

Your Benefits & How-To Guide



1. Benefits and services.

Services Covered

- Provider office visits – routine, urgent, and emergency care.
- Medical care during pregnancy.
- Hospital services.
- Hospital stays including a semiprivate room, medical services, surgery, anesthesiology, and drugs.
- Basic vision care.
- Basic hearing care.
- Basic dental care.
- Family planning (birth control).
- Chiropractic care.
- X-rays and laboratory services.
- Immunizations (shots) for children younger than 21.
- Flu shots.
- Prescription drugs – some may require prior authorization.
- Some over-the-counter drugs prescribed by a provider.
- Home health services.
- Physical, occupational, and speech therapy.
- Durable medical equipment (DME) and supplies - such as wheelchairs or crutches.
- Hospice care.
- Second opinions.
- Disease screenings and treatment – such as tuberculosis, HIV, AIDS and sexually transmitted diseases.
- Ambulance transportation for an emergency.
- Specialty care – most members need a referral from a PCP to see a specialist. Members with Passport Advantage (you have Passport Health Plan and have chosen Passport Advantage for your Medicare Advantage plan), or children in out-of-home placement (foster care, etc) do not need a referral to see a specialist.
 - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – health checkups, screenings, and immunizations for children aged birth to 21. See more information about EPSDT in the “Family Care” section on page 18.

Services Not Covered

- Services, medicines and medical equipment that are not medically necessary.
- Abortions, unless the life of the mother is in danger, or in the event of rape or incest.
- Cosmetic surgeries and medicines.

- Long-term institutional care.
- Experimental procedures.
- Hysterectomy, if performed for hygiene or sterilization reasons only.
- Infertility treatment (medical or surgical).
- Oral surgery that is cosmetic.
- Paternity testing.
- Personal care items such as hair brushes, shampoo, toothpaste, feminine hygiene products, etc.
- Personal items or services while you are in the hospital, such as television or telephone.
- Funeral or burial costs.
- Reversing or changing back surgeries like tubal ligation (having your tubes tied) or vasectomy.
- Making mentally ill patients or persons in the hospital sterile. Sterile means you cannot have a baby.
- Sex change operations.
- Specialty care not set up by your PCP. This does not apply to Passport Advantage members (you have Medicare and Passport Health Plan) or children in out-of-home placement (foster care, etc). See the “When You Need to See a Specialist” section on page 15.

2. Pharmacy Services.

Getting Prescriptions

How do you get your prescriptions?

- Go to a pharmacy that is signed up with Passport Health Plan and give them your prescription.
- Show them your Passport Health Plan ID card and your Medicaid ID card.

*See your Primary Care Provider & Direct Access Services Directory for the names of pharmacies near you. Member Services can also help you find a pharmacy near you.

General information about your prescriptions:

- You will get no more than a 30-day supply of any drug at one time.
- If a generic form of the medicine is available, it will be given to you.
- Some over-the-counter medicines may be paid for with a prescription. The medicine must be part of your treatment plan.
- You may be asked to pay a \$1 copay for each prescription, including over-the-counter medicines. See the “Copays and Premiums” sheet in the back of this Handbook.
- Some medicines may need prior authorization. This means the medicine must be okayed before you can get them.

Where can you find a list of covered drugs?

The complete list of medicines that we pay for is on the Passport Health Plan website: www.passporthealthplan.com. You may also call Member Services for this list. Because new medicines come out all the time, we update the list on a regular basis.

What medicines are not covered by Passport Health Plan?

- Cosmetic products. For example: hair removal or hair growth products.
- Stop-smoking products. Other stop smoking help and medicines may be available for members who choose to be in our Yes, You Can! Quit Smoking Program. Please call 1-800-578-0603, press 0, then press 78366.
- Medicines to help you get pregnant.
- Medicines used for research that are not approved by the Food and Drug Administration (FDA).
- Medicines that are not medically necessary.
- Erectile dysfunction drugs (Viagra, Levitra, and Cialis).
- Herbal supplements.

Prior Authorization

What is prior authorization?

Some medicines must be approved by Passport Health Plan before you can get them. This is called prior authorization. Whenever you get a new prescription, ask your provider if the medicine needs a prior authorization. If it does, ask if there is another medicine that can be used that does not need a prior authorization.

What if you need a medicine that must be prior authorized?

- Your provider must fill out an authorization request form and send it to Passport Health Plan's pharmacy benefits manager (PBM).
- The PBM checks to see if the request meets the medical guidelines for the medicine.
- If the authorization is approved, a note is sent to your provider and the pharmacy.
- If the authorization is not approved, you and your provider will get a letter stating the reason for the decision.
- If you disagree with the decision, you may file an appeal. Please see the "Filing an Appeal" section under #13. It tells how to appeal a medical decision.

What medicines need prior authorization?

- Brand name forms of a medicine, if there is a generic form of the drug.
- Some medicines that need special handling, delivery, monitoring, or that need to be taken in a special way.

3. Copayments and other charges for which the member is responsible.

Some members have to pay a small amount for prescriptions, dental services, and vision services. This amount is called a copay. It is called a copay because you pay some and Passport Health Plan will pay the rest.

These copays include:

- \$1 for each prescription, including over-the-counter medications. Please note:
 - The pharmacy must fill your prescription the first time, even if you cannot pay.
 - If you cannot pay the copay when you get your prescription, you should pay it the next time.

- The pharmacy may tell you they will not fill your prescriptions anymore if you don't pay the copay.
- \$0 - \$2 for each dental visit, excluding routine dental services such as cleanings.
- \$0 for each visit with the following:
 - Opticians
 - Optometrists
 - Other providers if they provide eye exams only. This might include your primary care provider, rural health clinic, etc.

**Copays may change. If so, Passport Health Plan will let you know.*

Remember, your part of the copay must be paid at the time you get the service. If you have any questions about copays, please call Member Services.

Member who do not have to pay a copay:

- Members 18 years and under including KCHIP members.
- Pregnant members.
- Members receiving services within the first 60 days after delivery of a baby.
- Members in a nursing facility.
- Members in a personal care home.
- Members in an intermediate care facility for people with mental retardation (ICF/MR).
- A foster child in state custody.
- American Indians or Alaskan natives served through KCHIP program.
- Members in hospice care.
- Pacific Islanders.

4. Restrictions on benefits that apply to services obtained outside the organization's system or service area.

Not all providers outside the service area are signed up with Passport Health Plan. If you go to one that is not signed up with us, you may have to pay the bill. The provider must be willing to bill Passport Health Plan for services.

5. How to obtain information about providers who participate with Passport Health Plan.

If you would like to know about the professional education, board certification status, training of physicians and other health care providers listed in this directory, please call Passport Health Plan's Member Services department at 1-800-578-0603, press 2 or TDD/TTY 1-800-691-5566 if you are hearing impaired. The information will be sent to you in the mail.

6. How to obtain primary care services, including direct access services.

Your first step as a Passport Health Plan member is to choose a primary care provider (PCP) by calling Member Services at 1-800-578-0603, press 2. Your PCP will take care of all your basic medical needs (see page 6 for more details). You can choose a PCP from the **Primary Care Provider Directory** inside your Member Handbook. You may also find this directory on our website at www.passporthealthplan.com. You can choose the same PCP for each member of the family or you can select a different PCP for everyone. Your choice depends on whether a PCP is taking new patients. Member Services can let you know if a provider is accepting new patients. If you are not sure which PCP to choose, Member Services can help you.

Direct Access Services

As a Passport Health Plan member, you may get some services without seeing your PCP. These services are called direct access services. Please see your Primary Care Provider & Direct Access Services Directory for more information.

Here is a list of direct access services that you may get without going to see your PCP:

- Chiropractic - first 12 visits are direct access. After 12 visits, your chiropractor will need to get approval from Passport Health Plan.
- Dental cleanings – 1 per year for adults 21 years and older, 2 per year for children 21 years and younger.
- Other dental services for children 21 years and younger, if needed.
- Diabetes eye test.
- Family planning (birth control).
- Maternity care.
- Immunizations (shots) for members younger than 21.
- Routine women's care (GYN - gynecology).
- Mammogram – breast cancer screening.
- Pap smears – cervical cancer screening.
- Basic vision care.
- Screenings and treatment from any Passport Health Plan provider for diseases passed on by having sex, HIV, or tuberculosis (TB).

7. How to obtain language assistance.

Are you a person who:

- Does not speak English?
- Does not speak English well?
- Has hearing problems?
- Has vision problems?

If you are one of these people or you know another Passport Health Plan member who is, the law says you can ask for an interpreter or translated material at no cost to you.

Here is what to do when you call Passport Health Plan:

- When you call Member Services, tell them the language you speak. They will make sure an interpreter is on the other line with you. You may also tell them if you would like information about the Plan in a different language or format such as a large type or Braille.

The law also says you have the right to receive interpretation or translation services, free of charge, when you visit your primary care provider, hospital, pharmacy or a specialist.

Here is what to do when you call a provider's office:

- When you call, tell them you will need an interpreter. You should also tell them the language you speak. They will make sure an interpreter is at your appointment.
- If you have any problems receiving interpretation or translation services, please call Member Services.

If you want to choose a provider who speaks a language other than English, call Member Services. They will help you find a provider within our service area who speaks your language, if one is available.

8. How to obtain a second opinion.

Second Opinions

You have the right to a second opinion. If you want another medical opinion, tell your primary care provider (PCP). He or she will fill out a referral form for another provider or contact Passport Health Plan for approval. You may have to take a referral form with you to the provider. This form tells the other provider that your PCP has approved the services.

9. How to obtain specialty care and behavioral health care services and hospital services.

Behavioral Health

Passport Health Plan wants members to get behavioral health care when needed. Your primary care provider (PCP) may treat your behavioral health and mental health care needs, or he or she may direct you to a behavioral health care provider. Passport Health Plan pays for prescriptions written for you by a psychiatrist or PCP. Services you get from behavioral health care providers, such as office visits and group therapy, are not covered by Passport Health Plan but are covered by Medicaid. We encourage you to talk to your PCP about any of these services. He or she can direct you to any Medicaid behavioral health or mental health provider.

The following agencies also provide behavioral health and mental health care services in the Passport Health Plan service area.

Communicare Inc.

Serving Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson, and Washington Counties.
For appointments, call (270) 769-1304.

Seven Counties Services, Inc.

Serving Bullitt, Jefferson, Oldham, Shelby, Spencer, Henry, and Trimble Counties.
For appointments, call (502) 589-1100 or 1-800-264-8799.

Northern Kentucky Regional Mental Health

Serving Carroll County.

For appointments, call (502) 732-9331.

For emergency care, call 1-877-331-3292.

Specialty Care

Your primary care provider (PCP) will help you choose a specialist for your condition. He or she will fill out a referral for the specialist. This form tells the specialist that your PCP has approved the services shown on the form. Make sure you go to a specialist who is signed up with Passport Health Plan. If you do not, you may have to pay for services.

*Members on Passport Advantage (you have Medicare and Passport Health Plan), or children living in out-of-home placement (foster care, etc.) do not need a referral to see a specialist.

Hospital Care

What happens when you go to the hospital?

Any time you go to a hospital, tell them you are a Passport Health Plan member. You should tell them you are a Passport Health Plan member even if you have other coverage. Take all your ID cards with you and show them at admission. If you are in a hospital and get a bill (not a statement) after you go home, call the hospital and make sure your Passport Health Plan information is on file.

Remember, always take your Medicaid ID card and Passport Health Plan ID card. This will help make sure that you do not get a bill from a practitioner.

10. How to obtain care after normal office hours.

Urgent Care

You should go to the urgent care center for something that is not a threat to your life, but needs to be looked at right away. You should try to contact your PCP before you go to an urgent care center. If you are not sure if your situation needs urgent care, your PCP can help you decide what to do.

11. How to obtain emergency care.

You should go to the emergency room when you think a medical situation, if not treated, will be a threat to your life or long-term health. The emergency room staff will decide how soon you will be seen.

Here are some examples of when you might go to the emergency room:

- Bad cuts or burns.
- Miscarriage (losing a baby) or pregnancy with vaginal bleeding.
- Head or eye injuries.
- Danger of loss of life or limb (such as an arm or a leg).
- Blackouts.
- A motor vehicle accident with an injury.
- Chest pain.
- High fever.
- Choking.
- A physical attack or rape.
- Hard breathing.
- Heavy bleeding.
- Loss of speech.
- Using too much medicine or drugs (overdose).
- Paralysis (unable to move).
- Poisoning.
- Possible broken bones.
- Convulsions (seizures).

*If 911 service is not available in the area, call the local operator.

There are times when it is hard to know if your situation is an emergency. If you are unsure, here are some ways to help you decide if a situation is an emergency:

1. Call your primary care provider (PCP)

He or she can help you decide if emergency care is needed. Be ready to tell your PCP as much as you know about the medical problem. Be sure to tell him or her:

- What the problem is.
- How long you or another family member has had the problem.
- What has been done for the problem so far.

Your PCP may ask other questions. He or she can help you decide:

- If you need an appointment.
- If you should go to the urgent care center.
- If you should go to the emergency room.

Write the names of all your family's PCPs and their telephone numbers in the front of this Handbook. Keep it in a handy place in case you need it.

2. Call Passport Health Plan's 24-hour Nurse Advice Line

If you cannot reach your PCP, you may call our Nurse Advice Line to speak with a registered nurse. A nurse is available 7 days a week, 24 hours a day. Be ready to tell the nurse as much as you know about the medical problem. He or she may ask other questions. The nurse will then help you decide what to do.

Nurse Advice Line

24-hours/7 days a week

1-800-606-9880

TDD/TTY 1-800-648-6056

If you go to the emergency room, call your PCP for follow-up care. Do not go to the emergency room for follow-up care.

12. How to obtain care and coverage when you are out of Passport Health Plan's service area.

If you are out of Passport Health Plan's service area and have an emergency, call 911. If 911 services are not available in the area, call the local operator or go to the nearest emergency room. If you need services when you are out of our service area, be sure to show all of your ID cards. Your ID cards have information the provider will need. If you need routine or urgent care, please call your primary care provider (PCP) and he or she will tell you what to do. Remember, not all providers outside the service area are signed up with Passport Health Plan. If you go to one that is not signed up with us, you may have to pay the bill. The provider must be willing to bill Passport Health Plan for services.

13. How to voice a complaint.

Grievance

We hope that you will always be satisfied with Passport Health Plan and our health care providers. When you have questions or concerns, or if you want to file a grievance, call Member Services at 1-800-578-0603, press 2 between 8:00 a.m. and 6:00 p.m., Monday through Friday. You may come to our office or write to us at:

Passport Health Plan

Member Services

305 W. Broadway, 3rd Floor

Louisville, KY 40202

14. How to appeal a decision that adversely affects coverage, benefits or your relationship with Passport Health Plan.

Appeals

If you are not happy with a decision made by Passport Health Plan, you may file an appeal with Passport Health Plan, or you may also request a State Hearing with the Department for Medicaid Services (DMS). You will not lose your Passport Health Plan membership or health care benefits if you file an appeal or ask for a State Hearing with DMS.

Filing an Appeal with Passport Health Plan

- You, your provider, or your authorized person may file your appeal. If your provider or someone other than your authorized person files your appeal, you must give him or her written permission to do so.
- Your appeal must be in writing. Passport Health Plan must receive the appeal within 30 calendar days of the date of the decision letter.
- If you ask for an appeal over the phone or in person, you must also give us a request in writing.

If you need help with filing your appeal, call Member Services at 1-800-578-0603, press 2. If you are a person with a hearing problem, you may call the TDD/TTY number at 1-800-691-5566.

Your written appeal should be sent to:

Appeals Coordinator
Passport Health Plan
305 W. Broadway, 3rd Floor
Louisville, KY 40202

What happens after you file an appeal?

- When you file an appeal, we will send you a letter within 3 business days. The letter will let you know that we have received your appeal. It will also tell you the date and time we will review your appeal.
- After you have filed your appeal, you can still send us anything related to your appeal. You can also present it in person on the appeal date stated in our letter.
- If at any time during the appeal process, you need more time to give us things related to your appeal, you may request up to 14 more days. This request must be in writing and sent to the Passport Health Plan appeals person.
- If we feel we cannot give you a fair decision within the required 30 calendar day time period, we may add up to 14 calendar days to our review time. We will send you a letter to let you know this.
- If you are getting authorized services that are now denied and you wish to keep getting these services, you must ask for an appeal in writing within 10 calendar days of the denial letter. Your request must clearly state that you wish to keep getting the services. You can keep getting services until the appeal decision is made. If the appeal decision agrees with Passport Health Plan's denial, you may have to pay for the services.
- Within 30 calendar days after we get your appeal, or within 44 calendar days if extra time is needed, we will send you a letter with our decision.

- If you do not agree with our decision about a specific issue, you have the right to a hearing with the Department for Medicaid Services (DMS). You can request a hearing at any time during Passport Health Plan's appeals process, but no later than 30 calendar days of the date of the last decision letter.
- You may also receive copies of any documents related to your appeal if you request them in writing.

Your written request should be sent to:

Appeals Coordinator
 Passport Health Plan
 305 W. Broadway, 3rd Floor
 Louisville, KY 40202

Medical Appeals

A provider who is like your PCP or special provider will look at your medical appeal. This provider will **not** be the same provider who decided to deny the service.

Expedited (Faster) Appeals

You can request an expedited appeal if your appeal is about care that you believe is medically necessary and needed soon. If your request does not qualify for an expedited appeal, it will become a regular appeal. You can make your request by calling 1-800-578-0636, extension 77307. We will let you know of the decision within 72 hours.

Non-Medical Appeals

The Passport Health Plan Appeals Committee will look at your non-medical appeal. The persons on this committee will be ones who had nothing to do with the decision you are appealing.

Requesting a State Hearing with the Department for Medicaid Services (DMS)

A State Hearing with the Department for Medicaid Services (DMS) is **not** a part of Passport Health Plan in any way. Passport Health Plan must follow the hearing decision.

- Requesting a State Hearing If You Do Not Agree With A Passport Health Plan Decision – You may request a State Hearing with the DMS at anytime during Passport Health Plan's appeal process, but no later than 30 days of the date of the last Passport Health Plan decision letter.
- Requesting a State Hearing to Leave Passport Health Plan – You may request a State Hearing with DMS if you want to leave Passport Health Plan. The request for the State Hearing may be filed at anytime.

To request a State Hearing with DMS, you must submit your request in writing, by fax, or in person to:
Kentucky Department for Medicaid Services
Division of Administrative and
Financial Management
275 East Main St., 6W-C
Frankfort, KY 40621
Fax number: (502) 564-6917

If you have any questions about a State Hearing with DMS, please call 1-800-635-2570. If you are a person with a hearing problem, please call the TDD/TTY number at 1-800-775-0296.

You may also contact Kentucky's Ombudsman if you have a complaint about your local Department for Community Based Services office or case worker:

Cabinet for Health Services
Office of the Ombudsman
275 East Main Street, 1E-B
Frankfort, KY 40621
1-800-372-2973

If you are a person with a hearing problem, you may call the TDD/TTY number at 1-800-627-4702.

15. How the organization evaluates new technology for inclusion as a covered benefit.

New technologies are medical treatments, drugs, or devices that have recently been developed and are not considered to be experimental. New ways of using current treatment, drugs or devices may also be seen as new technologies. New technologies are studied for safety and to see if they do what they are supposed to do. A new technology may still be studied until the right medical specialist sees it as standard care. Passport Health Plan decides if a new method becomes a standard of care with help from special providers. The Plan adds new technologies to its benefits when it decides they are standard care.

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