Nevada

Anthem®

Member Handbook

1-844-396-2329 (TTY 711)

www.anthem.com/nvmedicaid

ANV-MHB-0005-20

Member Handbook

Nevada

1-844-396-2329 (TTY 711)

www.anthem.com/nvmedicaid

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

ANV-MHB-0005-20

Anthem

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

You've probably already received your Anthem member ID card. If not, you should receive it in a few days. Your ID card tells you when your Anthem membership starts. The name of your primary care provider (PCP) is on the card, too. Please check your ID card right away. If the name of your doctor or any other information isn't right, please call us at 1-844-396-2329 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Pacific time. We'll send you a new ID card with the correct information. If you have a new doctor, make an appointment with him or her soon to discuss your health needs.

Benefits beyond what you'd expect

With Anthem, you get your regular Medicaid and Nevada Check Up benefits, plus extras designed to make a difference in your life:

- Need a doctor's help late at night? Use LiveHealth Online to video chat with a doctor anytime. They can help with minor illnesses like colds, allergies, flu or infections.
- Do you have a child between the ages of 5 and 14? They can join a Boys & Girls Club at no cost to you. The clubs provide many fun and educational activities for children. It's a great place to go after school.
- We also offer free sports physicals every 12 months for children ages 6 to 18.

We're just a call or a click away.

When you have questions or need help, our team is ready and willing to assist. Our website has many of the answers you need. Visit www.anthem.com/nvmedicaid to:

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

You can also call Member Services at 1-844-396-2329 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Pacific time. If you have health questions and want to talk with a registered nurse, call our 24/7 NurseLine at the phone number above. Our nurses are available anytime, day or night.

Sincerely,

Anthem Blue Cross and Blue Shield Healthcare Solutions

ANV-MHB-0005-20

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

- Carson City: 1-775-684-3651
- Elko: 1-775-753-1191
- Las Vegas: 1-702-668-4200
- Reno: 1-775-687-1900

Frequently asked questions

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

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

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

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

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

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

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

8. How can I get another copy of my ID card?
   See the **Go online** section; **Get the Anthem Medicaid app** section or the **Your Anthem identification card** section.

ANTHEM BLUE CROSS AND BLUE SHIELD HEALTHCARE SOLUTIONS MEMBER HANDBOOK

Desert Canyon, Building 9
9133 W. Russell Road
Las Vegas, NV 89148
1-844-396-2329
(TTY 711)
www.anthem.com/nvmedicaid

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

Table of Contents

WELCOME TO ANTHEM BLUE CROSS AND BLUE SHIELD HEALTHCARE SOLUTIONS!

Your new health plan

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

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

The state requires us to give you the information below.

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

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

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

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

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

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

How to get help

Call Member Services

We're here to help you. Call us at 1-844-396-2329 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Pacific time if you:

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

Call the Anthem 24/7 NurseLine

Call our 24/7 NurseLine at 1-844-396-2329 (TTY 711) anytime, day or night. Our nurses can help if you have health-related questions or need advice on:

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

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

Go online

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

- Choose or find a primary care provider (PCP) in the Anthem network.
- Change your PCP.
- Request an ID card.
- Update your address or phone number. Please also call Nevada Medicaid at:
  - Carson City: 1-775-684-3651.
  - Elko: 1-775-753-1191.
  - Las Vegas: 1-702-668-4200.
  - Reno: 1-775-687-1900.
- Download or request a member handbook or provider directory.
- Learn about community programs and services.
- Ask questions or make comments to help improve Anthem.
- Learn about your rights and responsibilities as a member.
- Report waste, fraud and abuse.
- Read what we're doing to keep your private information safe and get a copy of the Anthem Notice of Privacy Practices. This Notice describes how your medical information may be used and shared, and how you can access it.
- Learn about pharmaceutical management procedures.

Get the Anthem Medicaid app

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

To download the app, go to the App Store®, Android Market, or visit our website at www.anthem.com/nvmedicaid.

Important phone numbers

Name	Description	Phone number
24/7 NurseLine	Get medical advice or talk with a registered nurse about any nonemergency health-related questions or concerns.	1-844-396-2329 (TTY 711)
Anthem Member Services	Get a member handbook, update your member identification card, find a new provider, schedule an appointment and much more.	1-844-396-2329 (TTY 711)
Behavioral health care	Find information about behavioral health care.	1-844-396-2331 (TTY 711)
Case Management	Call Member Services to be connected with a case manager.	1-844-396-2329 (TTY 711)
Disease Management programs	Speak with a Disease Management case manager if you have a chronic condition.	1-888-830-4300 (TTY 711)
Emergencies	**Call or go to the nearest hospital emergency room.**	**911**
EyeQuest	Get information about your vision benefits.	1-888-300-9025 (TTY 1-800-466-7566)
MTM	Arrange for transportation to medically needed appointments and treatments (not available for Nevada Check Up members).	Toll free at 1-844-879-7341
Nevada Check Up	Get Nevada Check Up program eligibility and premium requirements.	Toll free in-state at 1-877-543-7669 (KIDS NOW) Toll free out-of-state at 1-800-992-0900
Nevada Medicaid	Get Medicaid program eligibility and other information.	1-775-684-7200 (North) 1-702-486-1646 (South) Toll free at 1-800-992-0900

About this member handbook

This handbook will help you understand your health care plan. The other side of this handbook is in Spanish. If you have questions, need help understanding or reading something in here, or want this in a different language, call us. We'll let you know when it can be available.

We can also get this member handbook in:

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

When there are benefit changes or other changes that impact your care and services, we'll let you know in one of these ways:

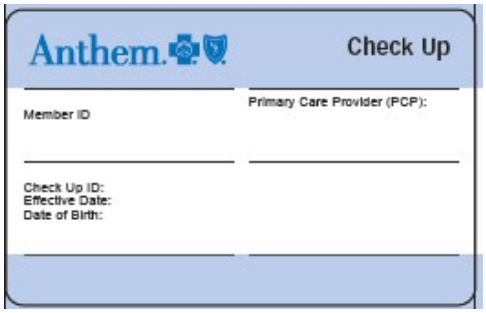
- We'll send you a letter.
- We'll send you a notice to keep with your member handbook.
- We'll update our member website at www.anthem.com/nvmedicaid.

Your Anthem identification card

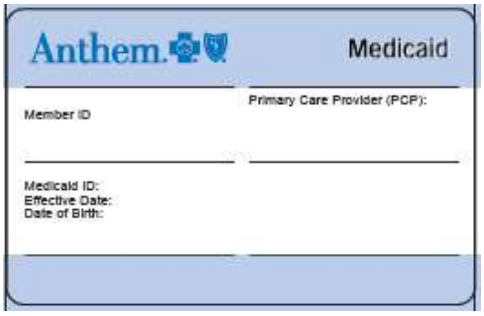
If you don't have your Anthem identification (ID) card yet, you'll get it soon.

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

This card identifies you as an Anthem member.



Nevada Check Up ID card



Nevada Medicaid ID card

Your Anthem ID card shows:

- The name and phone number of your PCP.
- Your Medicaid or Nevada Check Up number.
- The date you became an Anthem member.
- Important phone numbers.

If your Anthem ID card is lost or stolen, call us right away at 1-844-396-2329 (TTY 711). We'll send you a new one.

For members who don't speak English:

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

For members who are deaf or hard of hearing:

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

YOUR PROVIDERS

Picking a primary care provider

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

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

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

If you aren't happy with the PCP we assigned, you can pick another one at any time. Just look in the provider directory that came with your new member package, or go online to www.anthem.com/nvmedicaid. Our search tool lets you search for providers by name, location and specialty. Need help? Call Member Services at 1-844-396-2329 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Pacific time. No matter how you make the change — online or on the phone — we'll send you a new member ID card.

If you're already seeing a PCP, you can look in the provider directory to see if that provider is in our network. If so, you can tell us you want to keep him or her by calling Member Services at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

Your PCP can be any of the following, as long as he or she is in the Anthem network:

- Family or general practitioner
- Internist
- Pediatrician
- Physician assistant
- Certified nurse practitioner
- Obstetricians/gynecologists (during pregnancy)

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

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

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

- Disability.
- Chronic condition.
- Complex condition.

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

Where to get a list of Anthem network providers

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

The directory also lists:

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

If you didn't receive a provider directory, please contact Member Services at 1-844-396-2329 (TTY 711). We'll send you a new directory. You can also search for a provider online by going to www.anthem.com/nvmedicaid and selecting Find a Doctor.

Seeing an out-of-plan provider

There may be times when you'll need to see a provider who isn't part of the Anthem network. If you were ill or injured before joining Anthem and were seeing a PCP who isn't in our network, please let us know about the care you were getting. In some cases, you may be able to keep seeing this PCP while you pick a new one in our network. Call Member Services at 1-844-396-2329 (TTY 711) to find out more. Anthem will work with you and your PCP to provide a smooth transition to your new PCP.

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

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

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

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

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

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

How to change your primary care provider

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

- Look in the Anthem provider directory that came with your new member package.
- Go to www.anthem.com/nvmedicaid to search for a new PCP or view the provider directory online.
- Call Member Services for help at 1-844-396-2329 (TTY 711).

When you ask to change your PCP:

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

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

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

- Your PCP doesn't have the right experience to treat you.
- The assignment to your PCP was made in error (like an adult assigned to a child's PCP).
- You fail to keep your appointments without calling the PCP to let them know or schedule a new appointment.
- You don't follow their medical advice over and over again.
- Your PCP agrees a change is best for you and your medical needs.

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

If you want to see a provider who isn't your PCP

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

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

Second opinions

Anthem members have the right to ask for a second opinion about any treatment or diagnosis at no cost. You can get a second opinion from a network provider or a non-network provider if a network provider isn't available.

Ask your PCP to submit a request for you to have a second opinion.

Picking an OB/GYN

Members can see a network OB/GYN. These services are no additional cost to members and include:

- Wellness visits.
- Prenatal care.

- Family planning.

You don't need a referral to see any qualified family planning provider, even if this provider isn't part of the Anthem network.

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

- Look in the Anthem provider directory that came with your new member packet.
- Go to our online provider directory at www.anthem.com/nvmedicaid.
- Call Member Services at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

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

If you're pregnant when you enroll in Anthem and your current provider isn't part of the Anthem plan, you may be able to continue getting OB/GYN care from your current provider. This is called continuity of care.

Going to a specialist

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

Examples of specialists are:

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

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

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

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

- Talk to your PCP.
- Call Member Services at 1-844-396-2329 (TTY 711).

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

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

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

GETTING HEALTH CARE

How to make an appointment with your PCP

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

Wellness visits can help you stay healthy and let your PCP take better care of you if you get sick. When you aren't feeling well, call your PCP's office. Let them know your symptoms, and they'll tell you how soon you need to be seen. If you need help making an appointment, call Member Services at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

Wait times for appointments	
Emergencies (Call 911 or go to the nearest hospital)	Immediately
PCP visits*	
Routine care	Within two weeks
Urgent care	Within two calendar days
Specialist visits*	
Routine care	Within 30 calendar days of referral
Urgent care	Within three calendar days of referral
Behavioral Health	
Non-life threatening emergency	Within six hours
Urgent Care	Within 48 hours
Initial visit for routine appointments	Within 10 business days
Prenatal care visits*	
First trimester	Within seven calendar days
Second trimester	Within seven calendar days
Third trimester	Within three calendar days
High-risk pregnancies	Within three calendar days or sooner if needed
*Same-day, medically needed appointments are also available.	

After-hours callbacks

We want you to be able to get care at any time. When your PCP's office is closed, an answering service will take your call. Your PCP should call you back within 30 minutes. Talk to your PCP and set up an appointment.

What to bring to an appointment

When you visit your provider, be sure you have:

- Your Anthem ID card.
- Any medicines you're taking.
- Any questions you may want to ask.

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

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

How to cancel an appointment

If you make an appointment and then can't go, it's important to:

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

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

Transportation

If you need a ride to and from your medical appointments for routine visits, call MTM toll-free at 1-844-879-7341. You can call to schedule a ride Monday through Friday from 7 a.m. to 5 p.m. Please call MTM as soon as possible and at least five business days before your scheduled appointment. MTM will work with you to find the right transportation for you and may consult your health care provider.

Nonemergency transportation service is only available to Medicaid recipients. Nevada Check Up members are not eligible for this service.

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

- Be sure to tell the hospital staff you're an Anthem member.
- Get in touch with your PCP as soon as you can. Your PCP can:
  - Arrange your ongoing treatment.
  - Help you get needed hospital care.

Access for members with special needs

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

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

WHAT DOES MEDICALLY NECESSARY MEAN?

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

- Consistent with the symptoms or diagnosis of the illness or injury being treated.
- Consistent with generally accepted qualified medical standards, including:
  - Guidelines and standards that are endorsed by professional health care or government agencies.
  - Generally accepted medical standards.
- Not experimental (not new or untried).
- Safe and effective for the member (Medicaid and Nevada Check Up will only cover items and services that are needed for the diagnosis or treatment of an illness or an injury, or to improve the working of a malformed body part).
- Not mainly for the ease of the member, the member's caregiver or the provider.

As an Anthem member, you should follow the treatment plan prescribed by your doctor. This will help you get well faster. If you don't follow the treatment plan, your condition may worsen. At the next medical necessity review, if your health services aren't helping you get better, the services could end.

HEALTH CARE BENEFITS AND PREMIUMS

Anthem benefits

Below is a summary of the health care services and benefits Anthem offers. Your PCP will either give you the care you need, or refer you to another provider.

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

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

If you have a question or aren't sure if Anthem offers a certain benefit, call Member Services at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

Prior authorization (preapproval)

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

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

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

Your PCP can ask for an expedited review if a delay could cause serious harm to your health. We'll notify your doctor of our decision within three days of getting the request.

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

HOW WE MAKE DECISIONS ABOUT YOUR CARE

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

We don't encourage providers to underuse services. In addition, we don't create barriers to getting health care. Providers aren't rewarded for limiting or denying care. Anthem providers use clinical practice guidelines to determine necessary treatments and services.

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

Some services are limited by number of visits or supply/equipment items. We have a process to review these requests from you or your provider for extra visits or extra supplies. We also have a process to review requests for non-covered services, when they are medically necessary. Remember to call us before you get medical services or ask your PCP to help you.

For some services, you may need to get a referral from your PCP and/or pre-approval from us before you get them or we might not pay for them. When you ask or your provider asks for certain care that needs a pre-approval, our Utilization Review team decides if the service is medically necessary and covered by Anthem.

Some of the services listed below may need pre-approval; please ask your provider for more information, or contact us Monday through Friday from 8 a.m. to 5 p.m. Pacific time. To speak to a UM representative, please call 1-844-396-2329 (TTY 711).

***Anthem doesn't cover testing, medication or treatment that is** experimental, such as a new treatment that's being tested or hasn't been shown to work.

Anthem covered services

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

COVERED SERVICE	ADDITIONAL INFORMATION
APPLIED BEHAVIORAL ANALYSIS (ABA) (Cont.)	• Family counseling. • Case management.
ASSISTANT SURGEON	An assistant surgeon aids the performing surgeon during a surgical procedure. These services are covered for qualifying procedures.
ASSISTIVE/AUGMENTATIVE COMMUNICATION DEVICES	Devices, such as speech synthesizers, that help members with limited vocal or verbal communication skill convey their thoughts.
AUDIOLOGY SERVICES	These services help decide whether a person can hear within the normal range and, if not, which parts of hearing have changed and to what degree. If an audiologist diagnoses a hearing loss, he or she will advise what options may help a patient (e.g., hearing aids, cochlear implants, surgery). Anthem covers: • Medically needed hearing aids. • Hearing aids and supplies made during a Healthy Kids checkup, for members under age 21 in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Certain limits apply.
BEHAVIORAL HEALTH	Covered services up to limits outlined in the Nevada Medicaid and Nevada Check Up program include: • Crisis Intervention for members who go through a psychiatric crisis to: – Reduce symptoms. – Help stabilize and restore a person to his or her former level of function. • Crisis Stabilization to help a person in crisis return to his or her prior level of function. • Prescribed Electroconvulsive Therapy to treat severe mental illness.

COVERED SERVICE	ADDITIONAL INFORMATION
BEHAVIORAL HEALTH (Cont.)	• Hospital-based Detoxification/Chemical Dependency. Services: – Aimed to restore the mental and physical well-being of those who abuse drugs or alcohol. *Certain limits apply as determined by the Nevada Medicaid and Nevada Check Up program. • Inpatient Professional Services given within an inpatient setting by: – Psychiatrists. – Psychologists. – Clinical social workers. – Therapists. – Medical doctors or specialists. – Certified Nurse Practitioners. • Intensive Outpatient Program for psychiatric and chemical dependency that: – Meets several times a week for at least three hours of mental health or substance/alcohol abuse services. – Aims to improve a person's level of function to prevent a relapse or hospital admission. • Medication Assisted Treatment such as a Methadone Maintenance Program for the treatment of heroin addiction. • Neurotherapy — also referred to as neurofeedback or EEG biofeedback — is a process to observe the central nervous system and the brain. This allows for a better understanding of possible irregularities in the brain, and treatment can train the brain to correct the irregularities. – Hospital observation services.

COVERED SERVICE	ADDITIONAL INFORMATION
BEHAVIORAL HEALTH (Cont.)	• Outpatient/ambulatory detox and/or rehab services: – Aimed to restore the mental and physical well-being of those who abuse drugs or alcohol. • Outpatient mental health/substance abuse services include: – Basic medical and therapeutic services. – Crisis services. – Review and diagnosis of care. – Individual, family and/or group therapy, unless part of an EPSDT screening. – Medication management. You may get these services from authorized physicians, psychologists or other mental health professionals. • Partial Hospital, Psychiatric and Chemical Dependency Treatment programs that: – Are offered Monday through Friday for at least six hours each day. – Are provided by a hospital in an outpatient setting. – Provide a range of psychiatric and substance abuse treatment services. – Offer partial hospital care as an alternative to inpatient psychiatric or substance abuse care. – Psychosocial rehabilitation services/basic skills training to help reach or maintain a person's greatest level of function. – Make the most of their personal strengths. – Develop ways to cope and deal with areas of weakness.

COVERED SERVICE	ADDITIONAL INFORMATION
BEHAVIORAL HEALTH (Cont.)	– Build a supportive environment in which to function. • Psychological and neuropsychological testing that is used by psychologists to test: – Mood. – Personality type. – Learning skills. These tests can be used to help decide a mental health diagnosis. Covered services include: – Neuropsychological testing. – Neurobehavioral testing. – Psychological testing. • Residential treatment center (RTC) (only for members under the age of 21). An RTC provides treatment for: – Alcohol and drug abuse to residents who don't require acute medical care. – Mental health to children and adolescents who don't need intense acute inpatient care. Services include: – Individual, group and family therapy. – Medication management. – Medical treatment. – Lab testing. – Room and board. **Nevada Check Up members through their 19th birthday** Anthem covers medically needed care (physician services, lab work, dental, X-ray services, etc.) and professional services provided in an RTC. Nevada Check Up covers the admission and daily room rate. **Medicaid members age 21 and older**

COVERED SERVICE	ADDITIONAL INFORMATION
BEHAVIORAL HEALTH (Cont.)	Anthem will cover services for the first month of admission. On the first day of the month after admission, the member will be disenrolled from Anthem and get all Medicaid-covered services from the fee-for-service program.
BIOFEEDBACK (AS PART OF NEUROTHERAPY) **Neurotherapy** — also referred to as neurofeedback or EEG biofeedback — is a process to observe the central nervous system and the brain. This allows for a better understanding of possible irregularities in the brain, and treatment can train the brain to correct the irregularities. **Biofeedback** treatment helps train people to improve their health by using signals from their own bodies. • Physical therapists use it to help stroke victims regain movement in paralyzed muscles. • Specialists use it to help their patients cope with pain. • Psychologists use it to help a tense and anxious individual learn to relax.	**Neurotherapy** — Anthem covers medically needed neurotherapy when given by a licensed qualified mental health professional (QMHP) within the scope of his or her practice. **Biofeedback** — A certified biofeedback technician may assist in giving biofeedback treatment, but a QMHP must provide the related psychotherapy. Certain limits apply.
BLOOD ADMINISTRATION AND OTHER BLOOD PRODUCTS	Anthem covers injecting of blood or blood products into a vein or artery.

COVERED SERVICE	ADDITIONAL INFORMATION
BOTOX INJECTIONS	Covered services include treatment for jerkiness of limbs as a result of a brain or spinal cord injury, including cerebral palsy. Treatment for cosmetic purposes isn't covered.
CASE MANAGEMENT	Case management is designed to respond to a member's needs when the member's condition or diagnoses require care and treatment for long periods of time. When a member is in a case management program: • An Anthem case manager helps identify settings in which care may be given. • A provider, on behalf of the member, may request the member take part in the program. The case manager will work with the member and the member's providers to decide: – The level and types of services needed. – Other settings where care may be given. – Equipment and/or supplies needed. – Nearby community-based services. – Communication needed between the member and the member's PCP and specialists. **Complete member assessment** A case manager will assess a member's health care needs. This assessment includes: • A range of questions to identify and assess the member's: – Medical and social needs. – Functional limits. – Ability for self-care.

COVERED SERVICE	ADDITIONAL INFORMATION
CASE MANAGEMENT (Cont.)	– Current treatment plan. • Phone interviews or home visits to collect and assess information received from members or their representatives; to complete the assessment, case managers will also get information from: – The member's family, PCP and specialists. – Other sources to set up and decide the member's current medical and nonmedical service needs. **Individualized plan of care** Case managers will use information from the assessment to help the member and his/her care team decide the proper case management services needed. The case manager will: • Work with the member, his or her family, and the member's providers to develop and set up the proper care plan. • Think of the member's needs for social, educational, therapeutic and other nonmedical support services as well as the strengths and needs of the family. When nonmedical needs are complex, case managers will work with: • Social workers. • Member advocates or outreach associates to contact members they haven't been able to reach. If a member is getting case management services from other sources (e.g., a community services organization), the care plan will define: • The process for managing medical, mental health/substance abuse, and social aspects of care.

COVERED SERVICE	ADDITIONAL INFORMATION
CASE MANAGEMENT (Cont.)	• The roles of each person on the care team.
CHEMOTHERAPY AND RADIATION	**Chemotherapy** is the use of drugs to kill bacteria, viruses, fungi, and — most often — cancer cells. • It can destroy cancer cells at sites great distances from the original cancer. • More than half of all people diagnosed with cancer receive chemotherapy. A **chemotherapy regimen** is a treatment plan and schedule that includes drugs to fight cancer, plus drugs to help support finishing the cancer treatment at the full dose or schedule. **Radiation therapy** is the use of a certain type of energy, called ionizing radiation, to kill cancer cells and shrink tumors. • In some cases, the goal of radiation treatment is to destroy an entire tumor. • In other cases, the goal is to shrink a tumor and relieve symptoms. In both cases, doctors plan treatment to spare as much healthy tissue as possible.
CHIROPRACTIC SERVICES	For Medicaid members under age 21 and Nevada Check Up members through their 19th birthday. Covered services include: Medically needed chiropractic services when referred to a chiropractor as part of a Healthy Kids checkup, and when a diagnosis of spinal subluxation is made by the referring doctor.
CIRCUMCISION	Circumcision is a covered benefit.
CLINICS	**Federally qualified health centers (FQHCs)** provide preventive services, or services to treat an illness or chronic disease.

COVERED SERVICE	ADDITIONAL INFORMATION
CLINICS (Cont.)	**Rural health clinics (RHCs)** provide preventive services. Members can receive covered services at these facilities from the following providers: • Physicians • Nurse practitioners • Physician assistants • Certified nurse-midwives • Visiting nurses • Clinical psychologists • Clinical social workers • Registered dietitians • Nutritional professionals **You can get these services without a referral from your PCP.**
COCHLEAR IMPLANTS	These devices: • Help capture, analyze and code sound. • Help a person identify and be aware of sounds. • Aid in communication for persons who are extremely hard of hearing.

COVERED SERVICE	ADDITIONAL INFORMATION
COSMETIC/PLASTIC/RECONSTRUCTIVE SURGERY PROCEDURES	**Cosmetic surgery**, performed to reshape normal structures of the body to improve a person's appearance and self-esteem, is not a covered benefit. **Reconstructive surgery,** performed on abnormal structures of the body caused by birth defects, developmental abnormalities, trauma or injury, infection, tumors or disease, may be covered. Reconstructive surgery is usually done to improve function, but in some cases may also be done to help come close to a normal appearance. This may include cleft palate repair, breast reconstruction, etc. Covered reconstructive surgery services include: • Surgery for the prompt repair of an injury caused by an accident. • Surgery to improve a malformed body part in order to improve function.
DENTAL SERVICES	Call LIBERTY Dental at 1-866-609-0418 or visit LibertyDentalplan.com/nvmedicaid for information about receiving dental services.
DERMATOLOGY	Dermatology is the science that treats the skin and its structure, function and diseases, including the hair and nails. Anthem covers this service.
DIABETIC SERVICES	Services include: • Screenings, which consist of lab tests for members who have certain risk factors for diabetes or who are diagnosed with prediabetes. • Training to teach members to self-manage their diabetes; the program includes: – Instructions on how to self-monitor blood glucose. – Training on diet and exercise.

COVERED SERVICE	ADDITIONAL INFORMATION
DIABETIC SERVICES (Cont.)	– An insulin treatment plan specifically for the person who is insulin-dependent. – Reasons for patients to use skills for self-management. • Supplies to self-test glucose levels of the blood to monitor and control diabetes including: – Glucometers. – Syringes. – Lancets. – Needles.
DIAGNOSTIC TESTING	Diagnostic testing includes: • Laboratory and radiology services including, but not limited to: – Blood chemistry. – Pathology testing: microbiology and other testing using physical specimens such as tissue, urine or blood. – Bone mass/density studies. – Testing for human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). – Lead blood screenings. – Prostate-specific antigen testing (PSA). – Sleep studies. – Portable X-ray services. – Preadmission tests. – Colorectal cancer screening procedures. – Positron emission tomography (PET) scans. • Nuclear medicine services include procedures and tests performed by a radioisotope lab using radioactive materials such as:

COVERED SERVICE	ADDITIONAL INFORMATION
DIAGNOSTIC TESTING (Cont.)	– Computed tomography (CT). – Magnetic resonance imaging (MRI). – Cardiac testing.
DIALYSIS SERVICES	Dialysis services are given to remove toxic materials and maintain fluid balances in cases of poor kidney function. Covered services include: • Home dialysis managed by the patient or a patient's representative under the guidance of a freestanding clinic. • Services received in an inpatient or outpatient hospital setting.
DISPOSABLE MEDICAL EQUIPMENT	Anthem covers medically needed disposable supplies that wouldn't generally be useful to a person without an illness or an injury. Members should ask their PCP if they need disposable medical equipment.
DRUGS/INJECTABLES/BIOLOGICALS	A **drug** is a substance (medication) that can be used to change chemical processes in the body. **Injectable** drugs are those drugs that are managed by a health professional or self-managed. These may be drugs such as insulin, growth hormones, etc. Over-the-counter drugs are those that are purchased without a prescription from a physician. **Biologicals** in medicine refer to substances made from a living organism or its products. Biologicals are used to prevent, diagnose, treat or relieve symptoms of a disease (for example, vaccines).

COVERED SERVICE	ADDITIONAL INFORMATION
DRUGS/INJECTABLES/BIOLOGICALS (Cont.)	Anthem doesn't cover: • Agents used for weight loss. • Agents used to promote fertility. • Agents used for cosmetic reasons or hair growth. • Less than effective drugs. • Experimental drugs. • Agents used for impotence/erectile dysfunction. Anthem has a list of commonly prescribed drugs. You or your child's PCP or specialist can choose drugs from this list to help you get well. This list is called a preferred drug list (PDL). It is part of the Anthem formulary. • The covered medicines on the PDL include prescriptions and certain over-the-counter medicines. • All Anthem network providers have access to this drug list. • Your or your child's PCP or specialist should use this list when he or she writes a prescription. • Certain medicines on the Anthem PDL need prior approval. • All medicines that aren't listed on the Anthem PDL need prior approval. • See the Medications section under the heading Special Kinds of Health Care. • Here's a list of things to remember: - Anthem covers up to a 30-day supply of prescriptions. - You can get prescriptions filled at any in-network pharmacy. - In-network pharmacies include most major pharmacy chains, and many independent community pharmacies. - CVS, Walmart, Raley's Pharmacy, Smith's Pharmacy, Save Mart

COVERED SERVICE	ADDITIONAL INFORMATION
DRUGS/INJECTABLES/BIOLOGICALS (Cont.)	Pharmacy and Rite Aid are part of our plan and will accept your Anthem ID card. - Walgreens is not in the Anthem plan. - You can find a list of in-network pharmacies in the provider directory you received with your new member package. **If you need help finding a pharmacy, call Member Services toll free or visit our website at www.anthem.com/nvmedicaid.**
DURABLE MEDICAL EQUIPMENT	Durable medical equipment is equipment: • Used to serve a medical purpose. • Fitted for use in the home. • Able to withstand repeated use. Covered services as determined by the Nevada Medicaid and Nevada Check Up program include: • Certain medically needed equipment (e.g., crutches, wheelchairs, ventilators, etc.). • Items that wouldn't generally be useful to a person without an illness or an injury. Members should ask their PCP if they need durable medical equipment. Anthem doesn't cover: • Physical fitness or personal recreation equipment. • Personal care or hygiene products. • Household items such as air conditioners and ceiling fans. • Environmental products. • TDD devices.
EARLY CHILDHOOD INTERVENTION (ECI) SERVICES	These services assist families with children ranging from birth to school age that have

COVERED SERVICE	ADDITIONAL INFORMATION
EARLY CHILDHOOD INTERVENTION (ECI) SERVICES (Cont.)	developmental disabilities and delays. The program provides screening and resource referral methods that support families in helping effected children reach their potential through developmental services.
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES (MEDICAID)/ WELL-BABY/WELL-CHILD SCREENINGS (NEVADA CHECK UP)	The EPSDT program covers screening and diagnostic services to decide health care needs and other measures to correct or improve: • Physical or mental defects. • Chronic conditions found in Medicaid members under age 21 and Nevada Check Up members through their 19th birthday. **This program is known as "Healthy Kids" in Nevada.** Covered services for Medicaid Members under age 21 and Nevada Check Up Members through their 19th birthday include: • Complete medical screenings, including: – Complete health and development history with assessment for both physical and mental health development. – Complete physical exam. – Proper immunizations (shots) according to age and health history. – Lab tests, including lead blood level assessment. – Health education. – Vision screening. – Hearing screening. Other EPSDT services, care and screenings for pregnant members under age 21 are not covered.
EMERGENCY SERVICES	Emergency services include inpatient and outpatient services by a qualified provider to assess or stabilize an emergency medical

COVERED SERVICE	ADDITIONAL INFORMATION
EMERGENCY SERVICES (Cont.)	condition. See the section **Different Types of Health Care** under the heading **Emergency Care** for more details.
EMERGENCY TRANSPORTATION	Anthem covers all emergency transportation. See the **Transportation** section for more details.
ENTERAL NUTRITION	Enteral nutrition, also called tube feeding, is a way to provide food through a tube placed in the nose, stomach or small intestines.
FAMILY PLANNING	Anthem covers family planning services for members of childbearing age. Members can receive family planning services from plan or non-plan providers. Services include: • Education. • Counseling. • Physical exams. • Birth control devices, implants, medication and supplies. Members don't need a referral for family planning services. See the **Family Planning Services** section under the heading **Special Kinds of Health Care** for more details. The following services aren't covered: • Tubal ligations and vasectomies for people who are: – Under age 21. – Mentally incompetent. – Institutionalized. • Sterilization reversals • Abortions (These services are excluded from family planning but may be covered under certain conditions; for example, to save the life of the mother, for rape or incest, or if medically necessary. Your provider will explain these services and ask you to sign a consent form.)

COVERED SERVICE	ADDITIONAL INFORMATION
GASTROENTEROLOGY SERVICES	Gastroenterology is a branch of medicine concerned with the structure, functions, diseases and pathology of the stomach and intestines.
GENDER REASSIGNMENT SERVICES	Transgender health care services covers treatment for gender dysphoria. Treatment includes both hormonal and surgical modalities, and psychotherapy based on medical necessity. Genital reconstruction surgery is covered for recipients who meet eligibility criteria under Nevada and federal laws.
GENETIC AND DNA TESTING	Genetic and DNA testing is considered medically needed to establish a diagnosis of inherited diseases when certain conditions are met. Covered services include: • Assessing if there is a genetic disorder. • Diagnosing such disorders. • Counseling and following up with members with known or supposed disorders. Anthem doesn't cover: • Prenatal diagnosis to find out the sex of the baby unless there is reason for genetic disease. • Self-testing home kits. • Genetic testing for cleft disorders. • Experimental genetic testing. • Blood typing for paternity testing.

COVERED SERVICE	ADDITIONAL INFORMATION
HIV/AIDS CARE	Anthem covers: • Standard diagnostic tests to diagnose HIV infection. • Medications to treat HIV infection. Anthem doesn't cover experimental or investigational studies or treatments.
HOME HEALTH CARE	Anthem covers medically needed home health care services provided at a member's home if services are clearly defined as part of an approved plan of care. Covered services include: • Personal care services. • Home environment evaluation. • Skilled nursing services. • Home health aide services. • Dietitian services. • Respiratory therapy. • Physical therapy (limit restrictions apply). • Occupational therapy (limit restrictions apply). • Speech therapy (limit restrictions apply).
HOME INFUSION/TOTAL PARENTERAL NUTRITION (TPN)	Services provided by a licensed nurse to administer drugs, intravenous fluids or total parenteral nutrition (TPN) through an intravenous catheter. TPN is given to people who aren't able to absorb nutrients through the intestinal tract.

COVERED SERVICE	ADDITIONAL INFORMATION
HOSPITAL INPATIENT MEDICAL AND SURGICAL	Anthem covers inpatient hospital care for medically necessary conditions. Inpatient hospital services include: • Room and board. • Nursing and provider services. • Diagnostic or therapeutic services. • Medical or surgical treatments and supplies. • Medication given while in the hospital.
HOSPITAL OUTPATIENT	Anthem covers outpatient hospital services.
HYPERBARIC OXYGEN (HBO) THERAPY	Hyperbaric oxygen (HBO) therapy treats: • Carbon monoxide poisoning. • Air embolism. • Smoke inhalation. • Acute cyanide poisoning. • Decompression sickness. • Certain cases of blood loss or anemia where increased oxygen may help balance the blood deficiency. Topical HBO therapy isn't covered.
HYSTERECTOMY	Anthem covers medically necessary hysterectomies. Your provider will require you to sign a consent form. A hysterectomy performed for the sole purpose of sterilization isn't covered.

COVERED SERVICE	ADDITIONAL INFORMATION
NUTRITION/DIETICIAN SERVICES	Anthem covers medically necessary services to address nutrition related issues for Medicaid recipients. To receive nutrition/dietician related services, members must have written orders of a physician, physician assistant (PA) or advanced practice registered nurse (APRN). A registered dietician must design and approve the treatment. Certain limitations apply.
MEDICAL REHABILITATION CENTER OR SPECIALTY HOSPITAL	Anthem covers medically needed services provided at freestanding rehab hospitals, or a rehab unit of a general hospital. Anthem also covers care provided in a freestanding long-term acute care hospital, or a long-term acute care unit of a general hospital.
OBESITY SURGERY/BARIATRIC SURGERY	Bariatrics is a branch of medicine to help prevent, control and treat obesity. **Obesity surgery/bariatric surgery** is a weight-loss method limited to people who meet the eligibility and medical necessity requirements. Anthem will cover services up to limits as outlined in the Medicaid and Nevada Check Up program.

COVERED SERVICE	ADDITIONAL INFORMATION
OPHTHALMOLOGY/OPTOMETRY SERVICES (VISION SERVICES)	Covered services include: • One complete eye exam every 12 months. • Refractive exams. • Frames. • Lenses. • Fitting, dispensing and adjustment of glasses. • Follow-up exams. • Contact lenses (in certain circumstances).
OUTPATIENT SURGERY	Anthem covers medically needed outpatient surgery.
PERSONAL CARE SERVICES	Anthem covers personal care services given to members who need help with daily living and meet the eligibility requirements. These services are given at certain times and as described in the Nevada Medicaid program. Covered services include: • Help with bathing, grooming or dressing. • Help with toileting needs. • Help with transferring and positioning people who can't walk. • Help with walking. • Help with eating. • Help with taking medicines. The following services aren't covered: • Tasks a person is able to perform. • Services given by willing caregivers. • Tasks that aren't on the approved service plan. • Services to maintain a household. • Services given to a person other than the planned receiver. Care is required to be given by a health care professional approved by the state.

COVERED SERVICE	ADDITIONAL INFORMATION
PHYSICIAN SERVICES	Anthem covers medically needed care provided by a: • Certified nurse-midwife. • Certified registered nurse practitioner. • Nurse anesthetist. • Physician/osteopath. • Physician assistant. Ask your PCP if you think you need to see one of these providers.
PODIATRY SERVICES	Anthem covers medically needed podiatry care for all Medicaid eligible individuals.
POST-STABILIZATION CARE	Post-stabilization care services are Medicaid-covered services you receive after emergency medical care. You get these services to help keep your condition stable after you have an emergency.
REHABILITATIVE THERAPY (PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY)	Anthem will cover the therapy needed to develop and maintain a safe rehabilitative plan.
SKILLED NURSING CARE	Anthem covers the first 45 days of medically needed care in a nursing facility. On the 46th day, you — the member — will be disenrolled from Anthem. The rest of your stay will be covered by Nevada Check Up or Nevada Medicaid.
SMOKING CESSATION PROGRAMS/SUPPLIES	Anthem covers products to help you stop smoking, including: • Over-the-counter (OTC) patches. • Gums. • Lozenges. • Inhalers. • Tablets. These products are available with a prescription from your PCP. Certain limitations apply.
SPECIAL CASE MANAGEMENT	Anthem covers special case management services for the following groups:

COVERED SERVICE	ADDITIONAL INFORMATION
SPECIAL CASE MANAGEMENT (Cont.) ***SED or SMI Determinations**	• Children and adolescents who are severely emotionally disturbed (SED).* • Adults with serious mental illness (SMI).* • Infants and toddlers with developmental delays. A case manager will help: • Assess and evaluate health care needs. • Develop a plan of care. • Get referrals and needed services. • Coordinate services between PCPs and specialists. • Monitor care and follow-up. **SED or SMI determination must be completed by a qualified Anthem provider.** **Upon determination, Medicaid members** who are diagnosed as being SED or SMI can choose to disenroll from Anthem and continue to get benefits through Medicaid. **Nevada Check Up members** diagnosed as SED or SMI don't have the option to disenroll and will continue to receive covered services through Anthem. Annually, Medicaid and Nevada Check Up members diagnosed as SED or SMI will be evaluated, and a new determination will be made. If the evaluation doesn't result in a redetermination as SED or SMI, the Medicaid member who chose to disenroll from Anthem will be re-enrolled as of the first day of the next possible month.
SWING BEDS	A swing bed is a bed in a rural or critical access hospital that can be used to provide either standard hospital care or skilled nursing care. Anthem covers the first 45 days of care from a swing bed in an acute hospital, when

COVERED SERVICE	ADDITIONAL INFORMATION
SWING BEDS (Cont.)	medically needed. Once the stay goes over 45 days, the member will be disenrolled from Anthem. The rest of the stay will be covered by Nevada Check Up or Medicaid.
TELEHEALTH (LiveHealth Online)	LiveHealth Online allows you to see a doctor through a video chat session on your smartphone, tablet or computer. Your video chats are private and secure. It's a convenient and easy way to see the doctor when it's late at night, you can't make it to the doctor's office, or you need an appointment fast.
TMJ TEMPOROMANDIBULAR JOINT	Covered for recipients age 20 years and younger. TMJ services may be provided by a dentist or medical doctor. Surgery to correct a wide range of diseases, injuries and defects to the head, neck, face, jaw, and hard and soft tissues of the lower jaw and face region is covered.
TRANSPLANTATION	Anthem covers the following transplants for Medicaid-eligible adults (21 and older) when medically needed and not experimental: • Cornea. • Kidney. • Liver. • Bone marrow. Anthem covers any medically needed transplant that isn't experimental for: • Medicaid members under age 21. • Nevada Check Up members through their 19th birthday.

Extra Anthem benefits

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

- Free Boys & Girls Club memberships for children ages 5 to 14.
- Free sports physicals every 12 months from a plan PCP for children ages 6 to 18.
- Free in-home pregnancy tests — so you can find out early if you're pregnant.

- New Baby, New Life℠ — education and rewards program for all pregnant members.
- My Advocate® program — screening and health education program for pregnant members.
- Books for Babies Program — no-cost books delivered to your home for newborns, 12 months and 24 months of age.
- 24/7 NurseLine — talk to a registered nurse about medical questions and concerns anytime, day or night.
- LiveHealth Online — "visit" a doctor through online video chat anytime, day or night, to get help when you need an appointment fast, or to get quick care for minor illnesses like colds, allergies, flu or infections.
- Free cellphone with free monthly minutes, data and text messages.
- Anthem Healthy Rewards programs — get debit card dollars for doing things that are good for your health.
- Holistic smoking cessation program — our program includes coaching, written and online education, and Nicotine replacement therapy (NRT) delivered to your home.
- Health education classes.
- Free dental hygiene kits to keep your teeth healthy.
- Help getting to your doctor with extra transportation benefits — we provide bus passes and free rides for members who do not meet the eligibility requirements for the Medicaid transportation benefit.
- Improved Member Services department — representatives provide personalized referral assistance and appointment scheduling to help you get to the doctor when you need care.
- Bedside delivery of medications — medicines delivered to you when you're discharged from a hospital setting.
- Transitional care assistance for extra help moving from a hospital stay to your home.
- GED/HiSet assistance — we'll cover the costs of the high school equivalency test.
- Identification support — if you lose your green card, ID or birth certificate, our behavioral health case managers will help you get a copy of the original document(s), and we'll cover the cost of the replacements.
- Community Resource Link — an online resource to help you find all available local community-based programs, benefits and services.
- Shelter bed reservations program — daily shelter beds available along with short-term, long-term and respite housing for those who qualify through New Hope Housing.

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

Nevada Check Up premiums

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

Remember, if you have a quarterly premium and don't pay it, your child will be disenrolled. This premium will go toward your family cost-share. Your family cost-share is based on your total family income. To find out more about premiums, call the Nevada Check Up program at 1-775-684-3777, or toll-free at 1-800-992-0900. You can also go to the Division of Health Care Financing and Policy website at http://dhcfp.nv.gov/Pgms/CPT/NevadaCheckUp/NCUMAIN/.

SERVICES COVERED BY NEVADA CHECK UP OR NEVADA MEDICAID

Some services are covered by Nevada Check Up or Medicaid instead of Anthem. You don't need a referral for these services.

These are called carved-out services and include:

- Adult day health care.
- Children in out-of-home placement.
- Home- and community-based waiver services.*
- Hospice.*
- Indian health service facilities and tribal clinics.
- Intermediate care facilities for members with intellectual disabilities.*
- Nonemergency transportation (only available to Medicaid members).**
- Nursing facility stays beginning on the 46th calendar day.*
- Evaluations/screening for appropriate level of care before admission to a facility residential treatment center for Medicaid members.*
- School-based child health care services (Anthem covers when provided by federally qualified health centers or rural health clinics).
- Treatment for severe emotional disturbance/serious mental illness.

If you have questions about how to obtain these services, please contact Anthem Member Services at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time. We can help you.

*Members who receive these services will be disenrolled from Anthem and will get health care benefits directly from fee-for-service Medicaid or Nevada Check Up.

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

SERVICES THAT DON'T NEED A REFERRAL

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

- Behavioral health care.
- Care provided by your plan PCP's nurse or doctor's assistant.
- Emergency care.

- Eye exams from a plan eye care provider (optometrist).
- Family planning services from any qualified family planning provider.
- Healthy Kids visits to a plan provider.
- Prenatal care from a plan obstetrician or certified nurse-midwife.
- Yearly exams from a plan OB/GYN.

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

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

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

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

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

Please contact Anthem Member Services at 1-844-396-2329 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. Pacific time to notify us of your transitional needs. We will assign a nurse to help coordinate your care as you join Anthem.

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

The following are not covered:

- Anything experimental, such as a new treatment that's being tested or hasn't been shown to work
- Anything that isn't medically needed
- Sterilization for members under age 21, or members who are institutionalized or mentally incompetent
- Elective abortions

If you choose to get a service that isn't covered, you'll have to pay for it. Your provider may ask you to sign a form. This form tells your provider you understand and agree to pay for the service.

NEW TECHNOLOGY

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

We use the following in our review process:

- Scientific literature
- Peer-reviewed medical journals

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

DIFFERENT TYPES OF HEALTH CARE

Routine, urgent and emergency care: what's the difference?

Routine care

In most cases, when you aren't feeling well and need medical care, you visit your PCP. This type of care is known as **routine care**. Some examples are most minor illnesses and injuries and regular checkups. You should be able to see your PCP within two weeks for routine care.

Your PCP also takes care of you before you get sick. This is called wellness care, and includes checkups, shots and screenings. See the section in this handbook **Wellness Care for Children and Adults**.

Urgent care

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

- Throwing up.
- Minor burns or cuts.
- Earaches.
- Headaches.
- Sore throat.
- Fever over 101 degrees.
- Muscle sprains/strains.

If you need urgent care:

- Call your PCP. Your PCP will tell you what to do.
- Follow your PCP's instructions. Your PCP may tell you to go to:
  - His or her office right away.
  - Some other office to get immediate care.
  - An urgent care location.
- Use LiveHealth Online at LiveHealthonline.com.

You can also call our 24/7 NurseLine at 1-844-396-2329 (TTY 711) if you need advice about urgent care. You should be able to see your PCP within two days for an urgent care appointment.

Emergency care

What is an emergency? An emergency is anything that could cause very serious harm or death if not treated immediately. This means someone with an average knowledge of health and medicine can tell

the problem may threaten your life or cause serious harm to you or your unborn child if you're pregnant. Here are some examples of problems that are most likely emergencies:

- Trouble breathing
- Chest pains
- Loss of consciousness
- Very bad bleeding that doesn't stop
- Very bad burns
- Shakes called convulsions or seizures

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

- Call 911.
- Go to the nearest hospital emergency room. The hospital doesn't need to be a part of the Anthem plan for you to get emergency care. You will be able to continue to get care until your health has stabilized.
- Go to an urgent care center.

You should be able to see a physician right away. You don't need a referral from your PCP or another provider to get emergency care.

If you want advice about emergency care, call your PCP or our 24/7 NurseLine at 1-844-396-2329 (TTY 711). Treatment for medical emergencies doesn't need prior approval by Anthem.

After you visit the emergency room, it's important to call your PCP as soon as possible. If you can't, have someone else call for you.

It may be necessary for you to get additional care to keep your condition stable after an emergency. This type of care is referred to as post-stabilization care. Post-stabilization care is a covered service.

How to get health care when your doctor's office is closed

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

- Call our 24/7 NurseLine to speak to a nurse 24 hours a day, seven days a week.
- Use LiveHealth Online to video chat with a doctor any time, day or night, to get quick care for minor illnesses like colds, allergies, flu or infections.

If you think you need emergency services, call 911 or go to the nearest emergency room right away.

How to get health care when you are out of town

- If you need emergency services when you're out of town, go to the nearest hospital emergency room or call 911.

- If you need urgent care:
  - Call your PCP. If your PCP's office is closed, leave a phone number where you can be reached. Someone should call you back within 30 minutes.
  - Follow your PCP's instructions. You may be told to get care right away.
  - Call our 24/7 NurseLine.
- If you need routine care like a checkup or a prescription refill:
  - Call your PCP.
  - Call our 24/7 NurseLine.

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

How to get health care when you can't leave your home

If you can't leave your home, we'll find a way to help take care of you. Call Member Services right away. We'll put you in touch with a case manager who'll help you get the medical care you need.

WELLNESS CARE FOR CHILDREN AND ADULTS

All Anthem members need to have regular wellness visits, including checkups and screenings, with their primary care provider (PCP). Your PCP will provide care based on nationally accepted guidelines. During a wellness visit, your PCP may detect problems before they worsen. When you become an Anthem member, make an appointment with your PCP within 90 days.

When you or your child misses one of your wellness visits

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

- Make an appointment with the PCP as soon as you can.
- Call Member Services if you need help setting up the appointment.

If your child hasn't visited his or her PCP on time, we'll send you a postcard reminding you to make your child's well-child appointment.

Wellness care for children, the Healthy Kids program

Why well-child visits are important for children

Children need more wellness visits than adults. These wellness visits for children are called Healthy Kids visits.

Healthy Kids is a program for:

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

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

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

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

Your child doesn't need a referral for these visits.

When your child should get Healthy Kids visits

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

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

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

Well-child care in your baby's second year of life

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

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

Well-child care for children ages 3 through 20

Your child should see the doctor again at ages 3, 4 and 5. Be sure to set up these visits. It's important to take your child to their PCP when scheduled.

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

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

Blood lead screening

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

Vision screening

Your child's PCP should check your child's vision at every well-child visit. Please see the section **Eye care** under the heading **SPECIAL KINDS OF HEALTH CARE** for more details.

Hearing screening

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

Immunizations (shots)

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

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

IMMUNIZATION (SHOT) SCHEDULE FOR CHILDREN

AGE ➡ VACCINE ⬇	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	19–23 mo	2–3 years	4–6 years	7–10 years	11–12 years	13–18 years
Hepatitis B	HepB	HepB			HepB							HepB Series if not given		
Rotavirus			Rota	Rota	Rota if needed									
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP				DTaP		Tdap	Tdap if not given
Haemophilus influenzae type b			Hib	Hib	Hib if needed	Hib								
Pneumococcal			PCV	PCV	PCV	PCV				PPSV if high-risk		PPSV if high-risk		
Inactivated Poliovirus			IPV	IPV	IPV						IPV	IPV Series if not given		
Influenza					Influenza (Yearly)									
Measles, Mumps, Rubella						MMR					MMR	MMR Series if not given		
Varicella						Varicella					Vari-cella	Varicella Series if not given		
Hepatitis A						HepA (2 doses)				HepA Series if high-risk				
Menin-gococcal*										MCV4 if high-risk			MCV4	MCV4 if not given
Human Papillomavirus													HPV (3 doses)	HPV Series if not given

*Meningococcal booster recommended at 16-17 years of age

Wellness care for adults

Staying healthy means seeing your PCP regularly for checkups. Use this chart to make sure you are up to date with your yearly wellness exams.

WELLNESS VISITS SCHEDULE FOR ADULT MEMBERS		
EXAM TYPE	**WHO NEEDS IT?**	**HOW OFTEN?**
Breast self-exam	Women age 20 and over	Once a month
Clinical breast exam	Women age 20-39	Every three years
	Women age 40 and over	Every year
Fecal blood occult test	Men and women age 50 and over	Every year
Mammograms (Breast X-ray)	Women age 40 and over	Every year
Pap smear and pelvic exam	All women over 18, and women under age 18 who are sexually active	Every year
Sigmoidoscopy and DRE/PSA or colonoscopy and DRE/PSA	Men and women age 50 and over	Every five years
Wellness visit	Men and women age 21–39	Every three years

SPECIAL KINDS OF HEALTH CARE

Eye care

Anthem members don't need a referral from their PCPs for eye care benefits. Members can get:

- One complete eye exam every 12 months.
- Refractive exams.
- Fittings, dispensing and adjustment of glasses.
- Frames and lenses.
- Follow-up exams.
- Contact lenses (in certain circumstances).

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

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

See **Ophthalmology/Optometry Services** under the section **Anthem covered services** for more details. If you need help finding a plan eye doctor (optometrist) in your area, call EyeQuest toll-free at 1-888-300-9025 (TTY 1-800-466-7566).

Behavioral health (mental health/substance abuse)

Sometimes, dealing with all of the tasks of a home and family can lead to stress. Stress can lead to depression and anxiety. It can also lead to problems with marriage, family and parenting. Stress can lead to alcohol and drug abuse, too.

If you or a family member are having these kinds of problems, you can get help. Call Anthem Member Services at 1-844-396-2329 (TTY 711). You can also get the name of a behavioral health specialist who will see you if you need one.

Your benefits include many medically needed services, such as:

- Inpatient mental health care.
- Outpatient mental health care and/or substance abuse treatment.
- Mental health rehabilitative treatment services.

You don't need a referral from your PCP to get these services or to see a behavioral health specialist in your network.

If you think a behavioral health specialist doesn't meet your needs, talk to your PCP. They can help you find a different kind of specialist.

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

If you have questions about referrals and when you need one, contact Member Services at 1-844-396-2329 (TTY 711).

Applied Behavioral Analysis

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

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

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

Our Behavioral Health team can guide your family through this process. They'll coordinate care and help you understand the healthcare system. Our goal is to help families make good use of their benefits. To learn more about the ABA benefit, call the Behavioral Health team at 1-844-396-2331 (TTY 711).

Family planning services

Anthem will arrange for counseling and education about planning a pregnancy. By talking to your PCP, you can learn about preventing pregnancy. You can also visit any family planning provider, even if the provider is not part of the Anthem network. You don't need a referral from your PCP.

Medications

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

The covered medicines on the PDL include:

- Prescriptions.
- Certain non-prescription or over-the-counter (OTC) medicines.

Go to www.anthem.com/nvmedicaid to get a copy of the PDL or call Pharmacy Member Services at 1-833-207-3116 (TTY 711) to request one.

Things to remember about the Preferred Drug List:

- The Preferred Drug List (PDL) is a smaller version of the complete formulary.
- The PDL lists preferred drugs commonly prescribed in certain categories.
- All Anthem network providers have access to this drug list.
- Your or your child's primary care provider (PCP) or specialist should use this list when he or she writes a prescription.
- Certain medicines on the PDL need prior approval. For those medicines, your doctor must get approval from Anthem before you can fill your prescription. Call Pharmacy Member Services at 1-833-207-3116 (TTY 711) to find out about the prior approval process for your medicine.

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

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

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

Walgreens is **not** a plan pharmacy.

For a complete list of plan pharmacies:

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

If you aren't sure if a pharmacy is in our plan, ask the pharmacist. You can also call Pharmacy Member Services for help at 1-833-207-3116 (TTY 711).

To get a prescription filled, follow these steps:

1) Take the written prescription from your provider to the pharmacy. Or your provider can call in the prescription to the pharmacy.

2) If you use a new pharmacy, tell the pharmacist about all of the medicines you are taking, including over-the-counter (OTC) medicines.
3) Show your Anthem ID card and your Medicaid ID card to the pharmacy.

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

- Will know all the medicines you are taking.
- Can watch for problems that may occur when you are taking more than one prescription.

Special care for pregnant members

New Baby, New Life℠ is the Anthem program for all pregnant members. It's very important to see your PCP or OB/GYN for care when you're pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important, even if you have already had a baby. With our program, members receive health information and rewards for completing necessary prenatal appointments.

Our program also helps pregnant members with complicated health care needs. Nurse case managers work closely with these members to provide:

- Education.
- Emotional support.
- Help in following their doctor's care plan.
- Information on services and resources in your community, such as transportation, Women, Infants, and Children (WIC), breastfeeding and counseling.

Our nurses also work with doctors to help keep you healthy and deliver healthy babies.

Get to know My Advocate

My Advocate® delivers maternal health education by phone, text messaging and smartphone app that is helpful and fun. You will get to know MaryBeth, the My Advocate automated personality. MaryBeth will respond to your changing needs as your baby grows and develops. You can count on:

- Education you can use.
- Communication with your case manager based on My Advocate messaging should questions or issues arise.
- An easy communication schedule.
- No cost to you.

With My Advocate, your information is kept secure and private. Each time MaryBeth calls, she'll ask you for your year of birth. Please don't hesitate to tell her. She needs the information to be sure she's talking to the right person.

Helping you and your baby stay healthy

My Advocate® gives you answers to your questions, plus medical support if you need it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn and answer a question or two over the phone. If you tell MaryBeth you have a problem, you'll get a call back from a case manager.

My Advocate topics include:

- Pregnancy and postpartum care.
- Well-child care.
- Postpartum depression.
- Immunizations.
- Healthy living tips.

When you become pregnant

If you think you are pregnant:

- Call your PCP or OB/GYN right away. You don't need a referral from your PCP to see an OB/GYN. Your OB/GYN should see you within seven days.
- Call Member Services if you need help finding a plan OB/GYN.

When you find out you are pregnant:

- Call your welfare caseworker; tell him or her you are pregnant. This is to make sure your baby gets the care he or she needs.
- Make an appointment as soon as possible.

We will send you an educational book, called the Pregnancy and Beyond Resource Guide. The book includes:

- Self-care information about your pregnancy.
- A section of the book for writing down things that happen during your pregnancy.
- Details on My Advocate® that tell you about the program and how to enroll and get health information to your phone by automated voice, text message or smartphone app.
- A Labor, Delivery and Beyond section with information on what to expect during your third trimester.
- A section of the book on having a healthy baby, postpartum depression and caring for your newborn, with helpful resources.
- Information about Making a Family Life Plan and long-acting reversible contraception (LARC).

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from WIC. Member Services can give you the phone number for the WIC program close to you. Just call us.

When you're pregnant, you must go to your PCP or OB/GYN at least:

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

Your PCP or OB/GYN may want you to visit more often based on your health needs.

When you have your baby

If you enrolled in My Advocate® and received educational calls during your pregnancy, you'll now get calls on postpartum and well-child education up to 12 weeks after your delivery.

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

- 48 hours after a vaginal delivery.
- 96 hours after a cesarean section (C-section).

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

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

- It's important to have a follow-up visit with your OB provider after you deliver. It would be best to see them within 1-3 weeks, but no later than 12 weeks after delivery. Your health is important to the whole family.
- Your PCP may want to see you sooner than three weeks if you had certain issues before or during delivery, such as high blood pressure, or if you had a cesarean section (C-section).

If you are a Nevada Check Up member:

- Call Nevada Check Up at 1-800-992-0900 within 14 calendar days of delivery. If you don't call Nevada Check Up within 14 calendar days of the birth, your baby will not be covered until the month after you call Nevada Check Up.

If you are a Medicaid member:

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

DISEASE MANAGEMENT

A Disease Management (DM) program can help you get more out of life. As part of your Anthem benefits, we're here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called DM case managers. They'll help you learn how to better manage your condition or health issue. You can choose to join a DM program for free.

What programs do we offer?
You can join a Disease Management program to get health care and support services if you have any of these conditions:

Asthma	HIV/AIDS
Bipolar disorder	Hypertension

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

How it works

When you join one of our DM programs, a DM case manager will:

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

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

How to join

We'll send you a letter welcoming you to a DM program if you qualify. Or call us toll free at 1-888-830-4300 (TTY 711), Monday through Friday from 8:30 a.m. to 5:30 p.m. local time.

When you call, we'll:

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

You can also email us at dmself-referral@anthem.com. Please be aware that emails sent over the internet are usually safe, but there is some risk that third parties may access (or get) these emails without you knowing. By sending your information in an email, you acknowledge (or know, understand) third parties may access these emails without you knowing.

You can choose to opt out (we'll take you out of the program) at any time. Please call us toll-free at 1-888-830-4300 (TTY 711) Monday through Friday from 8:30 a.m. to 5:30 p.m. local time to opt out. You may also call this number to leave a private message for your DM case manager 24 hours a day.

Useful phone numbers
In an emergency, call 911.

Disease Management
Toll-free 1-888-830-4300 (TTY 711)
Monday through Friday
8:30 a.m. to 5:30 p.m. local time
Leave a private message for your case manager 24 hours a day.

After-hours:
Call the 24/7 NurseLine
24 hours a day, seven days a week
1-844-396-2329 (TTY 711)

Disease Management rights and responsibilities
When you join a Disease Management (DM) program, you have certain rights and responsibilities. You have the right to:

- Get details about us, such as:
  - Programs and services we offer.
  - Our staff and their qualifications (skills or education).
  - Any contractual relationships (deals we have with other companies).
- Opt out of DM services.
- Know which DM case manager is handling your DM services, and how to ask for a change.
- Get support from us to make health care choices with your health care providers.
- Ask about all DM-related treatment options (choices of ways to get better) mentioned in clinical guidelines (even if a treatment is not part of your health plan), and talk about options with treating health care providers.
- Have personal date and medical information kept private.
- Know who has access to your information and how we make sure your information stays secure, private and confidential.
- Receive polite, respectful treatment from our staff.
- Get information that is clear and easy to understand.
- File complaints to Anthem by calling 1-888-830-4300 (TTY 711) toll-free Monday through Friday from 8:30 a.m. to 5:30 p.m. local time and:
  - Get help on how to use the complaint process.
  - Know how much time Anthem has to respond to — and resolve issues of — quality and complaints.
  - Give us feedback about the DM program.

You also have the responsibility to:

- Follow the care plan that you and your DM case manager agree on.
- Give us information needed to carry out our services.

- Tell us and your health care providers if you choose to opt-out (leave the program).

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

SPECIAL ANTHEM SERVICES FOR HEALTHY LIVING

Health information

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

- Ask your primary care provider (PCP).

Call us. Our 24/7 NurseLine is available 24 hours a day, seven days a week to answer your questions. They can tell you:

- If you need to see your PCP.
- How you can help take care of some health problems you may have.

Health A to Z

Anthem wants to help you make better health choices with Health A to Z. This is an online resource that's easy to use and includes a symptom checker, tests, tools and information on many health topics. Health A to Z is your one-stop for questions about your health. Access Health A to Z on our website at www.anthem.com/nvmedicaid, and choose *Programs and Info in Your Community*.

Health education classes

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

Some of the classes include:

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

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

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

Community events

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

You can learn about topics like:

- Healthy eating.
- Asthma.
- Stress.

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

Anthem also sponsors monthly member meet and greets that provide information to educate you about your health care benefits and available services. These meet and greets are held throughout Clark and Washoe counties. Please call Member Services or go online to www.anthem.com/nvmedicaid for a list of upcoming dates and locations.

Boys & Girls Club

Anthem offers this special benefit to members ages 6 to 11. Children can join their neighborhood Boys & Girls Club for free. The clubs are a great place for children to go after school. They have computers, homework help, sports, business training and much more. There is something for everyone. Anthem will pay for your child's annual membership. Each Boys & Girls Club site has different services and may have additional costs. Please call Member Services to learn how to join.

Domestic violence

Domestic violence is abuse. Abuse is unhealthy. Abuse is unsafe. It is never OK for someone to hit you. It is never OK for someone to make you afraid. Domestic violence causes harm and hurt on purpose. Domestic violence in the home can affect your children, and it can affect you. If you feel you may be a victim of abuse, call or talk to your PCP. Your PCP can talk to you about domestic violence. He or she can help you understand you have done nothing wrong and don't deserve abuse.

Safety tips for your protection:

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

If you have questions or need help:

- Call our 24/7 NurseLine at 1-844-396-2329 (TTY 711).
- Call the National Domestic Violence hotline number at 1-800-799-7233 (TTY 711).

MINORS

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

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

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

Members under age 18 may be emancipated minors if they:

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

ADVANCE DIRECTIVES (LIVING WILLS OR DURABLE POWERS OF ATTORNEY)

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

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

You can have either a living will or a durable power of attorney for health, or you can have both documents. A living will is your personal statement regarding the types of life-sustaining treatment you want if you're not able to share your desires. A durable power of attorney for health care covers more than the living will. It covers any medical decisions, not just decisions concerning life-sustaining treatment.

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

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

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

- Call your PCP or specialist to remove the living will from your medical record.

- Fill out and sign a new form if you wish to make changes in your living will.

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

Right to object

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

Individual and institutional objection

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

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

If your PCP or other provider objects to the request for care you make in your advance directive, you have the right to select another PCP or provider who will honor your request. Please call Member Services at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time for help.

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

Division of Health Care Financing and Policy
1100 E. William St., Suite 101
Carson City, NV 89701
1-775-684-3676

GRIEVANCES AND MEDICAL APPEALS

If you have any questions or concerns about your Anthem benefits, please call Member Services at 1-844-396-2329 (TTY 711). You can also write to us.

Grievances

If you have a problem with our services or network providers, we would like you to tell us about it. Please call Member Services and we will try to solve your problem on the phone.

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

- Write a letter to us and include information, such as:
  - The date the problem happened.
  - The names of people involved.

  - Details about the problem.
- File a grievance on the phone.
- Ask Member Services for help with writing a letter; include information such as the date the problem happened and the people involved.
- Send your letter to:

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

When we get your call or letter, we will:

1. Send you a letter within five calendar days to let you know we received your grievance.
2. Look into your grievance in a timely manner.
3. Send you a letter within 90 calendar days of when you first told us about your grievance; the letter will tell you what we decide.

Second level grievance review

You may file a second level grievance review if you're not happy with our decision, and your grievance is about:

- Your ability to receive benefit coverage.
- Access to care.
- Access to services.
- Payment for services.

Ask us for a second level grievance review in writing within 90 calendar days of the date on the original grievance resolution letter we sent you. Mail your second level grievance review request to the same address that you sent your initial grievance request. We'll send you a letter within five calendar days to let you know we got your request. Someone at a higher level than the reviewer who looked at your initial grievance request will look at your second level request. We'll send you a letter with our decision within 30 calendar days. The second level grievance review is the final level of review for grievances.

Appeals

Medical appeals

There may be times when Anthem says we will deny, end or reduce a service we approved. We may also say we won't pay for all or part of the care your provider asked for. If we decide to deny the care a provider asked for, or to end or reduce a service you're currently approved to get, we'll send you a letter called a Notice of Action.

For standard approval requests, Anthem has 14 days to respond and either approve or deny the service request.

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

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

A medical appeal is when you ask us to look again at the care we said we wouldn't pay for. You must file for a medical appeal within 90 calendar days from the date on our first denial letter. A medical appeal can be filed by:

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

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

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

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

You can appeal our decision in two ways:

1. Call us
   - Call Member Services and ask to appeal.
   - Let us know if you want someone else to help you with the appeal process, such as a family member, friend, your PCP or the provider taking care of you at the time.

   If you call us, we will:
   - Send you a Request for Appeal Review form. **You must complete and sign this form and return it to us within 10 calendar days.**
   - Send you a letter within five calendar days from when we get your signed form to let you know we got your request for an appeal.

     If you are asking for an expedited appeal, you don't need to send us any documents in writing. See the section called **Expedited Appeals** for details.
2. Write us
   - Send us a letter letting us know the care you are looking for and the people involved.

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

  Medical Appeals
  Anthem Blue Cross and Blue Shield Healthcare Solutions
  P.O. Box 62429
  Virginia Beach, VA 23466-2429
  Fax: 1-888-235-9334

You or the person filing the appeal on your behalf can present information about your appeal either in writing or in person.

When we get your letter, we will send you a letter within five calendar days. The letter will let you know we got your request for appeal.

After we receive your appeal:

- A different provider than the one who made the first decision will look at your appeal.
- We will send you and your provider a letter telling you our decision within 30 calendar days from when we get your appeal.

We'll tell you and your provider how to find out more about the decision. We'll tell you your rights to request a state fair hearing if you aren't happy with our decision. You may also request a copy (free of charge) of the documents used to make the appeal decision, including your medical records and guidelines.

If we need more information about your appeal:

- We may ask for medical records to help us make a decision. You, your PCP or the provider giving you care must forward the records to us within seven calendar days.
- Upon state approval or your request, we may extend the appeal process for 14 calendar days if it is in your best interest.
- If the state approves our extension request, we will let you — or the person you asked to file the appeal for you — know in writing the reason for the delay.

You may ask us to extend the process if you know more information that we should consider.

After you have completed the Anthem appeal process, you may ask for a state fair hearing. See the section **Fair hearings** for more details.

Expedited appeals

You or the person you ask to file an appeal for you can request an expedited appeal. You can request an expedited appeal if you or your provider feels that taking the time for the standard appeals process could seriously harm your life or your health.

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

1. Call Member Services toll-free at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

2. Mail a letter to:

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

When we get your letter or call, we will send you a letter with our decision within 72 hours.

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

- Upon state approval, we may extend the appeals process for 14 days.
- If the state approves our extension request, we will let you know in writing the reason for the delay.

You may also ask us to extend the process if you have more details that we should review.

If we don't agree that your request for an appeal should be expedited, we'll:

- Call you right away.
- Send you a letter within two calendar days to let you know how the decision was made, and that your appeal will be reviewed through the standard review process of 30 calendar days.

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

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

Provider payment appeals

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

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

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

A payment appeal is when your provider asks Anthem to look again at the service we said we wouldn't pay for. Your provider must ask for a payment appeal within 90 calendar days of receiving the EOB.

Payment appeals must be submitted in writing by your provider.

Fair hearings

You have the right to ask for a fair hearing from the state after the Anthem appeal process has been exhausted. You may ask for a fair hearing within 120 calendar days from the date of the appeal denial letter.

You can ask for a fair hearing by sending the Member State Fair Hearing form we sent you with the denial notice or a letter asking for a state fair hearing with the Anthem denial notice to:

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

If you have any questions about your rights to request a fair hearing, call Anthem Member Services. If you have questions regarding the fair hearing, you may call the hearings supervisor in the Las Vegas area at 1-702-486-3000, ext. 43604; or the Carson City area at 1-775-684-3604. You may also call toll-free 1-800-992-0900, ext. 43604.

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

Continuation of benefits

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

Your first request to continue benefits may be verbal. But you must also ask in writing. If you want to keep getting benefits, please fill out the Request to Continue Benefits during an Appeal or a Fair Hearing form and return it to:

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

To continue services during the appeal or fair hearing:

- You must request to continue benefits within 10 calendar days of the notice of action or by the effective date of the reduction, suspension or termination of the service.
- Any previously authorized course of treatment must have ended or been suspended or reduced.
- Services must have been ordered by an authorized provider.
- The coverage period of the original approval must still be in effect.

We must continue coverage of your benefits until:

- You withdraw the appeal.
- 10 days from the date of our first decision if you haven't requested a fair hearing.
- A fair hearing decision is reached and isn't in your favor.
- Authorization expires or your service limits are met.

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

If a decision is made in your favor as a result of your appeal or fair hearing, we'll authorize and pay for the services we denied coverage of before.

OTHER INFORMATION

If you move or your family size changes

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

If you're a Nevada Check Up member, you should call Nevada Check Up when your family size changes or you move to a new address. Please find the number to call under the section **Important Phone Numbers**.

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

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

Keep the right care. You need to renew your benefits every 12 months. If you don't, you could lose your Medicaid or Nevada Check Up benefits, even if you still qualify.

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

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

If you don't renew your eligibility by the date in the letter, you'll lose your health care benefits. Your DWSS or welfare caseworker can answer your questions about renewing your benefits. We want you to keep getting your health care benefits from us as long as you still qualify. Your health is very important to us.

If you're no longer eligible for Medicaid or Nevada Check Up

You'll be disenrolled from Anthem if you're no longer eligible for Medicaid or Nevada Check Up benefits. If you're ineligible for Medicaid or Nevada Check Up for two months or less and then become eligible again, you'll be re-enrolled in Anthem. If possible, you'll be given the same PCP you had when

you were with Anthem before. You'll be assigned to the same PCP as your other family members where appropriate.

How to disenroll from Anthem

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

If you don't like something about Anthem, please call Member Services. We'll work with you to try to fix the problem. If you're still not happy, you may:

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

  HPES
  P.O. Box 30042
  Reno, NV 89520.
  Please include your Medicaid number, your address and your phone number.

- Change health plans after the first 90 days of enrollment with good cause. Good cause reasons to disenroll are:
  - You move out of the service area.
  - Anthem doesn't, because of moral or religious objections, cover the service you seek.
  - You need related services, not available in our network, to be performed at the same time, and your PCP or other provider believes getting the services separately would subject you to unnecessary risk.
  - Poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with your health care needs, or if DHCFP imposes sanctions against Anthem.
- Change health plans without cause during the annual open enrollment period.
  - If you choose Anthem or a new managed care organization during open enrollment, you will be enrolled in the plan for the next 12 months. You can choose to switch back to your old managed care organization within the first 90 days after open enrollment. On the 91st day, you can only change health plans during the next 12 months if you can show good cause.

  Wanting to go to a provider that isn't in the Anthem network isn't considered "good cause."

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

- Call Anthem Member Services toll-free to request a disenrollment form.
- Send us a letter; include:
  - Your name.
  - Anthem ID number.
  - A phone number where you can be reached.
  - A complete description of your request to disenroll including specific supporting documentation of a good cause reason listed above.

Send the completed disenrollment form or letter to:

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

When we get your disenrollment form or letter, we'll review your request within 14 calendar days of when we receive it. We'll send you a letter within 10 calendar days of when we make our decision.

The letter will let you know what we decide. If your health condition requires a faster response, we'll make our decision as quickly as possible based upon your medical needs.

Reasons you can be disenrolled from Anthem

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

You could be disenrolled if:

- You are no longer eligible for Medicaid or Nevada Check Up.
- You move out of the Anthem service area.
- You don't pay your Nevada Check Up premiums on a quarterly basis.
- You let someone else use your Anthem ID card.
- You try to hurt a provider, a staff person or Anthem associate.
- You steal or destroy property of a provider or Anthem.
- You try to hurt other patients or make it hard for you or other patients to get needed care.
- You have to stay in a nursing facility for more than 45 days.
- You have to stay in a swing bed at an acute hospital for more than 45 days.
- You are placed in an intermediate care facility for the mentally disabled or an institution for mental diseases.
- You need adult day health care.
- You choose a Home and Community Based Services waiver program.
- You're detained by or entrusted to the state.
- You're placed in a residential treatment center (Medicaid members only).

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

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

When going to a provider, always verify that he or she is in the Anthem network. Always show your Anthem ID card when you visit a provider, go for tests or to the hospital. Showing your member ID card tells the provider to bill the covered medical services to Anthem.

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

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

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

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

Claims
Anthem Blue Cross and Blue Shield Healthcare Solutions
P.O. Box 61010
Virginia Beach, VA 23466-1010

You can also call Member Services for help.

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

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

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

  Signature: _____

  Date: _____

If you have other health insurance (coordination of benefits)

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

Changes in your Anthem coverage

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

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

How to tell Anthem about changes you think we should make

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

Anthem Blue Cross and Blue Shield Healthcare Solutions
P.O. Box 62509
Virginia Beach, VA 23462

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

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

How Anthem measures the quality of your care

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

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

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

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

- Frequency of childhood wellness visits.
- Childhood immunizations.

- Lead screenings.
- Mammograms and Pap smears.
- Pregnancy care.
- Diabetes screenings and tests.

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

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

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

What does this mean to you?

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

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

- Get tests and health care services on time.
- Keep appointments for routine checkups to help keep you healthy.
- Read and follow the instructions on any reminders you get from Anthem.

If you have a question about your health or the kind of care you might need, please call our 24/7 NurseLine at 1-844-396-2329 (TTY 711). Nurses are available anytime, day or night.

How Anthem pays providers

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

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

If you want more details about how our contracted providers or any other providers in our network are paid, please call the Anthem Member Services department or write to us at:

Anthem Blue Cross and Blue Shield Healthcare Solutions
P.O. Box 62509
Virginia Beach, VA 23462

YOUR RIGHTS AND RESPONSIBILITIES AS AN ANTHEM MEMBER

Your rights

As an Anthem member, you have the right to:

- Be treated with respect and in terms of your dignity and right to privacy; this includes:
  - Knowing your medical records and discussions with your primary care providers (PCPs) will be kept private and confidential.
  - Being treated fairly.
- Receive information about Anthem, our services, PCPs and providers, and your rights and responsibilities.
- Choose a PCP who is part of the Anthem network and to refuse care from specific PCPs and providers; this includes:
  - Knowing how to choose and change your health plan and PCP.
  - Choosing any health plan you want that is available in your area and choosing your PCP from that plan.
  - Changing your PCP.
  - Selecting a specialist to serve as your PCP if you have a chronic condition.
  - Changing your health plan without penalty.
- Participate in the decision-making process for your health care; this includes:
  - Working as part of a team with your PCP to decide what health care is best for you.
  - Taking part in an honest discussion on the proper or medically needed treatment options for your condition, without concern about the cost or benefit coverage.
  - Deciding on care recommended by your PCP.
  - Being told and understanding the results of the decision.
  - Refusing treatment.
- Express and expect resolution of grievances and appeals about:
  - Anthem.
  - Our network PCPs and providers.
  - The care you're provided.
- Create an advance directive to tell your doctor the kind of care you want if you're not able to communicate your decisions.
- Have access to your medical records in agreement with all Federal and state laws, and be able to request the records be changed or corrected in agreement with Federal and state laws.
- Make suggestions about the Anthem Member Rights and Responsibilities policy.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Get information on available treatment options and alternatives in a way you are able to understand.

Your responsibilities

As an Anthem member, you have the responsibility to:

- Provide information, the best that you can, to help Anthem and our providers give you the right care, including:
  - Telling your PCP about your health.
  - Talking to your PCP about your health care needs and asking questions about your treatment options.
  - Helping your PCP get your medical records.
  - Providing your PCP with the right information.
- Follow instructions and guidelines given by Anthem, your PCP and other providers.
- Understand your health problems and work with your PCP and providers to find an agreed upon plan to help treat your illness or condition, including:
  - Working as a team with your PCP to decide what health care is best for you.
  - Understanding how what you do can affect your health.
  - Doing the best you can to stay healthy.
  - Treating providers and staff with respect.
- Notify Anthem if you have other health insurance.
- Carry your ID card at all times.

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

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

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

Important terms

Fraud is any deception or misrepresentation made intentionally through willful ignorance or reckless disregard by a person or entity, in order to receive benefits or funds to which they aren't entitled.

Abuse includes practices that are inconsistent with sound financial, business or medical practices that results in unnecessary cost to the government healthcare program, such as Medicaid or Check Up, or in reimbursement for services that aren't medically necessary or that fail to meet professionally recognized standards for health care. It also includes any practices by Medicaid and Check Up members that result in unnecessary costs to the Medicaid or Check Up programs. **An overpayment is a payment made to a provider that is over the amount due for the service provided.**

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

To report doctors, clinics, hospitals, nursing homes or Medicaid or Nevada Check Up enrollees, write or call Anthem at:

Corporate Investigations Department
Anthem Blue Cross and Blue Shield Healthcare Solutions
4425 Corporation Lane
Virginia Beach, VA 23462
1-844-396-2329 (TTY 711)

Suspicions of fraud and abuse can be emailed directly to the Anthem Blue Cross and Blue Shield Healthcare Solutions Corporate Investigations department at medicaidfraudinvestigations@anthem.com.

Online: Suspicions of fraud and abuse can also be sent to the Corporate Investigations department through the Anthem website at www.anthem.com/nvmedicaid. There are fraud and abuse links on the website to report details about a possible issue. This information is sent directly to the email address above, which is checked every business day.

You can also call the Attorney General's Fraud Hotline at 1-800-266-8688 or call the Nevada Medicaid Fraud Control Unit at 1-775-684-1100 or 1-702-486-3420.

WE HOPE THIS BOOK HAS ANSWERED MOST OF YOUR QUESTIONS ABOUT ANTHEM. FOR MORE INFORMATION, CALL MEMBER SERVICES AT 1-844-396-2329 (TTY 711).

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

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

Anthem

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

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

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

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

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

When is it OK for us to use and share your PHI?
We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for health care or services before you get them
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't want this, please visit **www.anthem.com/nvmedicaid** for more information.

- **For health care business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK
  - With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you

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

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

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

What are your rights?
- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.

- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

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

Contacting you
We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 1-844-203-3796 to add your phone number to our Do Not Call list.

What if you have questions?
If you have questions about our privacy rules or want to use your rights, please call Member Services at **1-844-396-2329**. If you're deaf or hard of hearing, call **TTY 711**.

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

Write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
90 Seventh St., Suite 4-100
San Francisco, CA 94103
Phone: 1-800-368-1019
TDD: 1-800-537-7697
Fax: 415-437-8329

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

Race, ethnicity and language
We receive race, ethnicity and language information about you from the state Medicaid agency and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:

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

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

- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Disclose to unapproved users

Your personal information

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

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

Revised January 5, 2018

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

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

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

Communicating with you is important

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

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

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 1-844-396-2329 (TTY 711).

Your rights

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

Grievance Coordinator
9133 W. Russell Rd.
Las Vegas, NV 89148

Phone: 1-844-396-2329 (TTY 711)
Fax: 1-888-235-9334
Email:NV1-qualitymanagement@anthem.com

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

- **On the Web:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **By mail:** U.S. Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F, HHH Building
  Washington, DC 20201
- **By phone:** 1-800-368-1019 (TTY/TDD 1-800-537-7697)

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

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

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

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