any way to first assess true needs or options, cannot be considered a high value Medical Home.
6. For chronic illness or a special needs child, your PC-MH sets up a plan of care to address ongoing health issues. Your PC-MH's ability to help coordinate and assure comprehensive service needs are met is very important for special needs children who require them. High value PC-MH's will make arrangements to have your special needs child care plan available for immediate access electronically for when you travel or access health records electronically when your child must see other specialists.
7. Your PC-MH treats the whole person and helps assess whether any behavior or emotional issue that concerns you or your child requires special services such as counseling or therapy and refers you, if needed.
8. Your PC-MH helps maintain good health by discussing and checking your health risks related to lifestyle issues. They may have special staff to discuss or provide you with information on many healthy life styles topics such as a smoking cessation, special diets, weight loss, and proper car seat use for your young children, etc.

Your Part In A Medical Home Relationship: To develop the quality Medical Home relationship based on mutual respect noted above also means taking action and responsibility on your part. Some considerations for your medical home and provider are as follows:

1. Show your insurance and Medical Home member cards at each visit to help the Medical Home with prompt and accurate billings.
2. Keep the time and date of appointments to the best of your ability. Call promptly to let them know when you are not able to keep an appointment.
3. Keep the Medical Home informed of any address or phone contact changes so they can give you appointment reminders.
4. Consult with your Medical Home before getting other health services or specialized care services from another provider. If you do have to get services outside the Medical Home in an emergency, be sure to tell your Medical Home about any services or prescriptions you get from another health service provider. This way they can always have the complete history and picture of your health needs.

5. Ask about and follow your Medical Home provider's instructions for what to do if your children may require services outside regular office hours. Do your best to use an emergency room for emergencies only.
6. Make sure your child has annual wellness visits, tests, and any needed immunizations. One of the best Medical Home values is to prevent illness and detect problems early.
7. Follow providers' instructions especially when ongoing health issues such as asthma or diabetes must be managed. If there are problems or issues, discuss honestly the reasons for not doing so.

Your Rights

1. You have the right to pick your PC-MH from a statewide directory.
2. You have the right to ask questions about the health care of your children and the decisions and recommendations made by your Medical Home.
3. You have the right to information in your child's medical record.
4. You can contact the WVCHIP claims payer customer service line anytime you have a question about payments.
5. You can appeal a denial of services by following the appeal procedure in this booklet.

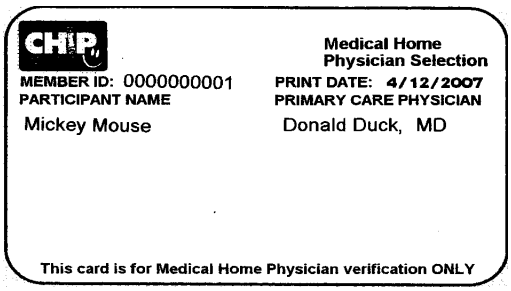
Selecting A Medical Home: select a physician from the WVCHIP Medical Home Directory at www.wvmmis.com. If your child's regular doctor is not listed in the directory, ask them to participate as a WVCHIP Medical Home by calling 1-888-483-0793. **Once you decide on a Medical Home physician, you can call the Molina customer service department at 1-800-479-3310 or complete the Medical Home Selection Form on page 52 and return it by mail.**

- If you need help selecting a medical home physician from the directory, try referrals from physicians, friends, relatives, business associates or hospitals.
- If you have recently moved to a new location, ask your former physician for a referral from the WVCHIP directory. You can also ask other doctors you respect and see regularly, such as an allergist.
- Referrals from people you know are usually based on trust and confidence, which is certainly in your favor. Remember, though, that your contacts' opinions may be largely based on how they click with the physician's personality and style. Only a visit with the doctor will reveal if their qualities suit you.
- Hospitals usually offer a referral service that can provide you with the names of staff doctors who meet certain criteria you may be seeking, such as gender, experience and location. However, the referral service cannot vouch for the physician's quality of care.

Checking the Medical Home Directory: If your child's physician is not in the directory, they can sign up at any time and be added as a medical home. The web directory will be updated monthly at www.wvmmis.com. You can also call Molina Medicaid Solutions at 1-800-479-3310 for a directory.

Group practices and Clinics as a Medical Home: You will still need to choose one physician in the group practice or clinic as your Medical Home. However, you can see any of the physicians within the group practice or clinic without making a copayment.

Copayments for a Medical Home Office Visit: After a medical home is selected, there will not be a copayment for an office visit to your medical home physician, this includes all well and non-well visits. When you show the medical home card pictured below at your medical home doctor's office, ***the copayment for a non-well visit is WAIVED.*** **Be sure to show both your medical home card, as well as your WVCHIP member card. NOTE: Copayments apply for non-well visits made outside your medical home.**


CHIP
Medical Home
Physician Selection
MEMBER ID: 0000000001
PRINT DATE: 4/12/2007
PARTICIPANT NAME
Mickey Mouse
PRIMARY CARE PHYSICIAN
Donald Duck, MD
This card is for Medical Home Physician verification ONLY

The Importance of a Medical Home (Cont.)

Members Without A Medical Home: Families without a medical home will be charged a copayment for non-well visits.

Enrollment Group	Copay (No medical home)	Copay (medical home)
WVCHIP Gold	$5.00	$0
WVCHIP Blue	$15.00	$0
WVCHIP Premium	$20.00	$0
WVCHIP Exempt	$0	$0

Remember, there is a limit on the total copayments a family pays per benefit year and these limits are tracked by your medical claims payer, Molina, and your pharmacy claims payer, Express Scripts, Inc.™ to keep you from exceeding your maximum out-of-pocket expense.

Questions About Selecting A Medical Home: Call Molina at 1-800-479-3310 or the WVCHIP Helpline at 1-877-982-2447.

Prescription Drug Plan

Pharmacy Network: If you are traveling out of state and need to access a Network pharmacy, contact **Express Scripts, Inc. ™ at 1-877-256-4689** to locate a participating pharmacy or visit their website at www.express-scripts.com.

Non-Network Pharmacy: If you use a non-network pharmacy, you will have to pay the full cost of the prescription at the time of purchase, and submit a completed claim form to Express Scripts. The prescription receipt must be attached to the form, (see pages 42-43) and the drug must be listed on WVCHIP's Preferred Drug List. You will be reimbursed the amount WVCHIP would have paid at a participating pharmacy, less any required copay (if applicable).

Mail the completed and signed prescription drug claim form along with the receipt or itemized bill to:

Express Scripts
Att: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872
Fax: (608)741-5475

You will usually be reimbursed within 30 days from receipt of your child's claim form. **The claim must be filed within six months from the date the prescription was filled.** Claims submitted after six months are not eligible for reimbursement. Cash register receipts and canceled checks are not acceptable proof of the covered child's claim. An itemized bill is required. Make sure the claim form is complete so there will not be a delay in payment. **Note:** If you need claim forms, call Express Scripts Member Services at 1-877-256-4689, or visit their web site at www.express-scripts.com. **(A copy of the Prescription Claim Form is on page 42-43).**

Prescription Drug Plan (Cont.)

Acute Medication: Coverage for medication taken for short time periods to treat an acute medical condition is limited up to a 30-day supply each time a prescription is filled or refilled. If more than a 30-day supply is purchased, WVCHIP will not pay the charge above the 30-day amount.

Maintenance Medication: You may receive up to a 90-day supply of ONLY the medications and classes listed below:

Antiarthritics	Gastrointestinal, colitis
Anticoagulants	High blood pressure
Anticonvulsants	Hormones, misc
Antihypertensives	Immunosuppressive agents
Antispasmodics	Legend vitamins including legend hemantinics, Vit. K)
Bronchodilators	Leukotriene receptor antagonists (asthma agents)
Cardiovascular agents	Lipotropics (cholesterol lowering agents)
Cholinergic stimulants (renal retention)	Mucolytics (pulmonary agents)
Corticosteroids, bronchial	Oral contraceptives
Cromolyn sodium (Intal®)	Legend potassium
Diabetic therapies	Selective serotonin reuptake inhibitors
Digestants	Serotonin and norepinephrine reuptake inhibitors
Disposable needles and syringes	Thyroid medications
Diuretics	Tuberculosis medications
Enzymes, systemic	Xanthine's (asthma agents)
Estrogens and progestin's	

Specialty Medications

All specialty medications require prior authorization. The process begins with a call to **HealthSmart** at 1-800-356-2392, Option 7. HealthSmart will review the drug for medical necessity, and if approved, will coordinate the purchase through an approved source.

Common Specialty Medications List

Drug Name	Category
Acthar® HP	Multiple Sclerosis
Actimmune	Anti-Neoplastic
Adcirca®	Pulmonary Hypertension
Afinitor	Anti-Neoplastic
Ampyra	Multiple Sclerosis
Aranesp®	Anemia
Arixtra®	Anti-Coagulant
Avonex® [QLL]	Multiple Sclerosis
Betaseron® [QLL]	Multiple Sclerosis
Boniva®	Osteoporosis
Cerezyme®	Gaucher Disease
Copaxone® [QLL]	Multiple Sclerosis
Eligard	Anti-Neoplastic
Enbrel®	Inflammatory Conditions
Enoxaparin Sodium	Anti-Coagulant
Epogen®	Anemia
Forteo®	Osteoporosis
Fragmin®	Anti-Coagulant
Genotropin®	Growth Hormone
Gilenya®	Multiple Sclerosis
Gleevec®	Anti-Neoplastic
Humatrope®	Growth Hormone
Humira® [QLL]	Inflammatory Conditions
Incivek	Hepatitis
Inlyta	Cancer
Intron A®	Interferon's
Jakafi®	Cancer
Kalydeco®	Respiratory Conditions
Kineret®	Inflammatory Conditions
Kuvan	Enzyme deficiencies
Letairis®	Pulmonary Arterial Hypertension
Leukine®	Hematopoietic
Lovenox®	Anti-Coagulant
Lupron Depot®	Endometriosis, Anti-Neoplastic, Precocious Puberty
Lupron Depot® - Ped	Precocious Puberty
Lupron®	Anti-Neoplastic
Methrotrexate	Anti-Neoplastic; Anti-Arthritis

Drug Name	Category
Neulasta® [QLL]	Neutropenia
Neupogen®	Neutropenia
Nexavar®	Anti-Neoplastic, Immunosuppressant
Norditropin®	Growth Hormone
Nutropin®	Growth Hormone
Octreotide Acetate	Endocrine disorders
Pegasys® [QLL]	Hepatitis C
Peg-Intron® [QLL]	Hepatitis C
Procrit®	Anemia
Pulmozyme®	Cystic Fibrosis
Rebif®	Multiple Sclerosis
Revatio®	Pulmonary Arterial Hypertension
Revlimid®	Anti-Neoplastic, Immunosuppressant
Riba pak	Hepatitis
Ribavirin®	Hepatitis C
Sandostatin LAR	Endocrine disorders
Simponi®	Rheumatoid Arthritis
Sprycel	Anti-Neoplastic
Sutent®	Anti-Neoplastic
Tarceva®	Anti-Neoplastic
Tasigna	Anti-Neoplastic
Temodar®	Anti-Neoplastic
Tev-Tropin®	Growth Hormone
Thalomid®	Anti-Neoplastic
Thyrogen® Kit	Diagnostic
Tobi® [QLL]	Cystic Fibrosis
Tracleer®	Pulmonary Arterial Hypertension
Tykerb	Anti-Neoplastic
Tyvaso®	Pulmonary Arterial Hypertension
Victrelis®	Hepatitis
Votrient	Anti-Neoplastic
Xalkori®	Cancer
Xeloda®	Anti-Neoplastic
Xenazine®	Central Nervous System (CNS) Disorders
Zoladex®	Anti-Neoplastic
Zolinza	Anti-Neoplastic
Zytiga®	Anti-Neoplastic

[QLL] This drug is subject to Quantity Level Limits (QLL)
This list is not all-inclusive and is subject to change throughout the Plan Year.

Refills
At least 75% of a prescription must be used before it can be refilled as prescribed by the child's physician.

WVCHIP Preferred Drug List (PDL)
The WVCHIP PDL is a list of carefully selected medications that assists in maintaining quality care while providing cost saving opportunities to the member and WVCHIP. WVCHIP requires you to pay a lower copayment for medications on the WVCHIP Preferred Drug List, and to pay the full retail price for medications not on the WVCHIP Preferred Drug List. By asking your doctor to prescribe WVCHIP Preferred Drug List medications, you can maintain high quality care while you help to control rising health care costs. The current preferred drug list is posted on the WVCHIP website at www.chip.wv.gov.

If you have any questions about the copayment structure or about the WVCHIP Preferred Drug List, please call ESI at **1-877-256-4689** or the WVCHIP Helpline at **1-877-982-2447**.

Several classes of prescription drugs require prior authorization for coverage by WVCHIP. Prior authorization is handled by the Rational Drug Therapy Program (RDTP), telephone number: 1-800-847-3859. If your medication is not approved for plan coverage, you will have to pay the full cost of the drug.

adalimumab (Humira®)*	growth hormones*
ambrisentan (Letairis)*	haloperidol (Haldol®)
amphetamines (Adderall XR®, Vyvanse®)	bandronate (Boniva®)
aripiprazole (Abilify®)	twoiloprost (Ventavis®)*
armodanfinil (Nuvigil®)	latanoprost (Xalatan®)
atomoxetine (Strattera®)	maraviroc (Selzentry®)*
becaplermin (Regranex®)	modafanil (Provigil®)
bosentan (Tracleer®)*	olanzapine (Zyprexa®, Zydis®, Relprevv®)
Brand medically necessary prescriptions.	oxycodone hydrochloride (Oxycontin®)
chenodiol (Chenodal™)*	paliperidone (Invega®)
clozapine (Clozaril)	perphenazine
combination beta2-agonist/corticosteroid inhalers (Advair Diskus®, Advair®, HFA, Symbicort®)	quetiapine (Seroquel®)
corticotrophin (Acthar®)*	raltegravir (Isentress®)*
c1 esterase inhibitor (Cinryze®)	rilonacept (Arcalyst®)*
dabigatran etexilate (Pradaxa®)	risperidone (Risperdal®)
dalfampridine (Ampyra®)	romiplostim (Nplate®)
dextromethorphan/quinidine (Nuedexta™)	sacrosidasesacrosildase (Sucraid®)*
diclofenac sodium gel (Solaraze®)	sapropterin dihydrochloride (Kuvan™)*
drospirenone; ethinyl estradiol (Ocella, Syeda, Zarah)	sildenafil (Revatio®)
eltrombopag olamine (Promacta®)*	stimulants (Concerta®, Focalin XR®, methylphenidate)
enfuvirtide (Fuzeon®)*	teriparatide (Forteo®)
erythroid stimulants (Epogen®, Procrit®, Aranesp®)*	tetrabenazine (Xenazine®)
etanercept (Enbrel®)*	thioridazine (Mellaril®)
etravirine (Intelence®)*	thiothixene
exenatide (Byetta®)	tolvaptan (Samsca®)*
fentanyl (Abstral®, Actiq®, Duragesic®, Fentora®, Lazanda®, and Onsolis®)	trifluoperazine
fingolimod (Gilenya®)	ziprasidone (Geodon®)

NOTE: members that are currently taking a drug that is used to treat, or is sensitive to, mental conditions, can continue to have their current prescription(s) covered even if their current medication is not on the WVCHIP Preferred Drug List when it is in one of the following seven drug classes: Antipsychotics; Serotonin Selective Response Inhibitors (SSRI's); Central Nervous System Stimulants; Anticonvulsants; Sedative Hypnotics; Aliphatic Phenothiazine's; and Attention Deficit Disorder Drugs.

What Drugs are Covered (Cont.)

NOTE: Members who are newly prescribed a drug used to treat, or is sensitive to, mental conditions in one of the seven drug classes named above will have prescriptions filled from WVCHIP Preferred Drug List, except in cases where there is a demonstrated need for exception due to medical necessity.

For the WVCHIP Preferred Drug List see the information on the WVCHIP web site at www.chip.wv.gov.

Drugs Requiring Step Therapy

WVCHIP requires that a generic prescription drug or lower cost therapy (1st line product) be tried as a first step product before a brand name (2nd line product) will be allowed. The drugs affected by this are listed in the following chart:

Drug Category	1st line product(s)	2nd line product(s)
COX-2	diclofenac potassium, diclofenac sodium, etodolac, EC naproxen, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketoralac, meclofenamate, mefenamic acid, meloxicam, nabumetone, naproxen, naproxen sodium, oxaprozin, piroxicam, sulindac, tolmetin sodium	Celebrex
Dipeptidyl peptidase-4 (DPP4) inhibitors	Metformin, metformin extended-release, metformin/glyburide, metformin/glipizide	Januvia, Janumet, Jentadueto, Juvisync, Janumet XR, Tradjenta
Sedative Hypnotics	Zaleplon, zolpidem, IR/CR	Rozerem
Topical Acne	Generic prescription topical acne products and cleansers	Brand name topical acne products cleansers, and kits
Topical Immuno-Modulators	Topical generic corticosteroids	Protopic

Drugs With Special Limitations

What Happens If You Are Filling A Prescription At The Pharmacy And Payment Is Denied Because Prior Authorization was not given?

When a medication is denied because the required prior authorization has not been given, the pharmacist will advise your physician to contact RDTP for review. If it is after office hours or your physician is unavailable, the pharmacist can provide your child with an emergency 5 day supply (some exceptions apply, i.e. controlled medication).

Over-the-Counter Drugs

WVCHIP does not cover over-the-counter drugs, or prescription drugs with over-the-counter equivalents. Non-sedating antihistamines are the exception. In this drug category only Claritin and Claritin D are covered. A prescription must be obtained from your physician in order for Claritin and Claritin D to be covered by the plan.

What if the Doctor Prescribes It?

Sometimes your doctor may prescribe a medication to be "dispensed as written" when a West Virginia Preferred Drug List (WVPDL) brand name or generic alternative drug is available. As part of your plan, an Express Scripts pharmacist or your retail pharmacist may discuss with your doctor whether an alternative formulary or generic drug might be appropriate for you. You may wish to discuss this with your physician to see if another medication on the WVPDL could be prescribed.

Quantity Limits (QLL)

Under the WVCHIP Prescription Drug Plan, certain drugs have preset quantity limitations. Select medications from the quantity limit list are provided below. If you are taking one of the medications with a quantity level limit and you need to get more of the medication than the Plan allows, ask your pharmacist or doctor to call **WVU's School of Pharmacy, Rational Drug Therapy Program at 1-800-847-3859** to discuss your refill options.

1. Antipsychotic drugs (Abilify® 30 units, Seroquel® varies, Zyprexa® 30 units, Zyprexa Zydis® 30 units)
2. Antiemetics:
   - Aloxi® is limited to 1 capsule/vial per prescription
   - Emend® 40 mg is limited to 1 capsule per prescription
   - Emend® 80 mg is limited to 2 capsules per prescription
   - Emend® 115 mg vial is limited to 1 vial per prescription
   - Emend® 125 mg is limited to 1 capsule per prescription
   - Emend® Bi-fold Pack is limited to 1 package per prescription
   - Emend® Tri-fold Pack is limited to 1 package per prescription
3. Cholesterol lowering medications. (Crestor® 30 units, lovastatin varies, pravastatin sodium 30 units, and simvastatin 30 units)
4. Enbrel®. Coverage is limited to 4 syringes or 8 vials per prescription
5. Fluconazole 150 mg. Coverage is limited to 2 tablets per prescription
6. Humira®. Coverage is limited to 2 syringes/pens per prescription
7. Ketorolac. Coverage is limited to one course of treatment (5 days) per 90-day period
8. Migraine medications.

Coverage is limited to quantities listed below:

Generic Name	Brand Name	Quantity Level Limit Per Prescription	Quantity Level Limit for 28-Day Period
Sumatriptan injection vials 4 mg/0.5 mL	generics	2 vials	16 vials
Sumatriptan injection vials, 6 mg/0.5 mL	generics	2 vials	16 vials
Zolmitriptan nasal spray 5 mg	Zomig®	1 box	3 boxes = 18 unit dose spray devices
Zolmitriptan tablets 2.5 mg and 5 mg, orally disintegrating	Zomig-ZMT®	6 tablets	18 tablets
Zolmitriptan tablets 2.5 mg and 5 mg	Zomig®	6 tablets	18 tablets

9. New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status. WVCHIP reserves the right to exclude a drug or technology from coverage until it has been proven effective
10. Other antidepressants (Budeprion SR® 60 units, Bupropion HCL SR® 60 units)
11. Sedative hypnotics (Ambien CR 15 units per 30 days, zolpidem 30 units)
12. Selective Serotonin Reuptake Inhibitors (Citalopram HBR 30 units, Fluoxetine HCL varies, fluvoaxmine maleate varies, paroxetine HCL® varies, Selfemra™ varies and sertraline HCL® varies)
13. Serotonin-Norepinephrine Reuptake Inhibitors (Cymbalta® varies, and Savella® varies)
14. Tamiflu® and Relenza®. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from RDTP. Tamiflu oral suspension – limit of 6 bottles per 365 days.
15. Vasodilator Antihypertensive (Doxazosin Mesylate® varies, and Terazosin HCL® varies)

This list is not all-inclusive and is subject to change.

What Drugs Are NOT Covered?

Anorexients (any drug used for weight loss purposes)	Omni pod or other disposable insulin delivery system
Brand name drugs not listed on WVCHIP Preferred Drug List. Providers must contact RDTP for more information	Over the counter drugs (except for OTC birth control, and when included in a compound with prescription drug)
Investigational or experimental drugs not approved by FDA	Pentazocine/acetaminophen (Talacen)
Drugs requiring PA when prescribed off label	Photo-aging and depigmentation products
Erectile dysfunction agents	Prescription drugs with OTC equivalents (except when included in a compound with a prescription drug)
Fertility drugs	Prescription drug claims not filed within 6 months of the purchase date
Fioricet with Codeine (butalbital/acetaminophen caffeine with codeine)	Requests for more than an 90-day supply of maintenance medications
Fiorinal with Codeine (butalbital/aspirin/caffeine with codeine)	Requests for more than a 30-day supply of acute medications
Hair growth stimulants	Requests for more than a 30-day supply of specialty medications
Homeopathic medications	Smoking deterrents
Immunizations, biological sera, blood or blood products (these are covered under the Medical Plan)	Stadol nasal spray
Medical or therapeutic foods	Three (3) month estrogen replacement

Diabetes Management

Blood Glucose Monitors: Covered diabetic insureds can receive a free Bayer Ascensia Breeze2® or Ascensia Contour® or Ascensia Contour® Next/EZ/USB®/Link blood glucose monitor with a current prescription. Simply ask your pharmacist, and he or she will contact Bayer by fax or mail to request the monitor.

Glucose Test Strips: The plan covers only Bayer Ascensia Breeze2®, Ascensia Contour® or Ascensia Contour® Next test strip.

Controlling Prescription Drug Costs

Mail Order Drug Program

This is a voluntary program which allows the covered child to order maintenance medications (those that the child takes long-term to treat an on-going medical condition) through the mail. Use of the mail order program may be more convenient for you. To participate in the Mail Order Drug Program, the child's parent or guardian and the child's physician need to complete an enrollment form. To get a copy of the form, call **Express Scripts, Inc. ™ at 1-877-256-4689**.

For More Information

WVCHIP's prescription drug benefits are administered by **Express Scripts, Inc. ™** If you have additional questions about prescription drug coverage, or about claims submitted on the insured child's behalf, contact Express Scripts, Inc. at 1-877-256-4689.

All prescription drugs requiring **prior authorization** are reviewed by **West Virginia University's School of Pharmacy, RDTP Program**. Physicians must contact customer service at **1-800-847-3859, or fax 1-800-531-7787,** before certain prescribed drug(s) will be covered by the plan. Since RDTP can only discuss reasons of medical appropriateness with the physician, only providers should contact them. Please refer to page 34-35 for drugs requiring prior authorization.

Medical & Prescription Drug Claims

What is an EOB?
After you receive a medical, vision or dental service, the health care provider (whether a doctor's office, hospital, dentist, etc.) sends a claim to Molina Medicaid Solutions for payment. Once the claim is processed, an EXPLANATION OF BENEFITS form (EOB) will be sent to you.

The EOB shows each service and the provider's charge and the amount paid by WVCHIP. Any copayments or non-covered amounts are reflected to show any amounts owed by the patient. You should not be asked to pay more than this amount.

As a reminder - an EOB just explains how your benefits were used.

How to File a Medical or Dental Claim

To file a medical claim for a child enrolled in the Plan, Molina requires an itemized bill that must include the following information:

1. the insured child's name and identification number
2. the nature of illness or injury
3. date(s) of service
4. a complete description of each service
5. the amount charged for each service
6. diagnosis and procedure codes for each illness/condition and procedure
7. the provider's name, address & FEIN (federal identification number)

If the necessary information is printed on your itemized bill, you do not need to use a WVCHIP claim form. (A copy of the Medical Claim Form is on the website www.chip.wv.gov).

Medical claims are processed by Molina and should be submitted to this address:

Molina, P.O. Box 3732, Charleston, WV 25337

Cash register receipts and canceled checks are not acceptable proof of your claim. An itemized bill is required.

Claims must be filed within six months of the date of service. Claims not submitted within this period will not be paid, and WVCHIP will not be responsible for payment.

If the child's medical claim is for an illness or injury wrongfully or negligently caused by someone else, and you expect the medical costs to be reimbursed by another party or insurance plan, a claim with WVCHIP should be filed within 6 months of the date of service to ensure that the claim will be paid. If you should later receive payment for the expenses, you must repay the amount you received from WVCHIP. (See Subrogation on page 45 for details.)

Claims Incurred Outside the U.S.A.
If a child enrolled in WVCHIP incurs medical expenses while outside the United States, you may be required to pay the provider yourself. Request an itemized bill containing all the information listed above from the child's provider and submit the bill and a claim form to Molina or Express Scripts, Inc. ™

Molina or Express Scripts, Inc. ™ will determine, through a local banking institution, the currency exchange rate, and you will be reimbursed according to WVCHIP's terms.

Appealing a Pharmacy Claim

If you have an issue with your prescription drug claim or prescription benefit or a denial of a medication, first call Express Scripts to ask for details. If the issue involves a prescription drug prior authorization request, ask your medical provider to contact Rational Drug Therapy Program (RDTP) for more information. If you are not satisfied with the outcome of the telephone inquiry, the second step is to appeal to Express Scripts or have your medical provider appeal any prior authorization issues to RDTP in writing via fax or regular mail. Please have your physician provide any additional relevant clinical information to support your request. **Mail your request with the above information to:**

Type of Error	Who to Call	Where to Write
Prior authorization or denial issue (for Physician's offices or pharmacists only)	RDTP 1-800-847-3859 FAX: 1-800-531-7787	Rational Drug Therapy Program WVU School of Pharmacy PO Box 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment denial issue	Express Scripts 1-877-256-4689	Express Scripts, Inc. Clinical Appeals (Client-WVC) BL0390 6625 W. 78th Street Bloomington, MN 55439

Express Scripts or RDTP will respond in writing to you and/or your physician with a letter explaining the outcome of the appeal. If this does not resolve the issue, the third step is to appeal in writing to the Executive Director of WVCHIP. Your physician must request a review in writing within thirty (30) days of receiving the decision from Express Scripts or RDTP. **Mail third step appeals to:**

Executive Director, WVCHIP, 2 Hale Street, Suite 101, Charleston, WV 25301

Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the claim and review should be included. When your request for review arrives, WVCHIP will reconsider the entire case, taking into account any additional materials that have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the covered person or his or her authorized representative. For more information about your drug coverage, please contact Express Scripts at 1-877-256-4689.

How to Reach Express Scripts

On the Internet: Visit Express Scripts' website at www.express-scripts.com anytime to learn about patient care, refill your mail service prescriptions, check the status of your mail service pharmacy order, request claim forms and mail service order forms or find a participating retail pharmacy near you.

By Telephone: For those insured's who do not have access to Express Scripts via the internet, you can learn more about your program by calling Express Scripts Member Services at 1-877-256-4689, 24 hours a day, 7 days a week.

West Virginia Children's Health Insurance Program

(Please print or type.)
Member's (child) Name _____
Last First Middle

Identification Number _____ Member's Date of Birth ____/____/____

Home Address _____

_____

Phone Number _____ - _____ - _____ Policyholder's Sex ☐ Male ☐ Female

Nature of Illness or Injury _____

Was illness or injury related to accident? ☐ Yes ☐ No

If yes, complete the following:
Date of accident: _____
Location of accident: _____

Was another party at fault? ☐ Yes ☐ No
Was illness or injury any way work related? ☐ Yes ☐ No

I certify that the above is correct and that I am claiming benefits only for charges incurred by the patient named above. I further authorize the release of any medical information necessary to process this claim.

Signature of Policyholder's
Parent / Guardian / Representative _____ Date _____

Itemized bills must accompany this claim form. These bills must include the following information:

1) Name of child covered by WVCHIP
2) The WVCHIP Policyholder's identification number
3) The nature of the illness or injury
4) Date(s) of service
5) A complete description of each service
6) The amount charged for each service
7) Diagnosis and procedure codes for each illness, condition and procedure
8) The provider's name, address, and NPI number

Mail to:
Molina
P.O. Box 3732
Charleston, WV
25337

If you have any question, please call Molina Medicaid Solutions toll-free at 1-800-479-3310.

Prescription Drug Reimbursement / Coordination of Benefits Claim Form

An incomplete form may delay your reimbursement.
See the back for instructions and complete all information.

Cardholder Information *See your prescription drug ID card.*

Group No.

Member ID

Member Name First Last

Street Address

City State ZIP

Patient Information

Patient Name First Last

Patient Date of Birth (Month/Day/Year) __/__/____

Sex

- ☐ Female
- ☐ Male

Relationship to Plan Member

- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Non-spouse Partner
- ☐ 8 Other

Pharmacy Information

Name of Pharmacy

Street Address

City State ZIP

Telephone (include area code) ___-___-____

Is this an on-site nursing home pharmacy? ☐ **Yes** ☐ **No**

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Express Scripts or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X _____

Signature of Pharmacist or Representative **(Required)**

NCPDP/NPI Required

Claim Receipts

Tape receipts or itemized bills on the back.
See back for details.
Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**

Make sure your pharmacist lists ALL the VALID NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

ONE CLAIM FORM PER COMPOUND SUBMISSION

☐ **Medication purchased outside of the United States**

Please indicate:

Country _____

Currency used _____

☐ **Allergy medication**

Coordination of Benefits

(Another Health Plan has paid a portion.) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

☐ Yes ☐ No

☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid (1)

☐ Card Program (3)

☐ Express Scripts Mail Order (4)

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.†

Please tape receipts on the back of this page.

Acknowledgment

I certify that the medication(s) described was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I certify that the medication(s) described were not for an on-the-job injury. *By completing this form, I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.**

X _____ _____

Signature of Member Date

*If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form.

Please request that your pharmacy contact Pharmacy Services at 800.922.1557 for assistance.

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

COMPOUND PRESCRIPTIONS ONLY

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx #

Date Filled __/__/____ Day Supply Quantity

Valid 11-digit Ingredient NDC	Metric Quantity	Ingredient Cost
	Total charge	

Instructions Read carefully before completing this form.

1. Always present your prescription drug ID card at the participating retail pharmacy.
2. Use this form when you have paid full price for a prescription drug at a retail pharmacy or need to submit claims under Coordination of Benefits rules:
3. **You must complete a separate claim form for each pharmacy used and for each patient.**
4. You must submit claims within 1 year of date of purchase or as required by your plan.
5. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed at the top of this page. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. The plan member should read the acknowledgment carefully, and then sign and date this form.
7. **Return the completed form and receipt(s)** to:
   Express Scripts
   ATTN: Commercial Claims
   P.O. Box 2872
   Clinton, IA 52733-2872
8. You may also **fax your claim form to: 608.741.5475**.

Please use one claim form per fax. Do not combine claims for different members in the same fax submission.

Additional Coordination of Benefits Instructions

Another Health Plan Paid

You must first submit the claim to the primary insurance carrier. Once the statement from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided at the top of this page, and attach the statement from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans

Retail pharmacies

If the primary plan is one in which a copayment or coinsurance is paid at a retail pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the copayment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

The Express Scripts Pharmacy

If the primary plan is mail order, complete this form and attach either the prescription receipt(s) that shows the copayment or coinsurance amount paid to the mail-order pharmacy or the statement of benefits you receive from the mail-order pharmacy.

† **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Appealing Health Service Issues

Each WVCHIP member and provider is assured a right to have a review of health services matters under WVCHIP. Health service matters may include (but are not limited to) such issues as correct or timely claims payment; a delay, reduction, or denial of a service, including pre-service decisions; and suspension or termination of a service, including the type and level of service. This same process can apply to prescription drugs or supplies available through WVCHIP for information on filing a Pharmacy Appeal).

Exception from Review: WVCHIP does not provide a right to review any matter whose only satisfactory remedy or decision would require automatic changes to the program's State Plan, or in Federal or State law governing eligibility, enrollment, the design of the covered benefits package that affects all applicants or enrollees or groups of applicants or enrollees, without respect to their individual circumstances.

WVCHIP assures the right of appeal in three steps or levels, except for emergencies, as described below.

1st level: The member, provider or representative must start the process within 60 days of learning of the denial of service. To start the appeal process, contact Molina at 1-800-479-3310 to explain the issue. This allows them to check the issue and present information concerning actions they have taken (such as a benefit limit, a date for claims processing, etc.). In most cases, they will give the needed information on the date of this phone contact. They will give a response no later than 7 days after the initial phone contact with them. For prior authorization medical decision denials, contact **HealthSmart at 1-800-356-2392.**

2nd level: If the information the member or provider receives after taking the first step does not resolve the issue, the member or provider must take it to this next step within 30 days after the 1st level response. The member or provider must write a letter explaining the problem and why there is continued disagreement with the information or response at the 1st level. All information pertinent to the appeal must be included with the request:

1. a written statement explaining the issue
2. all copies of supporting documents or statements that have been provided about the issue
3. a copy of the denied claim (the Explanation of Benefits) and /or written statement provided to either the member or provider by Molina

Appeal letters in Level 2 should be mailed to:

Incorrect Payment, Claims
Timely Filing, Claims Management, Dental
Molina
P.O. Box 3732
Charleston, WV 25337

Prior Authorization Denials
HealthSmart
Appeals
PO Box 2451
Charleston, WV 25329

A written response will be issued within 30 days. For payment issues the claim will be reprocessed for payment if that is the proper resolution. For all other issues, a letter explaining the actions they are prepared to take, or the reasons for their action with respect to benefits (an Explanation of Benefits).

3rd level: After receiving the written response, the member or provider may appeal this decision to a third step review by requesting that the Executive Director review the Level 2 case file. Copies of all written statements of facts, issues, letters and relevant information provided in the case file must be mailed to:

Executive Director, WVCHIP, 2 Hale Street, Suite 101, Charleston, WV 25301

Within 30 days, the Director will send a written decision which takes into account all written materials provided by both parties at Level 3. The decision will explain whether the actions taken at Level 2 will be upheld or changed. If the issue of appeal is about clinical or medical matters, the Executive Director may consider a review by the consulting Medical Director.

Total Time Limit for the Appeal Process

Many appeals are decided within thirty (30) days; however, any appeal must be completed within ninety (90) days from the date of the initial phone contact to the issuance of a written decision at 3rd level.

Appealing Health Service Issues (Cont.)

IMPORTANT NOTE: Expedited reconsiderations are only to be requested if the authorization request is medically urgent.

Medically Urgent is defined as follows: A delay in service could seriously jeopardize

1) the life or health of the member;
2) the ability of the member to regain function;
3) in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without care or treatment that is the subject of the case.

An expedited review process may take place within 72 hours (or up to a maximum of 14 days, if the member requests an extension). After starting Level 1, and making a written notice by facsimile copy of a request for an emergency review, you may go directly to Level 3 for resolution.

Controlling Costs

Benefit Plan Fee Schedules: WVCHIP pays health care providers according to maximum fee schedules and rates established by WVCHIP. If a provider's charge is higher than the WVCHIP maximum fee for a particular service, WVCHIP will allow only the maximum fee. The "allowed amount" for a particular service will be the lesser of either the provider's charge or the WVCHIP maximum fee.

Physicians and other health care professionals are paid according to a Resource Based Relative Value Scale (RBRVS) fee schedule. This type of payment system sets fees for professional medical services based on the relative amounts of work, overhead and malpractice insurance expenses involved. These rates are adjusted annually. West Virginia physicians who treat WVCHIP patients must accept WVCHIP's allowed amount as payment in full; they may not bill additional amounts to WVCHIP patients.

Most inpatient and outpatient hospital services are paid on a "prospective" basis by which West Virginia hospitals know in advance what WVCHIP will pay per outpatient service or per admission. WVCHIP's reimbursement to hospitals is based on Diagnosis-Related Groups (DRGs), which is the system used by Medicare. West Virginia hospitals are provided specific information about their reimbursement rates for WVCHIP.

Prohibition of Balance Billing: Any West Virginia or WVCHIP network health care provider who treats a Plan member must accept assignment of benefits and cannot bill the members for any charges above the WVCHIP fee allowance or for any discount amount applied to a provider's charge to determine payment. This is known as the "prohibition of balance billing" and applies to any WVCHIP provider.

Note: ***It is the obligation of the parent or guardian of the member to present the WVCHIP member card to the provider, i.e. physician's office, hospital, etc, at the time of service or within 30 days from the date of service. If the member card with correct billing identification is not provided in a timely manner which causes delays of the provider's submission of the claim to WVCHIP within the timely filing limits, the provider may hold the guardian or member responsible for payment of the claim. Parent or guardian may also be held responsible for any service provided that is not a covered benefit under the WVCHIP program.***

Recovery of Incorrect Payments: If WVCHIP, Molina, or Express Scripts, Inc. (ESI) discovers that a claim has been incorrectly paid, or that the charges were excessive or for non-covered services, WVCHIP, Molina, and ESI have the right to recover the payments from any person or entity.

You must cooperate fully to help recover any such payment. WVCHIP will request refunds or deduct overpayments from a provider's check in order to recover incorrect payments. This provision shall not limit any other remedy provided by law.

Subrogation

If WVCHIP pays a child's medical expenses for an illness, injury, disease or disability, and another person is legally liable for those expenses, WVCHIP has the right to be reimbursed for the expenses already paid. WVCHIP can collect only those amounts related to that illness, injury, disease or disability. This process is known as subrogation.

WVCHIP has the right to seek repayment of expenses from, among others, the party that caused the sickness, injury, disease, or disability; that party's liability carrier; or the policyholder's own auto insurance carrier in cases of uninsured/underinsured motorist coverage or medical pay provisions. Subrogation applies, but it is not limited to, the following circumstances:

1. payments made directly by the person who is liable for the child's sickness, injury, disease, or disability, or any insurance company which pays on behalf of that person, or any other payments on his or her behalf; and

2. any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist policy or medical pay provisions on the child's behalf; and

3. any payments from any source designed or intended to compensate the child for sickness, injury, disease, or disability sustained as the result of the actual or alleged negligence or wrongful action of another person.

This right of subrogation shall constitute a lien against any settlement or judgment obtained by or on behalf of an insured for recovery of such benefits.

Responsibilities of the Insured

It is the obligation of the parent or guardian of the member to:

1. notify WVCHIP in writing of any injury, sickness, disease or disability for which WVCHIP has paid medical expenses on the child's behalf that may be attributable to the wrongful or negligent acts of another person; and
2. notify WVCHIP in writing if you retain the services of an attorney, and of any demand made or lawsuit filed on the child's behalf, and of any offer, proposed settlement, accepted settlement, judgment, or arbitration award; and
3. provide WVCHIP or its agents with any information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance required in assimilating such information, and cooperate with WVCHIP or its agents in defining, verifying or protecting its rights of subrogation and reimbursement; and
4. promptly reimburse WVCHIP for benefits paid on the child's behalf attributable to the sickness, injury, disease, or disability, once you have obtained money through settlement, judgment, award, or other payment.

Failure to comply with any of these requirements may result in:

1) WVCHIP withholding payment of further benefits; and/or
2) Your obligation to pay attorney fees and/or other expenses incurred by WVCHIP in obtaining the required information or reimbursement.

These provisions shall not limit any other remedy provided by law. This right of subrogation shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Please note: As with any claim, a claim resulting from an accident or other incident that may involve subrogation should be submitted within WVCHIP's filing requirement of six months. It is not necessary that any settlement, judgment, award, or other payment from a third party has been reached or received before filing the child's claim with WVCHIP.

Detecting and Reporting Fraud & Abuse

The United States spends over $1 trillion on health care each year. It is estimated that fraudulent billings to health care programs are anywhere from 3% to 15% of this amount. These estimates put the amount attributable to fraud anywhere from $30 billion to $150 billion per year. These fraudulent claims increase the burden to society and represents money that could be better spent elsewhere. For example, the money that WVCHIP pays for fraudulent claims could better be used by providing coverage to an additional number of kids or providing additional benefits for our existing members.

What is Fraud & Abuse: Fraud is an intentional deception made for personal gain. It is to willfully and knowingly act deceptively to obtain something of value. Abuse is to obtain something of value by providing incorrect or misleading information, but not necessarily a willful or intentional act. Fraud and abuse may be committed by health care providers or members of group insurance plans (including members of WVCHIP, Medicaid, or Medicare), as well as others involved with the delivery of health care.

Examples of Provider Fraud

- Payments (in cash or kind) in return for your WVCHIP member number
- Waiving copayments
- Balance billing for services not provided
- Billing for a non-covered service as a covered service (e.g. billing a "tummy-tuck" (non-covered) as a hernia repair (covered))
- Every patient in a group setting receiving the same type of service or equipment on the same day
- Services listed on your Explanation of Benefits (EOB) that you don't remember receiving or didn't need (See page 51 for EOB form explanation)
- Intentional incorrect reporting of diagnoses or procedures (up-coding), or billing for separate parts of a procedure rather than the whole procedure (unbundling) to maximize payment
- Accepting or giving kickbacks for member referrals
- Prescribing additional and unnecessary treatments (over-utilization)

Examples of Member Fraud

- Providing false information when applying for WVCHIP coverage
- Forging prescriptions or selling prescription drugs
- "Loaning" or using another person's member card

Tips to Help Prevent Fraud

There are things you can do to help fight fraud and abuse in WVCHIP:

- Look at your WVCHIP EOB carefully to make sure that WVCHIP has been billed for medical or dental services or equipment that you actually received. Check to see that the date of service is correct.
- DO NOT give your WVCHIP member card number to anyone except your doctor, clinic, hospital, or other health care provider who is providing services to you. DO NOT let anyone borrow your WVCHIP member card.
- DO NOT ask your doctor or other health care provider for medical care that you do not need.
- Ask for copies of everything you sign. Keep these copies for your records.
- DO NOT share your WVCHIP information, or other medical information, with anyone except your doctor, clinic, hospital, or other health care provider.
- If you are offered free tests or screenings in exchange for your WVCHIP member card number, be suspicious. Be careful about accepting medical services when you are told they will be free of charge.
- Give your WVCHIP member card only to those who have provided you with medical services.
- If anyone claims they know how to make WVCHIP pay for health care services or goods that WVCHIP usually does not pay for, you should avoid them.

What Should You Do If You Suspect Fraud?

If you suspect fraud, report it. To report suspected fraud and abuse, please call the WVCHIP HelpLine at 1-877-982-2447. You will be asked to provide all pertinent information and the HelpLine operator will make sure the information gets to the appropriate place for investigation. Be ready to provide the WVCHIP member name and number, the name of the healthcare provider, the date of service, the amount of money that was either approved or paid (as listed on your EOB), as well as a description of the acts that you suspect involves either fraud or abuse relating to your allegation.

Privacy Notice

Effective date: April 14, 2003

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.

SUMMARY

In order to provide you with benefits, West Virginia Children's Health Insurance Program (CHIP) will receive personal information about your health, from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

Occasionally, we may use members' information when providing treatment. We use members' health information to provide benefits, including making claims payments and providing customer service. We disclose members' information to health care providers to assist them to provide you with treatment or to help them receive payment, we may disclose information to other insurance companies as necessary to receive payment, we may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members' information as required by law or as permitted by CHIP policies.

KINDS OF INFORMATION THAT THIS NOTICE APPLIES TO

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your health information.
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to respond to your requests or concerns within a timely manner.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

WHO MUST ABIDE BY THIS NOTICE

- CHIP.
- All employees, staff, students, volunteers and other personnel whose work is under the direct control of CHIP.

The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION.

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Treatment. We may use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers and others, whose work is under our direct control, may read your health information to learn about your medical condition and use it to help you make decisions about your care. For instance, a health plan nurse may take your blood pressure at a health fair and use the results to discuss with you related health issues. We will also disclose your information to others to provide you with options for medical treatment or services. For instance, we may use health information to identify members with certain chronic illnesses, and send information to them or to their doctors regarding treatment alternatives.

2. Payment. We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our customer service department or at our claims processing administrator may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the subscriber and each dependent that are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information

confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company that we contract with to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others who we contract with to provide administrative services. This includes our third-party administrators, lawyers, auditors, accreditation services, and consultants, for instance. These third-parties are called "Business Associates" and are held to the same standards as WVCHIP with regard to ensuring the privacy, security, integrity, and confidentiality of your personal information. If, in the course of healthcare operations, your confidential information is transmitted electronically, WVCHIP requires that information be sent in a secure and encrypted format that renders it unreadable and unusable to unauthorized users.

4. Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process. We will only disclose the minimum amount of health information necessary to fulfill the legal requirement.

5. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations. We will only disclose the minimum amount of health information necessary to fulfill the investigation request.

8. Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.

9. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

11. Research. We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

12. Information to Members. We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.

YOUR RIGHTS

1. Authorization. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. We will only disclose the minimum amount of health information necessary to fulfill the authorization request. If you authorize us to use or disclose your health information, in additional circumstances you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

2. Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication. If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

4. Inspect And Receive a Copy of Health Information. You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Health Information. You have the right to ask us to amend health information about you, which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

7. Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. Complaints. You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the: Region III, Office for Civil Rights, U.S. Department of Health and Human Services, 150 South

Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information, which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all subscribers within 60 days of the effective date.

WHO TO CONTACT

- For more information about this notice, or
- For more information about our privacy policies, or
- If you have any questions about the privacy and security of your records, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices. Copies of this notice are also available at local WV DHHR offices and by email. You may contact the person named below by mail or phone at (304) 558-2732 or send an email to: wvchip@wv.gov to request the notice electronically. This notice is also available on our website: www.chip.wv.gov.

WVCHIP HIPAA Compliance Officer ● #2 Hale Street, Suite 101 ● Charleston, WV 25301

Drafted: April 14, 2003

Revised: June 2011

Check the CHIP Health e-Library for Facts, Fun, & Tips

www.chip.wv.gov or click on the Healthy Kids icon or.....

Prevention And Getting Care

- The Immunization Tables for When Kids Get Their Shots
  http://www.chip.wv.gov/SiteCollectionDocuments/Immunization%20Schedules-Birth%20thru%20Age%2018.pdf
- The Pediatric Recommended Schedule for Preventive (Wellness) Visits
  http://www.chip.wv.gov/SiteCollectionDocuments/Preventive%20Services%20Timeline.pdf
- Ages and Stages Questionnaire (ASQ): Before your child's next well-child visit, you can check your child's development by filling out an ASQ to see how they are doing. It can help you have a more meaningful discussion with your child's pediatrician. To get a paper copy, please call the WVCHIP Call Center at 1-877-982-2447, and they will mail you a free copy.
- Find a Dentist for Your Location
  http://www.insurekidsnow.gov/state/westvirginia/westvirginia_oral.html

Quick Checks And Urgent Care Emergencies

- What to Do When My Child Has a Fever?
  http://www.chip.wv.gov/SiteCollectionDocuments/Child%20Fever%20Precaution%20Steps.pdf
- Kids Doc Symptom Checklist
  http://www.healthychildren.org/english/tips-tools/symptom-checker/Pages/default.aspx
- When Should I Take My Child to the Emergency Room?
  http://www.chip.wv.gov/SiteCollectionDocuments/Emergency%20Room%20Use%20Oct%202012.pdf
- Contacting the Poison Center
  http://www.wvpoisoncenter.org/Default.aspx

Special Needs And Extra Help

- Fitness and Diet the 5-2-1-0 Way!
  http://www.chip.wv.gov/SiteCollectionDocuments/5210%20Flyer%202013.pdf
- Help Me Grow: A program aimed at ages 1 to 5 that connect parents and health providers to special services needs in their communities such as Early Head Start, Family Resource Centers, Parenting Classes and Support Groups, Child Nutrition and more! Call 1-800-642-8522 or Go to:
  http://www.dhhr.wv.gov/helpmegrow/Pages/default.aspx

Videos

- Don't Think Sugary Sodas Matter? Watch this!
  http://www.youtube.com/watch?v=62JMfv0tf3Q
- Brushing Baby's Teeth: Oral Health for Babies & Toddlers
  http://www.webmd.com/parenting/baby/caring-babies-teeth

Medications and Information

- Antipsychotic Medicines for Children and Teens (A Review of the Research for Parents and Caregivers)
  http://www.chip.wv.gov/SiteCollectionDocuments/Antipsychotic%20Medicines%20for%20Children%20%20Teens.pdf

WVCHIP MEDICAL HOME PROGRAM

Medical Home Physician Selection Form

Guardian Name _____ Guardian ID _____
Address _____ Daytime Phone _____
City, State Zip _____

Covered Individual	Date of Birth	Member ID	Medical Home Provider NPI

Comments

GUARDIAN's SIGNATURE: _____ DATE: _____

**If you do not have your provider's NPI number, please include their full name and address.

Coverage in the Medical Home Program will not start until the first day of the month after we get this form.

Please return this form to:

Molina Medicaid Solutions
PO Box 2673
Charleston, West Virginia 25301-2673

Or FAX to (304) 340-2763

WVCHIP
2 Hale Street, Suite 101
Charleston, WV 25301

Who To Call With Questions

Utilization Management, Prior Authorizations	**HealthSmart**	**(toll free) 1-800-356-2392** **(fax number) 1-855-619-4678**
Claims	**Molina**	**(toll free) 1-800-479-3310**
Orthodontia Prior Authorizations	**WVCHIP**	**Mail to: WVCHIP, 2 Hale Street, Suite 101, Charleston, WV 25301**
Prescription Drug Benefits & Claims Pharmacy Help Desk Common Specialty Drugs Prescription Drug Prior Authorization Program	**Express Scripts, Inc™** **Express Scripts, Inc™** **HealthSmart** **WVU's School of Pharmacy (Rational Drug Therapy Program - RDTP)**	**(toll free) 1-877-256-4689** **www.express-scripts.com** **(toll free) 1-800-824-0898** **(toll free) 1-800-356-2392** **www.healthsmart.com** **(toll free)1-800-847-3859** **(fax number) 1-800-531-7787**
Eligibility, Application Status, Renewals and General Information	**WVCHIP Helpline**	**(toll free) 1-877-982-2447** **www.chip.wv.gov**
Online Electronic Application Applying for WVCHIP	**WVInRoads**	**www.wvinroads.org**
Change of Address or Household Status or to Add a Newborn	**DHHR Change Center**	**(toll free) 1-877-716-1212**
General Health Information Help Lines	**CAMC** **WVU Healthline**	**(toll free) 1-888-432-5849** **(toll free) 1-800-982-8242**