Medicaid

Select Health Community Care

Fair Treatment Notice

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

We provide free aid to those with disabilities to help them communicate with us. This may be sign language interpreters or information in other formats (large print, audio, electronic).

Help for those whose first language is not English, such as interpreters or members materials in other languages. Need help? Call Selecth Health Member Services at **800-538-5038**.

If you feel you've been treated unfairly, call Select Health 504/ Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

LANGUAGE ACCESS SERVICES

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Selec tHealth。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę'ę'', t'áá jiik'eh, éí ná hólǫ', kojį' hódíílnih Select Health.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select Health.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez Select Health.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth. まで、お電話にてご連絡ください。

SelectHealth

ПАЖЊА: Ако говорите Српски, бесплатне услуге пмоћи за језик, биће вам доступне. Контактирајте Select Health.

تنبيه: إذا كنت تتحدث عربي، فستتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل بـ Select Health.

توجه: اگر به زبان ار او را د کنی صحبت می‌کنید، خدمات کمک زبانی، بصورت رایگان در اختیار شما ست. با Select Health تماس بگیرید.

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Phone Numbers and Contact Information

SELECT HEALTH NUMBERS

Name	Help Offered	Contact Information
Select Health Member Services	Help with understanding: • Your insurance plan • Prescription drugs and pharmacies • Benefits and coverage • Claims payments	**855-442-3234** Hours: Weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m. TTY/TDD users, please call 711
Select Health Member Advocates®	• Help finding the right doctor • Help making an appointment • Facts about a doctor	**800-515-2220** Hours: Weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.
Behavioral Health Advocates℠	• Help finding a mental health provider • Help making an appointment	**800-876-1989** Hours: Weekdays from 8:00 a.m. to 6:00 p.m.
Care Management	• Help with medical or behavioral health care and more	**800-442-5305** Hours: Weekdays, from 8:00 a.m. to 5:00 p.m.
Select Health Healthy Beginnings®	• Help with a safe and healthy pregnancy	**866-442-5052**, option 1 Hours: Weekdays, from 8:00 a.m. to 5:00 p.m.
Restriction Program	• Help with the Restriction Program	**800-442-5305**

SELECT HEALTH NUMBERS

Name	Help Offered	Contact Information
Pharmacy Services	• Prescription drugs and pharmacies • Benefits and coverage	**855-442-9900** Hours: Weekdays, from 7:00 a.m. to 9:00 p.m., and Saturdays, from 9:00 a.m. to 3:00 p.m.
Appeals	• Help reviewing an Adverse Benefit Determination to see if the right decision was made when your request for service was denied	**844-208-9012** Weekdays, from 8:00 a.m. to 5:00 p.m.
Select Health Website	• Member Handbook • Community resources • Wellness	**selecthealth.org**

STATE MEDICAID NUMBERS

Name	Help Offered	Contact Information
DWS (Department of Workforce Services)	• Eligibility for Medicaid or CHIP • Lost or stolen cards • Food stamps • Other programs	**801-526-0950** **866-435-7414** **jobs.utah.gov/assistance**
HPR (Health Program Representative)	• Medicaid • CHIP • Health plans • Rights & Responsibilities • Providers	**866-608-9422** **dhhs.utah.gov**
Medicaid Benefits Constituent Services	• Medicaid and CHIP questions and concerns	**877-291-5583**
Medicaid Information Line	• Claims • Billing questions	**800-662-9651** **medicaid.utah.gov**
Medicaid Member Information	• Enrollment eligibility • Plan Information	**844-238-3091**
MyBenefits	• Check your Medicaid coverage and plan information	**844-238-3091** **mybenefits.utah.gov**
Pregnancy Risk Line	• Information for people who are pregnant, thinking of becoming pregnant, or breastfeeding	**800-822-2229** Hours: Weekdays, from 8:00 a.m. to 5:00 p.m. All phone calls are free and confidential
Utah Medicaid	• Medicaid • CHIP	**medicaid.utah.gov**

OTHER NUMBERS

Name	Help Offered	Contact Information
Utah Poison Control	• Resource for poison information and help	**800-222-1222** Hours: 24 hours a day; 7 days a week
Behavioral Health CrisisLine (UNI)	• Free help for a mental health crisis	**801-587-3000** **9-8-8** Hours: 24 hours a day; 7 days a week

Introduction

Welcome and thank you for choosing Select Health Community Care®. Your health is important to us, and we will do all we can to help you with your healthcare needs.

This handbook explains the Medicaid services we cover. If you would like a printed copy of the handbook or Provider and Pharmacy Directory, please call Member Services at **801-442-3234** or toll-free at **855-442-3234**. You can also find these resources and more on our website at **selecthealth.org/plans/medicaid.**

Please note: the benefits in this guide may change. If so, we will let you know at least 30 days before any big changes are made to your benefits.

Language Services

HOW CAN I GET HELP IN OTHER LANGUAGES?

If you are deaf, blind, have a hard time hearing or speaking, or if you speak a language other than English, call Member Services at **801-442-3234** or toll-free at **855-442-3234**. We will find someone who speaks your language, free of charge.

If you are hard of hearing, call Utah Relay Services at 711 or **801-715-3470** or toll-free at **800-346-4128**. Utah Relay Services is a free public telephone relay service or TTY/TTD. If you need Spanish relay services, call **888-346-3162**.

If you feel more comfortable speaking a different language, please tell your doctor's office or call Member Services. We can have an interpreter go with you to your doctor visit. We also have many doctors in our network who speak or sign other languages.

You may also ask for our documents in any language you need by calling our Member Services team.

Changed your address or phone number? Contact the Department of Workforce Services (DWS) at 801-526-0950 to ensure you aren't missing important communications.

Rights and Responsibilities

WHAT ARE MY RIGHTS?

You have the right to:

- Have information presented to you in a way that you will understand, including help with language needs, visual needs, and hearing needs.
- Be treated fairly and with respect.
- Have your health information kept private.
- Receive information on all treatment alternative options.
- Make decisions about your health care, including agreeing to treatment.
- Take part in decisions about your medical care, including refusing service.
- Ask for and receive a copy of your medical record.
- Have your medical record corrected, if needed.
- Receive medical care regardless of race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability.
- Obtain information about grievances, appeals, and hearing requests.
- Ask for more information about our plan structure and operations.
- Get emergency and urgent care 24 hours a day, seven days a week.
- To use any hospital or other medical facility for emergency services.
- Not feel controlled or forced into making medical decisions.
- Know how we pay providers, including your right to request information about physician incentive plans.
- Create an advance directive that tells doctors what kind of treatment you do and do not want in case you become too sick to make your own decisions.
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation. This means you cannot be held against your will. You cannot be forced to do something you do not want to do.
- Use your rights at any time and not be treated badly if you do. This includes treatment by our health plan, your medical providers, or the State Medicaid agency.
- To be given health care services that are the right kind of services based on your needs.
- To get covered services that are easy to get to and are available to all members. All members include those who do not prefer speaking in English, or have physical or mental disabilities.
- To get a second opinion at no charge.
- To get the same services offered under the fee-for-service Medicaid program.
- To get covered services out-of-network if we cannot provide them.

WHAT ARE MY RESPONSIBILITIES?

Your responsibilities are to:

- Follow the rules of this plan.
- Read this Member Handbook.
- Show your Medicaid Member Card each time you get services.
- Cancel doctor appointments 24 hours ahead of time if needed.
- Respect the staff and property at your provider's office.
- Use providers (doctors, hospitals, etc.) in the Select Health Community Care network.
- Pay your copayments (copays).

ENDING YOUR MEMBERSHIP

If you want to change your health plan, you must call or see a Medicaid Health Program Representative (HPR) and ask if you are eligible for a health plan change. To speak with an HPR, call **866-608-9422**.

Select Health can cancel your membership if you do anything on the list below:

- You are abusive or you make threats or are violent.
- You don't follow the member responsibilities listed in this handbook.

Medical Policies

When we make a decision on coverage for care, we do not randomly deny or reduce coverage only because of a diagnosis, type of illness, or a condition you have. We make decisions based on the Utah Medicaid Coverage and Reimbursement Code Lookup.

Please note: Utah Medicaid's decision on costs for care may change at times. The Department of Health decides on how new technology is covered and how much they will cost. We use these things to make sure our decisions are fair, consistent, and correct.

Contacting My Medicaid Plan

WHO CAN I CALL WHEN I NEED HELP?

Our member services team is here to help you and answer your questions. You can call us at **801-442-3234** or toll-free at **855-442-3234** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturday, from 9:00 a.m. to 2:00 p.m.

We can help you:

- Find a provider.
- Change providers.
- Answer questions about bills.
- Understand your benefits.
- Find a specialist.
- With a complaint (also called a grievance) or an appeal.
- Answer questions.

You can also find us online at **selecthealth.org/plans/medicaid**.

Medicaid Benefits

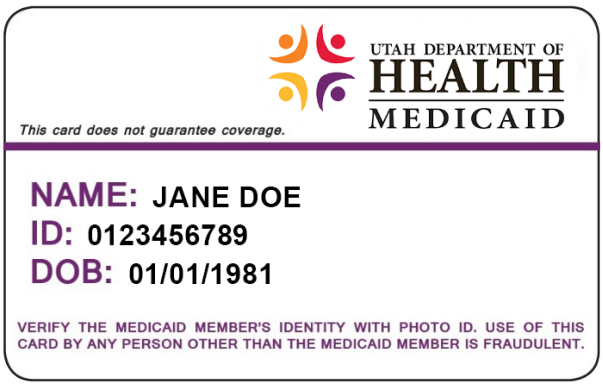
HOW DO I USE MY MEDICAID BENEFITS?

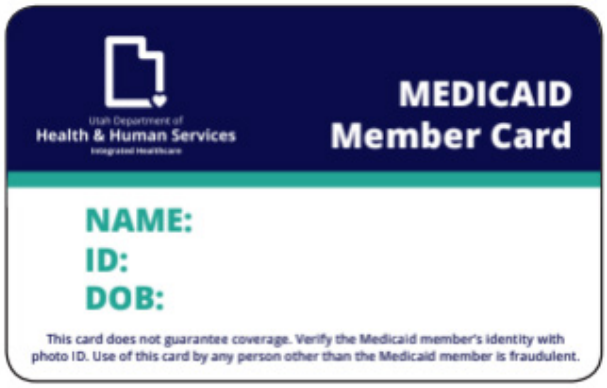
Each Medicaid member will get a Medicaid Member Card. You will use this card whenever you are eligible for Medicaid. You should show your Medicaid Member Card before you receive services or get a prescription filled.

Always make sure that the provider accepts your Medicaid plan or you may have to pay for the service.

WHAT DOES MY MEDICAID MEMBER CARD LOOK LIKE?

The Medicaid Member Card is wallet-sized and will have the member's name, Medicaid ID number, and date of birth on the card. Your Medicaid Member Card will look like one of these:





DO NOT lose or damage your card or give it to anyone else to use. If you lose or damage your card, call the Department of Workforce Services (DWS) at **1-866-435-7414**, or a Health Program Representative (HPR) at **1-866-608-9422** to get a new card.

CAN I VIEW MY MEDICAID BENEFITS ONLINE?

You can check your Medicaid coverage and plan information online at **mybenefits.utah.gov.**

Primary individuals can look at coverage and plan information for everyone on their case. Adults and children 18 and older can view their own coverage and plan information. Access to this information may also be given to medical representatives.

For more information on accessing or looking at benefit information, please visit **mybenefits.utah.gov** or call **1-844-238-3091**.

You may also look at your plan benefits online at **selecthealth.org/plans/medicaid.**

Not sure when your renewal date is? You can check by calling the Department of Workforce Services (DWS) at **866-435-7414** or visit **jobs.utah.gov** to find a DWS office near you.

If you got a letter to reapply for Medicaid (or think it's time to), here are ways to renew your coverage:

- Online: Reapply right away using "My Case" at **jobs.utah.gov/mycase.**
- By mail: Watch your mailbox for an application from the Utah Department of Health Medicaid Office.
- In-person: For in-person help to apply for insurance, call **2-1-1** or visit **Take Care Utah** to find a trained assister near you.

If it is time for you to renew, please don't wait. If you do not respond, your coverage will end automatically.

If you no longer qualify for Medicaid, you can still stay with Select Health. We offer many types of plans, including: CHIP, Medicare, Individual plans that could include tax credits through **Healthcare.gov**, short-term coverage, and employer plans. Our Member Services team is happy to answer any questions about keeping your current doctors and maintaining care while changing plans. Please call us at **800-538-5038**.

Finding a Provider

WHAT IS A PRIMARY CARE PROVIDER?

A Primary Care Provider (PCP) is a doctor that you see for most of your health care needs and provides your day-to-day health care. Your PCP knows you and your medical history. With a PCP, your medical needs will be managed from one place. It is a good idea to have a PCP because they will work with us to make sure that you get the care that you need.

HOW DO I CHOOSE A PRIMARY CARE PROVIDER?

You will need to choose a PCP from our provider directory, **selecthealth.org/find-a-doctor.** The provider directory includes information about provider name, address, phone number, professional qualifications, specialty, medical school attended, and board certification status. Once you have chosen a PCP, you will need to contact Member Services and let them know. If you need help choosing a PCP, call Member Advocates at **800-515-2220**. If you have a special health care need, one of our care managers will help you choose a PCP.

HOW CAN I CHANGE MY PRIMARY CARE PROVIDER?

Call Member Services at **801-442-3234** or toll-free at **855-442-3234** if you want to change your PCP.

SELECT HEALTH MEMBER ADVOCATES

Member Advocates can help you find the right care for your needs. They can also help with:

- Scheduling a visit, as well as care for urgent health issues.
- Finding the closest office, doctor, or behavioral health doctor with the nearest available appointment.
- Giving facts about a doctor such as age, training certifications, medical school, and languages spoken.
- Helping you know and get the most out of your benefits.

Call Member Advocates at **800-515-2220** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

ONLINE DOCTOR AND FACILITY SEARCH

The online doctor and facility search gives you fast, helpful information about doctors and hospitals on your plan.

The most up-to-date list of doctors (Primary Care, Secondary Care, and Ancillary Care) and facilities can be found at **selecthealth.org/find-a-doctor.** If you would like a printed copy of the doctor list, you can call Member Services and ask that a printed copy be mailed to you, free of charge.

You can search using these criteria and more to help you find a doctor or office to meet your needs:

Doctor Information:

- Gender
- Languages spoken
- Office hours

Facility Information:

- Facility type
- Plans accepted
- Location

MOBILE APP

If you've got a smartphone, we've got you covered. With the Select Health mobile app, you have access to your health plan when you need it.

Use your insurance plan on the go. Login to our secure app and find out how easy it is to:

- Search for doctors and hospitals.
- Look up pharmacies and medications.
- See Intermountain InstaCare® wait times and locations. You can even reserve your place in line.

Find us on Google Play® and the Apple® App Store℠.

WHAT IS A NOTICE OF DOCTOR TERMINATION?

Select Health will give you 15 days' notice when your doctor is no longer on your health plan. Call us if you need help finding a new PCP.

Copayments, Copays, and Cost Sharing

WHAT ARE COPAYMENTS, COPAYS AND COST SHARING?

You may have to pay a fee for some services. This fee is called a copayment, copay, or cost sharing.

WHO DOES NOT HAVE A COPAY?

These members never have a copay:

- Alaska Natives
- American Indians
- Members on hospice care
- Members who qualify for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits
- Pregnant women

WHAT SERVICES DO NOT HAVE COPAYS?

Some services that do not have copays are:

- Lab and radiology
- Family planning services
- Immunizations (shots)
- Preventive services
- Tobacco cessation services (Help quitting smoking)
- Outpatient behavioral health (mental health and substance use disorder) services

WHAT IS AN EXPLANATION OF BENEFITS (EOB)?

Any time you have a copay or get a non-covered service, we will send you an EOB. An EOB is not a bill.

An EOB shows:

- What your doctor charged for you care.
- What we paid for your care.
- Copays you paid.
- How close you are to your out-of-pocket maximums.

Always read your EOB. If you did not get services listed on the EOB, talk with Member Services.

WHEN DO I PAY COPAYS?

You may have to pay a copay if you:

- See a doctor.
- Go to the hospital for outpatient care.
- Have a planned hospital stay.
- Use the emergency room when it is not an emergency.
- Get a prescription drug.

COPAY AMOUNT CHART

Service	Copay
Emergency Room (ER)	$8 copay for non-emergency use of the ER
Inpatient Hospital	$75 copay per inpatient hospital stay (started July 1, 2017)
Pharmacy	$4 copay per prescription, up to $20 per month
Physician Visits, Podiatrist & Outpatient Hospital Services	$4 copay, up to $100 per year combined (including ophthalmologists)
Vision Services	$4 copay for ophthalmologists

WHAT IS AN OUT-OF-POCKET MAXIMUM?

Medicaid has a limit on how much you have to pay in copays. This is called an out-of-pocket maximum and applies to specific types of services and for specific time periods.

WHAT HAPPENS WHEN I REACH MY OUT-OF-POCKET MAXIMUM?

Make sure you save your receipts every time you pay your copay. Once you reach your out-of-pocket maximum, contact Medicaid at **1-866-608-9422** to help you through the process.

OUT-OF-POCKET MAXIMUM COPAYS:

- Pharmacy - $20 copay per month.
- Physician, podiatry, and outpatient hospital services - $100 copay per year* combined.

*A copay year starts in January and goes through December.

Please note: You might not have a copay if you have other insurance, including Medicare.

For more information, please refer to the Medicaid Member Guide. To request a guide, call **1-866-608-9422**. Information is also online at **www.medicaid.utah.gov.**

WHAT SHOULD I DO IF I GET A MEDICAL BILL?

If you get a bill for services that you believe should be covered by Medicaid, call Select Health Member Services for assistance. Do not pay a bill until you talk to Select Health Member Services. You might not be reimbursed if you pay a bill on your own.

You may have to pay a medical bill if:

1. You agree (in writing) to get specific care or services not covered by Medicaid before you get the service.
2. You ask for and get services that are not covered during an appeal or Medicaid State Fair Hearing. You only pay for the services if the decision is not in your favor.
3. You do not show your Medicaid Member Card before you get services.
4. You are not eligible for Medicaid.
5. You get care from a doctor who is not with your Medicaid plan, or is not enrolled with Utah Medicaid (except for emergency services).

Choosing the Right Care

If you can, it's best to see your doctor for all nonurgent health issues. But there may be times when you need care right away and can't get in to visit your doctor. When this happens, use one of these:

Intermountain Health Answers℠

If you are not sure where to start, Intermountain Health Answers can help. A team of caring and experienced registered nurses are available 24 hours a day to listen to your concerns, answer questions, and help you decide what you need to do to feel better.

The nurses can offer home-based remedies, tell you when to see a doctor, and/or refer you to the most appropriate care. To reach Health Answers, call **844-501-6600**.

Intermountain Connect Care©

Get care for you or your child 24 hours a day, 7 days a week. Use a smartphone, tablet, or PC to talk to a real doctor whenever, wherever.

The $49 cost is covered by Community Care Medicaid. Make sure to enter your Medicaid information so you will not be charged for the visit.

This tool is best for health problems that are not urgent, such as sinus pain, stuffy and runny nose, sore throats, eye infections, and more. If the doctor feels that your health problem cannot be taken care of using this tool, they will suggest you see a doctor in person. To learn more, visit **intermountainhealthcare.org/accessing-care/telehealth/connect-care.**

Emergency Care and Urgent Care

WHAT IS AN EMERGENCY?

An emergency is a medical condition that needs to be treated right away. An emergency is when you think your life is in danger, a body part is hurt badly, or you are in great pain.

WHAT IS AN EXAMPLE OF AN EMERGENCY?

Emergencies can include:

- Poisoning
- Overdose
- Severe burns
- Chest pain
- Pregnant with bleeding and/or pain
- Bleeding that will not stop
- Heavy bleeding
- Loss of consciousness
- Suddenly not being able to move or speak
- Broken bones
- Problems breathing
- Other symptoms where you feel that your life is at risk

WHAT SHOULD I DO IF I HAVE AN EMERGENCY?

Call 911 or go to the closest emergency room.

Remember:

- Go to the emergency room only when you have a real emergency.
- If you are sick, but it is not a real emergency, call your doctor or go to an urgent care clinic.
- If you are not sure if your problem is a true emergency, call your doctor for advice.
- There is no prior authorization needed to get emergency care.
- You may use any hospital or other medical facility to obtain emergency care.

WHAT IF I HAVE QUESTIONS ABOUT POISON DANGER?

For poison, medication, or drug overdose emergencies or questions, call the Poison Control Center at **800-222-1222**. If someone is not breathing, call 911 for help.

The Poison Control Center has trained staff on duty 24/7. They can answer questions about poison emergencies and tell you what to do next.

Examples of poison emergencies:

- Chemicals on the skin or in the eyes
- Inhaled fumes after mixing chemicals together or after a gas leak
- Drug or supplement overdose
- A bad reaction to medicine

WILL I HAVE TO PAY FOR EMERGENCY CARE?

There is no copay for use of the emergency room in an emergency. A hospital that is not on your plan may ask you to pay at the time of service. If so, submit your emergency service claim to Select Health. Select Health will pay the claim. You do not need prior approval. If you use an emergency room when it is not an emergency, you will be charged a copay.

WHAT SHOULD I DO AFTER I GET EMERGENCY CARE?

Talk with your PCP about any emergency care you receive.

WHAT IS URGENT CARE?

Urgent problems usually need treatment within 24 hours. If you are not sure a problem is urgent, call your doctor or an urgent care clinic. You may also call our Nurse Phone Line at **844-501-6600.** To find an urgent care clinic, call Member Services at **801-442-3234** or toll-free at **855-442-3234** or visit our website at **selecthealth.org/plans/medicaid.**

WHEN SHOULD I USE AN URGENT CARE CLINIC?

You should use an urgent care clinic if you have one of these minor problems:

- Common cold, flu symptoms, or a sore throat
- Earache or toothache
- Back strain
- Migraine headaches
- Prescription refills or requests
- Stomach ache
- Cut or scrape

Post-Stabilization Care

WHAT IS POST-STABILIZATION CARE?

Post-stabilization care happens when you are admitted to the hospital from the emergency room. This care is covered and includes all tests and treatment until you are stable.

WHEN IS POST-STABILIZATION CARE COVERED?

Select Health covers this type of care in all hospitals. Once your condition is stable, you may be asked to transfer to a hospital on your plan.

DO I NEED PRIOR APPROVAL FOR POST-STABILIZATION CARE?

You do not need prior approval for post-stabilization care if it is received within the Select Health network.

Post-stabilization care received at an out-of-network facility does need notice and prior approval for continued care once the emergency has been stabilized.

CAN I GET EMERGENCY CARE OUTSIDE OF UTAH?

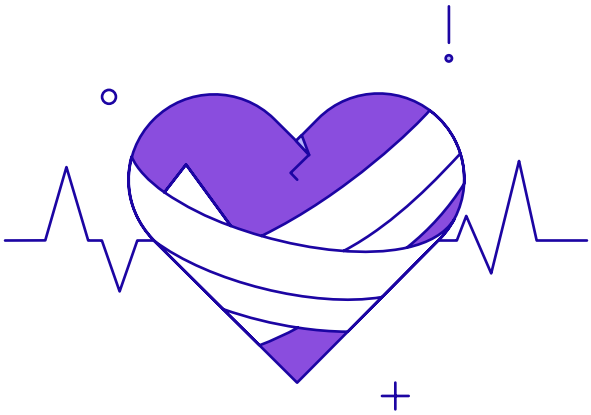
When you are outside of Utah, you are covered only for emergency care. If you have an emergency outside Utah, go to the closest ER. Show your State Medicaid ID Card.

If you need to get a prescription for your emergency, ask the drugstore if they will talk with your health plan or call the Utah Medicaid Information Line at **800-662-9651** before you get the medicine. Medicaid will not pay members back for a prescription they paid for themselves.

Call Member Services at **855-442-3234** about your emergency within 48 hours. An ER staff person can call for you. Make sure to see your PCP if you need follow-up care when you return.

CAN I GET EMERGENCY OR URGENT CARE OUTSIDE OF THE UNITED STATES?

Emergency and urgent care services are **not** covered outside of the United States.



Family Planning

WHAT FAMILY PLANNING SERVICES ARE COVERED?

Family planning services include:

- Information about birth control
- Counseling to help you plan when to have a baby
- Access to birth control (see table below)

You do not have to pay a copayment for family planning and birth control treatments. You can see any provider that accepts Medicaid for family planning and birth control. This means you can get these services from in-network or out-of-network providers. You can also see the provider without a referral.

You can get the following birth control with a prescription from any provider who takes Medicaid or Select Health Community Care:

Types of Birth Control	
Condoms	Yes *OTC
Contraceptive Implants	Yes
Creams	Yes *OTC
Depo-Provera	Yes
Diaphragm	Yes *OTC
Foams	Yes *OTC
IUD	Yes
Morning After Pill	Yes
Patches	Yes
Pills	Yes
Rings	Yes
Sterilization (Tubes tied or Vasectomy)	Yes **Consent form required
Non-surgical Sterilization (like Essure®)	Yes **Consent form required

*OTC means over-the-counter

**Sterilization consent forms must be signed 30 days before surgery.

Some may require prior authorization for coverage.

WHAT FAMILY PLANNING SERVICES ARE NOT COVERED?

Non-covered family planning services include:

- Infertility drugs
- Invitro fertilization
- Genetic counseling

For more information about family planning services, call Member Services at **801-442-3234** or toll-free at **855-442-3234**.

There are limits on abortion coverage. Select Health will cover the cost of an abortion only in cases of rape, incest, or if the mother's life is in danger. Specific documentation is required for abortions.

Benefits and Care Covered By Your Medicaid Plan

CARE MANAGEMENT

Do you have care programs for members with health problems?

We have trained nurses and social workers to help members with health problems like asthma, heart failure, depression, substance use disorder, diabetes, and more.

If you have a health problem and would like to sign up for a care program, call Care Management at **801-442-5305** or toll-free at **800-442-5305**, weekdays, from 8:00 a.m. to 5:00 p.m.

Nurse care managers can:

- Help you get access to the care you need.
- Work with your doctors to manage your care.
- Help you continue getting care if you change health plans.
- Connect you with available social and community resources.

We also offer wellness classes and materials to help you live healthy if you have a chronic health problem. Visit **selecthealth.org/wellness** for more information.

CARE MANAGEMENT PROGRAMS FOR CHILDREN

What if my child has special healthcare needs?

Caring for a child with healthcare problems or special needs can be tough. We have care programs and nurse care managers to help you deal with these health issues.

If you have a child with special needs and want to sign up for a care program, call Care Management **800-442-5305**, option 2 weekdays, from 8:00 a.m. to 5:00 p.m.

A nurse care manager can:

- Answer your questions.
- Manage your child's care with doctors.
- Help you with your child's care needs.

Children may also need other kinds of care. Some of this care may be for physical or speech therapy, healthcare goods (such as wheelchairs), or home care. Your child's doctor will need to call Member Services for prior approval.

EYE CARE (VISION)

Do you cover eye care?

Pregnant persons, and children, can get eye tests and glasses at no cost. They can also get contact lenses at no cost with prior approval. All other members can get one eye test per year with no dollar limit, though glasses are not covered. Your plan will pay for tests and exams for eye problems if needed.

HEALTHCARE SUPPLIES

Does Select Health cover healthcare supplies?

Yes. Your doctor will need to write an order for any supplies you need. You can then have the order filled by any healthcare supplier listed on the approved provider list. Covered healthcare supplies include:

- Wheelchairs
- Prosthetic devices
- Bandages or wound care supplies
- Oxygen
- Other medically necessary supplies

HOME HEALTHCARE

What is home healthcare?

Home healthcare is for people who are ill, but the care needed is given at home instead of in a hospital or nursing home. Your doctor needs to get prior approval for this care.

Some types of care you might get in your home are:

- IV drugs
- Physical therapy
- Nursing
- Care from a home health aide
- Health supplies such as oxygen

If you need home healthcare services, talk to your doctor. If approved, you will be able to choose a home healthcare doctor from the Select Health Approved Provider List.

HOSPICE CARE

What is hospice care?

Hospice is end-of-life care. It is supportive care in the final stages of a terminal illness. Hospice care can be covered if prior approval is given. Once approved, a hospice care agency can be chosen from the Approved Provider List to give end-of-life care.

LAB AND X-RAY SERVICES

Are x-rays and blood tests covered?

We cover lab and X-ray services that are covered by Medicaid. You can get these services in your doctor's office, or you can go to an approved clinic, lab, or hospital for these services.

SELECT HEALTH HEALTHY BEGINNINGS℠

Do you have a care program for pregnant people?

Yes, we have a program called Healthy Beginnings℠. This program works with your doctor to help you have a safe and healthy pregnancy. Once signed up, you will be able to talk to a nurse care manager who will be able to:

- Answer your questions.
- Give you emotional support.
- Help you find the right doctors.

You will get a book on pregnancy that covers the baby's growth, nursing, and more. You may also get incentives when you meet program goals. If you have questions about the program or would like to sign up, call Healthy Beginnings at **866-442-5052**.

MIDWIFE SERVICES

Can a nurse-midwife deliver my baby?

Certified nurse-midwives can deliver babies in the hospital. Deliveries and prenatal care at Birthing Centers are not covered. If a C-section is needed, your doctor will deliver your baby.

You can choose a certified nurse-midwife from the Approved Provider List to care for you while you are pregnant.

NEWBORN COVERAGE

Will my baby be covered?

Your baby will become a member of both Medicaid and Select Health at birth. Please call Member Services and your Medicaid case worker after the baby is born. We will need your baby's information and the doctor's name.

During the first month of your baby's life, if your baby's doctor is not on the Approved Provider List, you can change his or her health plan. If you need help finding an approved doctor for your baby, call Member Services at **855-442-3234**.

NURSING HOME CARE

What is short-term nursing home care?

Short-term care is when someone goes from a hospital to a nursing home for recovery. Select Health pays for short-term nursing home care for 30 days or fewer. Medicaid Long-term Care pays for care needed over 30 days.

A doctor must order short-term care, and you must use a nursing home on the Approved Provider List.

OVER-THE-COUNTER (OTC) DRUGS

We cover some OTC drugs. Though OTC drugs can be purchased without a prescription, you need a prescription from your doctor for Select Health to pay for OTC drugs. If you have a copay, the amount you pay for an OTC drug will count toward your monthly out-of pocket maximum.

PERSONAL CARE SERVICES

What are personal care services?

Personal Care Services help with things like bathing, eating, and dressing. These services are given by a home healthcare aide if you can't do these things alone.

Your doctor needs prior approval for these services. If approved, you can choose a home healthcare agency from the Approved Provider List to help you with your care needs.

PHYSICAL THERAPY (PT) AND OCCUPATIONAL THERAPY (OT)

These types of care need to be ordered by a doctor. You need to see a licensed therapist from the Approved Provider List. Depending on your Medicaid plan, there may be limitations on the number of OT or PT visits you can have. Call Member Services to ask about your plan benefits.

PRESCRIPTION DRUGS

Does my health plan pay for prescription drugs?

We cover select generic and name-brand drugs when prescribed by a doctor from our Approved Provider List. Some prescriptions need prior approval. If your doctor writes a prescription for a name-brand drug, it will be replaced with its generic equal unless prior approval is received.

If you do not get prior approval for a drug that needs prior approval, you will have to pay the full retail price of the drug. For more information, look at the Preferred Drug List found on our website at **selecthealth.org/pharmacy/pharmacy-benefits.**

- You must use a drugstore from the Approved Provider List.
- You must show your state Medicaid ID card.

- We will not replace lost, stolen, or ruined drugs before the refill date.
- We will only cover up to 30 days of medication.

Drugs that call for step therapy are covered only after you have tried the other treatment(s) and it didn't work. Step therapy may apply to either name-brand or generic drugs.

Some drugs will be covered by state Medicaid. They will decide which drugs are covered and what guidelines will be met before they cover them. Drugs covered by the state Medicaid agency most often fall into these categories:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Antidepressants
- Antianxiety
- Anticonvulsants
- Antipsychotic
- Hemophilia factor
- Immunosuppressives
- Substance abuse (opioid or alcohol)

Select Health does not cover prescriptions if you have Medicare. Prescriptions for people with Medicare are covered by Medicare Part D.

The only prescriptions covered by Select Health Community Care for members with Medicare are:

- Some cough and cold medicines
- Medicaid-covered OTC medicine prescribed by your doctor

If you have questions about your drug benefits, call Pharmacy Services at **855-442-9900** weekdays, from 7:00 a.m. to 9:00 p.m., and Saturdays, from 9:00 a.m. to 3:00 p.m.

PREVENTIVE CARE SERVICES FOR ADULTS

Are Wellness Visits covered?

Yes. Yearly wellness visits are covered. Adults can get one wellness visit every 12 months. Meeting with your doctor once a year helps you get the preventive care that you need to live the healthiest life possible.

Preventive care services for adults are limited. Call Member Services, **801-442-3234**, for information on specific preventive services.

Do you call or send reminders for preventive care exams and tests?

We send mailers and brochures about the need for special preventive care services. We also call you when it's time for tests, like mammograms or well child visits. We use an automated calling system that sends you to Member Services after the preventive care message so you can set a time.

PREVENTIVE CARE SERVICES FOR CHILDREN AND TEENS (YOUNGER THAN 21)

Do you have preventive care and Well-child visits for children and teens?

We offer Well-child visits for children starting at birth through age 20. This includes medical tests and shots to make sure your children are healthy. We will also make phone calls to remind you about vaccines and exams for your children.

PREVENTIVE CARE SERVICES FOR PREGNANT PEOPLE

Do you offer preventive care services to pregnant people?

We have preventive care services for pregnant people, including tests for problems that may develop during pregnancy, like anemia and diabetes.

Call Member Services if you have questions about your preventive care benefits.

PODIATRY SERVICES

Can I see a podiatrist if I need to?

We cover podiatry services for children and pregnant people. There are also limited benefits for adults on Medicaid. If you need to see a podiatrist, talk to your doctor. Your doctor will have to get prior approval for you to see a podiatrist from the Approved Provider List.

SPEECH AND HEARING SERVICES

Are hearing aids covered?

We cover speech and hearing services, as well as hearing aids for children and pregnant women. If you need these services, you can have your doctor refer you, or you can choose a therapist (audiologist) from our Approved Provider List.

TOBACCO CESSATION

Does Medicaid offer a program to stop smoking?

The Utah Tobacco Quit Line, available online at **waytoquit.org** and by phone at **800-QUIT-NOW**, gives free treatment to all Medicaid members who want to quit smoking. If you call the quit line, you will:

- Be given a trained coach to help you quit smoking.
- Get up to five private sessions with a coach.
- Get a self-help book.
- Learn how to help a friend or family member quit.
- Find out about free Nicotine Replacement Therapy (NRT) (You must be 18 or older to get NRT).
- The Quit Line is private with coaches that speak English and Spanish. Other languages are spoken, if needed.

Phone coaching is one of the best ways to help people quit smoking or chewing tobacco. You don't need to find a ride or get child care—just pick up the phone and call.

We cover some smoking cessation products for Medicaid members. You can learn more about these products from your Quit Now coach. Talk to your doctor if you need a prescription.

Medicaid has a free support program to help pregnant women stop smoking. Please call **1-866-608-9422** for help getting these services.

These services may require prior authorization.

Benefits and Care Still Covered By Your Medicaid Plan

WHAT BENEFITS ARE COVERED BY MY MEDICAID PLAN?

Depending on the type of plan you have you may have coverage for these benefits and care through the Medicaid program. For more information about your Medicaid benefits, see the state Medicaid Member Guide.

DENTAL CARE

Can I see a dentist?

We only cover emergency dental care.

The Family Dental Plan also has clinics where you can get dental care. For help finding a dentist, call the Medicaid Information Line at **800-662-9651**.

BEHAVIORAL HEALTH SERVICES

If you live in any county other than Wasatch, Medicaid enrolls you in the Prepaid Mental Health Plan (PMHP) for your area. If you live in Wasatch County, you can get mental health services from Wasatch County Family Clinic or any Medicaid provider. You must get behavioral health services through your PMHP. If you want to get care from someone outside the PMHP, you need approval from the PMHP before you get the care. If you don't, you may have to pay the doctor for the care. If you are an American Indian, you can get care from the PMHP or you can also get care from Indian healthcare doctors, the Indian Health Program, or an Urban Indian Organization. PMHPs provide behavioral healthcare in a hospital and provide outpatient mental healthcare. Covered care includes:

- Evaluations
- Psychological testing
- Medication management
- Individual/group therapy
- Psychosocial rehabilitation care
- Case management services
- Respite care
- And more

ALCOHOL AND DRUG DETOX (OUTPATIENT)

Are alcohol and drug abuse treatment covered?

You can get outpatient care for alcohol and drug use from a Medicaid-approved substance use treatment provider. American Indians can get care from any doctors in their county or from Indian healthcare doctors, as well as an Indian Health Program or an Urban Indian Organization.

Waiver Programs

WHAT ARE WAIVER PROGRAMS?

People with special needs can get Medicaid through waiver programs. You can only join a waiver program if you need care that is similar to the care provided in a hospital, nursing home, or care facility for the mentally challenged. Waivers let Medicaid pay for support and care that help people live safely at home or in the community. Each program has set rules and benefits.

For more about how to apply for a waiver program through the state, call the numbers below:

Community Supports, Acquired Brain Injury, Physical Disabilities Waivers

Department of Human Services, Division of Services for People with Disabilities

Website: **dspd.utah.gov**

Phone: **844-ASK-DSPD** or **844-275-3773**

Email: **dspd@utah.gov**

New Choices Waiver

Department of Health, Bureau of Authorization and

Community Based Services

Website: **health.utah.gov/ltc/NC/NCHome.htm**

Phone: **800-662-9651**

Email: **newchoiceswaiver@utah.gov**

Waiver for Individuals Age 65 or Older (Aging Waiver)

Department of Human Services, Division of Aging and Adult Services

Website: daas .utah .gov

Phone: **801-538-4171**

Email: **dhsinfo@utah.gov**

Technology Dependent or Medically Complex Children's Waivers

Department of Health, Bureau of Authorization and Community Based Services

Website: **health.utah.gov/ltc/**

Phone: **800-662-9651**

Email: **techdependent@utah.gov** or **mccw@utah.gov**

Employment-related Personal Assistant Services (EPAS)

Website: **health.utah.gov/ltc/**

Phone: **801-538-6955**

Specialists

WHAT IF I NEED TO SEE A SPECIALIST?

If you need a service that is not provided by your PCP, you can see a specialist in the network. You do not need a referral to see a specialist.

You should be able to get in to see a specialist:

- Within 30 days for non-urgent care.
- Within two days for urgent, but not life-threatening care (e.g., care given in a doctor's office).

If you have trouble getting in to see a specialist when you need one, call Member Advocates at **801-442-4993** or toll-free at **800-515-2220** for help.

Indian Health Service (IHS)

WHAT IS INDIAN HEALTH SERVICE?

The Indian Health Service is an agency with the Department of Health and Human Services, responsible for providing federal health services to American Indians and Alaska Natives.

If you are an American Indian or Alaska Native, make sure your status is confirmed by DWS. To contact DWS, call **1-866-435-7414**. American Indians/Alaska Natives do not have copays.

American Indian and Alaska Natives who have a managed care plan may also receive services directly from an Indian health care program. This means a program run by the Indian Health Service, by an Indian Tribe, Tribal Organization, or an Urban Indian Organization.

Prior Authorization

WHAT IS PRIOR AUTHORIZATION?

Some services must be approved by Select Health before you receive them. This approval is called prior authorization. It is important to get prior authorization before you receive the service.

If you need a service that requires prior authorization, your provider will ask Select Health for it. If approval is not given for payment of a service, you may request an appeal from Select Health . Please call Member Services at **801-442-3234** or toll-free at **855-442-3234** if you have any questions.

Restriction Program

WHAT DOES IT MEAN TO BE IN THE RESTRICTION PROGRAM?

Medicaid members who need help properly using health care services may be enrolled in the Restriction Program. Members in the Restriction Program are limited to one doctor and one main pharmacy. All medical services and prescriptions must be approved or coordinated by the member's doctor. All prescriptions must be filled by the member's main pharmacy. Ongoing use of health care services is reviewed often.

Examples of improper use of services include:

- Using the emergency room for routine care
- Seeing too many doctors
- Filling too many prescriptions for pain medications
- Getting controlled or abuse-potential drugs from more than one prescriber
- Paying cash for Medicaid covered services

We will contact you if we notice you are improperly using services.

Other Insurance

WHAT IF I HAVE OTHER HEALTH INSURANCE?

Some members have other health insurance, including Medicare, in addition to Medicaid. Your other insurance or Medicare is called primary insurance.

If you have other insurance, your primary insurance will pay first. Please bring all of your health insurance cards with you to your provider visits.

Other health insurance may affect the amount you need to pay. You may need to pay your copay at the time of service.

Please tell your doctor and us if you have other health insurance. You must also tell the Office of Recovery Services (ORS) about any other health insurance you may have. Call ORS at **801-536-8798**. This helps Medicaid and your providers know who should pay your bills. This information will not change the services you receive.

Advance Directive

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a legal document that allows you to make choices about your health care ahead of time.

There may be a time when you are too sick to make decisions for yourself. An advance directive will make your wishes known if you cannot do it yourself.

There are four types of advance directives:

- Living Will (End of life care)
- Medical Power of Attorney
- Mental Health Power of Attorney
- Pre-Hospital Medical Care Directive (Do Not Resuscitate)

Living Will: A living will is a document that tells doctors what types of service you do or do not want if you become very sick and near death, and cannot make decisions for yourself.

Medical Power of Attorney: A Medical Power of Attorney is a document that lets you choose a person to make decisions about your health care when you cannot do it yourself.

Mental Health Power of Attorney: A Mental Health Power of Attorney names a person to make decisions about your mental health care in case you cannot make decisions on your own.

Pre-Hospital Medical Care Directive: A Pre-Hospital Medical Care Directive tells providers if you do not want certain lifesaving emergency care that you would get outside a hospital or in a hospital emergency room. It might also include care provided by other emergency response providers, such as firefighters or police officers. You must complete a special orange form. You should keep the completed orange form where it can be seen.

To find out more information on how to create one of the Advance Directives, please go to:
intermountainhealthcare.org/advanceplanning
or call **801-442-3234** or toll-free at **855-442-3234**.

Appeals and Grievances

WHAT IS AN ADVERSE BENEFIT DETERMINATION?

An adverse benefit determination is when we:

- Deny payment or pay less for services that were provided
- Deny a service or approve less than you or your provider asked for
- Lower the number of services we had approved or end a service that we had approved
- Deny payment for a covered service
- Deny payment for a service that you may be responsible to pay for
- Did not make a decision on an appeal or grievance when we should have
- Did not provide you with a doctor's appointment or a service within 30 days for a routine doctor visit or
- 2 days for an urgent care visit
- Deny your request to dispute a financial liability

You have a right to receive a Notice of Adverse Benefit Determination if one of the above occurs. If you did not receive one, contact Member Services and we will send you a notice.

WHAT IS AN APPEAL?

An appeal is our review of an adverse benefit determination to see if the right decision was made.

HOW DO I FILE AN APPEAL REQUEST?

- You, your provider, or any authorized representative may request an appeal.
- An appeal form can be found on our website at **selecthealth.org/member-care/forms**.
- A request for an appeal can be made in the following ways:
  Mail: **Select Health Appeals Department**
  P.O. Box 30192
  Salt Lake City, Utah 84130-0192
  Fax: **801-442-0762**
  Phone: **801-442-9950** or toll-free at **844-208-9012**
- Submit the appeal request within 60 days from the notice of adverse benefit determination.
- If you need help filing an appeal request, call us at **801-442-3234** or toll-free at **855-442-3234**.
- If you are deaf or hard of hearing, you can call Utah Relay Services at 711 or **800-346-4128**.

HOW LONG DOES AN APPEAL TAKE?

We will give you a written appeal decision within 30 calendar days from the date we get your written appeal.

Sometimes we might need more time to make our decision. We can take up to another 14 calendar days to make a decision. If we need more time, we will let you know in person or through a phone call as quickly as possible, or in writing within two days.

CAN I GET A DECISION ON AN APPEAL MORE QUICKLY?

If waiting 30 days for our decision will harm your health, life, or ability to maintain or regain maximum function, you can ask for a quick appeal. This means we will make a decision within 72 hours.

Sometimes we might need more time to make a quick appeal decision. We can take up to another 14 calendar days to make a decision. If we need to take more time, we will let you know in person or through a phone call as soon as possible, or in writing within two days.

If we deny your request for quick appeal, we will also let you know in person or through a phone call as soon as possible, or in writing within two days.

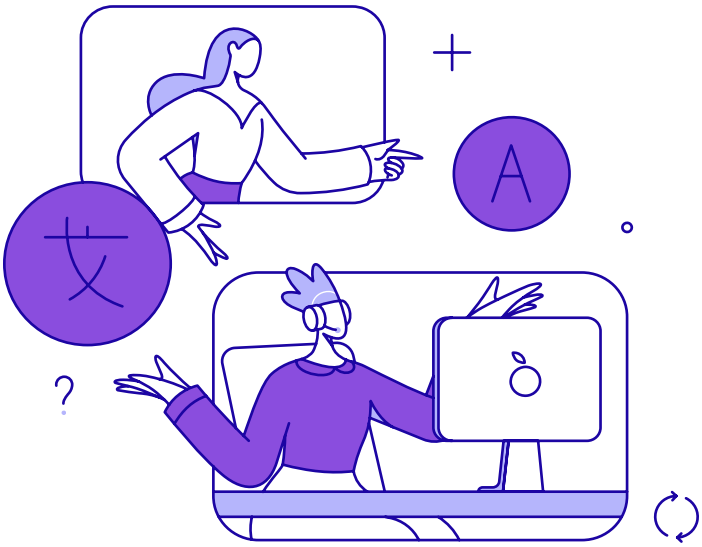
HOW DO I REQUEST A QUICK APPEAL?

You can ask for a quick appeal over the phone or in writing. Call us at **801-442-9950** or toll-free at **844-208-9012**, or write to us at:

Select Health Appeals Department
P.O. Box 30192
Salt Lake City, Utah 84130-0192

WHAT HAPPENS TO MY BENEFITS DURING AN APPEAL?

Your benefits will not be stopped because you asked for an appeal. If your request for an appeal is because we reduced, suspended or stopped a service you have been getting, tell us if you want to keep getting that service. You may have to pay for the service if the appeal decision is not in your favor.



WHAT IS A STATE FAIR HEARING?

A State Fair Hearing is a hearing with the State Medicaid agency about your appeal. You, your authorized representative, or your provider, can ask for a State Fair Hearing. When we tell you about our decision on your appeal request, we will tell you how to ask for a State Fair Hearing if you do not agree with our decision. We will also give you the form to Request a State Fair Hearing to send to Medicaid.

HOW DO I REQUEST A STATE FAIR HEARING?

If you or your provider are unhappy with our appeal decision, you may submit to Medicaid the form to Request a State Fair Hearing. The form must be sent to Medicaid within 120 calendar days of our appeal decision.

WHAT IS A GRIEVANCE?

A grievance is a complaint about anything other than an adverse benefit determination. You have the right to file a grievance. This gives you a chance to tell us about your concerns.

You can file a grievance about issues related to your care such as:

- When you do not agree with the amount of time that the plan needs to make an authorization decision
- Whether care or treatment is appropriate
- Access to care
- Quality of care
- Staff attitude
- Rudeness
- Any other kind of problem you may have had with us, your health care provider or services

HOW DO I FILE A GRIEVANCE?

You can file a grievance at any time. If you need help filing a grievance, call us at **801-442-3234** or toll-free at **855-442-3234**.

If you are deaf or hard of hearing, you can call Utah Relay Services at 711 or **800-346-4128**, and they can help you file your grievance with us.

You can file a grievance either over the phone or in writing. To file by phone, call Member Services at **801-442-3234** or toll-free at **855-442-3234**. To file a grievance in writing, please send your letter to:

Select Health Appeals Department
P.O. Box 30192
Salt Lake City, Utah 84130-0192

We will let you know our decision about your grievance within 90 calendar days from the day we get your grievance. Sometimes we might need more time to make our decision. We can take up to another 14 calendar days to make a decision. If we need more time to make a decision, we will let you know in person or through a phone call as soon as possible, or in writing within two days.

Fraud, Waste, and Abuse

WHAT IS HEALTH CARE FRAUD, WASTE, AND ABUSE?

Doing something wrong related to Medicaid could be fraud, waste, or abuse. We want to make sure that your health care dollars are used the right way. Fraud, waste, and abuse can make health care more expensive for everyone.

Let us know if you think a health care provider or a person getting Medicaid is doing something wrong.

Some examples of fraud, waste, and abuse are:

By a Member

- Letting someone else use your Medicaid Member Card
- Changing the amount or number of refills on a prescription
- Lying to receive medical or pharmacy services

By a Provider

- Billing for services or supplies that have not been provided
- Overcharging a Medicaid member for covered services
- Not reporting a patient's misuse of a Medicaid Member Card

HOW CAN I REPORT FRAUD, WASTE, AND ABUSE?

If you suspect fraud, waste, or abuse, you may contact:

Select Health Compliance Department

- **801-442-4845** or our 24-hour hotline at **800-442-4845**

Provider Fraud

- The Office of Inspector General (OIG)
  Email: **mpi@utah.gov**
  Toll-Free Hotline: **1-855-403-7283**

Member Fraud

- Department of Workforce Services Fraud Hotline
  Email: **wsinv@utah.gov**
  Telephone: **1-800-955-2210**

You will not need to give your name to file a report. Your benefits will not be affected if you file a report.

Transportation Services

WHAT TYPE OF TRANSPORTATION IS COVERED UNDER MY MEDICAID?

Some Medicaid members qualify for transportation services. To find out if you qualify, call the Department of Workforce Services (DWS) at **1-800-662-9651.** If you qualify, you will have access to the following services.

UTA Bus Pass, including Trax (Front Runner and Express Bus Routes are not included): If you are able to ride a bus, call DWS to ask if your Medicaid program covers a bus pass. The pass will come in the mail. Show your Medicaid Member Card and bus pass to the driver.

UTA Flextrans: Special bus services for Medicaid clients who live in Davis, Salt Lake, Utah, and Weber counties. You may use Flextrans if:

- You are not physically or mentally able to use a regular bus
- You have filled out a UTA application form to let them know you have a disability that makes it so you cannot ride a regular bus. You can get the form by calling:
- Salt Lake and Davis counties: **801-287-7433**
- Davis, Weber, and Box Elder counties: **1-877-882-7272**
- You have been approved to use special bus services and have a Special Medical Transportation Card.

Modivcare (formerly LogistiCare): Non-emergency door-to-door service for medical appointments and urgent care. You may be eligible for Modivcare if:

- There is not a working vehicle in your household
- Your physical disabilities make it so you are not able to ride a UTA bus or Flextrans
- Your doctor has completed a Modivcare Utah Physician's Certificate. **modivcare.com/facilities/ut**

When approved, you can arrange for this service by calling Modivcare at: **1-855-563-4403**, or by visiting their website at **modivcare.com/facilities/ut.** You must make reservations with Modivcare three business days before your appointment. Urgent care does not require a three- day reservation. Modivcare will call your doctor to make sure the problem was urgent. Eligible members will be able to receive services from Modivcare statewide.

CAN I GET HELP IF I HAVE TO DRIVE LONG DISTANCES?

- Mileage Refund: Talk to a DWS worker if you have questions about a mileage refund. You will only be refunded if there is NOT a cheaper way for you to get to your doctor. Check with a DWS worker to see about mileage refund for EPSDT well-child medical and dental visits.

HOW DO I GET TO THE HOSPITAL IN AN EMERGENCY?

If you have a serious medical problem and it is not safe to drive to the emergency room, call 911. Utah Medicaid covers emergency medical transportation.

HOW DO I GET TO THE DOCTOR WHEN IT IS NOT AN EMERGENCY AND I CANNOT DRIVE?

Medicaid can help you get to the doctor when it is not an emergency.

To get this kind of help you must:

- Have Traditional Medicaid on the date the transportation is needed
- Have a medical reason for the transportation

Call the Department of Workforce Services (DWS) **866-435-7414** to find out if you can get help with transportation.

- Overnight Costs: In some cases, when overnight stays are needed to get medical treatment, Medicaid may pay for overnight costs. The cost includes lodging and food. Overnight costs are rarely paid in advance. Contact a DWS worker to find out what overnight costs may be covered by your Medicaid program.

Transportation is not available to pick up prescriptions unless you are on the way to or from a visit with a Medicaid doctor. For exceptions, check with a Medicaid eligibility worker.

Nursing Home Transportation: Nursing homes are required to give transportation to medical appointments for their residents. Residents cannot get bus passes. Any other non-emergency transportation needed that the nursing home does not give needs prior approval.

Out-of-State Travel: If you get approval to receive care out-of-state, this transportation may also be approved. This includes airfare, taxi to and from the airport, and travel between your hotel/motel, hospital, or clinic. Reimbursement (up to the maximum allowed) for meals and lodging may also be approved.

LOW-COST TRANSPORTATION CHOICES

2-1-1: Can help you find organizations that give basic transportation including gas money voucher programs and special arrangements for older adults, people with disabilities, and other residents who have no transportation or are not able to use public transportation. Also included are programs that give information, emergency help, and other supportive care. Call **2-1-1** or visit their website at **211utah.org.**

PUBLIC TRANSPORTATION RIDER TOOLS

Use UTA Rider Tools Trip Planner, Schedules & Maps, Vehicle Locator, Ride Time, and App Center to help you plan your transit trip.

UTA App Center

- Transit App: The Transit UTA App helps you find your best transit choices by showing you all of the nearby choices. You can check live transit schedules, plan your trip, and get step-by-step navigation for all kinds of urban transportation, including buses, Trax, Uber, or even bike share. For information on how to use the app to plan your trip, visit **transitapp.com.**
- iRideUTA App: The iRideUTA app shows the real-time locations of UTA Buses, Trax, and FrontRunner. Download it on your smartphone to quickly and simply see UTA routes, stops, and even vehicle locations.

HIVE Pass: The HIVE Pass is a program in Salt Lake City offered to all City residents with the goal of making transit more accessible with lower costs. The cost of the pass to residents is $42 per month, half of the price for a normal monthly UTA pass.

Your home address must be in Salt Lake City limits to be eligible for a HIVE Pass.
Visit **slc.gov/transportation/hivepass/** or call **801-596-RIDE (801-596-7433**) for more information or to sign up.

Utah Transit Authority (UTA): UTA offers discounted fares to people over age 65 and paratransit for people with disabilities who cannot use the normal bus system.

Visit **rideutah.com** or call **888-RIDE-UTA (888-743-3882**) for more information.

For Paratransit, call **801-BUS-RIDE (801-287-7433).**

Amount, Duration, and Scope of Benefits

Benefit	Traditional
Abortion	Limited Call Member Services **801-442-3234** or toll-free at **855-442-3234** for Benefit information
Ambulance	Not Covered by Select Health • Covered by Fee for Service Medicaid
Birth Control & Family Planning	Covered No copay required (See birth control chart on page 14)
Chiropractic	Not Covered by Select Health • May be covered by Fee for Service Medicaid for EPSDT Members and pregnant women. Call Medicaid **800-662-9651**
Dental Benefits	Not Covered by Select Health • May be covered by Fee for Service Medicaid or Medicaid Dental plan. Call Medicaid **1-800-662-9651**
Doctor Visits	Covered See copay chart on page 10
Emergency and Urgent Care	Covered No copay • (Must use a network provider for urgent care)
Eye Exam	Covered No copay Limited to one exam every 12 months
Eyeglasses	Covered No copay • Covered only for pregnant women and those eligible for EPSDT services.
Hospice Care	Covered No copay (see page 16 for additional information)
Inpatient Hospital Care	Covered (See page 10 for copay chart)
Lab and X-Ray Services	Covered No copay
Medical Supplies	Covered No copay
Nursing Home	Covered by Select Health for up to 30 days. Stays over 30 days covered by Medicaid Fee for Service • Call Medicaid **800-608-9422**
Personal Care Services	Covered • Requires prior Authorization
Pharmacy	Covered (See page 10 for copay chart)
Physical and Occupational Therapy	Covered (See page 10 for copay chart) (See page 16 for Details)

Podiatry	Covered (See page 10 for copay chart) (Limited benefit for adults)
Preventive Services	Limited Call Member Services **801-442-3234**
Outpatient Care	Covered (See page 10 for copay chart)
Over-the-Counter Drugs	Covered (See page 10 for copay chart) • Contact SelectHealth for Over the Counter PDL
Speech and Hearing Services	Covered (Limited) No copay • Audiology and hearing services including hearing aids and batteries are covered only for pregnant women and those eligible for EPSDT services.
Non Emergent Medical Transportation Services	Not Covered by Select Health • Covered by Fee For Service Call Medicaid **800-662-9651**

CAN I GET A SERVICE THAT IS NOT ON THIS LIST?

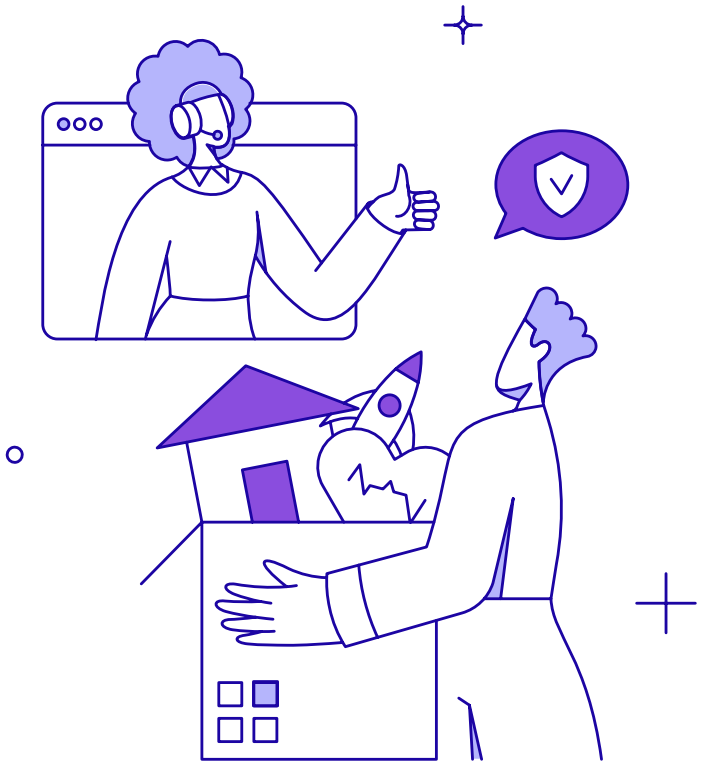
Generally, Medicaid does not pay for non-covered services. However, there are some exceptions:

- Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery
- Reconstructive procedures to correct serious functional impairments (for example, inability to swallow)
- When performing the procedure is more cost effective for the Medicaid program than other alternatives
- Members who qualify for EPSDT may obtain services which are medically necessary but are not typically covered

If you would like to request an exception for a non-covered service, you can make that request by calling Member Services at **801-442-3234** or toll-free at **855-442-3234**.

WHAT IF I CHANGE HEALTH PLANS?

We will work with your new health plan to make sure you get the services that you need. We follow Medicaid's guidelines on how to do this. These guidelines are called transition of care guidelines.
They can be found at **medicaid.utah.gov/managed-care/.**



Notice of Privacy Practices

HOW DO WE PROTECT YOUR PRIVACY?

We strive to protect the privacy of your Personal Health Information (PHI) in the following ways:

- We have strict policies and rules to protect PHI
- We only use or give out your PHI with your consent
- We only give out PHI without your approval when allowed by law
- We protect PHI by limiting access to this information to those who need it to do given tasks and through physical safeguards

You have the right to look at your PHI.

HOW DO I FIND OUT MORE ABOUT PRIVACY PRACTICES?

Contact Member Services if you have questions about the privacy of your health records. They can help with privacy concerns you may have about your health information.

They can also help you fill out the forms you need to use your privacy rights.

The complete notice of privacy practices is available at **intermountainhealthcare.org/websiteinformation/ privacy-notices/patients/.** You can also ask for a printed copy of this information by contacting Member Services at **801-442-3234** or toll-free at **855-442-3234**.

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Select Health Advantage: **855-442-9900** (TTY: 711) /

Select Health : **800-538-5038.**

Select Health

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