2025–2026 West Virginia Member Handbook

HIGHMARK. HEALTH OPTIONS

Because Life.™

WV.HighmarkHealthOptions.com

Mountain Health Trust

West Virginia Children's Health Insurance Program

HELP IN YOUR LANGUAGE

If you do not speak English, call us at **1-833-957-0020 (TTY: 711)**. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.

Spanish: Si usted no habla inglés, llámenos al **1-833-957-0020 (TTY: 711)**. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

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WELCOME

Welcome to the Highmark Health Options Medicaid and WVCHIP (West Virginia Children's Health Insurance Program) managed care program! We are glad you have enrolled with us. This handbook gives you the information you need to know about your health care plan. Please read this handbook to understand the way your plan works and to help you get the most from Highmark Health Options. It will answer many of the questions that come up about your benefits and the services offered by Highmark Health Options.

ABOUT YOUR PLAN

Highmark Health Options has a contract with the West Virginia Department of Human Services (DoHS). We are able to select a group of health care providers to form a provider network of doctors and specialists, hospitals, and other health care providers. Our providers help to meet the health care needs of people with Medicaid and WVCHIP.

The Provider Directory lists all of our network providers you can use to get services across the state. It can also be found online at WV.HighmarkHealthOptions.com. If you want a copy of Provider Directory search results, please call 1-833-957-0020 (TTY: 711).

CONTACT US

Member Services Department
Hours of Operation: Monday–Friday, 8 a.m.–5 p.m.
Address: 614 Market St., Parkersburg, WV 26101
Toll-Free: 1-833-957-0020
TTY: 711
Online: WV.HighmarkHealthOptions.com

You can call Member Services toll-free anytime you have a question about your health plan or a health problem. It will speed up the process if you have your member identification (ID) number with you when you call.

If you do not understand or speak English, we can help. Please call us toll-free at 1-833-957-0020 (TTY: 711). We can answer questions about your benefits in your language. We have free interpreter services and can help you find a health care provider who can communicate with you in any language.

For people with disabilities, we can help. Highmark Health Options offers services so that you can communicate with us and your provider. We provide free sign language interpreter services and a TTY phone number: 1-833-957-0020 (TTY: 711). We can offer this handbook and all written materials in many formats, such as large print, at no cost to you. Please call us at 1-833-957-0020 (TTY: 711) to ask for materials in another format.

For other important phone numbers, please see the Important Contact Information section in the back of this handbook.

You can call or visit our website to:

- Ask questions about Medicaid and WVCHIP services, benefits, and copayments.
- Change your primary care provider (PCP) or get help choosing a provider.
- File a complaint or appeal.
- Replace a lost member ID card.
- Get help with referrals.
- Let us know if you are pregnant.
- Let us know if you give birth to a new baby.
- Ask about any change that might affect you or your family's benefits.
- Let us know about any changes to personal information.
- Request interpreter services or help for people with disabilities.
- Find community resources and educational materials.
- Access online versions of the Member Handbook and Provider Directory that you can search.

SECURE MEMBER PORTAL

Highmark Health Options has a secure online tool where you can access your personal health information, and other benefit information such as:

- Authorization status.
- Temporary member ID card.
- The name and phone number of your PCP.
- Cost sharing information.
- Member Handbook.
- Health and wellness information.

For more information and to access, visit our website at WV.HighmarkHealthOptions.com or download Healthable, the member portal app, for free from the Apple App Store for iPhone and iPad or Google Play for Android™ devices. Data rates apply.

WHAT YOU SHOULD KNOW

CONFIDENTIALITY

We respect your right to privacy. We will never give out your medical information or social security number without your written permission unless required by law. To learn more about your rights to privacy, please call Member Services at 1-833-957-0020 (TTY: 711) or visit our website at WV.HighmarkHealthOptions.com. You can find our notice of privacy practices in the back of this handbook.

DISCRIMINATION

Your benefits must comply with the 1964 Civil Rights Act. Discriminatory administration of benefits because of sex, race, color, religion, national origin, ancestry, age, political affiliation, or physical, developmental, or mental challenges is not allowed.

If you have questions, complaints, or want to talk about whether you have a disability according to the Americans with Disabilities Act (ADA), you can contact the State ADA Coordinator at:

West Virginia Department of Administration
Building 1, Room E-119
1900 Kanawha Blvd. East
Charleston, WV 25305
304-558-4331

DEFINITIONS

Appeal: A way for you to request the review of a Highmark Health Options decision if you think we made a mistake. For example, you might not agree with a decision that denies a benefit or payment.

Authorized Representative: Any person or entity acting on behalf of a member and with the member's written consent. Some authorized representatives may have the legal right to act on your behalf.

Copayment: A fixed dollar amount you may pay each time you get a covered service or supply.

Durable Medical Equipment (DME): Certain items your provider can order for you to use if you have an illness or injury, such as a walker or a wheelchair.

Emergency Medical Condition: An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room (ER) Care: Emergency services you receive in an ER.

Emergency Services: Services you receive to evaluate or treat an emergency medical condition.

Excluded Services: Health care services that Highmark Health Options does not pay for or cover.

Federal Poverty Level (FPL): A measure of income issued every year by the Department of Health and Human Services to determine your eligibility for certain programs and benefits.

Gender Affirmation Surgery: Surgeries that change the physical appearance and function of a person's sex traits to align with their gender identity.

Gender Dysphoria: A distressed state arising from conflict between a person's gender identity and the sex the person has or was identified as having at birth.

Grievance: A complaint you make, either in writing or verbally to Highmark Health Options.

Habilitation Services and Devices: Services or items that help you keep, learn, or improve skills and functioning for daily living. They can be either inpatient or outpatient.

Health Insurance: A contract that requires Highmark Health Options to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home such as nurse visits or physical therapy.

Hospice Services: Services to provide comfort and support for members and their families in the last stages of a terminal illness. A terminal illness means the provider believes the member has six months or less to live if the illness runs its natural course.

Hospitalization: Admission to a hospital for treatment that usually requires an overnight stay.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Medically Necessary: Health care services or supplies needed to get and stay healthy.

Minor: Persons under the age of eighteen (18) years.

Network: A group of providers who has contracted with Highmark Health Options to give care to members.

Non-medical Home Physician Visit: Health care from a provider that is not the member's PCP.

Non-Participating Provider: A doctor, hospital, facility, or other health care professional who has not signed a contract to provide services to Highmark Health Options members.

Physician Services: Health care services that a licensed medical physician provides or coordinates.

Plan: An entity that provides, offers, or arranges coverage of certain health care services needed by plan members. You are a member of our health plan, Highmark Health Options.

Prior Authorization: Approval from Highmark Health Options that may be required before you get certain services or treatments in order for them to be covered.

Participating Provider: A doctor, hospital, facility, or other licensed health care provider who has signed a contract agreeing to provide services to Highmark Health Options members. They are listed in your Provider Directory.

Premium: The amount you pay for your health insurance every month based on your income.

Prescription Drugs: Drugs and medicine that, by law, require a prescription.

Prescription Drug Coverage: Health insurance that helps pay for prescription drugs. Highmark Health Options does not provide prescription drug coverage, but the state of West Virginia does.

Primary Care Physician: A Highmark Health Options doctor who directly provides and coordinates your health care services.

Primary Care Provider (PCP): A physician, nurse practitioner, physician assistant, or other participating provider you have chosen to be your personal doctor. Your PCP works with you to provide and coordinate your health care, such as giving you checkups and shots, sending you to specialists if needed, or admitting you to the hospital.

Provider: A health care professional or a facility that delivers health care services, like a doctor, nurse, or hospital.

Rehabilitation Services and Devices: Health care services and items that help you recover from an illness, accident, injury, or surgery.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A doctor who focuses on a specific kind of health care such as a surgeon or a cardiologist (heart doctor).

Telehealth: Sometimes called telemedicine or virtual visit, uses video calling and other technologies to help you see your provider without an in-person office visit.

Urgent Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away.

WVCHIP Gold: WVCHIP enrollment group for children in families with incomes at or below 150 percent of the FPL.

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

WVCHIP Premium: The enrollment group for members in families with incomes over 211 percent up to 300 percent of the FPL that requires monthly premium payments.

WVCHIP Exempt: The enrollment group members who are Native American/Alaskan Natives who are members of a federally recognized tribe and are exempt from copayments and other cost sharing.

YOUR RIGHTS

As a member of Highmark Health Options, you have rights around your health care. You have the right to:

- Ask for and obtain all included information.
- Be told about your rights and responsibilities.
- Get information about Highmark Health Options, our services, our providers, and your rights.
- Be treated with respect and dignity.
- Not be discriminated against by Highmark Health Options.
- Access all services that Highmark Health Options must provide.
- Choose a provider in our network.
- Take part in decisions about your health care.
- Refuse treatment and choose a different provider.
- Get information on treatment options and different courses of care.
- Have your privacy respected.
- Ask for and get your medical records.
- Ask that your medical records be changed or corrected if needed.
- Be sure your medical records will be kept private.
- Recommend changes in policies and procedures.
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation.
- Get covered services, no matter your cultural or ethnic background or how well you understand English.
- Get covered services regardless of if you have a physical or mental disability, or if you are homeless.
- Refer yourself to in-network and out-of-network family planning providers.
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services.
- Get emergency post-stabilization services.
- Get emergency health care services at any hospital or other setting.
- Accept or refuse medical or surgical treatment and to make an advance directive.
- Have your parent or a representative make treatment decisions when you can’t.
- Make complaints and appeals.
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services.
- Ask for a state fair hearing after a decision has been made about your appeal.
- Request and get a copy of this member handbook.
- Disenroll from your health plan.

YOUR RESPONSIBILITIES

As a member of Highmark Health Options, you also have some responsibilities:

- Read through and follow the instructions in this handbook.
- Work with your PCP to manage and improve your health.
- Ask your PCP any questions you may have.
- Call your PCP at any time when you need health care.
- Give information about your health to Highmark Health Options and your PCP.
- Always remember to carry your member ID card.
- Only use the ER for true emergencies.
- Keep your appointments.
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know.
- Follow your PCP's recommendations about appointments and medicine.
- Go back to your PCP or ask for a second opinion if you do not get better.
- Call Member Services at 1-833-957-0020 (TTY: 711) whenever anything is unclear to you or you have questions.
- Treat health care staff and others with respect.

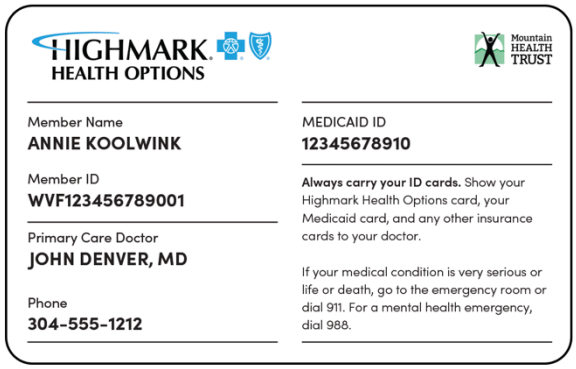
STEPS TO YOUR GETTING CARE

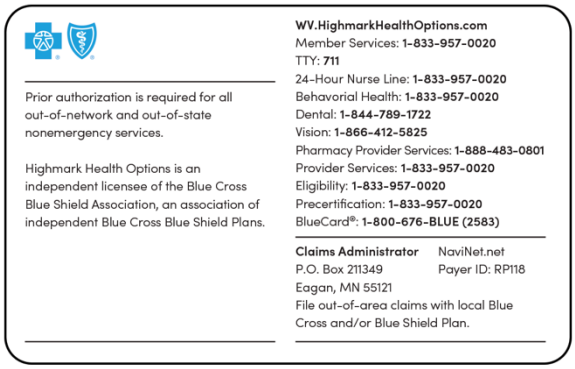
YOUR MEMBER ID CARD

After you join Highmark Health Options, we will send you your member ID card in the mail. Each member of your family who has joined Highmark Health Options will receive his or her own card. If you have not received your Member ID card after 14 business days, please call Member Services at 1-833-957-0020 (TTY: 711).

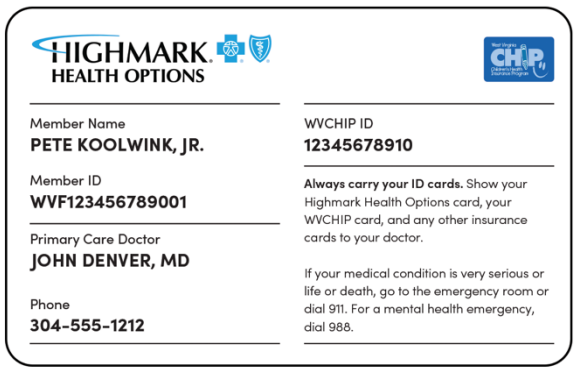
It is important to always keep your member ID card with you. You will need it any time you get care. Your card is your proof that you are a member of Highmark Health Options. You should also keep your Medicaid Benefit card. You need it to get care that is not covered by Highmark Health Options.

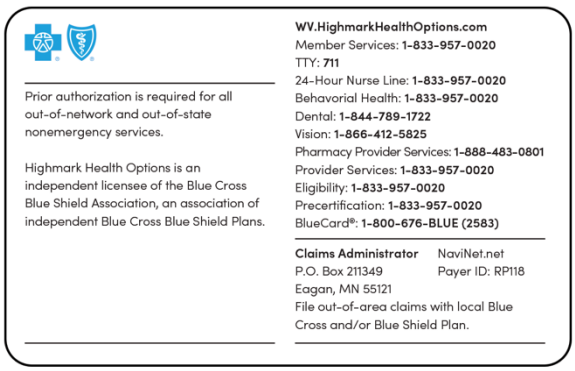
Your Mountain Health Trust Member ID card should look like this:





Your WVCHIP Member ID card should look like this:





Your card has your Member ID number, your PCP's name and office phone number, the start date of your health coverage, and other important phone numbers. Having your card out when you call Member Services can help us serve you faster.

Please call Member Services immediately at 1-833-957-0020 (TTY: 711) if:

- You lose your card.
- Your card is stolen.
- You have not received your card(s).
- Any of the information on the card(s) is wrong.
- You have a baby or add a new member to your family.
- You move.
- Someone in your family dies.

Please call your county DoHS immediately at 1-877-716-1212 if you move to another state or to another county.

CHOOSING YOUR PRIMARY CARE PROVIDER

Each member of Highmark Health Options chooses a PCP from the Provider Directory. Your Provider Directory should have arrived with this handbook. Inside, there is a list of all the doctors, hospitals, dental and specialty care providers, and other providers who work with Highmark Health Options. You can also find this list at WV.HighmarkHealthOptions.com. Member Services can help you select a PCP to best fit your needs. If you do not pick a PCP from the directory, we will choose one for you.

You may be able to select a specialist as your PCP if you have a chronic illness. Please call Member Services to learn more at 1-833-957-0020 (TTY: 711). If you already have a PCP and believe you need a specialist, you or your provider should call Member Services. Women can also receive women's health care services from an obstetrical/gynecological provider (OB/GYN) without a referral from your PCP.

Upon request, a description of physician reimbursement is available to Highmark Health Options members.

HOW TO SCHEDULE AN APPOINTMENT

You will visit your PCP for all of your routine health care needs. Highmark Health Options will ensure hours of operation are convenient and do not discriminate against enrollees.

All new members should try to schedule an appointment within 30 calendar days. You can schedule your appointments by calling the PCPs office phone number. Your PCP's name and office phone number will be listed on your member ID card. You can call twenty-four (24) hours a day, seven (7) days a week. On the day of your visit, remember to bring your member ID card. Please show up on time and call to cancel an appointment if you cannot make it.

To schedule a visit with a specialist, first contact your PCP for a referral. Your PCP will call Highmark Health Options for a referral to a specialist in our network. Your referral must be approved by Highmark Health Options.

CHANGING YOUR PRIMARY CARE PROVIDER

You can change your PCP for any reason by calling Member Services at 1-833-957-0020 (TTY: 711) or by going to WV.HighmarkHealthOptions.com. We will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so he or she can get to you know you and your medical history.

Sometimes PCPs leave our network. If this happens, we will let you know by mail within 15 business days. We can assign you a new PCP or you can pick a new one yourself. If we need to assign you a new PCP for another reason, we will let you know.

WHERE TO GET MEDICAL CARE

Please read below to understand what type of care you may need in different situations.

ROUTINE CARE

You should see your PCP for all routine health care visits. Routine visits are when a delay in medical care would not cause a serious problem with your health. Some reasons to get a routine health care visit include checkups, screenings, physicals, and care for diabetes and asthma. You can call your PCP to schedule these visits at any time. You and your PCP should work together to get you the care you need including the following:

- Well-Care Visits. A well-care visit is when you or your child sees a PCP when healthy to stay healthy. These visits are not for treating conditions or diseases, so you should schedule a well-care visit even if you do not feel sick. During the appointment, your PCP will review your medical history and health. Your PCP may suggest ways to improve your health too. You can learn more about well-care visits under the section titled, “More Information about Your Coverage”.
- After Hours Care. You can reach your PCP even if it is after normal business hours. Just leave a voicemail with your name and phone number. Your PCP or another PCP from the same office will call you back as soon as possible or during office hours.

URGENT CARE

You can visit an urgent care center when you have an injury or illness that needs care right away but is not an emergency. Some examples of when to get urgent care are:

- A sprained ankle.
- A bad splinter.
- The flu.

You can also get urgent care if you or your child are traveling and are too far from your PCP’s office. You can schedule an urgent care appointment by calling your PCP. You should explain the medical problem so that your PCP can make your appointment or help you decide what to do.

If you think you might need urgent care when you or your child are away from your home or after hours, you can also call the 24-hour nurse line at 1-833-957-0020 (TTY: 711). They can help you decide what care your child needs.

EMERGENCY CARE

You should get emergency care when you have a very serious and sudden medical problem. An emergency would make someone think he or she needs to be treated right away. Some examples of an emergency are:

- Vaginal bleeding.
- A heart attack.
- Severe chest pain.

- Seizures.
- Rape.

You should not go to the ER for things like:

- Colds.
- Minor cuts and bruises.
- Sprained muscles.

If you believe you have a medical emergency, call 911 immediately or go to the nearest ER. When you get there, show your member ID card. You do not need approval from your PCP or Highmark Health Options. If you are traveling and away from home when you have a medical emergency, go to the nearest ER. You have the right to go to the nearest hospital, even if it is not in our network. If you are not sure what to do, call your PCP or Highmark Health Options at 1-833-957-0020 (TTY: 711). Remember to use the ER only if you have an emergency. You are always covered for emergencies.

If you need to stay in the hospital after an emergency, please make sure Highmark Health Options is called within 24 hours. If you are told that you need other medical care to treat the problem that caused the emergency, the provider must call Highmark Health Options. If you are able, call your PCP to let him or her know that you have a medical emergency. You will need to schedule follow-up services with your PCP.

For more information about emergency transportation and getting care after an emergency, please see the Mountain Health Trust Covered Benefits table.

YOUR BENEFITS

You can get many services through Highmark Health Options and others through Fee-for-Service Medicaid and WVCHIP. For most benefits, you will need to go through your PCP. There are some services that do not require a referral from your PCP. This means that you do not need approval from your PCP. Look in your Provider Directory for the list of providers who offer these services. You can schedule the appointment yourself. If you have any questions, Highmark Health Options can help. Just call us at 1-833-957-0020 (TTY: 711).

COVERED SERVICES

Your covered services must be medically necessary. You should get these services from providers in the Highmark Health Options network. Your PCP should provide covered services or refer you to another provider to do so. These include medical, behavioral, dental, and vision services. Benefit packages differ, depending on your age. You can see any differences in the table that follows. You can get the services listed in the Mountain Health Trust Covered Benefits table by using your Highmark Health Options member ID card.

Telehealth lets your provider care for you without an in-person office visit. Telehealth is done online with internet access on your computer, tablet, or smartphone.

- Telehealth visits are covered, just like in-person visits.
- Medicaid/WVCHIP will only pay for telehealth for covered benefits.
- Ask your provider if they do phone or video visits.

Mountain Health Trust Covered Benefits
Medical • Primary Care Office Visits and Referrals to Specialists. • Physician Services. Certain services may need prior authorization or have service limits. May be delivered through telehealth. • Laboratory and X-Ray Services. Includes lab services related to substance use disorder (SUD) treatment. A physician must order the services, and certain procedures have service limits. • Clinics. Includes general clinics, birthing centers, and health department clinics. • Vaccinations. Vaccinations are included for children and as approved for adults.
Specialty • Podiatry. Includes treatment of acute conditions for children and adults. Includes some surgeries, treatment of fractures and other injuries, and orthotics. Routine foot care is not covered. • Handicapped and Children with Special Health Care Needs Services. Includes coordinated services and limited medical services, equipment and supplies.

Mountain Health Trust Covered Benefits
Emergency • Post-Stabilization Services. Includes care after an emergency health condition is under control. Care provided in a hospital or other setting. • Emergency Transportation. Includes ambulance and air ambulance. Out of state needs prior authorization. To call for emergency transportation, dial 911.
Preventive Care and Disease Management • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Includes health care services for any medical or psychological condition discovered during screening (for children under age twenty-one (21) only). • Tobacco Cessation. Includes therapy and counseling and Quitline services. Guidance and risk-reduction counseling covered for children. • Sexually Transmitted Disease Services. Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.
Maternity • Right From The Start. Includes prenatal care and care coordination. No prior authorization needed. • Family Planning. Includes all family planning providers and services. Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Hysterectomies, pregnancy terminations, and infertility treatments are not covered. No referral needed for out-of-network providers. • Maternity Care. Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.
Other • Federally Qualified Health Centers. Includes physician, physician assistant, nurse practitioner, and nurse midwife services. • Prosthetics. Customized special equipment is considered. Certain procedures have services limits or need prior authorization. • Durable Medical Equipment (DME). Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. Certain procedures have services limits or need prior authorization. Customized special equipment considered. • Ambulatory Surgical Care. Includes services and equipment for surgical procedures. Physician services; lab and x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs; and DME are **not** covered. • Organ and Tissue Transplants. Corneal transplants only. • Gender Affirmation for Gender Dysphoria. Procedure that aligns an individual's biological sex with their gender identity. Adults must be twenty-one (21) years or older prior to being considered for the procedure. Prior authorization is required.

Mountain Health Trust Covered Benefits
Nursing • Nurse Practitioner Services. Some procedures have service limits. • Private Duty Nursing. Includes twenty-four (24)-hour nursing care (not covered for adults ages twenty-one (21) years and over). Prior authorization may be needed.
Rehabilitation • Physical Therapy. Twenty (20) visits per year (combined for physical and occupational therapy). • Occupational Therapy. Twenty (20) visits per year (combined for physical and occupational therapy). • Speech Therapy. Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (for children under age twenty-one (21). Some procedures have service limits or need prior approval. • Chiropractor Services. Includes radiological exams and corrections to subluxation. Certain procedures have service limits. • Pulmonary Rehabilitation. Includes procedures to increase strength of respiratory muscle and functions. • Cardiac Rehabilitation. Includes supervised exercise sessions with electrocardiograph monitoring. • Inpatient Rehabilitation. Includes inpatient rehabilitation services and general medical outpatient services that meet the certification requirements.
Hospital • Inpatient. Includes all inpatient services (including bariatric and corneal transplants). Corneal transplant services must be in a center approved by Medicare and Medicaid. Adults in institutions for mental diseases and some behavioral health inpatient stays are not included. • Outpatient. Includes preventive, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.
Home Health Care • Includes services given at member's residence. This does not include a hospital nursing facility, ICF/IDD, or state institutions. Some suppliers have service limits.
Hospice • Includes nursing care, physician services, medical social services, short-term care, durable medical equipment, drugs, biologicals, home health aide, and homemaker. Requires physician certification. For adults ages twenty-one (21) and older, rights are waived to other treatment services related to the terminal illness.

Mountain Health Trust Covered Benefits
Dental • Adults twenty-one (21) and older. Includes diagnostic, preventive, and restorative services. Services also include emergency procedures to treat fractures, pain, or infection. Non-emergency coverage limited to $2,000 per two-year budget period per member. There are no dollar limits on covered dental services for WVCHIP members. • Children under age twenty-one (21). Includes emergency, non-emergency, and orthodontic services.

Behavioral Health
• Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility (PRTF). Includes services for children under age twenty-one (21) with mental illness and substance abuse. Procedure specific limits on frequency and units.
• Inpatient. Hospital services for the diagnosis and treatment of behavioral health and substance use disorder (SUD).
• Inpatient Psychiatric. Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed.
  ○ Under age twenty-one (21). Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification that community outpatient behavioral health services did not meet the member's treatment needs is required. Pre-admission and continued stay prior authorization is required.
  ○ Age twenty-one (21) to sixty-four (64). Includes services at an Institution for Mental Diseases (IMD).
• Outpatient. Includes services for individuals with mental illness and substance abuse. Limits frequency and amount of services. Providers must be ACT certified. Children's residential treatment is excluded from this benefit.
• Psychological Services. May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions.
• Drug Screening. Includes laboratory service to screen for presence of one (1) or more drugs of use.
• Substance Use Disorder (SUD) Services. Includes targeted case management and physician-supervised medication and counseling services provided to treat those with a SUD. Opioid treatment program services will be provided through fee-for-service (FFS) Medicaid.

Mountain Health Trust Covered Benefits
Vision • Includes eye exams, treatment, lenses, frames, and repairs for children under twenty-one (21) years of age. Includes medical treatment, one pair of glasses after cataract surgery, and contact lenses (for certain diagnosis) for adults twenty-one (21) years of age and older. Does not cover prescription sunglasses or designer frames.
Tubal Ligation • Family planning service for individuals of childbearing age to permanently prevent pregnancy. Service requires informed consent and medical necessity.

Benefits Under Fee-for-Service Medicaid and WVCHIP
Abortion – Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Physician certification required. All Federal and State laws regarding this benefit apply.
Early Intervention Services for Children Three (3) and Under – Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.
Nursing Facility Services – Includes nursing, social services, and therapy.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed sixty (60) hours per month without prior authorization.
Personal Care for Aged/Disabled – Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Aged and Disabled Waiver. Limited on per unit per month basis. Requires physician order and nursing plan of care.
ICF/IDD Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for intellectual/developmental disabilities. Requires physician or psychiatrist certification.
Prescription Drugs – Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Hemophilia blood factor, Hepatitis-C, weight gain, cosmetic, hair growth, fertility, less than effective and experimental drugs are not covered. Drugs dispensed by a physician at no cost are not covered.

Benefits Under Fee-for-Service Medicaid and WVCHIP
Organ Transplant Services – Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/ research nature or for end-stage diseases. Must be used to manage disease.
School-Based Services – Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting. Limited to individuals under age twenty-one (21).
Transportation – Nonemergency transportation. Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate and private vehicle transportation). Prior authorization is required. To get transportation, call Modivcare at 1-844-889-1941 (TTY: 1-866-288-3133).
Substance Abuse Services – Physician-supervised opioid agonist medication and counseling services provided to those with severe opioid use disorder.

In addition to your benefits, Highmark Health Options offers value-added services. When eligible members complete the healthy behaviors in the table that follows, they will receive a reward. We offer these services to encourage health education and to promote health. Copayments may not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services.

Value-Added Services and Rewards
Benefits for expecting and new moms • Eligible members can earn up to $175 for attending scheduled exams before and after baby's birth. • Free Pacify account and app for video visits and calls, 24/7. No appointment needed. Experts answer in 5 minutes or less. Ask about breastfeeding, formula feeding, pumping, weaning, adding solid foods, crying and colic, and teething. Plus look up these topics on the app. • Free Count the Kicks app for tracking baby's daily movements in the third trimester of pregnancy.
Childhood Development Sensory and Stimulation Toys For eligible members up to age 12 with autism, ADHD, or other similar diagnosis.
Career Pathways Covers professional development, mentorship, and employment assistance for high school juniors and seniors (age 16-18) and members transitioning out of treatment or incarceration. Includes opportunities that can lead to getting a job and continuing education.

Value-Added Services and Rewards
Diabetes Prevention Program Age 18 and older: For eligible members diagnosed with both prediabetes and high BMI.
Enhanced Dental Care Expecting moms of any age are eligible for two extra cleanings before and 6 weeks after giving birth.
Filters For Safe Drinking Water Covers one water faucet filter system plus two extra filters per household per year. Note: One filter lasts about four months.
Foodsmart A 12-week online program provides eligible members with personalized help and access to affordable healthy food options.
Healthy Rewards Program Provides the chance to earn rewards of $5-$25 for activities like wellness visits and screenings. Rewards are put on a debit card.
Healthy Transitions Meal Delivery Provides free meal delivery to the home for eligible members who had a hospital stay.
Healthy Weight Program Age 18 and older: Helps eligible members eat healthier, move more, and lose weight.
Shoot Your Shot Vaccine Program Age 18 and older: Coupon to cover the cost of one Class X Hunting/Fishing/Trapping license per year upon receiving annual flu shot.
Hypoallergenic Pillowcases and Mattress Protectors For eligible members diagnosed with asthma.
Junior Member Advisory Council Ages 13-17: Earn a $5 gift card by attending quarterly virtual meetings to offer feedback and express concerns about their health and well-being.
Medication Lock Box Covers one box per eligible member.
Outdoor Activities Program Sponsorship Ages 5-18: Covers cost for 4-H clubs, health camps, and other supervised activities, including an ATV safety course.

Value-Added Services and Rewards
Wider Circle Program Age 18 and older: Helps members live happier, healthier lives with social groups in their own neighborhood.

COMMUNITY SERVICES

Community services are programs and services that improve the health of people, families, and communities. The programs mentioned below are not a full list of the programs and services available in West Virginia. Please call 1-833-957-0020 (TTY: 711) or visit our website at WV.HighmarkHealthOptions.com for a list of resources.

FIND HELP

Find Help is a free resource that can connect you with services you need. Do you need help with paying your bills or finding food or housing? Visit HMHealthOptions.FindHelp.com. Enter your ZIP code to get started.

You can also call, text or chat for help by dialing 211. The service is available 24 hours a day, 7 days a week. A trained specialist will help you. The 211 service is free and confidential.

WEST VIRGINIA WOMEN, INFANTS, AND CHILDREN (WIC)

WIC provides nutritional services to improve the health of women, infants and children in West Virginia by providing nutrition and breastfeeding counseling and education; as well as health monitoring and nutritious foods.

The West Virginia WIC program may be able to help you and your family to get better nutrition. To reach the office of the West Virginia WIC program call 304-558-0030 or go to their website at ONS.WVDHHR.org.

HELP ME GROW

Help Me Grow is a referral service that connects families with developmental resources for their children birth through five (5) years. The goal of Help Me Grow is to identify children at-risk and get them connected to the help they need.

Parents, families and friends can call Help Me Grow directly to speak to a care coordinator who can talk with them about how their child is doing, mail a developmental screening tool and connect them to the appropriate resources. To reach the Help Me Grow hotline call 1-800-642-8522.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

The CSHCN program provides specialized medical care for children who have certain chronic, disabling medical conditions and who meet eligibility requirements.

Children who have a diagnosis covered by CSHCN and receive West Virginia Medicaid or WVCHIP may be eligible to receive care management and/or limited services from the program. For more information, call 1-800-642-9704.

WORKFORCE WEST VIRGINIA

WorkForce West Virginia offers tools to help with job searches, unemployment, and training. The education and training opportunities provide work skills needed by businesses. Visit their website at WorkforceWV.org.

MORE INFORMATION ABOUT YOUR COVERAGE

Please read below for more details about your coverage. If you have any questions, please call Member Services at 1-833-957-0020 (TTY: 711).

WELL-CHILD VISITS

Well-child visits, also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, are important to make sure children are healthy and stay healthy. The EPSDT benefit covers all medically necessary and preventive health care services for members up to age twenty-one (21). Both sick and well-care services are provided by your PCP at no cost.

Some screenings that children can get include:

- Physical exams.
- Laboratory tests.
- Vision testing.
- Immunizations.
- Hearing test.
- Dental services.
- Behavioral health screening.
- Health education.
- Health and development history.

Check-ups and screenings are needed to detect health problems. Your PCP can diagnose and treat any health issues early before they become more serious. Call your PCP or Member Services to schedule a well-child visit. Transportation and scheduling help are also available upon request at no cost.

DENTAL SERVICES

Dental care is important to your overall health. Highmark Health Options uses a dental benefit manager, United Concordia Dental, to provide dental services to Mountain Health Trust members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Members under twenty-one (21) years of age should visit their dentist for a check-up once every six months. Check-ups begin at six months after an infant's first tooth erupts or by twelve months of age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Members up to twenty-one (21) can also access the Fluoride Varnish Program, offered by providers certified from the West Virginia University School of Dentistry. For more information about the Fluoride Varnish Program, ask your provider. Children are covered for non-emergency and emergency dental services.

For adults twenty-one (21) years and older, emergency and non-emergency (preventive and therapeutic) dental services are covered. Adult non-emergency coverage is limited to $2,000 per member per two-year budget period. There are no dollar limits on covered dental services for WVCHIP members. These services may be provided by a dentist, orthodontist, or oral surgeon. Some examples of a dental emergency include:

- Severe pain.
- Hemorrhage.
- Traumatic injury to the teeth and surrounding tissue.
- Unusual swelling of the face or gums.

If you need to speak with someone about your dental coverage, call United Concordia Dental Member Services at 1-844-789-1722, Monday – Friday, 8 a.m. – 5 p.m.

BEHAVIORAL HEALTH SERVICES

Highmark Health Options provides behavioral health inpatient and outpatient services to members. This benefit includes mental health services, substance abuse (alcohol and drugs) services, case management, rehabilitation and clinic services, and psychiatric residential treatment services.

You do not need a referral for behavioral health services. Your PCP or Member Services can help you get these services from behavioral health providers. You can also call Member Services at 1-833-957-0020 (TTY: 711).

Call 911 right away if there is a mental health or substance abuse emergency. Call the Suicide and Prevention Lifeline at 988 if you or another person are having thoughts about harming yourself, mental health or substance use crisis, or any other kind of emotional distress.

COURT ORDERED SERVICES

Medically necessary court ordered treatment services may be covered by Highmark Health Options. Court ordered services are subject to Medicaid or WVCHIP review and determination.

DRUG FREE MOMS AND BABIES PROGRAM

The Drug Free Moms and Babies (DFMB) program supports healthy outcomes for pregnant and postpartum women and babies in Medicaid and WVCHIP by providing prevention, early intervention, addiction treatment, and recovery support.

Covered benefits through this program include:

- Care coordination with Highmark Health Options case managers, DFMB care coordinators, DFMB community health workers, and DFMB providers.
- Early intervention through provider outreach and education.
- Recovery support services.
- Addiction treatment.
- Assistance with health-related social needs of members.
- Long-term follow-up with recovery coach to help women stay in the path of recovery and access to needed resources.
- Services are limited to the duration of the member's pregnancy and one year postpartum.

SERVICES NOT COVERED

Some services are not available through Highmark Health Options, Medicaid, or WVCHIP. If you choose to get these services, you may have to pay the entire cost of the service. Highmark Health Options is not responsible for paying for these services and others:

- All non-medically necessary services.
- Services from non-enrolled or non-participating providers.
- Services that require a prior authorization but did not get a prior authorization.
- Sterilization of a mentally incompetent or institutionalized individual.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practice, who is responsible for the diagnosis or treatment of a particular patient's condition.
- Organ transplants, except in some instances.
- Treatment for infertility and the reversal of sterilization.
- All cosmetic services, except in the case of accidents or birth defects.
- Christian science nurses and sanitariums.

This is not a complete list of the services that are not covered by Medicaid and WVCHIP. If you have a question about whether a service is covered, please call Member Services at 1-833-957-0020 (TTY: 711).

GETTING YOUR BENEFITS

REFERRALS AND SPECIALTY CARE

Referrals are not needed when you go to see your PCP. For women, referrals are not needed for appointments with your OB/GYN. If you need health care that your PCP cannot give, your PCP must refer you to another provider who can. Usually, you will be referred to a specialist in our network. When your PCP refers you, the necessary care you get from a specialist will be covered. To see our list of specialists, please call us at 1-833-957-0020 (TTY: 711) or visit WV.HighmarkHealthOptions.com. Member Services can also help you if you believe you are not getting the care you need.

SERVICE AUTHORIZATIONS

If you need to see a provider who is not on our list, your PCP must ask Highmark Health Options for approval. Asking for an out-of-network referral is called a service authorization request. It is important to remember that your PCP must ask us for approval before seeing an out-of-network provider. You or your PCP can call Member Services at 1-833-957-0020 (TTY: 711). If you are approved to see a provider who is outside of our plan, your visits will be covered. If we do not approve a service authorization, we will send you a written notice. You can appeal the decision.

PRIOR AUTHORIZATIONS

Sometimes you may need certain services or treatments that require approval. Before you get this type of care, your provider must ask Member Services. If the care is best for your needs, then it will be covered. If we do not approve a prior authorization, we will send you a written notice. You can appeal the decision.

OUT-OF-NETWORK SERVICES

If we are unable to provide certain covered services, you may get out-of-network services. The cost will be no greater than it would be if you received the services within our network. Services will be provided in an acceptable and timely manner.

COST SHARING

Cost sharing, or a copayment, is the money you need to pay at the time of service. The amount of the copayment will change depending on the service and your FPL or enrollment group. Please see the tables below for more details about Medicaid and WVCHIP copayments.

MEDICAID

Copayments will be collected for:

- Inpatient and outpatient services.
- Physician office visits, including nurse practitioner or physician assistant visits.
- Non-emergency use of an ER.
- Pharmacy.
- Adults age twenty-one (21) and older that are not specifically exempt, as listed below.

Medicaid Service	Up to 50.00% FPL	50.01 – 100.00% FPL	100.01% FPL and Above
Inpatient Hospital (Acute Care)	$0	$35	$75
Office Visits (Physicians and Nurse Practitioners)	$0	$2	$4
Outpatient Surgical Services in a Physician's Office; Ambulatory Surgical Center; or Outpatient Hospital (Excluding ERs)	$0	$2	$4
Non-Emergency Use of ER	$8	$8	$8

PHARMACY COPAYMENTS

Pharmacy copayments are the same for all Medicaid members regardless of income, however out of pocket maximums do apply.

Pharmacy	
Total Allowed Charge	**Copayment**
$0.00 - $5.00	$0
$5.01 - $10.00	$0.50
$10.01 - $25.00	$1
$25.01 - $50.00	$2
$50.01 and above	$3

Copayments will not be collected for:

- Family planning services.
- Emergency services.
- Behavioral health services.
- Medicaid members under age twenty-one (21).
- Pregnant women (including twelve (12) months after pregnancy).
- American Indians and Alaska Natives.
- Members getting hospice care.
- Members in nursing homes.
- Other members or services not under the State Plan authority.
- Members who have met their household maximum limit for cost-sharing per calendar quarter.
- Members with primary insurance other than Medicaid.

WVCHIP

WVCHIP members participate in some level of cost sharing (copayments and premiums), except for those children registered under the federal exception for Native Americans or Alaskan Natives.

Cost-sharing amounts are determined by the coverage or enrollment group.

Medical Services and Prescription Benefits	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
Physician Visit (Non-Medical Home)	$5	$15	$20
Inpatient Hospital Admissions	No Copay	$25	$25
Outpatient Surgical Services	No Copay	$25	$25
Urgent Care	$5	$15	$20
Emergency Department (Waived If Admitted)	No Copay	$35	$35
Dental Benefit	No Copay	No Copay	$25 Copay for Some Non-Preventive Services
Generic Drugs	No Copay	No Copay	No Copay
Brand Prescriptions	$5	$10	$15

There will be no copayments for:

- Preventive services.
- Visits to your PCP.
- Immunizations.
- Maternity services.
- Pregnant women over nineteen (19) years of age.
- Vision services.
- Behavioral Health.
- SUD services.

For more information on copayment amounts, please call Member Services at 1-833-957-0020 (TTY: 711).

OUT-OF-POCKET MAXIMUMS

For WVCHIP members, the maximum copayment amounts applied during a calendar year are listed in the table on the following page. A calendar year is the twelve (12) month period beginning January 1 and ending December 31. The maximum copayment is different depending on the number of children in the family who are covered under WVCHIP.

# of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
1 Child Medical Maximum	$150	$150	$200
2 Children Medical Maximum	$300	$300	$400
3 or More Children Medical Maximum	$450	$450	$600
Dental Services	Does Not Apply	Does Not Apply	$150 Per Family
Prescription Medications	Contact Pharmacy Services at 1-888-483-0797.		

ACCESS AND AVAILABILITY GUIDE

Highmark Health Options offers services in every county of West Virginia. The table below lists how long it should take for you to be seen by a provider in different situations.

Type of Visit:	When You Should be Seen:
Routine Care	Within 21 Calendar Days
Urgent Care	Within 48 Hours
Initial Prenatal Care	Within 14 Days of Known Pregnancy
Emergency Care	Immediately

The following table shows what your travel time should be for your appointments.

Traveling to Your:	Should Take No Longer Than:		Should Be No Further Than:	
PCP	30 Minutes		20 Miles	
OB/GYN	30 Minutes		25 Miles	
Specialist You See Often	30 Minutes		20 Miles	
Hospital	Urban: 45 Minutes	Rural: 90 Minutes	Urban: 30 Miles	Rural: 60 Miles
Dentist	30 Minutes		25 Miles	
Dental Specialist	60 Minutes		45 Miles	
Behavioral Health Provider, Clinic, or Facility	60 Minutes		45 Miles	
SUD Provider, Clinic, or Facility	60 Minutes		45 Miles	

LETTING US KNOW WHEN YOU ARE UNHAPPY

When you have a problem, try speaking with Member Services or your PCP to resolve it. If you are still unhappy or do not agree with a decision we have made about your health care, there are different types of complaints you can make. These are known as grievances and appeals. You can also request a state fair hearing once you have gone through the process for grievances and appeals.

Information on the number of grievances and appeals filed with Highmark Health Options and their outcome is available upon request.

APPEALS

As a member of Highmark Health Options, you have the right to appeal a decision. You can file an appeal for many reasons like if you do not agree with our decision about your service authorization, prior authorization request, and non-payment of a claim. Our decision to reduce, suspend, or stop services will be sent to you in a Notice of Action letter. You will have sixty (60) calendar days from the date of the Notice of Action to file an appeal with Highmark Health Options. If you would like your benefits to continue while the appeal is pending, you or your provider must file a request within ten (10) calendar days. You can file an appeal by calling Member Services at 1-833-957-0020 (TTY: 711) or you can do so in writing. If you choose to write to us, you will need to include your address. With written consent, you can also have someone else, like your PCP, file an appeal on your behalf. Unless you request an expedited (fast) appeal resolution, you must follow up a verbal appeal with a written, signed appeal.

To file a written appeal, please mail it to:

Highmark Health Options West Virginia
Attn: Appeals and Grievances
P.O. Box 1709
Parkersburg, WV 26102

Highmark Health Options will respond to your appeal within 30 calendar days from the day your appeal is received. If it is in your interest, you can ask for a delay in our decision for up to fourteen (14) calendar days. If we need to delay our decision for another reason, we will give you written notice within two (2) calendar days. For appeals that need to be resolved more quickly, we will give you our decision within seventy-two (72) hours after receiving your appeal. You may have to pay the cost of services, depending on the outcome.

If you need help with an appeal, you can call us toll-free at 1-833-957-0020 (TTY: 711). We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

COMPLAINTS/GRIEVANCES

As a member of Highmark Health Options, you have the right to file a complaint, also called a grievance, at any time. You can file a complaint if you are unhappy with something about Highmark Health Options or one of our providers. You can also file a complaint if you disagree with our decision about your appeal. To file an informal complaint, call us at 1-833-957-0020 (TTY: 711) to let us know that you are unhappy with Highmark Health Options or your

healthcare services. You can also take steps to file a formal complaint or allow someone like your PCP to do so on your behalf. If you choose to write to us, you will need to include your address.

To file a written complaint, please mail it to:

Highmark Health Options West Virginia
Attn: Appeals and Grievances
P.O. Box 1709
Parkersburg, WV 26102

We will usually get our answer to you within thirty (30) calendar days, and no later than ninety (90) calendar days, from the date your complaint is received. If it is in your interest, you can ask for a delay in our decision for up to fourteen (14) calendar days. If we need to delay our decision, we will give you written notice within two (2) calendar days.

If you need help with a complaint, you can call us toll-free at 1-833-957-0020 (TTY: 711). We can assist you in completing forms. We also can offer auxiliary aids, interpreters, and other services.

FAIR HEARINGS

As a member of Highmark Health Options, you have the right to request a state fair hearing. You can only request a state fair hearing after you have received notice that Highmark Health Options is upholding the decision to reduce, suspend, or stop your benefits for a MHT covered service. You must request the state fair hearing no later than 120 calendar days from the date of our decision notice. It is our job to mail you the form and give you the information you need.

Once you get the form, please mail it back to:

West Virginia Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

If you would like your benefits to continue while the hearing is going on, you or your provider must file a request within ten (10) calendar days. You may have to pay the cost of services, depending on the outcome. Parties to the state fair hearing can include the state, Highmark Health Options, your representative, or the representative of a deceased member. The state will hear your case and decide within ninety (90) calendar days of your request for a state fair hearing.

Please call Member Services at 1-833-957-0020 (TTY: 711) if you have questions about requesting a state fair hearing. You can also call the DoHS at 1-877-716-1212.

REPORTING FRAUD

Report suspected fraud, waste or abuse by a Highmark Health Options member or provider to our special investigative unit (SIU). Please call 1-833-957-0020 (TTY: 711). You may also complete the fraud, waste, and abuse reporting form on our website or by mailing it to us. You do not need to give us your name or information when you call or fill out the form.

Highmark Health Options West Virginia
Attn: SIU
614 Market Street
Parkersburg, WV 26101

WV.HighmarkHealthOptions.com

Some examples of fraud, waste or abuse include, but are not limited to:

- Receiving money or gifts in return for your member number.
- Billing for a non-covered service as a covered service.
- Requesting cash payments from members for office visits.
- Using another person’s Medicaid or WVCHIP card.

OUR POLICIES

ADVANCE DIRECTIVES

Under federal and state law, you have the right to make decisions about your medical care, including an advance directive. An advance directive is a legal document with your wishes about your medical treatment. It allows you to plan ahead and make decisions around your health. An advance directive is a way to let your doctors know what kind of treatment you do or do not want if there comes a time when you are too sick to make your decisions known. You can also allow someone you trust to make care and treatment decisions for you. Many people choose a relative or someone they know well.

You should speak with your doctor about making an advance directive. You do not have to fill one out, but you may want to. If you decide to let someone you trust make treatment decisions for you, be sure to speak with that person. Making an advance directive requires filling out forms and stating your wishes in writing. It will become a part of your medical records. Remember, you can change your advance directive at any time.

Your doctor and Member Services can help you to fill out or answer questions about advance directives.

ENDING YOUR MEMBERSHIP

If you do not wish to be a member of Highmark Health Options, you have the right to disenroll at any time. You may re-enroll with another managed care organization (MCO). The enrollment broker can help you. Just call Mountain Health Trust at 1-800-449-8466 (TTY: 711 or 1-304-344-0015), Monday through Friday from 8 a.m.–6 p.m.

Sometimes members are disenrolled from the health plan involuntarily. This can happen if:

- You are no longer eligible for Medicaid or WVCHIP managed care.
- You move out of West Virginia.
- You are placed in an inpatient facility, nursing facility, state institution, or intermediate care facility for intellectual/developmental disabilities for more than thirty (30) calendar days.
- You were incorrectly enrolled in Highmark Health Options.
- You die.

If this happens, your services may stop suddenly. The enrollment broker and Member Services can answer any questions you may have about disenrollment. If you move out of the county or out of state, call the county DoHS office at 1-877-716-1212.

APPROPRIATE TREATMENT OF MINORS

Oral interpreters for minors are available in the case of an emergency.

REPORTING ABUSE AND NEGLECT

If you need to report abuse and neglect of a child or adult, please call the DoHS Centralized Intake for Abuse and Neglect hotline at **1-800-352-6513**. The hotline is operated twenty-four (24) hours a day, seven (7) days a week. If it is an emergency situation, call 911.

THIRD-PARTY LIABILITY

If you have insurance other than Medicaid or WVCHIP, please call Member Services to let us know. Please call and let us know if another insurance company has been involved with your:

- Worker's compensation claim.
- Personal injury.
- Medical malpractice lawsuit.
- Car accident.

You must use any other health insurance you have first before using Medicaid or WVCHIP.

BALANCE BILLING

Your provider must accept assignment of benefits and cannot bill you for any charges above the fee allowance or for any discount amount applied to a provider's charge to determine payment. This is known as the "prohibition of balance billing" and applies to any MHT provider.

RECOMMENDING CHANGES IN POLICIES OR SERVICES

If you have recommendations or ideas, please tell us about them. You can help us make changes to improve our polices and services. To let us know, please call Member Services at 1-833-957-0020 (TTY: 711).

CHANGES TO YOUR HEALTH PLAN

If there are any changes to your benefits or other information in this handbook, we will let you know at least thirty (30) calendar days before the effective date of the change and no later than the actual effective date. Please let us know if you have any questions about program changes.

ACCREDITATION REPORT

Highmark Health Options is accredited by the National Committee for Quality Assurance (NCQA). Call us at 1-833-957-0020 (TTY: 711) to ask for a summary of our accreditation report. You can also find the report on our website at WV.HighmarkHealthOptions.com.

IMPORTANT CONTACT INFORMATION

The table below provides information about services that members can call for support. For information about other services you may need, you can call us at 1-833-957-0020 (TTY: 711).

Entity	Description	Phone Number	Street Address	Hours of Operation
Highmark Health Options Member Services	Available to answer questions about your health care needs and services to help you.	Toll-Free: 1-833-957-0020 (TTY: 711)	614 Market St. Parkersburg, WV 26101	Monday–Friday 8 a.m.–5 p.m.
County Department of Human Services (DoHS)	The WV DoHS of your county.	304-558-0684		
West Virginia Bureau for Medical Services	The state agency that administers the Medicaid and WVCHIP programs.	304-558-1700	350 Capitol St. Room 251 Charleston, WV 25301	
Medical Management	Available to ensure you get all the care and services you need.	1-833-957-0020 (TTY: 711)		Monday–Friday 8 a.m.–5 p.m.
Enrollment Broker	Available to answer questions you may have about enrolling with an MCO.	1-800-449-8466 (TTY: 1-304-344-0015)		Monday–Friday 8 a.m.–6 p.m.
Emergency	Available for inpatient and outpatient services given by a qualified provider to stabilize an emergency medical condition.	911		24/7
Dental	Highmark Health Options uses United Concordia Dental to answer questions related to dental benefits and connect you to a dental service provider.	1-844-789-1722 (TTY: 711)	United Concordia Insurance Co. 1800 Center St. Camp Hill, PA 17011	Monday–Friday 8 a.m.–5 p.m.

Entity	Description	Phone Number	Street Address	Hours of Operation
Vision	Highmark Health Options uses Vision Service Plan to answer questions related to vision benefits and connect you to a vision service provider.	1-866-412-5825 (TTY: 711)	Vision Service Plan Insurance Co. 3333 Quality Dr. Rancho Cordova, CA 95670	Monday–Sunday 6 a.m.–5 p.m.
Behavioral Health	Highmark Health Options provides coverage for all inpatient and outpatient services to members.	1-833-957-0020 (TTY: 711)		Monday–Friday 8 a.m.–5 p.m.
Pharmacy	Available to answer questions related to your prescription drug benefits.	1-855-230-7778 (TTY: 1-800-759-1089)		24/7
Grievances/Appeals	Available to assist in filing a grievance or appeal including help in completing forms, offering auxiliary aid or interpreters, and other services.	1-833-957-0020 (TTY: 711)	Attn. Appeals and Grievances 614 Market St. Parkersburg, WV 26101	Monday–Friday 9 a.m.–5 p.m.
State Fair Hearing	Available to answer questions about requesting a state fair hearing.	1-833-957-0020 (TTY: 711)	Attn. Appeals and Grievances 614 Market St. Parkersburg, WV 26101	Monday–Friday 9 a.m.–5 p.m.
Fraud, Waste, and Abuse	The SIU investigates cases of suspected fraud, waste, or abuse by a Highmark Health Options member or provider.	1-844-325-6256		Monday–Friday 9 a.m.–5 p.m.

Entity	Description	Phone Number	Street Address	Hours of Operation
Modivcare Transportation Services	Provides non-emergency transportation services.	1-844-889-1941 (TTY: 1-866-288-3133) After 5 p.m., call: 1-844-549-8353		Monday–Friday 9 a.m.–5 p.m.

IMMUNIZATION SCHEDULES

Immunizations are important to keep your child healthy. The tables on the following pages provide the CDC recommended immunization schedules for children up to age eighteen (18). Please visit https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html for detailed notes and recommendations on this immunization schedule.

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).

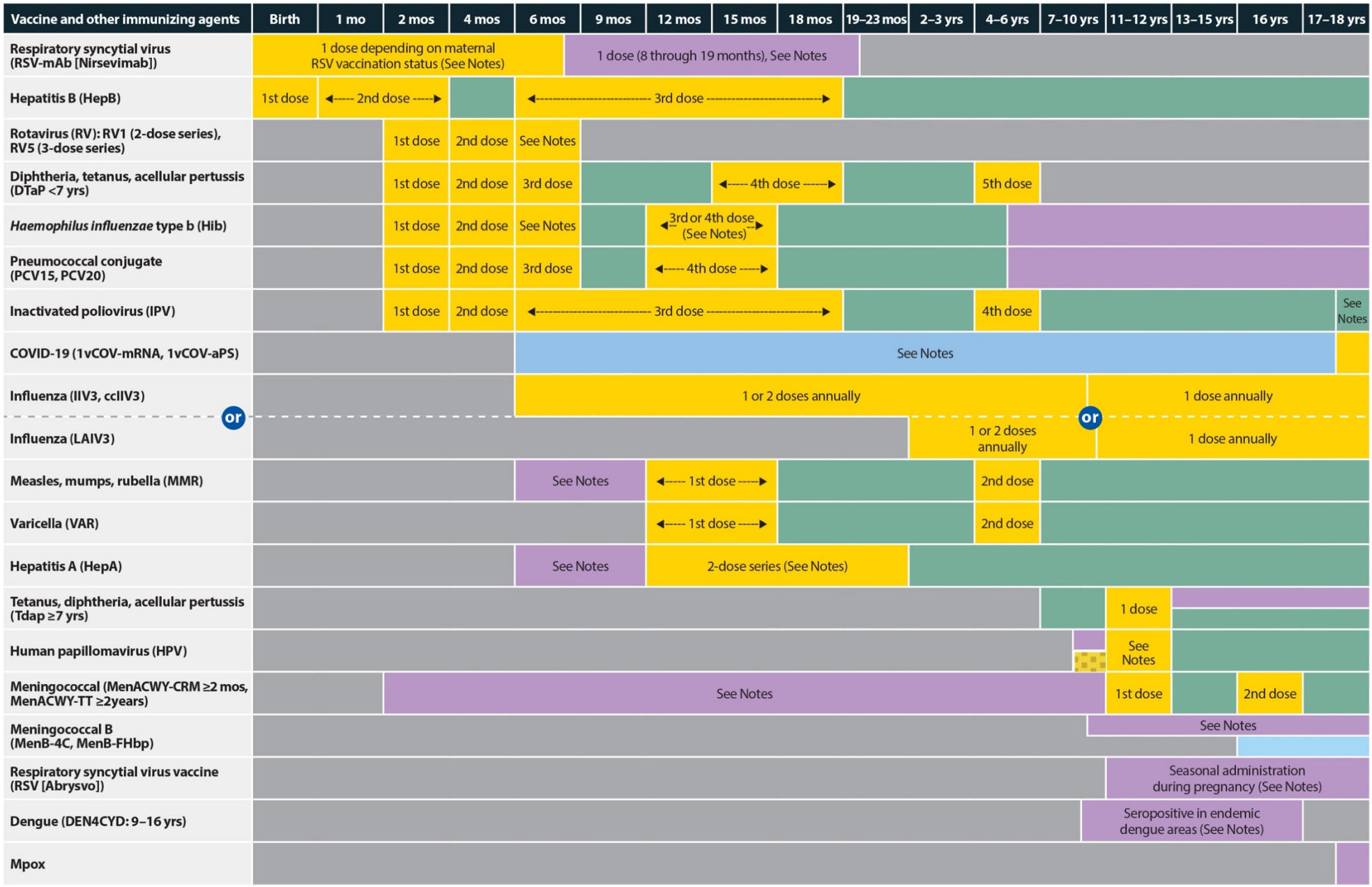


Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2025

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months** A fifth dose is not necessary if the fourth dose was administered at age 4 years or older ***and*** at least 6 months after dose 3
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix), Vaxelis or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; **OR** if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; **OR** if both doses were PedvaxHIB and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months ***and*** previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); **OR** if current age is 12 months or older ***and*** at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** This dose is only necessary for children age 12 through 59 months regardless of risk, or age 60 through 71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older ***and*** at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years **OR** if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count[a]		CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease	Diabetes
			<15% or <200/mm³	≥15% and ≥200/mm³						
RSV-mAb (nirsevimab)		2nd RSV season		1 dose depending on maternal RSV vaccination status (See Notes)			2nd RSV season for chronic lung disease (See Notes)	1 dose depending on maternal RSV vaccination status (See Notes)		
Hepatitis B										
Rotavirus		SCID[b]								
DTaP/Tdap	DTaP Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19		See Notes		See Notes						
Influenza inactivated		Solid organ transplant: 18yrs (See Notes)								
LAIV3							Asthma, wheezing: 2–4 years[c]			
MMR	*									
VAR	*									
Hepatitis A										
HPV	*	3-dose series (See Notes)								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration (See Notes)									
Dengue										
Mpox	See Notes									

Recommended for all age-eligible children who lack documentation of a complete vaccination series

Not recommended for all children, but recommended for some children based on increased risk for or severe outcomes from disease

Vaccination is based on shared clinical decision-making

Recommended for all age-eligible children, and additional doses may be necessary based on medical condition or other indications. See Notes.

Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction

Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated

No Guidance/ Not Applicable

a. For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

b. Severe Combined Immunodeficiency

c. LAIV3 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH AND FINANCIAL INFORMATION MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Highmark Health Options is required by law to protect the privacy of your health information and non-public personal (financial) information. This protection extends to all forms of communication (oral, written, and electronic) of this information. Also, Highmark Health Options is required to give you this notice about how it uses or shares ("discloses") your health and personal ("non-public") information. We are required to notify you if you are affected by a breach of unsecured health information.

To provide services to you, Highmark Health Options will share your health information with:

- You or someone who acts for you.
- Doctors and health care providers who care for you.
- Our contracted vendors who help us provide services to you (such as member services support and pharmacy benefit management).
- Other government programs such as Medicare and Medicaid to manage your benefits and payments.
- State and federal agencies that have the legal right to receive such data.
- The U.S. Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

Highmark Health Options will use your health information to:

- Coordinate and manage your care.
- Determine your eligibility for your plan benefits.
- Pay for your health care.
- Contact you about new or changed benefits.
- Contact you for appointment reminders, medication management, or disease management programs and alternative treatments that may interest you.
- Check the quality of our services and make improvements where required.
- Conduct or arrange for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs.
- Plan and carry out our business activities, management and general administration.
- Give you information about health-related benefits and services that may be of interest to you.

Highmark Health Options may also use or share your health information:

- For public health activities (such as reporting disease outbreaks; child abuse and neglect; reporting domestic violence; preventing or controlling disease, injury or disability).
- For government health care oversight activities (such as fraud investigations, audits, and activities related to oversight of the health care system).
- For judicial and administrative proceedings (such as in response to a court order).

- For law enforcement purposes or when required by law, for example, locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.
- For purposes of national security.
- To comply with worker's compensation or similar laws.
- For research studies that meet all privacy law requirements such as research related to the prevention of disease or disability.
- To avoid a serious and likely threat to health or safety.
- To create a collection of information that can no longer be traced back to you.
- To group health plans, to coordinate plans and to permit the plan to administer benefits.
- To coroners, medical examiners, funeral directors, and organ donations.
- To your school when proof of immunization is required by law.
- To others involved in your health care (if you are not present or able to agree to these disclosures of your health information, we may use our professional judgment to determine whether the disclosure is in your best interest).
- For underwriting purposes if needed, however, we are not allowed to use or share your genetic information to decide whether coverage can be given or at what price.

Marketing

If we receive compensation from another company for providing you with information about other products or services (other than drug refill reminders or generic drug availability), we will obtain your authorization to share information with this other company.

Sharing information for other purposes

Highmark Health Options must have your written permission (an "authorization") to use or give out your health and claims information for any purpose that is not listed in this notice. Giving us permission to use or give out your health and claims information will not be a condition for getting health care and will not be used to determine your eligibility for enrollment or benefits, or for paying claims. You may take back ("revoke") your written permission at any time, except if Highmark Health Options already acted based on your permission.

Some examples of when we need your permission to use or give out your information are:

- For fundraising.
- For selling your protected health information (PHI).

You have the right to:

1. Get a copy of your health and claims information. You can ask to see or get a copy of your health or claims records and other health information we have about you. We will provide a copy or a summary of your health or claims records within 10 calendar days of your request.

2. Ask us to correct health and claims records. You can ask us to change your health and claims records if you feel they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days. If Highmark Health Options cannot

change your records, you may have a statement of your disagreement added to your personal medical information.

3. Get a list of those with whom we've shared information. You can ask for a list (called "an accounting") of the times we've shared your health information within the last six years. You must tell Highmark Health Options the dates for which you are requesting the list. The list will not cover information that was given to you or your personal representative, or information given for health care payments, for Highmark Health Options business operations, or for law enforcement needs.

4. Request confidential communications. You can ask us to contact you in a specific way, for example, on a home or office phone or to a different address. We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

5. Ask us to limit what we use or share. You can ask us not to share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

6. Choose someone to act for you. If you have given someone medical power of attorney, or if someone is your legal guardian, that person can act for you and make choices about your health information. We will make sure the person has this authority before we take any action.

7. Get a copy of this privacy notice. Contact us for a separate paper copy or email copy of this notice.

What is the non-public information that Highmark Health Options collects and shares about you?

It is personal information but is non-medical, for example, the information you completed on your enrollment application that identifies who you are and how you can be contacted.

Also, it is information collected for a request for services by you or your doctor.

Also, it is information collected to answer a question or concern from you.

With whom does Highmark Health Options share your non-public information?

With health care providers, for example, physicians, hospitals, long term care agencies, durable medical equipment providers, and pharmacies.

With those who plan your benefits and your care, for example, for utilization reviews; external reviews; and case management.

How does Highmark Health Options protect your non-public information?

Highmark Health Options does not make your non-public information available to anyone other than those necessary to provide medical or health plan services to you.

Highmark Health Options does not give out your non-public information, except if required or permitted by law.

Highmark Health Options does not give out your non-public information to anyone unrelated to providing your care under the health plan unless you or your representative gives permission.

You have the right to give or withhold permission for other uses or disclosures of this information, except as required by law.

Questions and complaints

If you have a question about this notice or believe Highmark Health Options has violated your privacy rights as stated in this notice, you can file a complaint by contacting:

Highmark Health Options West Virginia
Attn: Privacy Office
614 Market Street
Parkersburg, WV 26101

For more information on filing a complaint or your rights stated in this notice, call Member Services at 1-833-957-0020 (TTY: 711).

Filing a complaint will not affect your benefits. Translations services are available at no cost to you.

Change to the terms of this notice

Highmark Health Options is required to follow the terms in this privacy notice. Highmark Health Options has the right to change the way your medical information is used and given out and to apply those changes to all the information we maintain about you. If Highmark Health Options makes any material changes, they will be posted on our website, and you will be notified within sixty (60) days of the change.

These privacy practices were revised Jan. 1, 2024.

HIGHMARK HEALTH OPTIONS

Highmark Health Options complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation. Highmark Health Options does not exclude people or treat them differently because of their race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

Highmark Health Options provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in a different way, including large print, audio, and Braille.

Highmark Health Options provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact Highmark Health Options Member Services at 1-833-957-0020 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m.

If you believe that Highmark Health Options has failed to provide these services or discriminated against you in another way because of your race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation, you can file a complaint with Highmark Health Options or the WV Human Rights Commission by mail, phone, or fax.

Highmark Health Options
Attn: Appeals and Grievances
614 Market Street
Parkersburg, WV 26101
1-833-957-0020 (TTY: 711)
Fax: 1-833-547-2022

WV Human Rights Commission
1321 Plaza East, Room 108A
Charleston, WV 25301
304-558-2616
Fax: 304-558-0085
hho.fyi/wv-hrc

If you need help filing a complaint, Highmark Health Options and the WV Human Rights Commission are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights online at OCRPortal.hhs.gov, and by mail, phone, or email:

U.S. Department of Health and Human Services
200 Independence Avenue SW
HHH Building Room 509F
Washington, DC 20201
1-800-368-1019 (TTY: 1-800-537-7697)
OCRMail@hhs.gov

A printable version of the complaint form is available at hho.fyi/complaint-form.

HIGHMARK HEALTH OPTIONS

Attention: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

Atención: Si usted habla español, por favor encuentren disponibles servicios de asistencia en español sin costo alguno. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

تنبيه :إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا .اتصل بالرقم الموجود على ظهر بطاقة الهوية الخاصة بك (TTY: 711).

Attention: Si vous parlez français, des services d’assistance linguistique vous sont offerts gratuitement. Veuillez appeler le numéro qui se trouve au verso de votre carte d’identification (TTY : 711).

Achtung: Wenn Sie Deutsch sprechen, steht Ihnen kostenlose Unterstützung in Ihrer Sprache zur Verfügung. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TYY: 711).

注意：如果您会说英语，则可以免费获得语言协助服务。 请拨打您身份证背面的号码（TTY：711）。

Attenzione: se parli inglese, sono a tua disposizione servizi di assistenza linguistica gratuiti. Chiama il numero sul retro della tua carta d'identità (TTY: 711).

Pansin: Kung nagsasalita ka ng Ingles, ang mga serbisyo ng tulong sa wika, na walang bayad, ay magagamit mo. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

Chú ý: Nếu bạn nói tiếng Anh, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn có dành cho bạn. Gọi đến số ở mặt sau thẻ ID của bạn (TTY: 711).

ध्यान दिनुहोस्: यदि तपाइँ अंग्रेजी बोल्नुहुन्छ भने, भाषा सहायता सेवाहरू, नि:शुल्क, तपाइँलाई उपलब्ध छन्। तपाईंको आईडी कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

注意: 英語を話せる場合は、言語支援サービスを無料でご利用いただけます。 ID カードの裏面に記載されている番号 (TTY: 711) に電話してください。

ध्यान दें: यदि आप अंग्रेजी बोलते हैं, तो भाषा सहायता सेवाएँ आपके लिए नि:शुल्क उपलब्ध हैं। अपने आईडी कार्ड के पीछे दिए गए नंबर (TTY: 711) पर कॉल करें।

ופמערקזאמקייט :אויב איר רעדן ענגליש, שפּראַך הילף באַדינונגס זענען בארעכטיגט פֿאַר איר .רופן דעם נומער אויף די צוריק פון דיין שיין קאָרט (TTY: 711).

주의: 영어를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 신분증 뒷면에 있는 전화번호(TTY: 711)로 전화하세요.

Akiyesi: Ti o ba sọ Gẹẹsi, awọn iṣẹ iranlọwọ ede, laisi idiyele, wa fun ọ. Pe nọmba ti o wa ni ẹhin kaadi ID rẹ (TTY: 711).

Внимание: если вы говорите по-английски, вам доступны бесплатные услуги языковой помощи. Позвоните по номеру, указанному на обратной стороне вашего удостоверения личности (TTY: 711).