Amerigroup RealSolutions® in healthcare

Enrollee Handbook

Planning for Healthy Babies®

800-600-4441 (TTY 711)
myamerigroup.com/ga

Amerigroup Community Care

Planning for Healthy Babies®

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myamerigroup.com

This Planning for Healthy Babies® handbook has important information about your Amerigroup Community Care benefits. Call Member Services toll free at **800-600-4441 (TTY 711)** for a translation.

Dear Planning for Healthy Babies® Enrollee:

Welcome to Amerigroup! As an enrollee in the Planning for Healthy Babies® program, you will get an Amerigroup enrollee ID card in a few days. Your ID card will tell you when your Amerigroup benefits start. The Planning for Healthy Babies® program offers three levels of service:

- Family Planning only (FP)
- Interpregnancy Care (IPC)
- Resource Mother Outreach (RMO)

For enrollees in IPC, the name of your primary care provider (PCP) is on your ID card. Please check the PCP's name on your ID card. If it's not right, please call us at **800-600-4441 (TTY 711)**.

Your enrollee handbook

Your enrollee handbook tells you how we work and how to get healthcare and stay healthy. You can go to **myamerigroup.com/ga** to view the enrollee handbook at any time. You can also ask for the latest handbook by calling Member Services toll free at **800-600-4441 (TTY 711)**.

Amerigroup website

There are lots of helpful resources on our website. Visit **myamerigroup.com/ga** to:

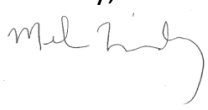
- Choose or find a PCP that works with our plan (IPC enrollees).
- Choose or find a family planning provider.
- Change your PCP (IPC).
- Ask for a new ID card if you lost yours.
- Update your address or phone number.
- Find medications covered by your plan.
- View our provider directory.

24-hour Nurse HelpLine

You can talk to a nurse on 24-hour Nurse HelpLine at **800-600-4441 (TTY 711)** 24 hours a day, seven days a week. Our nurses can answer healthcare questions you may have. They can also help IPC or RMO enrollees access RMO services.

Thank you for choosing us to help you get quality healthcare benefits.

Sincerely,



Melvin W. Lindsey
Plan President
Amerigroup Community Care

Amerigroup Community Care
Enrollee Handbook for the Planning for Healthy Babies® Program
740 W. Peachtree Street
Atlanta, GA 30308
800-600-4441 (TTY 711) • myamerigroup.com/ga

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WELCOME TO AMERIGROUP COMMUNITY CARE

About your new health plan

Amerigroup Community Care is a Georgia care management organization (CMO). We provide healthcare coverage to Planning for Healthy Babies® enrollees. The Georgia Department of Community Health contracted with us to manage their Medicaid Planning for Healthy Babies® (P4HB) program. The P4HB program has three levels of service:

- **Family Planning:** Provides family planning and supplies like contraception, limited prescription drugs, patient education, counseling, and referral services.
- **Interpregnancy Care:** Offers family planning and related services plus interpregnancy care services. You'll get limited primary care services, management and treatment of chronic diseases, substance abuse treatment, case management, limited dental care, non-family planning prescription drugs, nonemergency medical transportation, and access to Resource Mother Outreach services.
- **Resource Mother Outreach:** Offers a range of support services like supportive counseling, short-term case management, and help with finding resources like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

HOW TO GET HELP

The Amerigroup Member Services department

If you need help understanding your handbook or have questions about your health plan, call Member Services at **800-600-4441 (TTY 711)**. You can call us Monday through Friday, 7 a.m. to 7 p.m. Eastern time, except for state holidays. Member Services can help explain many things, including:

- This enrollee handbook
- Your Amerigroup benefits
- Getting healthcare
- Enrollee ID cards
- Doctor appointments
- Resource Mother services
- Transportation
- Special needs
- Health education classes
- Healthy living
- Changing your PCP
- Out-of-town care
- Finding a pharmacy in your plan
- Your primary care provider
- Your family planning provider
- IPC- or FP-related urgent care services
- IPC- or FP-related emergency care services

The services you can get depend on the service level you're enrolled in. P4HB service level-specific information can be found as follows:

- Family Planning information begins on page 4
- Interpregnancy Care information begins on page 12
- Resource Mother Outreach information begins on page 24

You can also find out what services you can get by calling Member Services at **800-600-4441 (TTY 711)**. Please also call Member Services if you:

- Move to a new home so that you can tell us your new address and phone number. You should also call Georgia Gateway at **877-423-4746** or your local county Division of Family and Children Services

(DFCS) office to let them know. You can visit dfcs.georgia.gov/locations to find out which location is closest to you.

- Become pregnant. You should also call your local county DFCS office to let them know.
- Need help in another language. For enrollees who do not speak English, we offer oral interpretation services for all languages free of charge. We also offer translation services by phone for doctor visits. Please call Member Services at **800-600-4441 (TTY 711)** at least 24 hours before your visit.
- If you have any problems with your care. We want you to be happy with your services through the doctors and hospitals who work with our plan.

For enrollees who are deaf or hard of hearing, please call TTY **711** for help. These services are free of charge.

Your Amerigroup enrollee handbook

This handbook will help you understand your Amerigroup health plan. If you have questions or need help understanding or reading it, call Member Services at **800-600-4441 (TTY 711)**. The other side of this handbook is in Spanish. We also have this enrollee handbook in:

- A large print version.
- An audio-taped version.
- A Braille version.

Amerigroup 24-hour Nurse HelpLine

You can call 24-hour Nurse HelpLine 24 hours a day, seven days a week, at **800-600-4441 (TTY 711)** if you need advice on:

- How soon you need care when you are sick.
- What kind of healthcare you need.
- What to do to take care of yourself until you see your family planning provider or IPC primary care provider.
- How you can get the care you need.

Other important phone numbers and websites

- If you have questions about enrollment and eligibility, call Planning for Healthy Babies® at **877-427-3224** or your Division of Family and Children Services (DFCS) caseworker. You can visit dfcs.georgia.gov/locations to find out which location is closest to you.
- If you need to tell us of a change of address, call your local county DFCS office.
- If you have questions about your medicines: Call Pharmacy Member Services at **833-205-6006**.
- Visit the Planning for Healthy Babies® website at medicaid.georgia.gov/planning-healthy-babies to learn more about the program.

Your Amerigroup ID card

Amerigroup P4HB enrollees get an enrollee ID card. If you do not have your ID card yet, you will get it soon. Please keep it with you at all times. You do not need to show your ID card for emergency care. Please call Member Services at **800-600-4441 (TTY 711)** if you did not receive your ID card.

Each ID card in the Planning for Healthy Babies® (P4HB) program is color-coded based on the service level you're in. This will help you identify the services you get:

- Family Planning (FP) only enrollees have ID cards with a pink P4HB logo
- Interpregnancy Care (IPC) enrollees have ID cards with a purple P4HB logo
- Resource Mother Outreach (RMO) enrollees have ID cards with a yellow P4HB logo

If your ID card is lost or stolen, call Member Services at **800-600-4441 (TTY 711)** right away. We will send you a new one.

Quality Management

Amerigroup has a Quality Management program that checks the quality of care and services given to our enrollees. We want to know what you do and do not like. Your ideas will help us make our plan better.

You can call Member Services at **800-600-4441 (TTY 711)** to ask for information on Quality Management. You can also get information on all of our network hospitals at hospitalcompare.hhs.gov. This website will help you compare the care these hospitals offer.

WHAT MEDICALLY NECESSARY MEANS IN THE P4HB PROGRAM

Medically necessary health services are those that:

a) Are needed to fix or improve a defect, a physical or mental illness, or a condition.
b) Are appropriate and consistent with the diagnosis, and not getting these services could have a bad effect on your medical condition.
c) Meet standards of acceptable medical practice.
d) Are provided in a safe, appropriate, and cost-effective place, given the type of illness and how severe the symptoms are.
e) Are not provided just because it's easiest for the enrollee or provider.
f) Are the most effective and cost-efficient choice for treatment, service, and setting.

Our medical directors decide if care is medically necessary based on the definition above. Amerigroup only covers medically necessary benefits that are part of your service level. Some medically necessary services needed for P4HB enrollees are outside of the Amerigroup P4HB benefits package.

Be sure to follow the treatment plan prescribed by your family planning provider or IPC primary care provider. If you have a family planning related illness or a condition that caused you to have a very low birth weight baby, this treatment plan can help make sure you get well faster. If you don't, it could take you longer to get well or your condition could get worse. If after a medical necessity review you ask for health services that are not helping you get better, those services could end.

FOR ENROLLEES RECEIVING FAMILY PLANNING SERVICES ONLY

Eligibility and enrollment for Family Planning services

To receive Planning for Healthy Babies® Family Planning services, you must:

- Be an uninsured woman 18 through 44 years of age with a Modified Adjusted Gross Income, or MAGI (household income without tax deductions), equal to or less than 211 percent of the Federal Poverty Level (FPL).
- Not otherwise be eligible for Medicaid/CHIP.
- Women who are losing Medicaid pregnancy coverage 6-12 months after they deliver their baby.

The Department of Community Health sent you a letter to let you know you're eligible for Family Planning (FP) services. If you want to join a different health plan, you have 90 days from the date of your enrollment to switch.

Your Family Planning Amerigroup enrollee ID card

Family Planning enrollees receive an Amerigroup enrollee ID card with a pink P4HB logo.
This ID card tells doctors and hospitals:

- You are an enrollee of Amerigroup.
- Amerigroup will pay for the medically needed benefits covered under the Family Planning service level.

Your ID card has important phone numbers you need, such as:

- Our Member Services department
- 24-hour Nurse HelpLine
- Our Pharmacy Member Services department

Choosing a family planning provider

As an Amerigroup enrollee enrolled to receive P4HB Family Planning (FP) services, you can choose a family planning provider (FPP). An FPP is a doctor, nurse, or other healthcare provider who provides or prescribes family planning services.

If you have not chosen an FPP, you can use our online provider search tool at **myamerigroup.com/ga**. To start searching, choose **Find a Doctor**. We can also help you choose a new FPP. Call Member Services toll free at **800-600-4441 (TTY 711)** for help.

If you are already seeing a doctor and you want to keep seeing this doctor, call and tell us you want to keep that doctor as your FPP.

Your FPP will provide you with:

- Education and counseling necessary to make informed choices and to understand contraceptive methods.
- Initial and annual complete physical exams.
- Follow-up, brief, and comprehensive visits.
- Pregnancy testing.
- Contraceptive supplies and follow-up care.
- Diagnosis and treatment of sexually transmitted diseases. Treatment for hepatitis and HIV/AIDS is not covered under the P4HB program.

Asking for a second opinion

You have the right to ask for a second opinion for any family planning service covered under the P4HB program. You can get a second opinion from any family planning provider at no cost to you.

Once approved, your provider will:

- Let you know the date and time of the visit
- Send copies of all related records to the doctor who will give the second opinion
- Let you and Amerigroup know the outcome of the second opinion

If your FPP's office moves, closes, or stops working with Amerigroup

Your FPP's office may move, close, or stop working with Amerigroup. If this happens, you can call Member Services at **800-600-4441 (TTY 711)**. We will help you find a new FPP.

If you want to change your family planning provider

If you want to change your FPP, we can help you find a new one:

- Call Member Services at **800-600-4441 (TTY 711)**.
- Visit us online at **myamerigroup.com/ga**. Select **Find a Doctor**.

If your FPP asks for you to be changed to a new FPP

Your FPP may ask for you to be changed to a new FPP if:

- You do not follow his or her medical advice over and over again.
- Your FPP agrees that a change is best for you.
- Your FPP does not have the right experience to treat you.

How to make a Family Planning appointment

To set up a visit with your FPP, call their office. Tell the staff if the visit is for:

- An annual family planning visit.
- A new method of birth control.
- A change to the birth control method you use now.
- Not feeling well for reasons related to family planning.

This will let the FPP's office know how soon you need to be seen. It may also help you be seen faster.

You should be told how long the waiting time will be when you get to your appointment. You can reschedule your appointment if you can't wait. Your wait time at the FPP's office should not be more than the following:

Type of appointment	Wait time
Scheduled appointment	No more than 30 minutes
Unscheduled or walk-in appointment	No more than 45 minutes

If you call after hours and leave a message, your FPP will call you back. Your wait time for a response should not be more than the following:

Type of call	Wait time
Urgent call	No more than 20 minutes
Other call	No more than one hour

Wait times for appointments

We want you to get care when you need it. When you make an appointment, your FPP should give you an appointment within the time frames below:

Type of appointment	Time frame
FPP (routine family planning visit)	No more than 14 calendar days
Urgent care providers	No more than 24 hours
Emergency providers	Right away, without prior authorization (24 hours a day, 7 days a week)

What to bring when you go for your Family Planning visit

When you go to your FPP visit, bring:

- Your enrollee ID card with the P4HB logo
- A list of the medicines you take now
- A list of questions for your FPP. You can ask about the side effects of your birth control method.

How to cancel your FPP visit

If you set up a visit with your FPP and then can't go, call the FPP's office. Tell the office to cancel the visit. You can set up a new visit when you call. Try to call at least 24 hours before the visit. This will let someone else see the FPP at that time.

FAMILY PLANNING HEALTHCARE BENEFITS

Covered services

Your FPP will give you the care you need or refer you to a provider who can give you the care you need. For some Amerigroup P4HB benefits, enrollees need prior authorization from us such as an inpatient admission for a family planning related problem.

The list below shows the P4HB healthcare services and benefits you can get from Amerigroup. Family Planning enrollees will receive the following benefits:

- Family planning initial or annual exams
- Follow-up, brief, and comprehensive family planning visits
- Contraceptive services and supplies
- Family planning education and counseling
- Counseling and referrals to:
  - Social services
  - Primary healthcare providers
- Family planning lab tests:
  - Pregnancy tests
  - Pap smear and pelvic exam:
    - A colposcopy (and procedures done with/during a colposcopy) or a repeat Pap smear performed as a follow up to an abnormal Pap smear which was done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are covered as a service related to the P4HB program.
    - Colposcopies, which are generally provided in an ambulatory surgery facility, a special procedure room, an emergency room, an urgent care center or a hospital, are not covered as services related to the program.
- Screening for sexually transmitted infections (STIs), including HIV/AIDS and hepatitis
- Treatment and follow-up for STIs, except HIV/AIDS and hepatitis:
  - Antibiotic treatment for STIs when the infections are identified during a routine family planning visit
  - A follow-up visit for the treatment/drugs may be covered
  - Subsequent follow-up visits to rescreen for STIs based on the Centers for Disease Control and Prevention (CDC) guidelines
- Emergency and urgent care services related to the P4HB program
- Drugs for the treatment of vaginal and genital skin infections/disorders and urinary tract infections when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit. A follow-up visit for the treatment/drugs may be covered.
- Treatments and services related to the P4HB program for major complications such as:
  - Treatment of a perforated uterus (a hole in the uterus) due to an intrauterine device insertion
  - Treatment of severe menstrual bleeding caused by a Depo-Provera injection
  - Treatment of complications from a sterilization (tubal ligation) procedure

- Tubal ligation (sterilization)
  - Treatment and follow-up of an STI diagnosed at the time of sterilization
- Family Planning pharmacy visits for eligible medications
- Multivitamins with folic acid or folic acid vitamin
- Select immunizations for enrollees age nineteen (19) and twenty (20) including: hepatitis B; tetanus-diphtheria (Td); and combined tetanus, diphtheria, pertussis vaccinations as needed
- Enrollees age 18 will receive vaccines at no cost under the Vaccines for Children (VFC) program
- Urgent care and emergency care services related to family planning

Amerigroup will only pay for services that are approved through the Planning for Healthy Babies® program and which we have approved. If you have a question or are not sure if we offer a certain benefit, you can call Member Services for help at **800-600-4441 (TTY 711)**.

SERVICES THAT DO NOT NEED A REFERRAL

For Family Planning enrollees, it is always best to ask your FPP for a referral for any Amerigroup service. You can get the following services without a referral from your FPP:

- Family planning-related emergency care services
- Care and annual exams from an Amerigroup OB/GYN or other family planning provider. You can even choose a FPP who is not enrolled with our plan
- Screening or testing for sexually transmitted infections during your family planning visits

TYPES OF HEALTHCARE

Routine care services related to family planning

As an enrollee receiving only Family Planning (FP) services, you should call your family planning provider (FPP) to make an appointment when medical care related to family planning is needed.

Urgent care services related to family planning

Some injuries and illnesses aren't emergencies but can turn into emergencies if they aren't treated within 24 hours. Some examples are:

- Severe uterine bleeding not related to your monthly period
- Pelvic pain after an IUD insertion

Urgent care services covered under the FP service level include treatments for injuries, illnesses or other conditions that aren't life-threatening and are related to family planning.

For urgent care services related to family planning, you should call your FPP. Your FPP will tell you what to do. Your FPP may tell you to go to his or her office right away. You may be told to go to a different office to get care fast. You should follow your FPP's instructions. In some cases, your FPP may tell you

to go to the emergency room at a hospital for care. See the next section about emergency care for more information.

You can also call 24-hour Nurse HelpLine for advice about urgent care. You should be able to see your provider within 24 hours for an urgent care appointment.

Urgent care services related to family planning, such as injury or illness, do not need prior authorizations. These services must be related to your family planning benefits. Services not related to your family planning benefits will not be covered.

Emergency care services related to family planning

Covered emergency care services must be related to family planning. This includes:

- Covered Family Planning inpatient and outpatient services related to the program
- Services related to Family Planning provided by a qualified provider
- Services related to Family Planning that are needed to test or stabilize an emergency medical condition

What is an emergency related to family planning?

An emergency related to family planning means the emergency must be covered under the Family Planning service level. It must be a medical problem where not seeing a doctor to get care right away could result in death or very serious harm to your body. The problem is so severe that someone with an average knowledge of health and medicine can tell that the problem:

- May be life-threatening or cause serious damage to your body
- May cause serious harm to a bodily function, organ, or body part

Here are some examples of problems that may be considered emergencies related to family planning:

- Severe menstrual bleeding from a Depo-Provera injection
- Treatment of complications during a sterilization procedure
- Very bad bleeding that does not stop
- Perforated uterus (a hole in the uterus)

Please note that as an enrollee of the Planning for Healthy Babies® program, your emergency care benefits are limited to severe complications or conditions related to the program. Enrollees with emergency medical conditions related to Family Planning conditions don't have to pay for follow-up screenings and treatments needed to diagnose specific conditions or to stabilize the enrollee. The P4HB program will not cover emergency room services that aren't related to family planning.

What are family planning related post-stabilization services?

Post-stabilization services related to family planning are covered services. You receive these services after emergency medical care services related to family planning have been provided to help keep your condition stable. You should call your FPP within 24 hours after you visit the emergency room for a

family planning related service. If you cannot call, have someone else call for you. Your FPP will give or arrange any follow-up care you need.

How to get family planning related healthcare when your provider's office is closed

Except in the case of an emergency or when you need care that does not need a referral, you should always call your family planning provider (FPP) before you get medical care services related to the program.

If you call your FPP's office when it is closed, leave a message with your name and a phone number where you can be reached. Someone should call you back soon to tell you what to do. You may also call the 24-hour Nurse HelpLine 24 hours a day, seven days a week for help at **800-600-4441 (TTY 711)**.

If you think you need emergency care (see previous section) related to family planning, call 911 or go to the nearest emergency room right away.

How to get family planning healthcare when you are out of town

If you need family planning related emergency care services when you are out of town, go to the nearest emergency room or call 911. If you need family planning related urgent care services, call your family planning provider (FPP). If your FPP's office is closed, leave a phone number where you can be reached. Your FPP or someone else should call you back. Follow the doctor's instructions. You may be told to get care where you are if you need it very quickly.

You can also call 24-hour Nurse HelpLine for help.

If you are outside of the U.S. and get non-emergency healthcare services, they will not be covered by Amerigroup or the Family Planning program.

Medicines for family planning related services

Amerigroup has a list of commonly prescribed drugs your FPP can choose if it relates to your family planning benefits. This list is called a preferred drug list (PDL). It is part of our formulary. There is no copay for medications covered under the Family Planning benefit.

The Family Planning program covered medicines may include:

- Contraceptives and contraceptive supplies
- Drugs for treatment of sexually transmitted infections, except HIV/AIDS and hepatitis
- Multivitamins with folic acid or folic acid vitamin

All FPPs who work with our plan have access to this drug list. Your FPP should use this list when he or she writes a prescription.

Certain medicines on the PDL may need prior authorization. It takes about 24 hours to complete a prior authorization review once we receive it from your doctor. Any medicines not related to your family

planning benefits will not be covered and a prior authorization is not allowed. Maintenance medicines for treating any chronic diseases are not covered. You can view the PDL for your plan at **myamerigroup.com/ga** under *Pharmacy & Prescription Drugs* to see the list of medicines your PCP can choose from. If you have any questions about your medicine, call Pharmacy Member Services at **833-205-6006**. You can also call Member Services at **800-600-4441 (TTY 711)** to ask for a copy of the PDL for drugs covered under the Family Planning program.

You can get prescriptions filled at pharmacies that work with our plan. You can also get a directory list of pharmacies at **myamerigroup.com/ga**. Select **Find a Doctor** and look for the *Pharmacy* link.

If you do not know if a pharmacy works with our plan, ask the pharmacist. You can also call Pharmacy Member Services at **833-205-6006 (TTY 711)** for help.

In order to get a prescription filled, you will need to take the written prescription from your FPP to the pharmacy. Or your FPP can call in the prescription to the pharmacy. You will need to show your Amerigroup ID card with the P4HB logo to the pharmacy.

It is good to use the same pharmacy each time. This way your pharmacist will know about problems that may occur when you are taking more than one prescription. If you use a new pharmacy, you should tell the pharmacist about all of the prescriptions and over-the-counter (OTC) medicines you are taking. You should always show your Amerigroup enrollee ID card with the P4HB logo when you have a prescription filled.

Emergency prescription medicine supply

Enrollees may ask for a three-day supply of their prescription from the pharmacy while waiting for approval. This is for certain medicines that need prior authorization. This will give you time to call your PCP and ask for a medicine that's on our formulary. This does not apply to medicines not related to your family planning benefits.

FOR ENROLLEES IN INTERPREGNANCY CARE

Eligibility for Interpregnancy Care

To receive Planning for Healthy Babies® Interpregnancy Care (IPC) services, you must meet these requirements:

- You must be an uninsured woman between the ages of 18 through 44.
- You must have a Modified Adjusted Gross Income equal to or less than 211 percent of the Federal Poverty Level (FPL).
- You must have delivered a very low birth weight (VLBW) baby (less than 1,500 grams or 3 pounds, 5 ounces).
- You must not otherwise be eligible for Medicaid or CHIP.

Enrollment in Interpregnancy Care

The Department of Community Health (DCH) sent you a letter to let you know you're eligible for Interpregnancy Care services. You have 90 days after your enrollment to switch health plans if you'd like. Once you choose or are assigned to Amerigroup, you have 30 calendar days to pick a primary care provider (PCP) and a family planning provider (FPP). If you don't pick your providers, you will be automatically assigned to them.

Your Interpregnancy Care Amerigroup enrollee ID card

Interpregnancy Care program enrollees receive an Amerigroup enrollee ID card that has a purple P4HB logo. This ID card tells doctors and hospitals:

- You are an enrollee of Amerigroup.
- Who your Amerigroup provider is.
- Amerigroup will pay for the medically needed benefits listed in the Amerigroup Healthcare Benefits section for the IPC program.

Your ID card has your PCP's name and number and the date you became an Amerigroup enrollee. Your ID card also has important phone numbers you need, such as:

- Our Member Services department
- 24-hour Nurse HelpLine
- Our Pharmacy Member Services department

Choosing a primary care provider

As an Amerigroup Interpregnancy Care (IPC)enrollee, you have a primary care provider (PCP). Your PCP will:

- Get to know you and your health history.
- Help you get good healthcare.
- Give you the basic health services you need.

PCPs can be any of the following as long as they work with our plan:

- General or family practitioners
- Internists
- Certified nurse practitioners specializing in family practice or women's health
- Public health departments, federally qualified health centers or rural health clinics

You can choose a new PCP if you don't want the one we chose for you. Find a new PCP in our online provider directory at **myamerigroup.com/ga**. Or call Member Services toll free at **800-600-4441 (TTY 711)** to ask for a hard copy. Member Services can also help you find a PCP if you'd like.

Already have a PCP you want to keep seeing? Look in our directory to find out if that provider works with our plan. Then call us and ask to keep that provider as your PCP.

If you call to change your PCP, the change will be made on the next business day. You'll get a new enrollee ID card in the mail within seven calendar days. Your new card will have the name of your new provider.

Choosing a family planning provider

As an Amerigroup Interpregnancy Care (IPC) enrollee, you can also choose a family planning provider (FPP) in addition to your PCP. An FPP is a doctor, nurse, or other healthcare provider who provides or prescribes family planning services. Your FPP could be one of these:

- General or family practitioner
- OB/GYN
- Internist
- Certified nurse practitioner specializing in family practice or women's health
- Public health department, federally qualified health center, or rural health clinic providing family planning services

Your FPP will provide you with:

- Education and counseling necessary to make informed choices and to understand contraceptive methods
- Initial and annual complete physical exams
- Follow-up, brief, and comprehensive family planning visits
- Pregnancy testing
- Contraceptive supplies and follow-up care
- Diagnosis and treatment of sexually transmitted infections

Choose your FPP by going to **myamerigroup.com/ga** and selecting **Find a Doctor**. Or call Member Services toll free at **800-600-4441 (TTY 711)** for help.

Choosing an OB/GYN as your family planning provider

You can see an obstetrician/gynecologist (OB/GYN) for family planning health needs. These services include:

- Annual family planning exam including a Pap test and follow-up exams
- Family planning (birth control pills, IUDs, etc.)

You don't need a referral to see your OB/GYN for family planning-related issues. If you don't want to go to an OB/GYN, your PCP may be able to treat you for your family planning health needs. Ask your provider if they can give you family planning care. If not, you will need to see a Family Planning Provider (FPP). Remember, you can choose a FPP who is not enrolled in our plan.

You can find a list of OB/GYNs who work with our plan or other FPPs in our provider directory at **myamerigroup.com/ga**. Select **Find a Doctor**. If you need help choosing an OB/GYN, call Member Services at **800-600-4441 (TTY 711)**.

Asking for a second opinion

You have the right to ask for a second opinion for any covered family planning or PCP service under your Interpregnancy Care benefit plan. You can get a second opinion from a network provider. You can also ask a non-network provider if there is not a provider you can go to in our network. Ask your PCP to ask for you to have a second opinion. This is at no cost to you.

Once approved, your FPP will:

- Let you know the date and time of the visit.
- Send copies of all related records to the provider who will give the second opinion.
- Let you and Amerigroup know the outcome of the second opinion.

If your family planning provider's office moves or closes

If this happens, we will call or send you a letter to tell you. In some cases, you may be able to keep seeing this provider for care until you choose a new one. Please call Member Services for more information.

If your provider asks for you to be changed to a new provider

Your provider may do this if:

- You do not follow his or her medical advice over and over again.
- Your provider agrees that a change is best for you.
- Your provider does not have the right experience to treat you.

How to get healthcare when your provider's office is closed

Except in the case of an emergency or when you need care that does not need a referral, you should always call your provider before you get medical care. Help from your provider is available 24 hours a day.

If you call your provider's office when it is closed, leave a message with your name and a phone number where you can be reached. Someone should call you back soon to tell you what to do. You may also call the 24-hour Nurse HelpLine 24 hours a day, seven days a week for help at **800-600-4441 (TTY 711)**.

If you think you need emergency care (see previous section), call 911 or go to the nearest emergency room right away.

How to get care when you cannot leave your home

We will find a way to help take care of you. If you cannot leave your home, call Member Services right away at **800-600-4441 (TTY 711)**. We will put you in touch with a case manager who will help you get the medical care you need.

How to make an appointment

To set up a visit with your PCP or FPP for family planning related services, call the provider's office. The phone number is on your ID card with the P4HB logo. Tell the provider's office if you do not feel well. This will let the provider's office know how soon you need to be seen. It may also help you be seen faster.

If you need help making an appointment, call Member Services at **800-600-4441 (TTY 711)**. When you call, let us know if you need a checkup or a follow-up visit.

You should be told what the waiting time is when you get to your appointment. You can reschedule your appointment if you can't wait. Your wait time at the provider's office should not be more than the following:

Type of appointment	Wait time
Scheduled appointment	No more than 30 minutes
Unscheduled or walk-in appointment	No more than 45 minutes

If you call after hours and leave a message, your provider will call you back. Your wait time for a response should not be more than the following:

Type of call	Wait time
Urgent call	No more than 20 minutes
Other call	No more than one hour

Wait times for appointments

We want you to get family planning services when you need it. When you make an appointment, your provider should give you an appointment within the time frames below:

Type of appointment	Time frame
Dental provider	No more than 21 calendar days
Urgent dental care	No more than 48 hours
PCP (routine visit)	No more than 14 calendar days
PCP (adult sick visit)	No more than 24 hours
Behavioral health providers	No more than 14 calendar days
Urgent care providers	No more than 24 hours
Emergency providers	Right away, without prior authorization (24 hours a day, 7 days a week)

What to bring when you go for your provider visit

When you go to your provider visit, bring:

- Your enrollee ID card with the P4HB logo.
- A list of the medicines you take now.
- A list of questions for your provider, if you have any.

How to cancel a visit

If you set up a visit with your provider and then can't go, call the provider's office. Tell the office to cancel the visit. You can set up a new visit when you call. Try to call at least 24 hours before the visit. This will let someone else see the provider at that time.

If you want us to cancel the visit for you, call Member Services at **800-600-4441 (TTY 711)**. If you do not call to cancel your visits repeatedly, your provider may ask for you to be changed to a new provider.

How to get to the provider or to the hospital

As an Interpregnancy Care enrollee, you have access to non-emergency transportation. If you need a ride for non-emergency medical care, call Member Services at **800-600-4441 (TTY 711)**. Be sure to call at least three days before the visit. Tell them the time of your appointment and where to pick you up. The vendor for your region will call you back to give you a pickup time.

You can also call the Georgia NEMT (Non-Emergency Medical Transportation) service directly. Call the vendor found next to the county where you live below. Be sure to call at least three days before a scheduled visit. You can call Monday through Friday, 7 a.m. to 6 p.m.

Region	Broker/ Phone Number	Counties Served
North	**Southeastrans** **Toll free 1-866-388-9844** **Local**	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe,

Region	Broker/ Phone Number	Counties Served
	678-510-4555	Oconee, Paulding, Pickens, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White, Whitfield
Atlanta	**Southeastrans 404-209-4000**	Fulton, DeKalb, Gwinnett
Central	**Modivcare** **Toll free 1-888-224-7981**	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox, Wilkinson
East	**Modivcare** **Toll free 1-888-224-7988**	Appling, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne, Wilkes
Southwest	**Modivcare** **Toll free 1-888-224-7985**	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster, Worth

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

Modivcare Customer Service Center	Reservations: 1-866-913-4506 Ride Assist: 1-866-913-4508
Routine reservation days and hours of operation:	☑ Open Monday-Friday from 8 a.m. to 5 p.m. ☑ Closed Saturday and Sunday ☑ Closed on national holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas)
Urgent reservation days and hours of operation:	☑ Transportation assistance for urgent and same-day reservations are available 24 hours a day, 7 days a week, 365 days a year
Ride assistance and hospital discharge days and hours of operation:	☑ Transportation assistance for trip recovery and after-hour discharges are available 24 hours a day, 7 days a week, 365 days a year

INTERPREGNANCY CARE HEALTHCARE BENEFITS

Covered services

Your provider will give you the care you need or refer you to a provider who can give you the care you need as covered in the program. Your provider will refer you for other covered services you may need. For some Amerigroup P4HB benefits, enrollees need prior authorization from Amerigroup such as an inpatient admission for a family planning related problem.

This list shows the P4HB healthcare services and benefits you can get from Amerigroup.
Interpregnancy Care enrollees receive the following benefits:

- Family planning initial and annual exams
- Follow-up, brief, and comprehensive family planning visits
- Contraceptive services and supplies
- Patient education and counseling
- Counseling and referrals to:
  - Social services
- Family planning lab tests:
  - Pregnancy tests
- Pap smear and pelvic exam:
  - A colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear, which is done as part of a routine/periodic family planning visit
  - Only those colposcopies which can generally be performed in the office or clinic setting are covered as services related to the program. Colposcopies, which are generally provided in an ambulatory surgery facility, a special procedure room, an emergency room, an urgent care center or a hospital, are not covered as services related to the program.
- Screening for sexually transmitted infections (STIs), including HIV/AIDs and hepatitis
- Treatment and follow-up for sexually transmitted infections (STIs), except HIV/AIDS and hepatitis:
  - Antibiotic treatment for STIs when the infections are identified during a routine family planning visit
  - A follow-up visit for the treatment/drugs may be covered
  - Subsequent follow-up visits to rescreen for STIs based on the Centers for Disease Control and Prevention guidelines
- Drugs for the treatment of vaginal and genital skin infections/disorders, and urinary tract infections when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit. A follow-up visit for the treatment/drugs may be covered.
- Treatment of major complications such as:
  - Treatment of a perforated uterus due to an intrauterine device insertion
  - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage
  - Treatment of surgical or anesthesia-related complications during a sterilization procedure

- Tubal ligation (sterilization)
  - Treatment and follow-up of an STI diagnosed at the time of sterilization
- Multivitamins with folic acid or a folic acid vitamin
- Management and treatment of chronic diseases
- Prescription drugs (non-family planning) for treating chronic diseases
- Select immunizations for enrollees age nineteen (19) and twenty (20) including: hepatitis B; tetanus-diphtheria (Td); and combined tetanus, diphtheria, pertussis vaccinations as needed
- Enrollees age 18 will receive vaccines at no cost under the Vaccines for Children (VFC) program
- Up to five office or outpatient visits through primary care services
- Limited dental services
- Substance abuse treatment, including detoxification and intensive outpatient rehabilitation
- Case management and Resource Mother Outreach services
- Non-emergency transportation
- Urgent care and emergency care services related to the Family Planning program

Amerigroup will only pay for services which are approved through the Planning for Healthy Babies® Interpregnancy Care and Family Planning programs and which we have approved. If you have a question or are not sure if we offer a certain benefit, you can call Member Services for help at **800-600-4441 (TTY 711)**.

How to get healthcare when you are out of town

If you need emergency care services related to the Family Planning program when you are out of town, go to the nearest emergency room or call 911. If you need urgent care services related to the program, call your provider. (See the section Urgent care services related to the program for more information.)

If your provider's office is closed, leave a phone number where you can be reached. Your provider or someone else should call you back. Follow the doctor's instructions. You may be told to get care where you are if you need it very quickly. You can also call 24-hour Nurse HelpLine for help. If you need routine care like a checkup or prescription refill when you are out of town, call your provider or 24-hour Nurse HelpLine at **800-600-4441 (TTY 711)**.

If you are outside of the U.S. and get non-emergency healthcare services, they will not be covered by Amerigroup or the Planning for Healthy Babies® program.

SPECIAL KINDS OF HEALTHCARE

Dental care

Interpregnancy Care enrollees do not need a referral from their providers for dental care benefits. These benefits include:

- Exams and cleanings every six months
- X-rays every 12 months

- Fillings and simple extractions
- Emergency services

To find a dentist who works with our plan in your area:

- Call DentaQuest toll free at **800-895-2218 (TTY 711)**
- Visit dentaquest.com and select:
    1. Members
    2. Georgia
    3. Find a dentist

To access information on DentaQuest's website, follow the directions below:

- Go to dentaquest.com
- Select the Members tab

Call Amerigroup Member Services at **800-600-4441** if you:

- Need help making a dental appointment.
- Need help getting to your dental appointment.

Recommendations for preventive dental care

Everybody is different, and every mouth is different. It is important that you talk with your dentist to figure out what is best for you. The best plan is to follow these steps:

- Find a dentist that you like and trust.
- See the dentist every six months.
- Stay with the same dental provider so that he or she can look after your oral health.

SERVICES THAT DO NOT NEED A REFERRAL

It is always best to ask your provider for a referral for any Amerigroup service.

But you can get the following services without a referral from your provider:

- Emergency care services related to the P4HB program
- Dental care from an Amerigroup dentist
- Screening or testing for sexually transmitted infections, including HIV, from an Amerigroup doctor

Case management and Resource Mother Outreach services

We have case managers and Resource Mothers to help you understand any special conditions that may have led to having a very low birth weight baby (VLBW), meaning your baby weighed 3.5 pounds or less at birth. Your case manager and Resource Mother will help you learn about your special condition, but it is also important for you to learn to care for yourself.

Your case manager and Resource Mother can help with:

- Making and reviewing a plan of care.
- Education on birth spacing and the use of effective contraceptive methods.
- Referrals and assistance to access providers.

- Coordination of care to providers, medical services, and support services.
- Resource mother outreach.

A nurse from our team will call you to:

- Educate you about the services we can offer.
- Talk to you about your health and how you are managing other aspects of your life.
- Ask you if you would like to participate in case management.

If you choose not to take part in case management or get help from a Resource Mother, you'll be transitioned to the Family Planning-only service level for P4HB.

You can also call 24-hour Nurse HelpLine if you need additional follow-up for ongoing care.

Medicines

Amerigroup has a list of commonly prescribed drugs from which your doctor can choose. This list is called a preferred drug list (PDL). It is part of our formulary. Interpregnancy Care members have a copay on all medications not covered under the Family Planning benefit.

Medicines covered under the Interpregnancy Care service level may include:

- Contraceptives and contraceptive supplies
- Prescription drugs, supplies, or devices related to a chronic disease or condition that may have caused your baby to have very low birth weight
- Prescription drugs for treatment of sexually transmitted infections except HIV/AIDS and hepatitis
- Multivitamins with folic acid or folic acid vitamin
- Substance abuse treatment

Some medicines are not covered, including:

- Alternative medicines, like echinacea and ginkgo biloba
- Antiseptics and disinfectants, like hydrogen peroxide
- Mouth, throat, and dental agents, like throat lozenges
- Various bulk chemicals
- Pharmaceutical adjuvants (ingredients used in shots to help them work better), like mineral oil

All providers who work with our plan have access to this drug list. Your provider should use this list when he or she writes a prescription. Certain medicines on the PDL may need prior authorization. It takes about 24 hours to complete a prior authorization review once we receive it from your doctor. Any medicines not related to your P4HB benefits will not be covered. You can view the PDL for your plan at **myamerigroup.com/GA** under *Pharmacy & Prescription Drugs* to see the list of medicines your provider can choose from. If you have any questions about your medicine, call Pharmacy Member Services at **833-205-6006**. You can also call Member Services at **800-600-4441 (TTY 711)** to ask for a copy of the PDL for drugs covered for Interpregnancy Care enrollees.

You can get prescriptions filled at pharmacies who work with our plan. You can find a pharmacy in the provider directory at **myamerigroup.com/ga**. Select **Find a Doctor** and look for the *Pharmacy* link. If

you do not know if a pharmacy works with our plan, ask the pharmacist. You can also call Pharmacy Member Services at **833-205-6006 (TTY 711)** for help.

In order to get a prescription filled, you will need to take your written prescription to the pharmacy. Or your provider can call in the prescription to the pharmacy. If you are on medication for asthma, depression, or diabetes, you can receive up to a 60-day supply at your pharmacy after two previous 30-day fills of the same dose. You will need to show your Amerigroup ID card with the P4HB logo to the pharmacy. You can also use the mail order (also referred to as home delivery) option and receive up to a 60-day supply for certain medications after two previous 30-day fills of the same dose at your pharmacy. If you have questions or would like to start using CarelonRx Home Delivery, please call **833-205-6006** anytime. CarelonRx will take care of everything, including calling your provider for a prescription refill.

It is good to use the same pharmacy each time. This way, your pharmacist will know about problems that may occur when you are taking more than one prescription.

If you use a new pharmacy, you should tell the pharmacist about all of the prescription and over-the-counter (OTC) medicines you are taking. You should always show your Amerigroup enrollee ID card with the P4HB logo when you have a prescription filled.

Emergency prescription medicine supply

Enrollees may ask for a three-day supply of their prescription from the pharmacy while waiting for approval. This is for certain medicines that need prior authorization. This will give you time to call your PCP and ask for a medicine that's on our formulary. This does not apply to medicines not related to your P4HB benefits.

TYPES OF HEALTHCARE

Routine care services related to Interpregnancy Care

In most cases, you call your primary care provider (PCP) to make an appointment when you need medical care. They'll help treat most minor illnesses and injuries, as well as give you regular checkups. This type of care is called routine care. Your PCP is someone you see when you are not feeling well, but that is only part of your PCP's job. Your PCP also takes care of you when you're not sick. This is called well care.

You should be able to see your PCP within 14 days for routine care. Except in limited situations, your medical benefit plan does not cover non-emergent services performed by an out-of-network provider when those services are offered by an in-network provider. Please call Member Services for more information.

Urgent care services related to Interpregnancy Care

The second type of care is urgent care. There are some injuries and illnesses that are not emergencies, but can turn into emergencies if they are not treated within 24 hours. Some examples of urgent care are:

- Severe bleeding
- Pelvic pain
- Burning sensation when urinating

Covered urgent care visits are for services related only to Interpregnancy Care and include treatments of injury, illness or other conditions that are not life-threatening.

Emergency care services related to Interpregnancy Care

Covered emergency care services must be related to Interpregnancy Care service level. This includes:

- Covered inpatient and outpatient services related to this service level
- Services related to this service level provided by a qualified provider
- Services related to this service level that are needed to test or stabilize an emergency medical condition

What is an emergency related to Interpregnancy Care?

An emergency related to the program means the emergency must be covered under the Interpregnancy Care service level. It must be a medical problem where not seeing a provider to get care right away could result in death or very serious harm to your body. The problem is so severe that someone with an average knowledge of health and medicine can tell that the problem:

- May be life-threatening or cause serious damage to your body or mental health.
- May cause serious harm to a bodily function, organ, or body part.
- May cause serious harm to self or others because of an alcohol or drug abuse emergency.
- May cause injury to self or bodily harm to others.

Here are some examples of problems that may be considered emergencies related to this service level:

- Severe menstrual bleeding from a Depo-Provera injection
- Treatment of complications during a sterilization procedure (tubal ligation)
- Very bad bleeding that does not stop
- Loss of consciousness
- Perforated uterus (a hole in the uterus)

Please note that as an enrollee of the Planning for Healthy Babies® program, your emergency care benefits are limited to severe complications or conditions related to your service level. Enrollees with emergency medical conditions related to interpregnancy conditions don't have to pay for follow-up screenings and treatments needed to diagnose specific conditions or to stabilize the enrollee. If you get Interpregnancy Care services through P4HB, we will only cover emergency room services related to the Interpregnancy service level.

FOR ENROLLEES GETTING RESOURCE MOTHER OUTREACH ONLY SERVICES

Eligibility for Resource Mother Outreach services

To receive Planning for Healthy Babies® Resource Mother Outreach Only services, you must meet these requirements:

- You must be a woman between the ages of 18 and 44.
- You must have a Modified Adjusted Gross Income equal to or less than 211 percent of the Federal Poverty Level (FPL).
- You must have delivered a very low birth weight (VLWB) baby (less than 1,500 grams or 3 pounds, 5 ounces).
- You must qualify under the Low Income Medicaid (LIM) class of assistance or the Aged, Blind and Disabled (ABD) classes of assistance under the Georgia Medicaid state plan.

Enrollment for Resource Mother Outreach Only services

The Department of Community Health sent you a letter to let you know you're eligible for Resource Mother Outreach (RMO) Only services.

Your Resource Mother Amerigroup enrollee ID card

Resource Mother Outreach Only enrollees receive an Amerigroup enrollee ID card with a yellow P4HB logo. This ID card has the date you became an Amerigroup enrollee and important phone numbers you need, such as 24-hour Nurse HelpLine. Your Medicaid benefits are listed under your state Medicaid program for LIM/ABD. Please contact Medicaid at **866-211-0950** or medicaid.georgia.gov for more information.

RESOURCE MOTHER OUTREACH HEALTHCARE SERVICES

Covered services

This list shows benefits you can get from Amerigroup. Resource Mother Outreach Only enrollees will receive the following P4HB benefits:

- Case management to help you manage any chronic conditions like diabetes
- Education classes for mothers of very low birth weight babies on parenting and child safety
- Assistance with:
  - Coordinating social services support for family and life issues
  - Finding and using community resources, including legal, financial assistance and other referral services
  - Linking mothers to community resources such as the Special Supplemental Nutritional program for Women, Infants, and Children (WIC)
- Support to help meet the health demands of mothers with very low birth weight babies

For all medical services, please see your Medicaid benefit booklet or your Georgia Families Handbook. Please contact Medicaid at **866-211-0950** or medicaid.georgia.gov or contact your Georgia Families

CMO to find the services that need authorization under your medical benefit plan. The Amerigroup P4HB program will only pay for Resource Mother Outreach Only services covered under the program. If you have a question or are not sure if we offer a certain benefit, you can call Member Services for help at **800-600-4441 (TTY 711)**.

Resource Mother Outreach services

We have case managers to help you understand and care for your condition. Your primary care provider will help you with your special condition, but it is also important that you learn to care for yourself.

Our case managers will also call you if:

- You need help taking care of your very low birth weight (VLBW) baby.
- You have need of coordination of care.
- You need additional follow-up for ongoing care. You may also call 24-hour Nurse HelpLine.

Your case manager can help with:

- Setting up healthcare services.
- Community services.
- Reviewing your plan of care and treatment as needed.

When you are called, a nurse will:

- Educate you about the services we can offer.
- Talk to you about your health and how you are managing other aspects of your life.

If you choose not to get Resource Mother Outreach (RMO) Only services, you'll be disenrolled from P4HB. You'll still have full Medicaid benefits.

Quality Management

If you have a complaint about medical services, please refer to your primary Medicaid benefit grievance program.

FOR ALL ENROLLEES WHO GET INTERPREGNANCY CARE, FAMILY PLANNING AND RESOURCE MOTHER OUTREACH SERVICES

Doctor's office and hospital access for enrollees with disabilities

The family planning and primary care providers and hospitals who work with our plan should help enrollees with disabilities get the care they need. Enrollees who use wheelchairs, walkers or other aids may need help to get into an office. If you need a ramp or other help, make sure your provider's office knows this before you go there. This way, they will be all set for your visit. If you want help talking to your provider about your special needs, call Member Services at **800-600-4441 (TTY 711)**.

Prior authorization

Some Amerigroup services, such as an inpatient admission for a family planning service, need prior authorization or approval. This means your doctor must ask us to approve them. Emergency, post-stabilization and urgent care services do not need approval.

We have a utilization review team that looks at approval requests. The team will:

- Decide if the service is needed.
- Decide if it is covered by Amerigroup.

Time frames for prior authorization requests

- Standard service authorizations: We will decide on non-urgent care services within 3 business days after we get the request. We will tell your provider about services that have been approved within 3 business days after we get the request. You or your provider can ask to extend the time frame up to 14 calendar days. All decisions and notifications must occur by the end of 14 calendar days if the time frame is extended.

- Expedited (fast) service authorizations: Your doctor can ask for an expedited review if it is thought a delay will cause grave harm to your health. We will decide on expedited service requests within 24 hours (one workday) from when we get the request. We will let your doctor know of services that have been approved by telephone or by fax within 24 hours (one workday) after we get the request. We can ask to extend the time frame up to five business days if we can justify to the Department of Community Health (DCH) our need for more information and how us taking more time is in your best interest. All decisions and notifications will occur by the end of the five business days if the time frame is extended.

All pharmacy prior authorization requests are completed within 24 hours after we get the request unless additional information is needed from the doctor. If additional information is needed, then the time frame can be extended up to 72 hours (3 days) after receiving the request. We will let the doctor know if the request is approved. If it's not, we will send you and the doctor a letter telling you this. Your doctor may prescribe another medicine or give us more information on why you need that medicine. If necessary, you can ask for a 72-hour supply of medication from the retail pharmacy while you wait for a decision on your prior authorization request.

Appeals for services outside of the P4HB Program are not handled by the Amerigroup P4HB Program.

You or your family planning or primary care provider (with your written consent to act as your representative) can ask for an appeal if we say we won't pay for the care. We will acknowledge your request for an appeal within 10 calendar days. We'll let you and your provider know the final decision within 30 calendar days after we get the appeal request. The appeal request can be for:

- Services that are not approved.
- Services that have been changed to less than what was requested.

BENEFITS AND SERVICES NOT COVERED BY THE PLANNING FOR HEALTHY BABIES® PROGRAM OR AMERIGROUP

No services or benefits will be covered or approved unless authorized by the Centers for Medicare & Medicaid Services (CMS) under the Planning for Healthy Babies® waiver. Amerigroup and the Planning for Healthy Babies® program cover only the services listed in the Covered services section of the IPC, FP, or RMO sections. CMS determines which technologies are included in the benefit program.

All other unrelated services are not covered. Some examples of services and benefits not covered include:

- Services given by a relative or enrollee of your household
- Abortions or abortion-related services
- Experimental and investigational items
- Cosmetic surgery
- Hysterectomy

For more information about services not covered by Amerigroup, please call Member Services at **800-600-4441 (TTY 711)**.

SPECIAL AMERIGROUP SERVICES FOR HEALTHY LIVING

Telehealth

Amerigroup and the Georgia Partnership for Telehealth (GPT) have made it easier to get care from specialists and behavioral healthcare.

About Georgia Partnership for Telehealth

The Georgia Partnership for Telehealth (GPT) makes it easier to get care in rural and hard to reach parts of Georgia through the use of:

- Telemedicine or care from a family planning provider through videoconferencing.
- A health information exchange where providers share information electronically.
- Telehealth technologies or tools for virtual medical care.

To learn more about telehealth services, call GPT toll free at **866-754-4325**. Or visit **gatelehealth.org** to find out where you can get telehealth services. You can also call your doctor or Member Services at **800-600-4441 (TTY 711)**.

Health information

Learning more about health and healthy living can help you stay healthy. One way to get health information is to ask your provider. Another way is to call us at **800-600-4441 (TTY 711)**. The 24-hour Nurse HelpLine is available 24 hours a day, 7 days a week to answer your health questions. They can tell you if you need to see your provider. They can also tell you how you can help take care of some health problems you may have.

Community events

We sponsor and participate in special community events and family fun days where you can get health information and have a good time. You can learn about topics like healthy eating, asthma, and stress. You and your family can play games and win prizes. We will be there to answer your questions about your benefits, too. To find out when and where these events will be Call Member Services, visit us on Facebook at **facebook.com/AmerigroupCorporation** or Your Community section at **myamerigroup.com/ga**.

Domestic violence

Domestic violence is abuse. Abuse is unhealthy. Abuse is unsafe. It is never OK for someone to hit you. It is never OK for someone to make you afraid. Domestic violence causes harm and hurts you on purpose. Domestic violence in the home can affect your children, and it can affect you. If you feel you may be a victim of abuse, call or talk to your provider. Your provider can talk to you about domestic violence. He or she can help you understand you have done nothing to deserve abuse.

Safety tips for your protection:

- Have a plan on how you can get to a safe place (like a women's shelter or a friend or relative's home).
- Always keep a small bag packed.
- Give your bag to a friend to keep for you until you need it.

If you have questions or need help, please call 24-hour Nurse HelpLine at **800-600-4441 (TTY 711)** or call the National Domestic Violence hotline number at 800-799-7233.

GEORGIA ADVANCE DIRECTIVE FOR HEALTHCARE ACT

Making a living will (advance directive)

P4HB enrollees have rights under the Georgia Advance Directive for Health Care Act. You have the right to:

- Control all aspects of your care and treatment.
- Get the care you want.

- Refuse the treatment you don't want.
- Ask for medical treatment to be withdrawn.

There are three parts to the Georgia Advance Directive for Health Care Act:

- Part 1 lets you choose a person to make decisions for you when you cannot make them yourself; this person is called a healthcare agent
- Part 2 lets you make choices about getting the care you want if you are too sick to decide for yourself
- Part 3 lets you choose someone you appointed as your guardian if a court says this is necessary

If you wish to sign an Advance Directive for Health Care form, you can:

- Ask your provider for the form.
- Call our Member Services department at **800-600-4441 (TTY 711)** for the form.

Take or mail the completed form to your provider who will then know what kind of care you want to have. You can change your mind at any time. If you do, call your provider to remove the form from your medical record. Fill out and sign a new form if you wish to make changes.

Remember to:

- Give a copy of the completed form to your healthcare agency, your family, and your provider
- Keep a copy at home in a place where it can be easily found if needed
- Look at the form regularly to make sure it says what you want

You can get a copy of the Georgia Advance Directive for Health Care Act by going online to http://aging.dhs.georgia.gov. You can ask for a copy of this form and its instructions at no cost by writing to the Georgia DHS Division of Aging Services at:

Georgia DHS Division of Aging Services
2 Peachtree St. NW
Suite 33-263
Atlanta, GA 30303

If you have questions or need more information, call the Division's Information and Referral Specialist at 404-657-5258. If you signed an advance directive and believe that your family planning or primary care provider or hospital has not followed the instructions in it, you can file a complaint. You can call the Department of Community Health at **800-878-6442.** You can also write to:

Regulation Division
Complaints and Investigations Healthcare Facility
Department of Community Health
2 Peachtree St. NW
Atlanta, GA 30303

COMPLAINTS, GRIEVANCES AND APPEALS

Complaints and Grievances

A complaint or grievance is an oral or written expression of dissatisfaction about services or care you received. We will try to solve your complaint on the phone. If we cannot take care of the problem during your call, you can file a grievance. Possible subjects for grievances include:

- Quality of care or services provided
- Rudeness of a provider or employee
- Failure to respect your rights

To file a grievance, you or your representative can call, fax, or send us a letter. You may call Member Services at **800-600-4441 (TTY 711)** for help with writing a letter. Send your letter to:
Amerigroup Community Care
Quality Management Department
Appeals and Grievances
740 W. Peachtree Street
Atlanta, GA 30308
Fax: **877-842-7183**

We'll send you a letter within 10 business days to let you know we got your grievance. If you need verbal translation of the letter is needed, please call Member Services toll free at **800-600-4441 (TTY 711)**.

We'll look into your grievance when we get it. We'll send you a letter within 90 calendar days or sooner, if your health condition calls for it, with a response to your grievance. This letter will tell you the decision Amerigroup made and the reasons for our decision.

A Member Services representative can provide:

- Help writing and filing a grievance letter.
- Other language translations.
- Help for those who are blind or have low vision.
- TDD/TTY lines for the deaf or hard of hearing toll free at **711**.

You, your parent, your legal guardian, or your authorized representative (a person you prefer to help you) can file a grievance. Your provider cannot file a grievance for you as your provider. You must send written approval to have a representative file a grievance for you.

Complaints or grievances do not relate to decisions to deny or limit services. Please call Member Services if you have questions or concerns about services or providers who work with our plan.

APPEALS

P4HB services are limited to those noted in the sections above. Amerigroup cannot pay for services that aren't related to the P4HB program. Sometimes, providers ask for services that aren't related to the P4HB program. If this happens, a letter will be mailed to you and your provider for services that aren't approved. This letter is called an adverse benefit determination.

An adverse benefit determination is when we:

- Deny or limit a service you or your provider asked us to approve.
- Lessen, suspend, or stop services you've been getting that we already approved.
- Fail to give services in the required time frame.
- Fail to give you a decision on an appeal you already filed in the required time frame.

The adverse benefit determination letter will explain how you, your legal representative, or your provider (with your written consent) or a legal representative of a deceased enrollee's estate can ask for an appeal of the decision. An appeal is when you ask us to look again at the care your provider asked for and we said we would not pay for.

You, your authorized representative (a person you prefer to help you), your IPC PCP or the family planning provider taking care of you at the time with your written consent, or a legal representative for a deceased enrollee's estate may request an appeal. If you use a representative (including your provider), you must write a letter or complete the authorized representative form that was provided to you, telling us this person is allowed to represent you.

You may file an appeal within 60 calendar days of the date of the first letter from us that says we will not pay for the service. You can ask for a continuation of benefits during the appeal process. See the **Continuation of Benefits** section for help.

You may ask for an appeal of our decision in two ways:

1. You may call Member Services at **800-600-4441 (TTY 711)**.
2. You can send us a letter to the address below. You may call Member Services at **800-600-4441 (TTY 711)** for help with writing a letter. Include information such as the care you are looking for and the people involved. Have your provider send us your medical information about this service. The address is:

Medical Appeals
Amerigroup Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

When we get your request, we will send you a letter within 10 working days. This letter will let you know we got your appeal request.

We will start working on your request when you first tell us you want an appeal. A provider who has not seen your case before will look at your appeal. He or she will decide how we should handle your

appeal. We will send you and your provider a letter with the answer to your appeal. The letter will tell you the reasons for our decision.

We will do this within 30 calendar days from when we get your appeal request. We have a process to answer your appeal quickly if the care your provider says you need is urgent. Please see the section **Expedited Appeals** for help.

If there is a delay we cannot control or more information is needed, we will send you a letter. The letter will tell you we may need to extend the time frame up to 14 calendar days to look at your appeal and why. If you or your authorized representative acting on your behalf with your written consent requests an extension, the review may be extended up to 14 calendar days.

If we aren't able to meet the required time frames noted above, you will receive a notice for failure to act.

At any time during the appeal process, you or your representative may:
- Have the right to access copies of all documents related to your appeal.
- Have the right to copies of all documents related to your appeal free of charge.
- Provide additional information or facts to Amerigroup in person or in writing.
- Get a copy, free of charge, of the benefit guide, guidelines, criteria, or protocol we used to decide your appeal.

If you need a verbal translation, please call Member Services at **800-600-4441 (TTY 711)** toll free.

A Member Services representative can provide:
- Help writing a request for an appeal.
- Help with filing an appeal.
- Verbal translation of other languages.
- Help for those who are blind or have low vision.

A toll-free TTY line for people who are deaf or hard of hearing is available by calling **711**.

If you, your authorized representative (a person you give permission to help you), your IPC PCP, or the family planning provider taking care of you at the time, with your written consent, or a legal representative of a deceased enrollee's estate files an appeal, we will not hold it against you, your authorized representative, or your provider. We will be here to help you get quality healthcare.

Expedited appeals

You, your authorized representative (a person you give permission to help you), your IPC PCP, or your family planning provider taking care of you at the time (with your written consent), the person you ask to file an appeal for you (with written consent), or a legal representative of a deceased enrollee's estate can request an expedited appeal.

You can ask for an expedited appeal if you or your provider feel that taking the time for the standard appeal process could seriously harm your life or your health.

You can ask for an expedited appeal in two ways:

- Call Member Services toll free at **800-600-4441 (TTY 711)**
- Fax Quality Management at **877-842-7183**

When we get your letter or phone call, we will send you a letter with the answer to your appeal request. The letter will tell you the reasons for our decision. We will do this within 72 hours after we get your appeal request or sooner if your health condition calls for it. You have the right to submit written comments, documents, or other information, such as medical records or provider letters that might help your appeal. You must do so within 72 hours of your request for an expedited appeal.

If we do not agree that your request for an appeal should be expedited, we will call you right away. We will send you a letter within two calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process. See the **Appeals** section for help. You may file a grievance if you do not agree with this decision by calling Member Services at **800-600-4441 (TTY 711)**.

If the decision of your expedited appeal agrees with our first decision, an Amerigroup representative will call you. We will also send you a letter within two calendar days to let you know our decision and that we will not pay for the service asked for.

If there is a delay we cannot control or more information is needed, we will send you a letter. The letter will tell you we need to extend the time frame up to 14 calendar days to look at your expedited appeal. If you or your authorized representative or provider acting on your behalf with your written consent requests an extension, the review may be extended up to 14 calendar days.

STATE FAIR HEARING

You, your authorized representative or a legal representative of a deceased enrollee's estate may ask for a state fair hearing. You must send a letter after you have gone through the Amerigroup appeal process. You must ask for a state fair hearing within 120 calendar days from the date of the Appeal Resolution letter.

At any time during the state fair hearing process, you or your representative may:

- Obtain and examine a copy of the documents that will be used for review.
- Provide additional information or facts to Amerigroup in person or in writing.

You can ask for a continuation of P4HB benefits during the state fair hearing process. See the section **Continuation of P4HB Benefits** for help. The decision reached by a state fair hearing will be final.

You can ask for a state fair hearing by sending a letter to:

Amerigroup Community Care
Quality Management Department
State Fair Hearings
740 W. Peachtree Street
Atlanta, GA 30308
You may also ask for a state fair hearing from the Department of Insurance. Their address is:

Department of Insurance
2 Martin Luther King, Jr. Drive
West Tower, Suite 704
Atlanta, GA 30334

The Department of Insurance telephone and fax information is:

Local phone: **404-656-2070**
Toll free: **800-656-2298**
Fax: **404-657-8542**

The Office of State Fair Hearings will tell you the time, place, and date of the hearing. An administrative law judge will hold the hearing. You may speak for yourself or let a friend or family member speak for you. You may get help from a lawyer. You may also be able to get free legal help. If you want a lawyer, please call one of these telephone numbers:

- Georgia Legal Services: **800-498-4469**
- Georgia Advocacy Office: **800-537-2329**
- Atlanta Legal Aid:
    - **404-377-0701** (DeKalb-Gwinnett counties)
    - **770-528-2565** (Cobb County)
    - **404-524-5811** (Fulton County)
    - **404-669-0233** (South Fulton-Clayton counties)
    - **678-376-4545** (Gwinnett County)
- State Ombudsman Office**: 888-454-5826**

You may also ask for free mediation services after you have filed a request for a hearing. Please call **404-657-2800**.

We will comply with the state fair hearing decision.

CONTINUATION OF P4HB BENEFITS

You may ask Amerigroup to continue to cover your P4HB benefits during the appeal and state fair hearing processes. If coverage of a service you are receiving is denied or reduced and you want to continue that service during your appeal or state fair hearing, you can call Member Services at **800-600-4441 (TTY 711)** to request it.

You must call to ask us to continue your P4HB benefits within 10 calendar days of when we mailed you the notice that said we wouldn't cover or pay for a service.

We must continue coverage of your P4HB benefits until:

- You withdraw the appeal, state fair hearing or formal grievance committee request.
- Ten calendar days from the date of the appeal decision letter have passed, and you have not made a request to continue P4HB benefits until a state fair hearing decision is reached.
- A state fair hearing decision is reached and is not in your favor.
- Authorization expires or your service limits are met.

You may have to pay for the cost of any continued P4HB benefit if the final decision is not in your favor. If a decision is made in your favor as a result of your appeal, Amerigroup will authorize and pay for the services we said we would not cover before.

Payment reviews

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

- The date you got the service.
- The type of service it was.
- The reason we cannot pay for the service.

The provider, healthcare place, or person who gave you this service will get a notice called an Explanation of Payment. If you get an EOB, you do not need to call or do anything at that time.

You may call if you want to or if your provider disagrees with the decision. You can ask Amerigroup to look again at the service we said we would not pay for. You must ask for us to do this within 30 calendar days of getting the EOB. To do this, you or your provider can call Member Services toll free at **800-600-4441 (TTY 711)**. You can also mail your request and medical information for the service to:

Amerigroup Community Care
Quality Management Department
Appeals and Grievances
740 W. Peachtree
Atlanta, GA 30308

We can accept your request by phone, but you must follow up in writing. You have the right to ask for a grievance. See the section **Complaints, Grievances, and Appeals** for help.

Appeals for services outside of the P4HB Program are not handled by the Amerigroup P4HB Program.

You or your family planning or primary care provider (with your written consent to act as your representative) can ask for an appeal if we say we won't pay for the care. We will acknowledge your request for an appeal within 10 calendar days. We'll let you and your provider know the final decision within 30 calendar days after we get the appeal request. The appeal request can be for:

- Services that are not approved.
- Services that have been changed to less than requested.

OTHER INFORMATION

If you move or your family size changes

You should call your Division of Family and Children Services caseworker as soon as you move or your family size changes to report the change or Georgia Gateway at **877-423-4746**. Once you call your caseworker, you should call Member Services at **800-600-4441**. You can also go to the Georgia Gateway website at gateway.ga.gov to report a move or change in family size. You will continue to get healthcare services through us in your current area until the address is changed. You must call Amerigroup before you can get any P4HB services in your new area unless it is an emergency.

Renew on time

We want you to keep getting your P4HB benefits from us if you still qualify. Your health is very important to us. **Keep the right care. Don't lose your P4HB benefits.**

You must renew your P4HB eligibility every 12 months. You'll get a renewal note in the mail before the deadline. It's important to follow the instructions in this letter. If you need help, call the P4HB line at **877-427-3224** for help or Member Services. If you don't renew by the date in the letter, you may lose your healthcare benefits. For help or to find out the date you need to renew your benefits, call the P4HB line at **877-427-3224**.

Reasons why you can be disenrolled from Amerigroup

There are several reasons you could be disenrolled from Amerigroup without asking to be disenrolled. These are listed below. If you have done something that may lead to disenrollment, we will contact you. We will ask you to tell us what happened.

You may be disenrolled from Amerigroup immediately if:

- You are no longer eligible for the P4HB program.
- You have reached the end of the 24-month eligibility for IPC services (you may be eligible for Family Planning services).
- You become pregnant while enrolled.

- You become infertile (sterile) through a medical procedure.
- You are sent to jail or prison.
- You use these services through fraud or abuse, such as letting someone else use your Amerigroup P4HB ID card.
- You are disenrolled by the Georgia Department of Community Health.
- You are placed in a long-term nursing facility, state institution, or intermediate care facility for the mentally disabled.

You will be unable to enroll in the P4HB program if you:

- Become pregnant.
- Are diagnosed as infertile (sterile).
- Are eligible for Medicaid (except for women who had a VLBW baby and are eligible for the Resource Mother Outreach Only services) or any other insurance program.
- Are sent to prison.

If you have any questions about your enrollment, call our Member Services department for help at **800-600-4441 (TTY 711)**.

How to disenroll from Amerigroup

If you do not like something about Amerigroup, please call Member Services. We will work with you to try and fix the problem. If you are still not happy, you may be able to change to another health plan. You can change health plans without cause during your first 90 days of enrollment. This means you need a reason, such as if you move or become pregnant. After that, you can change health plans every 12 months. Enrollees may request disenrollment for cause at any time. Please call Member Services for disenrollment forms and assistance.

If your disenrollment request is received between the 1st and the 24th of the month, your disenrollment will be effective on the first day of the following month in which it was filed. If your disenrollment request is received after the 24th calendar day of the month, after the managed care monthly process, your disenrollment will be effective on the first day of the second month after the request was received. For example, if your disenrollment request is received on April 24, your disenrollment will be effective May 1. If your disenrollment request is received on April 25, your disenrollment will be effective June 1.

Please call Member Services at **800-600-4441 (TTY 711)** for disenrollment forms and assistance.

If you get a bill

Always show your Amerigroup P4HB ID card when you see a provider, go to the hospital, or go for tests. Even if your provider told you to go, you must show your Amerigroup P4HB ID card (for RMO enrollees, show your current Medicaid or Georgia Families card) to make sure you are not sent a bill for services covered by Amerigroup.

You do not have to show your Amerigroup ID card before you get emergency care. If you do get a bill, send it to us with a letter saying that you have been sent a bill.

Send the letter to the address below:

Amerigroup Community Care
40 W. Peachtree Street
Atlanta, GA 30308

You can also call our Member Services department for help at **800-600-4441 (TTY 711)**.

How to tell us about changes you think we should make

We want to know what you like and do not like about the Amerigroup P4HB Program. Your ideas will help us make us better. Please call Member Services to tell us your ideas. Member Services is available Monday through Friday from 7 a.m. to 7 p.m. Eastern time to serve you.

You can also send a letter to:

Amerigroup Community Care
740 W. Peachtree Street
Atlanta, GA 30308

We have a group of members and enrollees who meet quarterly to give us their ideas. These meetings are called member advisory meetings. This is a chance for you to find out more about us, ask questions and give us suggestions for improvement. If you would like to be part of this group, call Member Services at **800-600-4441 (TTY 711)**.

We also send surveys to some members and enrollees about the P4HB program. The surveys ask questions about what you do and don't like about us. If we send you a survey, please fill it out and send it back. Our staff may also call to ask what you like and don't like about your plan. Please tell them what you think. Your ideas can help us make us better.

How we pay providers

Different providers who work with our plan have agreed to be paid in different ways by us. Your provider may be paid each time he or she treats you (fee-for-service). Or your provider may be paid a set fee each month for each enrollee whether or not the enrollee actually gets services (capitation).

These kinds of pay may include ways to earn more money. Payment is based on different things like enrollee satisfaction, quality of care, accessibility, and availability.

Contact us to find out more about how:

- We pay our contracted doctors and other providers who work with us.
- Our plan is set up and run.

Call Member Services at **800-600-4441 (TTY 711)**. Or write us at:

Amerigroup Community Care
740 W. Peachtree Street
Atlanta, GA 30308

Medical advances and new technology

Our medical directors and the doctors who work with our plan look at new medical advances (or changes to existing technology) in:

- Medical procedures
- Pharmaceuticals
- Medical devices

They review new advances and technologies to decide if:

- These advances or technologies should be covered benefits.
- The government has agreed the treatment is safe and effective.
- The results of the advances or technologies are as good as or better than treatments covered by your current benefits.

They also look at scientific literature to find out if:

- The government thinks these new procedures or treatments are safe and effective.
- They have the same or better outcomes than the treatments we use now.

They do this to decide if we should include these procedures and treatments in our plan.

YOUR RIGHTS AND RESPONSIBILITIES AS AN AMERIGROUP P4HB ENROLLEE

Your rights

Our enrollees have the right to:

- Get timely and proper notice; you must get notice in writing before we take any action to end your Amerigroup coverage.
- Get a Medicaid fair hearing if you disagree with a decision we make about your healthcare coverage.
- Get a copy of the enrollee handbook and other materials in your own language.
- Get a copy of the Notice of Privacy Practices that updates you about your rights on protected health information (PHI) and our responsibility to protect your PHI. This includes the right to know how we handle, use, and give out your PHI.
- PHI is defined by HIPAA Privacy Regulations as information that:
  - Identifies you or can be used to identify you.
  - Either comes from you or has been created or received by a healthcare provider, a health plan, your employer, or a healthcare clearinghouse.
  - Has to do with your physical or behavioral health condition, providing healthcare to you or paying for providing healthcare to you.
- Information about medical and pharmacy benefits.
- Have access to providers who work with our plan.
- Know how to get a current directory of doctors who work with our plan.
- Know how to change your PCP if you get IPC services.
- Get information about your Amerigroup doctors and other providers who work with our plan; call Member Services at **800-600-4441 (TTY 711)**.
- Have access to a PCP or a backup PCP 24 hours a day, 365 days a year for urgent care (this is for IPC enrollees and is shown on the enrollee ID card with the purple P4HB logo).
- Call 911 without notification if you have an emergency situation.
- Direct access to women's routine and preventive GYN healthcare.
- Have a doctor make the decision to deny or limit your coverage.
- Have no gag rules, which means that doctors are free to discuss all medical treatment options, even if they are not covered services.
- Know how we pay doctors, so you know if there are rewards or fines tied to medical decisions.
- Know how to make a complaint to Amerigroup.
- Know how to ask us for an appeal of a decision to not pay for a service or limit coverage.
- Know you or your doctor cannot be penalized for filing a complaint or appeal.
- Be treated with respect and dignity by healthcare providers, their staff, and all individuals employed by our company.
- In accordance with federal law (42 CFR 438.10), you have the right to get information in a way and format that is easily understood, such as:
  - Materials in your prevalent non-English language
  - Enrollee handbook
  - Plan benefit information (medical and pharmacy)
  - Oral interpretation services free of charge

  - Disenrollment information
  - Applicable cost-sharing information (excludes DJJ and FC)
  - Access to network providers and how to change your PCP and obtain a provider directory
  - Access to physician incentive plans upon request
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.
- Have information about Amerigroup, its services, policies and procedures, and providers; enrollee rights and responsibilities; and any changes made.
- Talk about your medical record with your doctor; you can ask for a summary of that record.
- Refuse treatment to the extent of the law and be aware of the results; this includes the right to refuse to be part of research.
- Decide ahead of time the kind of care you want if you become sick, injured, or seriously ill by making a living will.
- Decide ahead of time the person you want to make decisions about your care if you are not able to by making a durable power of attorney.
- Expect that your records and communications will be treated confidentially and not released without your permission.
- Choose a primary care provider (PCP), choose a new PCP, and have privacy during a visit with a doctor for those who get IPC services.
- Have your medical information given to a person you choose to coordinate care when you are unable to or have it given to a person who is legally authorized when concern for your health makes it inadvisable to give such information to you.
- As required by federal law (42 CFR 438.206 through 438.210), have medical services available to you, including coordination of care, access to specialists, and authorization of services.
- Be free from liability and receiving bills from providers for medically needed or covered services that we authorized or covered but for which the provider was not paid.
- Information about cost sharing.
- Only be responsible for copays as described in this enrollee handbook.
- Be free from any Amerigroup debts in the event of insolvency and liability for covered services in which the state does not pay Amerigroup.
- Be free from payment for covered services in which the payment exceeds the amount you would be responsible for if Amerigroup provided the service.
- Continue as an enrollee of Amerigroup despite your health status or need for care.
- Call 24-hour Nurse HelpLine 24 hours a day, seven days a week toll free at **800-600-4441 (TTY 711)**.
- Call our Member Services department toll free at **800-600-4441 (TTY 711)** from 7 a.m. to 7 p.m. weekdays, except for state holidays.
- Get help from someone who speaks your primary language at no cost to you.
- Get help through a TTY/TDD line if you are deaf or hard of hearing at **711** at no cost to you.
- Expect doctors' offices to have wheelchair access.
- Receive information on available treatment options and alternatives, regardless of cost or benefit coverage.
- Ask for and receive a copy of your medical records and ask to amend or correct the record.

- Not be restrained or secluded if doing so is:
  - For someone else's convenience.
  - Meant to force you to do something you do not want to do.
  - To punish you.
- Take part in making decisions about your healthcare with your doctor.
- Make suggestions about the Amerigroup enrollee rights and responsibilities policy.
- Discuss questions you may have about your medical care or services with Amerigroup; call Member Services at **800-600-4441 (TTY 711)**.
- Facts about how to disenroll.
- Amerigroup does not prohibit, or otherwise restrict healthcare professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, the risks, benefits, and consequences of treatment or non-treatment.

Your responsibilities

Our enrollees have the responsibility to:

- Notify their PCPs as soon as possible after getting emergency treatment for enrollees who get IPC services.
- Go to the emergency room when there is an emergency.
- Call Amerigroup if they have a problem and need help.
- Tell their PCPs about symptoms or problems and ask questions for enrollees who get IPC services.
- Read this enrollee handbook to understand how Amerigroup works.
- Notify Amerigroup if a family member enrolled with Amerigroup has died. Someone must also notify Amerigroup if you die.
- Give Amerigroup proper identification when they enroll.
- Treat their doctors, the doctors' staff, and Amerigroup employees with respect and dignity.
- Not be disruptive in their doctors' offices.
- Respect the rights and property of all providers.
- Cooperate with people providing their healthcare.
- Get information about treatment and consider this treatment before it is done.
- Discuss any problems in following their doctors' directions.
- Consider the results of refusing treatment recommended by their doctors.
- For those who get IPC services, help their PCPs get their medical records from the doctor they had before; you should also help your PCP fill out new medical records if you get IPC services
- Respect the privacy of other people waiting in doctors' offices.
- For those who get IPC services, get permission from their PCPs, or the PCPs' associates before seeing a consultant or specialist; you should also get permission from your PCP before going to the emergency room unless you have an emergency medical condition if you get IPC services.
- Call Amerigroup and change their PCPs before seeing a new PCP for those who get IPC services.
- Learn and follow the Amerigroup policies and procedures outlined in this handbook until they are disenrolled.

- Make and keep appointments and be on time. Always call the doctor's office if you need to cancel an appointment, change your appointment time or will be late.
- Discuss complaints, concerns, and opinions in an appropriate and courteous way.
- Tell their doctors who they want to be told about their health.
- Get medical services from their PCP for those who get IPC services.
- Receive Resource Mother Outreach services to better understand your health and how to take care of your baby if you get IPC services.
- Know and get involved in their healthcare; talk with your doctor about recommended treatment; then follow the plans and instructions for care agreed upon with your provider.
- Know how to take their medicines the right way.
- Carry their Amerigroup ID card at all times; report any lost or stolen cards to Amerigroup quickly; also, contact Amerigroup if information on your ID card is wrong or if your name, address, or marital status has changed.
- Carry their Medicaid ID card at all times.
- Show their ID cards to each provider.
- Tell Amerigroup about any doctors they are currently seeing.
- Provide true and complete information about their circumstances.
- Report change in their circumstances.
- Give Amerigroup and their doctors the information they need to take care of their medical needs.

Nondiscrimination Notice

Amerigroup is a Health Plan licensed as a Care Management Organization in the state of Georgia who administers the Medicaid, and Children's Health Insurance Programs in Georgia. Amerigroup doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Amerigroup directly or through a contractor or any other entity with which Amerigroup arranges to carry out its programs and activities.

Fraud or other Misrepresentation Notice

Amerigroup will not intentionally misrepresent information or furnish false statements to a Member, Potential Member, or health care Provider.

HOW TO REPORT SOMEONE WHO IS MISUSING THE PLANNING FOR HEALTHY BABIES® PROGRAM

If you know someone who is misusing the Planning for Healthy Babies® (P4HB) program, you can report them. To report doctors, clinics, hospitals, nursing homes or Planning for Healthy Babies® enrollees, write or call Amerigroup.

You can at:

Amerigroup Community Care
740 W. Peachtree St.
Atlanta, GA 30308
800-600-4441 (TTY 711)

To report doctors, clinics, hospitals, nursing homes or Planning for Healthy Babies® enrollees, you can also write or call the Department of Community Health's Program Integrity Section.

Program Integrity Section
Department of Community Health
P.O. Box 38436
Atlanta, GA 30334
Toll free: **800-533-0686**
Local: **404-206-6480**

WE HOPE THIS BOOK HAS ANSWERED MOST OF YOUR QUESTIONS ABOUT THE AMERIGROUP P4HB PROGRAM. FOR MORE INFORMATION, YOU CAN CALL THE AMERIGROUP MEMBER SERVICES DEPARTMENT AT 800-600-4441 (TTY 711).

DEFINITIONS

- **Appeal:** An appeal is a request you make when you don't agree with a decision we made about your care.
- **Copayment:** A copayment or copay is the amount the member may need to pay for a covered service.
- **Durable Medical Equipment (DME):** Medical equipment that is ordered by a doctor for use in the home. For example, wheelchairs, ventilators, or crutches are types of DME.
- **Emergency Medical Transportation:** Ambulance services for an emergency medical condition.
- **Emergency Room Care:** Emergency services you receive in an emergency room.
- **Emergency:** An emergency is when not seeing a doctor to get care right away could result in death or very serious harm to your body.
- **Excluded Services:** Healthcare services that your Amerigroup plan doesn't pay for or cover.
- **Grievance**: A complaint or grievance is an oral or written expression of dissatisfaction about services or care you received.
- **Habilitation Services:** Healthcare services that help you keep, learn, or improve skills and functioning for daily living.
- **Health Insurance:** A type of insurance coverage that pays for medical expenses.
- **Home Healthcare:** Medical care provided in a patient's home.
- **Hospice Services:** Supportive care to people in the final phase of a terminal illness and their families.

- **Hospital Outpatient Care:** Medical care or treatment that does not require an overnight stay in a hospital.
- **Hospitalization:** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
- **Medically Necessary:** Healthcare services needed to correct or make better a defect, physical or mental illness, or condition in line with accepted medical practices.
- **Network:** The providers and facilities your health plan has contracted with to provide healthcare services.
- **Non-participating Provider:** A provider who doesn't have a contract with your health plan to provide services to you.
- **Participating Provider:** A healthcare provider in your Amerigroup network. Also called an in-network provider.
- **Physician Services:** Healthcare services a doctor provides or coordinates.
- **Plan:** Amerigroup is your health plan, or Plan, which pays for and coordinates your healthcare services.
- **Preauthorization:** A decision by Amerigroup that a service or prescription drug is medically necessary for you. Sometimes called prior authorization. Emergency services, services related to an emergency medical condition, and urgent care do not need approval.
- **Premium:** An amount you pay for your health insurance.
- **Prescription Drug Coverage:** When the health plan helps pay for prescription and OTC medications.
- **Prescription Drugs:** Medications that by law require a prescription.
- **Primary Care Physician or Primary Care Provider:** Your primary care provider is the doctor or other healthcare provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and providers about your care and refer you to them. Usually, you must see your primary care provider before you see any other healthcare provider.
- **Provider:** Any doctor, hospital, agency, or other person who has a license or is approved to deliver healthcare services. A provider may also be a clinic, pharmacy, or facility.
- **Rehabilitation Services:** Healthcare services that help you recover from an illness, accident, or major operation. These services may include physical therapy, occupational therapy, speech-language pathology, and psychiatric rehabilitation services.
- **Skilled Nursing Care:** Certain skilled services that can only be performed by licensed nurses in your home or in a nursing home.
- **Specialist:** A physician who provides healthcare for a specific disease or part of the body. You may need a referral from your PCP to get services from some specialists.
- **Urgent care:** There are some injuries and illnesses that are not emergencies, but can turn into an emergency if they are not treated within 24 hours.

Notice of Privacy Practices

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

myamerigroup.com

HIPAA notice of privacy practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in March 2021.

Please read this notice carefully. This tells you:

- **Who can see your protected health information (PHI).**
- **When we have to ask for your OK before we share your PHI.**
- **When we can share your PHI without your OK.**
- **What rights you have to see and change your PHI.**

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

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

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

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

When it is OK for us to use and share your PHI

We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it is OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals, and others get you the care you need
- **For payment, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care
  - When we say we will pay for healthcare or services before you get them (called prior authorization or preapproval)
  - To find ways to make our programs better, as well as support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you do not want this, please visit **amerigroup.com/amerigroup/privacy-policy.html** for more information.
- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it is OK
  - With someone who helps with or pays for your healthcare, if you cannot speak for yourself and it is best for you

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

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

Other ways we can — or the law says we have to — use your PHI:

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

Your rights

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We do not have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we do not have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we shared your PHI with someone else. This will not list the times we shared it because of healthcare, payment, everyday healthcare business, or some other reasons we did not list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What we have to do

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

Contacting you

We, along with our affiliates and vendors, may call or text you using an automatic telephone dialing system or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we will not contact you in this way anymore. Or you may call **844-203-3796 (TTY 711)** toll free to add your phone number to our Do Not Call list.

What to do if you have questions

If you have questions about our privacy rules or want to use your rights, please call Member Services toll free at **800-600-4441 (TTY 711)** Monday through Friday, 7 a.m. to 7 p.m. Eastern time.

What to do if you have a complaint

We are here to help. If you feel your PHI has not been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

You may write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth St. SW
Atlanta, GA 30303-8909
Phone: **800-368-1019**
TDD: **800-537-7697**
Fax: **404-562-7881**

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we will tell you about the changes in a letter. We also will post them on the web at **amerigroup.com/amerigroup/privacy-policy.html.**

Race, ethnicity, language, sexual orientation and gender identity
We get race, ethnicity, language, sexual orientation and gender identity information about you from state agencies for Medicaid and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:
- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information
We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It is often taken for insurance reasons.
- We may use your PI to make decisions about your:
  - Health.
  - Habits.
  - Hobbies.
- We may get PI about you from other people or groups such as:
  - Doctors.
  - Hospitals.

  - Other insurance companies.
- We may share PI with people or groups outside of our company without your OK in some cases.
- We will let you know before we do anything where we have to give you a chance to say no.
- We will tell you how to let us know if you do not want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

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Amerigroup Community Care follows Federal civil rights laws. We don't discriminate against people because of their:

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

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

Communicating with you is important

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

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

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 1-**800-600-4441 (TTY 711)** if you're a Georgia Families member, or at **1-855-661-2021 (TTY 711)** if you're a Georgia Families 360°$_{SM}$ member.

Your rights

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

Grievance Coordinator
740 W. Peachtree Street
Atlanta, GA 30308

Phone: **800-600-4441 (TTY 711)**
Fax: **877-842-7183**

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

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

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

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

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

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