Fair Treatment Notice

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

We provide free:

> Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).

Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at 1-800-538-5038 or SelectHealth Advantage Member Services at 1-855-442-9900 (TTY Users: 711).

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

Language Access Services

ATENCION: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth.

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

ПОДУШЬКИ: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika. Contactez SelectHealth.

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


di: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다。SelectHealth. 번으로 전화해 주십시오。

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

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Phone Numbers and Contact Information

SELECTHEALTH NUMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Help Offered</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>SelectHealth Healthy</td>
<td>Help with a safe and healthy pregnancy</td>
<td>866-442-5052, option 1</td>
</tr>
<tr>
<td>Begnings*</td>
<td></td>
<td>Hours: Weekdays, from 8:00 a.m. to 5:00 p.m.</td>
</tr>
<tr>
<td>Restriction Program</td>
<td>Help with the Restriction Program</td>
<td>800-442-5305</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Prescription drugs and pharmacies</td>
<td>855-442-3234</td>
</tr>
<tr>
<td></td>
<td>Benefits and coverage</td>
<td>Hours: Weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.</td>
</tr>
<tr>
<td>Appeals</td>
<td>Help reviewing an Adverse Benefit Determination to see if the right decision was made when your request for service was denied</td>
<td>844-208-9012</td>
</tr>
<tr>
<td>SelectHealth Website</td>
<td>Member Handbook</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community resources</td>
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<tr>
<td></td>
<td>Wellness</td>
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<td></td>
<td>selecthealth.org</td>
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</tbody>
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STATE MEDICAID NUMBERS

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

OTHER NUMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Help Offered</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utah Poison Control</td>
<td>Resource for poison information and help</td>
<td>800-222-1222</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hours: 24 hours a day; 7 days a week</td>
</tr>
<tr>
<td>Behavioral Health CrisisLine (UNI)</td>
<td>Free help for a mental health crisis</td>
<td>801-587-3000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hours: 24 hours a day; 7 days a week</td>
</tr>
</tbody>
</table>

...
Introduction
Welcome and thank you for choosing SelectHealth Community Care® Integrated Health. Your health is important to us, and we will do all we can to help you with your healthcare needs. We are an integrated care plan. This means we cover physical health, mental health, and substance use disorder (SUD) services if you need them.

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

Language Services

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

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

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

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

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

Rights and Responsibilities

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

WHAT ARE MY RESPONSIBILITIES?
Your responsibilities are to:
› Follow the rules of this integrated care plan
› Read this Member Handbook
› Show your Medicaid Member Card each time you get services
› Cancel doctor appointments 24 hours ahead of time if needed
› Respect the staff and property at your provider’s office
› Use providers (doctors, hospitals, etc.) in the SelectHealth Community Care network
› Pay your copayments (copays)

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

SelectHealth can cancel your membership if you do anything on the list below:
› You are abusive or you make threats or act violent
› You don’t follow the member responsibilities listed in this handbook
Medical Policies
When we make a decision on coverage for care, we do not randomly deny or reduce coverage only because of a diagnosis, type of illness, or a condition you have. We make decisions based on the Utah Medicaid Coverage and Reimbursement Code Lookup. 

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

Contacting My Medicaid Plan

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

We can help you:
› Find a provider
› Change providers
› Answer questions about bills
› Understand your benefits
› Find a specialist
› With a complaint (also called a grievance) or an appeal
› With other questions.
You can also find us online at selecthealth.org/plans/medicaid.

Medicaid Benefits

HOW DO I USE MY MEDICAID BENEFITS?
Each Medicaid member will get a Medicaid Member Card. You will use this card whenever you are eligible for Medicaid. You should show your Medicaid Member Card before you receive services or get a prescription filled. Always make sure that the provider accepts your Medicaid plan or you may have to pay for the service.

WHAT DOES MY MEDICAID MEMBER CARD LOOK LIKE?
The Medicaid Member Card is wallet-sized and will have the member’s name, Medicaid ID number and date of birth on the card. Your Medicaid Member Card will look like this:

![Image of Medicaid Member Card]

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

CAN I VIEW MY MEDICAID BENEFITS ONLINE?
You can check your Medicaid coverage and plan information online at mybenefits.utah.gov.

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

For more information on accessing or looking at benefit information, please visit mybenefits.utah.gov or call 1-844-228-3091.

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

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

If you got a letter to reapply for Medicaid (or think it’s time to), here are ways to renew your coverage:
› Online: Reapply right away using “My Case” at jobs.utah.gov/mycase.
› By mail: Watch your mailbox for an application from the Utah Department of Health Medicaid Office.

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

HOW CAN I CHANGE MY PRIMARY CARE PROVIDER?

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

SelectHealth Member Advocates
Member Advocates can help you find the right care for your needs. They can also help with:
› Scheduling a visit, as well as care for urgent health issues
› Finding the closest office, doctor (including mental health providers), or hospital services with the earliest available appointment
› Giving facts about a doctor such as age, training certifications, medical school, and languages spoken
› Helping you know and get the most out of your benefits

ONLINE DOCTOR AND FACILITY SEARCH
We have a list of approved doctors and information about each doctor on our website. Visit selecthealth.org/findadoctor and choose the “Community Care” network. This is where you will find the most up-to-date list of doctors (Primary Care, Secondary Care, and Ancillary Care). You can also use the “Facility Search” to find in-network facilities.

It is important to choose a doctor and facility that is on this list. This means the doctor/facility is in-network. Seeing in-network providers protects you from paying more in out-of-pocket costs.

Call Member Services if you would like a copy of the doctor list, free of charge.

Here are a few ways you can filter your search to find the best doctor or office for your needs:

Doctor Information:
› Gender
› Languages spoken
› Office hours

Facility Information:
› Facility type
› Plans accepted
› Location
SelectHealth Mobile App
If you’ve got a smartphone, we’ve got you covered. With the SelectHealth mobile app, you have access to your health plan when you need it.
Use your insurance plan on the go. Log into our secure app and find out how easy it is to:
› Search for doctors and hospitals
› Look up pharmacies and medications
› See Intermountain InstaCare® wait times and locations. You can even reserve your place in line.
Find us on Google Play® and the Apple® App Store™.

WHAT IS A NOTICE OF DOCTOR TERMINATION?
SelectHealth will give you 15-days notice when your doctor is no longer on your health plan. Call us if you need help finding a new PCP.

OTHER THINGS YOU NEED TO KNOW:
› Your doctor doesn’t have to see you if you don’t pay your copay at the time of the visit
› Your doctor can bill you or turn your account over to a collection agency for unpaid copays
› Always keep your copay stubs for 12 months
› Medicare or other coverage may change your copay amounts

Copayments, Copays and Cost Sharing
WHAT ARE COPAYMENTS, COPAYS AND COST SHARING?
You may have to pay a fee for some services. This fee is called a copayment, copay, or cost sharing.

WHO DOES NOT HAVE A COPAY?
These members never have a copay:
› Alaska Natives
› American Indians
› Members on hospice care
› Members who qualify for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits
› Pregnant women

WHAT SERVICES DO NOT HAVE COPAYS?
Some services that do not have copays are:
› Lab and radiology
› Family planning services
› Immunizations (shots)
› Preventive services
› Tobacco cessation services
› Outpatient behavioral health (mental health and substance use disorder) services

WHAT IS AN EXPLANATION OF BENEFITS (EOB)?
Any time you have a copay or get a non-covered service, we will send you an EOB. An EOB is not a bill.
An EOB shows:
› What your doctor charged for your care
› What we paid for your care
› Copays you paid
› How close you are to your out-of-pocket maximums
Always read your EOB. If you did not get services listed on the EOB, talk with Member Services.

WHEN DO I PAY COPAYS?
You may have to pay a copay if you:
› See a doctor
› Go to the hospital for outpatient care
› Have a planned hospital stay
› Use the emergency room when it is not an emergency
› Get a prescription drug

WHAT IS AN OUT-OF-POCKET MAXIMUM?
Medicaid has a limit on how much you have to pay in copays. This is called an out-of-pocket maximum and applies to specific types of service and for specific time periods.

WHAT HAPPENS WHEN I REACH MY OUT-OF-POCKET MAXIMUM?
Make sure you save your receipts every time you pay your copay. Once you reach your out-of-pocket maximum, contact Medicaid at 1-866-608-9422 to help you through the process.
Out-of-pocket maximum copays:
› Pharmacy - $20 copay per month
› Physician, podiatry, and outpatient hospital services - $100 copay per year* combined

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

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

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

WHAT SHOULD I DO IF I GET A MEDICAL BILL?
If you get a bill for services that you believe should be covered by Medicaid, call SelectHealth Member Services for assistance. Do not pay a bill until you talk to SelectHealth Member Services. You might not be reimbursed if you pay a bill on your own.

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

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

Intermountain Health Answers
If you are not sure where to start, Intermountain Health Answers can help. A team of caring and experienced registered nurses are available 24 hours a day to listen to your concerns, answer questions, and help you decide what you need to do to feel better.
The nurses can offer home-based remedies, tell you when to see a doctor, and/or refer you to the most appropriate care. To reach Health Answers, call 844-501-6600.

Intermountain Connect Care
This online tool gives you access to care 24 hours a day, 7 days a week by letting you talk to a doctor using a mobile phone, tablet, or PC.
The $49 cost is covered by Community Care Medicaid. Make sure to enter in your Medicaid information so you will not be charged for the visit.
This tool is best for health problems that are not urgent such as sinus pain, stuffy and runny nose, sore throats, eye infections, and more. If the doctor feels that your health problem cannot be taken care of using this tool, they will suggest you see a doctor in person. To learn more, visit intermountainhealthcare.org/services/urgent-care/connect-care.
Emergency Care and Urgent Care

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

WHAT IS AN EXAMPLE OF AN EMERGENCY?
Emergencies can include:
- Poisoning
- Overdose
- Severe burns
- Chest pain
- Pregnant with bleeding and/or pain
- Bleeding will not stop
- Heavy bleeding
- Loss of consciousness
- Suddenly not being able to move or speak
- Problems breathing
- Other symptoms where you feel that your life is at risk

WHAT SHOULD I DO IF I HAVE AN EMERGENCY?
Call 911 or go to the closest emergency room.
Remember:
- Go to the emergency room only when you have a real emergency.
- If you are sick, but it is not a real emergency, call your doctor or go to an urgent care clinic.
- If you are not sure if your problem is a true emergency, call your doctor for advice.
- There is no prior authorization needed to get emergency care.
- You may use any hospital or other medical facility to obtain emergency care.

WHAT IF I HAVE QUESTIONS ABOUT POISON DANGER?
For poison, medication, or drug overdose emergencies or questions, call the Poison Control Center at 800-222-1222.

IF SOMEONE IS NOT BREATHING, CALL 911 FOR HELP.
The Poison Control Center has trained staff on duty 24/7. They can answer questions about poison emergencies and tell you what to do next.

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

WILL I HAVE TO PAY FOR EMERGENCY CARE?
There is no copay for use of the emergency room in an emergency. A hospital that is not on your plan may ask you to pay at the time of service. If so, submit your emergency service claim to SelectHealth. SelectHealth will pay the claim. You do not need prior approval.

If you use an emergency room when it is not an emergency, you will be charged a copay.

WHAT SHOULD I DO AFTER I GET EMERGENCY CARE?
Call us as soon as you can after getting emergency care. Notify your PCP to tell the PCP about your emergency visit.

WHAT IS URGENT CARE?
Urgent problems usually need treatment within 24 hours. If you are not sure if your problem is urgent, call your doctor or an urgent care clinic.

WHEN SHOULD I USE AN URGENT CARE CLINIC?
You should use an urgent care clinic if you have one of these minor problems:
- Common cold, flu symptoms, or a sore throat
- Earache or toothache

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

WHEN IS POST-STABILIZATION CARE COVERED?
SelectHealth covers this type of care in all hospitals. Once your condition is stable, you may be asked to transfer to a hospital on your plan.

DO I NEED PRIOR APPROVAL FOR POST-STABILIZATION CARE?
Prior approval is not required for post-stabilization care when services are done at an in-network facility.

CAN I GET EMERGENCY CARE OUTSIDE OF THE UNITED STATES?
Emergency and urgent care services are not covered outside of the United States.
Family Planning

WHAT FAMILY PLANNING SERVICES ARE COVERED?

Family planning services include:
› Information about birth control
› Counseling to help you plan when to have a baby
› Access to birth control (see table below)

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

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

<table>
<thead>
<tr>
<th>Types of Birth Control</th>
<th>Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td>Yes</td>
</tr>
<tr>
<td>Contraceptive Implants</td>
<td>Yes</td>
</tr>
<tr>
<td>Creams</td>
<td>Yes</td>
</tr>
<tr>
<td>Depo-Provera</td>
<td>Yes</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>Yes</td>
</tr>
<tr>
<td>Foams</td>
<td>Yes</td>
</tr>
<tr>
<td>IUD</td>
<td>Yes</td>
</tr>
<tr>
<td>Morning After Pill</td>
<td>Yes</td>
</tr>
<tr>
<td>Patches</td>
<td>Yes</td>
</tr>
<tr>
<td>Pills</td>
<td>Yes</td>
</tr>
<tr>
<td>Rings</td>
<td>Yes</td>
</tr>
<tr>
<td>Sterilization (Tubes tied or Vasectomy)</td>
<td>Yes **Consent form required</td>
</tr>
<tr>
<td>Non-surgical Sterilization (like Essure)</td>
<td>Yes **Consent form required</td>
</tr>
</tbody>
</table>

*OTC means over-the-counter
**Sterilization consent forms must be signed 30 days before surgery.
Some may require prior authorization for coverage.

WHAT FAMILY PLANNING SERVICES ARE NOT COVERED?

Non-covered family planning services include:
› Infertility drugs
› In vitro fertilization
› Genetic counseling

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

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

Specialists

WHAT IF I NEED TO SEE A SPECIALIST?

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

You should be able to get in to see a specialist:
› Within 30 days for non-urgent care
› Within two days for urgent, but not life-threatening care (e.g., care given in a doctor’s office)

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

Care Management

DO YOU HAVE CARE PROGRAMS FOR MEMBERS WITH HEALTH PROBLEMS?

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

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

Eye Care (Vision)

DO YOU COVER EYE CARE?

Nineteen and 20 year olds with EPSDT benefits can get eye tests and glasses at no cost. They can also get contact lenses at no cost with prior approval. If you have a Traditional or Nontraditional plan, you get one eyeglass test per year with no dollar limit (no glasses). Both plans pay for tests for eye problems if needed.
What is Home Healthcare?
Home healthcare is for people who are ill, but the care needed is given at home instead of in a hospital or nursing home. Your doctor needs to get prior approval for this care. Some types of care you might get in your home are:
- IV drugs
- Physical therapy
- Health supplies such as oxygen
- Nursing
- Care from a home health aide
If you need home healthcare services, talk to your doctor. If approved, you will be able to choose a home healthcare doctor from the SelectHealth Approved Provider List.

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

Lab and X-ray Services
ARE X-RAYS AND BLOOD TESTS COVERED?
We cover lab and X-ray services that are covered by Medicaid. You get these services in your doctor’s office, or you can go to an approved clinic, lab, or hospital for these services.

Nursing Home Care
WHAT IS SHORT-TERM NURSING HOME CARE?
Short-term care is when someone goes from a hospital to a nursing home for recovery. SelectHealth pays for short-term nursing home care for 30 days or fewer. Medicaid Long-term Care pays for care needed over 30 days.
A doctor must order short-term care, and you must use a nursing home on the Approved Provider List.

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

Personal Care Services
WHAT ARE PERSONAL CARE SERVICES?
Personal care services help with things like bathing, eating, and dressing. These services are given by a home healthcare aide if you can’t do these things alone. Your doctor needs prior approval for these services. If approved, you can choose a home healthcare agency from the Approved Provider List to help you with your care needs.

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

Prescription Drugs
DOES MY HEALTH PLAN PAY FOR PRESCRIPTION DRUGS?
We cover select generic and name-brand drugs when prescribed by a doctor from our Approved Provider List. Some prescriptions need prior approval. If your doctor writes a prescription for a name-brand drug, it will be replaced with its generic equal unless prior approval is received.

If you do not get prior approval for a drug that needs prior approval, you will have to pay the full retail price of the drug. For more information, please see the preferred drug list found at selecthealth.org/plans/medicaid.
- You must use a drugstore from the Approved Provider List
- You must show your state Medicaid ID Card
- We will not replace lost, stolen, or ruined drugs before the refill date
- We will only cover up to 30 days of medication

Drugs that call for step therapy are covered only after you have tried the other treatment(s) and it didn’t work. Step therapy may apply to either name-brand or generic drugs. Some drugs will be covered by state Medicaid. They will decide which drugs are covered and what guidelines will be met before they cover them. Drugs covered by the state Medicaid agency most often fall into these categories:
- Attention Deficit Hyperactivity Disorder (ADHD)
- Antidepressant
- Antianxiety
- Anticonvulsant
- Antipsychotic
- Hemophilia factor
- Immunosuppressive
- Substance use disorder (opioid or alcohol)

If you have questions about your drug benefits, call Pharmacy Services at 801-442-3234 or toll-free at 855-442-3234 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturday, from 9:00 a.m. to 2:00 p.m.

PREVENTIVE CARE SERVICES FOR ADULTS
Are Preventive Care Services Covered?
We offer limited preventive care services to Traditional and Nontraditional Medicaid members. We also cover certain other preventive services as part of the standard coverage. Copays often apply to these services.

Preventive care can help your doctor find problems early when they are simpler to care for. If a problem is found that needs more care or testing, copays may apply. Preventive care services are covered once a year (unless noted otherwise) and do not need prior approval. Call Member Services if you have questions about your preventive care benefits.

Do You Call or Send Reminders for Preventive Care Exams and Tests?
We send mailers and brochures about the need for special preventive care services. We also call you when it’s time for tests, like mammograms or well child visits. We use an automated calling system that sends you to Member Services after the preventive care message so you can set a time.

PODIATRY SERVICES
Can I See a Podiatrist If I Need to?
We cover podiatry services for children and pregnant women. There are also limited benefits for adults with Traditional and Nontraditional Medicaid. If you need to see a podiatrist, talk to your doctor. Your doctor will have to get prior approval for you to see a podiatrist from the Approved Provider List.

SPEECH AND HEARING SERVICES
Are Hearing Aids Covered?
Some speech and hearing services are covered. Hearing aids are not covered. Contact Member Services for details.
TOBACCO CESSATION

Does Medicaid Offer a Program to Stop Smoking?
The Utah Tobacco Quit Line, available online at quitnow.net and by phone at 800-QUIT-NOW, gives free treatment to all Medicaid members who want to quit smoking. If you call the quit line, you will:

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

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

Tobacco cessation programs do not provide prescription medications (nicotine patches, gum, or lozenges). You will need to secure a prescription for these products from your Quit Now coach. Talk to your doctor if you need a prescription.

Medicaid has a free support program to help pregnant women stop smoking. Please call your HPR for help with these services.

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

WHAT ARE THE BENEFITS COVERED BY MY MEDICAID PLAN?
Depending on the type of plan you have, Traditional, or Nontraditional, you may have coverage for these benefits and care through the Medicaid program.

For more information about your Medicaid benefits, see the state Medicaid Member Guide.

DENTAL CARE
Can I See a Dentist?
We only cover emergency dental care.

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

Behavioral Health Services

WHAT BEHAVIORAL HEALTH SERVICES ARE COVERED?
Behavioral health services are services for mental health and substance use disorders. Inpatient hospital care for mental health problems and inpatient medical detoxification services for Substance Use Disorders (SUDs) are also covered.

Outpatient behavioral health services include:

› Evaluations
› Psychological testing
› Individual, family, and group therapy
› Individual and group therapeutic behavioral services
› Medication management
› Individual skills training and development
› Psychosocial rehabilitation services (day treatment)
› Peer support services
› Targeted case management services
› Mobile Crisis Outreach Team (MCOT)
› Behavioral Health Receiving Center

Services are provided by licensed mental health and SUD professionals, including doctors, nurses, psychologists, licensed clinical social workers, clinical mental health counselors, SUD counselors, targeted case managers, and others.

If you want more information on any of these services, call us at 801-442-3234 or toll-free at 855-442-3234.

ARE ANY OTHER BEHAVIORAL HEALTH SERVICES COVERED?
Yes, other covered services include:

› Electroconvulsive therapy (ECT)
› Respite care
› Psycho-educational services
› Personal services
› Supportive living

If you have questions, your provider will talk with you about these services.

ALCOHOL AND DRUG DETOX (OUTPATIENT)
Are Alcohol and Drug Abuse Treatment Covered?
You can get outpatient care for alcohol and drug use from a Medicaid-approved substance use treatment provider. American Indians can get care from any doctors in their county or from Indian healthcare doctors, as well as an Indian Health Program or an Urban Indian Organization.

Waiver Programs

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

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

Community Supports, Acquired Brain Injury, Physical Disabilities Waivers
Department of Human Services, Division of Services for People with Disabilities
Website: dosp.utah.gov
Phone: 844-ASK-DSPD or 844-275-3773
Email: dosp@utah.gov

New Choices Waiver
Department of Health, Bureau of Authorization and Community Based Services
Website: health.utah.gov/ltc/NC/NCHome.htm
Phone: 800-662-9651, option 6
Email: newchoiceswaiver@utah.gov

Waiver for Individuals Age 65 or Older (Aging Waiver)
Department of Human Services, Division of Aging and Adult Services
Website: dasa.utah.gov
Phone: 801-538-4171
Email: dhisinfo@utah.gov

Technology Dependent or Medically Complex Children’s Waivers
Department of Health, Bureau of Authorization and Community Based Services
Website: health.utah.gov/ltc/EPAS
Phone: 800-662-9651, option 6
Email: techdependent@utah.gov or techdependent@utah.gov

Employment-related Personal Assistant Services (EPAS)
Website: health.utah.gov/ltc/DAAS/Utah
Phone: 801-538-4171
Email: daas@utah.gov

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

Employment-related Personal Assistant Services (EPAS)
Website: health.utah.gov/ltc/DAAS/Utah
Phone: 801-538-4171
Email: daas@utah.gov
Indian Health Services (IHS)

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

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

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

Prior Authorization

WHAT IS PRIOR AUTHORIZATION?
Some services must be approved by SelectHealth before you receive them. This approval is called prior authorization. It is important to get prior authorization before you receive the service.

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

Restriction Program

WHAT DOES IT MEAN TO BE IN THE RESTRICTION PROGRAM?
Medicaid members who need help properly using health care services may be enrolled in the Restriction Program. Members in the Restriction Program are limited to one doctor and one main pharmacy. All medical services and prescriptions must be approved or coordinated by the member’s doctor. All prescriptions must be filled by the member’s main pharmacy. Ongoing use of health care services is reviewed often.

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

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

Other Insurance

WHAT IF I HAVE OTHER HEALTH INSURANCE?
Some members have other health insurance, including Medicare, in addition to Medicaid. Your other insurance or Medicare is called primary insurance.

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

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

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

Advance Directive

WHAT IS AN ADVANCE DIRECTIVE?
An advance directive is a legal document that allows you to make choices about your health care ahead of time. There may be a time when you are too sick to make decisions for yourself. An advance directive will make your wishes known if you cannot do it yourself.

There are four types of advance directives:
- Living Will (End of life care)
- Medical Power of Attorney
- Mental Health Power of Attorney
- Pre-Hospital Medical Care Directive (Do Not Resuscitate)

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

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

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

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

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

Telehealth or Telemedicine

CAN I USE TELEHEALTH OR TELEMEDICINE?
Telemedicine is using technology to deliver medical care from a distance, usually by phone, internet, or video. Some services can be done through telehealth or telemedicine. Intermountain Connect Care is an online tool that gives you access to care 24 hours a day, 7 days a week by letting you talk to a doctor using a mobile phone, tablet, or PC. The $49 cost is covered by Community Care Medicaid. Make sure to enter in your Medicaid information so you will not be charged for the visit.

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

If you want more information about services that can be provided through telehealth or telemedicine, call us at 801-442-3234 or toll-free at 855-442-3234.
Appeals and Grievances

WHAT IS AN ADVERSE BENEFIT DETERMINATION?
An adverse benefit determination is when we:
› Deny payment or pay less for services that were provided
› Deny a service or approve less than you or your provider asked for
› Deny your request to dispute a financial liability
› Deny payment for a covered service
› Deny payment for a service that you may be responsible to pay for
› Deny a service or approve less than you or your provider asked for
› Deny payment for a covered service
› Deny your request to dispute a financial liability

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

WHAT IS AN APPEAL?
An appeal is our review of an adverse benefit determination to see if the right decision was made.

HOW DO I FILE AN APPEAL REQUEST?
› You, your provider, or any authorized representative may request an appeal.
› An appeal form can be found on our website at selecthealth.org/member-care/forms.
› A request for an appeal can be made in the following ways:
   - Mail: SelectHealth Appeals Department P.O. Box 30192 Salt Lake City, Utah 84130-0192
   - Fax: 801-442-0762
   - Phone: 801-442-9950 or toll-free at 844-208-9012
› Submit the appeal request within 60 days from the notice of adverse benefit determination.
› If you need help filing an appeal request, call us at 801-442-5234 or toll-free at 855-442-3234.
› If you are deaf or hard of hearing, you can call Utah Relay Services at 711 or 800-346-4128.

HOW LONG DOES AN APPEAL TAKE?
We will give you a written appeal decision within 30 calendar days from the date we get your written appeal. Sometimes we might need more time to make our decision. We can take up to another 14 calendar days to make a decision. If we need more time, we will let you know by phone or in person as quickly as possible, or in writing within two days.

CAN I GET A DECISION ON AN APPEAL MORE QUICKLY?
If waiting 30 days for our decision will harm your health, life, or ability to maintain or regain maximum function, you can ask for a quick appeal. This means we will make a decision within 72 hours.
Sometimes we might need more time to make a quick appeal decision. We can take up to another 14 calendar days to make a decision. If we need to take more time, we will let you know in person or through a phone call as soon as possible, or in writing within two days.

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

HOW DO I REQUEST A QUICK APPEAL?
You can ask for a quick appeal over the phone or in writing. Call us at 801-442-9950 or toll-free at 844-208-9012, or write to us at:
SelectHealth Appeals Department
P.O. Box 30192
Salt Lake City, Utah 84130-0192

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

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

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

WHAT IS A GRIEVANCE?
A grievance is a complaint about anything other than an adverse benefit determination. You have the right to file a grievance. This gives you a chance to tell us about your concerns.
You can file a grievance about issues related to your care such as:
› Staff attitude
› Rudeness
› Any other kind of problem you may have had with us, your health care provider, or services

HOW DO I FILE A GRIEVANCE?
You can file a grievance at any time. If you need help filing a grievance, call us at 801-442-3234 or toll-free at 855-442-3234.
If you are deaf or hard of hearing, you can call Utah Relay Services at 711 or 800-346-4128, and they can help you file your grievance with us.
You can file a grievance either over the phone or in writing. To file by phone, call Member Services at 801-442-3234 or toll-free at 855-442-3234. To file a grievance in writing, please send your letter to:
SelectHealth Appeals Department
P.O. Box 30192
Salt Lake City, Utah 84130-0192

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

WHAT IS HEALTH CARE FRAUD, WASTE, AND ABUSE?

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

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

Some examples of fraud, waste, and abuse are:

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

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

HOW CAN I REPORT FRAUD, WASTE, AND ABUSE?

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

Internal SelectHealth Compliance Department
- 801-442-4845 or our 24-hour hotline at 800-442-4845

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

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

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

Transportation Services

HOW DO I GET TO THE HOSPITAL IN AN EMERGENCY?

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

WHAT TYPE OF TRANSPORTATION IS COVERED UNDER MY MEDICAID?

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

UTA Flextran: Special bus services for Medicaid clients who live in Davis, Salt Lake, Utah, and Weber counties. You may use Flextran if:
- You are not physically or mentally able to use a regular bus
- You have filled out a UTA application form to let them know you have a disability that makes it so you cannot ride a regular bus. You can get the form by calling:
  - Salt Lake and Davis counties: 801-287-7433
  - Weber County: 888-882-7272
- You have been approved to use special bus services and have a Special Medical Transportation Card.

Modivcare (formerly LogisticCare): Non-emergency door-to-door service for medical appointments and urgent care. You may be eligible for Modivcare if:
- There is not a working vehicle in your household
- Your physical disabilities make it so you are not able to ride a UTA bus or Flextrans

Low-Cost Transportation Choices

Transportation Services

PUBLIC TRANSPORTATION RIDER TOOLS

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

UTA App Center
- Transit App: The Transit UTA App helps you find your best transit choices by showing you all of the nearby choices. You can check live transit schedules, plan your trip, and get step-by-step navigation for all kinds of urban transportation, including buses, Trax, and FrontRunner. Download it on your smartphone to quickly and simply see UTA routes, stops, and even vehicle locations.
### Amount, Duration, and Scope of Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Traditional</th>
<th>Non-Traditional</th>
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<tbody>
<tr>
<td><strong>Abortion</strong></td>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Call Member Services 801-442-3234 or toll-free at 855-442-3234 for Benefit Information</td>
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<td><strong>Ambulance</strong></td>
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</tr>
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<td>Not Covered by SelectHealth</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Birth Control &amp; Family Planning</strong></td>
<td>Covered</td>
<td>Not Covered by SelectHealth</td>
</tr>
<tr>
<td><strong>Chiropractic</strong></td>
<td>Not Covered by SelectHealth</td>
<td>Not Covered by SelectHealth</td>
</tr>
<tr>
<td><strong>Dental Benefits</strong></td>
<td>Not Covered by SelectHealth</td>
<td>Not Covered by SelectHealth</td>
</tr>
<tr>
<td>May be covered by Fee for Service Medicaid</td>
<td>May be covered by Fee for Service Medicaid for EPSDT Members and pregnant women. Call Medicaid 800-662-9651</td>
<td>May be covered by Fee for Service Medicaid for EPSDT Members and pregnant women. Call Medicaid 800-662-9651</td>
</tr>
<tr>
<td><strong>Doctor Visits</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>See copay chart on page 10</td>
<td>See copay chart on page 10</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Emergency and Urgent Care</strong></td>
<td>Covered</td>
<td>No copay</td>
</tr>
<tr>
<td>(Must use a network provider for urgent care)</td>
<td>No copay (Must use a network provider for urgent care)</td>
<td>(Must use a network provider for urgent care)</td>
</tr>
<tr>
<td><strong>Eye Exam</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>No copay</td>
<td>No copay</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Eyeglasses</strong></td>
<td>Covered</td>
<td>No copay (see page 16 for additional information)</td>
</tr>
<tr>
<td>Limited to one exam every 12 months</td>
<td>No copay (see page 16 for additional information)</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>No copay</td>
<td>Covered (See page 10 for copay Chart)</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td>Covered</td>
<td>Not Covered by SelectHealth</td>
</tr>
<tr>
<td>(See page 10 for copay Chart)</td>
<td>Not Covered by SelectHealth</td>
<td>Not Covered by SelectHealth</td>
</tr>
<tr>
<td><strong>Lab and X-Ray Services</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>No copay</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td>Covered</td>
<td>No copay</td>
</tr>
<tr>
<td><strong>Nursing Home</strong></td>
<td>Covered by SelectHealth for up to 30 days. Stays over 30 days covered by Medicaid Fee for Service</td>
<td>Covered by SelectHealth for up to 30 days. Stays over 30 days covered by Medicaid Fee for Service</td>
</tr>
<tr>
<td>Call Medicaid 800-608-9422</td>
<td>Call Medicaid 800-608-9422</td>
<td>Not Covered by SelectHealth</td>
</tr>
<tr>
<td><strong>Personal Care Services</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Requires prior Authorization</td>
<td>Requires prior Authorization</td>
<td>Requires prior Authorization</td>
</tr>
<tr>
<td><strong>Physical and Occupational Therapy</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>(See page 10 for copay chart)</td>
<td>Covered (See page 10 for copay chart)</td>
<td>Covered</td>
</tr>
<tr>
<td>(See page 16 for Details)</td>
<td>Covered (See page 16 for Details)</td>
<td>Covered (See page 16 for Details)</td>
</tr>
<tr>
<td><strong>Podiatry</strong></td>
<td>Covered (See page 10 for copay chart)</td>
<td>Covered (See page 10 for copay chart)</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Call Member Services 801-442-3234</td>
<td>Call Member Services 801-442-3234</td>
<td>Call Member Services 801-442-3234</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>(See page 10 for copay chart)</td>
<td>(See page 10 for copay chart)</td>
<td>(See page 10 for copay chart)</td>
</tr>
<tr>
<td><strong>Over-the-Counter Drugs</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>(See page 10 for copay chart)</td>
<td>(See page 10 for copay chart)</td>
<td>(See page 10 for copay chart)</td>
</tr>
<tr>
<td><strong>Speech and Hearing Services</strong></td>
<td>Covered (Limited)</td>
<td>Not Covered by SelectHealth</td>
</tr>
<tr>
<td>No copay</td>
<td>No copay</td>
<td>Not Covered by SelectHealth</td>
</tr>
<tr>
<td><strong>Non-Emergent Medical Transportation Services</strong></td>
<td>Covered by Fee for Service Call Medicaid 800-662-9651</td>
<td>Covered by Fee for Service Call Medicaid 800-662-9651</td>
</tr>
</tbody>
</table>
| **Can I Get a Service that is Not on This List?**

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

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

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

**What If I Change Health Plans?**

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

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**Notice of Privacy Practices**

**How do we protect your Privacy?**

- We strive to protect the privacy of your Personal Health Information (PHI) in the following ways:
  - We have strict policies and rules to protect PHI
  - We only use or give out your PHI with your consent when allowed by law
  - We protect PHI by limiting access to this information to those who need it to do given tasks and through physical safeguards

You have the right to look at your PHI.

**How do I find out more about Privacy Practices?**

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

The complete notice of privacy practices is available at intermountainhealthcare.org/websiteinformation/privacy-notices/patients/. You can also ask for a hard copy of this information by contacting Member Services at 801-442-3234 or toll-free at 855-442-3234.
SelectHealth obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth Advantage: 855-442-9900 (TTY: 711) / SelectHealth: 800-538-5038.