Dear Gateway Health Member,

I would like to take this opportunity to welcome you to Gateway HealthSM. We are pleased you have chosen us as your partner in better health.

Gateway HealthSM is a managed healthcare plan. This means that we work with your doctor, or primary care physician (PCP), to service your total healthcare needs. Your PCP’s name and phone number is on your ID card. Present this card and your ACCESS card whenever you seek medical attention. Please call us right away if there are any mistakes on your ID card.

In addition to providing high-quality care, Gateway HealthSM offers extra benefits to members based on specific needs. Our Prospective Care Management (PCM®) Program provides members with disease specific education, self care instruction and help in finding community-based services. Some of these programs include:

- Gateway to Lifestyle ManagementSM
  - MOM Matters® Program gives pregnant members the support to have a healthy baby.
  - Asthma Program helps members learn how to keep their asthma under control.
  - Cardiac Program helps adult members with Congestive Heart Failure, a heart attack or coronary artery disease to live a healthier life.
  - Chronic obstructive pulmonary disease (COPD) program helps members learn how to manage their symptoms so that they can be more active.
  - Diabetes Program helps members with diabetes and their families understand how diet and medication can keep blood sugar under control.

- Growing Up with GatewaySM helps children remain healthy.

- Transition Management gives you support after you are discharged from a hospital or nursing home stay.

This Member Handbook explains the benefits and services available to you as a member of Gateway HealthSM. It also explains what to do in an emergency or urgent medical situation. Please read this handbook carefully to learn more about the healthcare services covered under the plan (such as Dental and Vision services). Keep this handbook in a safe place for quick and easy reference later on.

I encourage you to use your Gateway HealthSM benefits and get the care that you need to stay healthy. If you have any questions about your coverage, or need information about how to use your benefits, please call the Member Services Department at 1-800-392-1147 (TTY/TDD users: 711). Member Services is available 24 hours a day, 7 days a week for your calls. I also invite you to visit our web site, GatewayHealthPlan.com, to find a physician, learn more about disease prevention programs, and a variety of other useful information.

Again, welcome to Gateway HealthSM A better way.

Sincerely,

Gateway HealthSM
Gateway’s Member Services Department

Gateway’s Member Services makes it easy for you to find a doctor in your area, order a new ID card or get answers to your questions about your healthcare coverage. We are available 24 hours a day, 7 days a week by calling toll-free at 1-800-392-1147 (TTY/TDD users: 711).

If you want to ask about a covered service or talk to someone about a problem, we are here for you and the call is free. You may also visit our website at gatewayhealthplan.com.

Non-English Speaking Members

If you do not speak English, call Member Services at 1-800-392-1147 (TTY/TDD users: 711) and an interpreter will be provided at no charge. You may also call Member Services if you need your printed Gateway information translated. Your doctor should be able to provide an interpreter for your appointments. If your provider is unable to provide an interpreter, please call Member Services at 1-800-392-1147 (TTY/TDD users: 711) for assistance.

SPANISH: LLAME A SERVICIOS PARA MIEMBROS, AL TELÉFONO 1-800-392-1147 (TTY/TDD: 711) Y SE LE FACILITARÁ UN INTÉRPRETE Y SI NECESITA QUE LE TRADUZCAN SU INFORMACIÓN GATEWAY, LLÁMENOS AL MISMO NÚMERO.

CROATIAN: Ako Vi ne govorite engleski, nazovite Usluzne Clanove na 1-800-392-1147 (TTY/TDD: 711), i Vi cete imati tumaca. Molimo Vas takode da nazovete ako Vase Gateway informacije trebaju biti prevedene.

RUSSIAN: Если вы не говорите по-английски, позвоните в Службу членской поддержки по телефону 1-800-392-1147 (TTY/TDD: 711) и вам будет предоставлен переводчик. Также звоните, если хотите получить перевод вашего буклета о программе Gateway.

VIETNAMESE: Neu khong noi duoc tieng Anh, xin goi Dich Vu Hoi Vien tai so 1-800-392-1147 (TTY/TDD: 711), de co mot thong dich vien giup do. Quy vi cung nen goi cho chung toi neu can dich cac thong tin ve Gateway cua mình.

Members with hearing and/or vision problems

Some members with hearing problems use a TTY/TDD (Telecommunication Device for the Deaf) service to make phone calls. You can still talk to Member Services by calling the PA State Relay Service by dialing 711 or 1-800-654-5984 and asking to be connected to Gateway Member Services at 1-800-392-1147.

Your Member Handbook and other Gateway information is available in large print, Braille, on cassette tape, or computer diskette at no cost to you.
Gateway Health ID Card

Gateway members will receive an identification card (ID card) for every member of the family enrolled in Gateway.

You can start using your ID card on the “effective date” that is printed on the upper left hand corner. The card is good for as long as you stay on Medical Assistance and remain a member of Gateway. Your ID card does not replace your ACCESS card from the Department of Public Welfare. Keep both cards!

You should keep your Gateway ID card and your ACCESS card with you at all times as well as verification of any other insurance coverage you may have. Show all insurance cards every time you go to the doctor or use any Gateway covered service. Use your ACCESS Card for services that are not covered by Gateway such as WIC, Medical Assistance Transportation Program (MATP), Mental Health and Drug and Alcohol services.

If your ID card is lost or stolen, call Member Services at 1-800-392-1147 (TTY/TDD users: 711). If your ACCESS card is lost or stolen, call your caseworker at your local County Assistance office.

How Can I Change My Doctor?

If you want to change your PCP for any reason, call Member Services at 1-800-392-1147 (TTY/TDD users: 711). A Member Services Representative will help you make the change and will tell you when you can start seeing the new doctor. Depending on when you call, you may not be able to see your new doctor until the first day of the next month. You will get a new ID card, which will have your new doctor’s name and phone number.

If you need a list of Gateway participating doctors, hospitals, dentists or other special providers, call Member Services at 1-800-392-1147 (TTY/TDD users: 711). You can also visit our website at gatewayhealthplan.com for a list of providers.

Your Primary Care Physician (PCP)

Your ID card also shows the name of the doctor (PCP) you selected when you enrolled with Gateway. If you didn’t select a PCP, one may have been assigned to you. Your PCP helps arrange your healthcare needs and works with Gateway to make sure you get the care you need. You can have the same PCP for the whole family, or a different doctor for each family member.
### PCP Appointments

If you need an appointment, call your doctor. The doctor’s phone number is on your ID card, and there is no charge for visits to your PCP. It is very important that you keep your appointments with your doctor. If you cannot make it for any reason, call the doctor’s office right away to let them know.

<table>
<thead>
<tr>
<th>New member appointment for your first examination...</th>
<th>You should have an appointment...</th>
</tr>
</thead>
<tbody>
<tr>
<td>members with HIV/AIDS</td>
<td>with PCP or specialist no later than 7 days after you become a member of Gateway unless a PCP or specialist is already treating you</td>
</tr>
<tr>
<td>members who receive Supplemental Security Income (SSI)</td>
<td>with PCP or specialist no later than 45 days after you become a member of Gateway unless a PCP or specialist is already treating you</td>
</tr>
<tr>
<td>members under age 21</td>
<td>with PCP for an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening no later than 45 days after you become a member of Gateway unless a PCP or specialist is already treating you</td>
</tr>
</tbody>
</table>

| Waiting time in the waiting room | with no more than 30 minutes or up to 1 hour of wait time when the doctor encounters an unanticipated urgent visit or is treating a member with a difficult need |

<table>
<thead>
<tr>
<th>Member who are pregnant...</th>
<th>You should have an appointment...</th>
</tr>
</thead>
<tbody>
<tr>
<td>pregnant women in their first trimester</td>
<td>with OB/GYN within 10 business days of Gateway learning you are pregnant</td>
</tr>
<tr>
<td>pregnant women in their second trimester</td>
<td>with OB/GYN within 5 business days of Gateway learning you are pregnant</td>
</tr>
<tr>
<td>pregnant women in their third trimester</td>
<td>with OB/GYN within 4 business days of Gateway learning you are pregnant</td>
</tr>
<tr>
<td>pregnant women with high-risk pregnancies</td>
<td>with OB/GYN within 24 hours of Gateway learning you are pregnant</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Appointment with your PCP...</th>
<th>You should have an appointment...</th>
</tr>
</thead>
<tbody>
<tr>
<td>emergency appointment</td>
<td>immediately with PCP or referred to an emergency facility</td>
</tr>
<tr>
<td>urgent medical condition</td>
<td>within 24 hours</td>
</tr>
<tr>
<td>routine medical appointment</td>
<td>within 10 business days</td>
</tr>
<tr>
<td>health assessment/ general physical examination</td>
<td>within 3 weeks of Enrollment</td>
</tr>
</tbody>
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<tr>
<th>Specialists (with referral)...</th>
<th>You should have an appointment...</th>
</tr>
</thead>
<tbody>
<tr>
<td>emergency appointment</td>
<td>immediately with Specialist or referred to an emergency facility</td>
</tr>
<tr>
<td>urgent medical condition</td>
<td>within 24 hours of referral</td>
</tr>
</tbody>
</table>
### Specialty Care Referral

Doctors that work with a certain area of medical care are called specialists. Some types of specialists are heart doctors, skin doctors, or someone who does surgery. If you need special care that your PCP cannot give you, your doctor may send you to a specialist. This is called a “referral.” Your PCP and the specialist will work together for your total healthcare needs. If you go to a specialist without your PCP’s referral, you may have to pay the specialist’s bill. If you have been seeing a specialist for an ongoing problem, you can ask your PCP to grant a standing referral to the specialist or the specialist can choose to be your PCP. Please call Member Services at 1-800-392-1147 (TTY/TDD users: 711) for help in getting your specialist to be your PCP or talk to your PCP about ordering a standing referral.

A specialist may send you to receive special services or tests. Some of those tests and services also require a referral. Examples of services and tests that require a referral are:

- Angiograms
- Bone Scans
- Chemotherapy (Hospital Setting)
- Endoscopies
- Nerve Conduction Testing
- Sleep Studies

**When You Do Not Need A Referral**

There are some special services that do not require a referral from your PCP. You can go to any Gateway participating doctor for the services listed below without a referral:

- OB/GYN visits (pelvic exams, PAP tests, mammograms, pregnancy care, woman care)
- Routine eye care
- Dental care
- Chiropractor visits (prior authorization is required for additional visits beyond the initial consultation)

For Family Planning services, you can go without a referral to any doctor, whether the doctor is a Gateway participating doctor or not.
You do not need a referral for behavioral health services including mental health care (depression) or drug and alcohol abuse.

Gateway’s goal is for you to be seen by the specialist that can best treat you. If there are not two specialists on the list of Gateway participating doctors that can treat you, Gateway will make arrangements with a specialist that is not on the Gateway list. Your PCP can help you make the request for care outside of Gateway’s list of participating doctors. If your request is denied by Gateway, you may file a grievance.

If you have been seeing a specialist for an ongoing problem, the doctor can choose to be your PCP. Please call Member Services at 1-800-392-1147 (TTY/TDD users: 711) for help in getting your specialist to be your PCP.

### Arranging Your Care

There are some services that Gateway must approve before you can get them. This is called prior authorization. You may have to pay when a service is provided without prior authorization. There are doctors and nurses who work for Gateway to help your doctor choose the best way to take care of you. These doctors and nurses are part of Gateway’s Health Services division. They make decisions about the care that is most likely to help you by using specific guidelines for medical decisions. The guidelines are based on whether the service is medically necessary. Medically necessary means the service or benefit will, or is reasonably expected to prevent the onset of an illness, condition or disability; is reasonably expected to reduce the physical, mental or developmental effects of an illness, condition, injury or disability; or will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

If you need a service that must be approved by Gateway before it is done, your doctor will call to get an approval. The doctors and nurses in Gateway’s Health Services division will look at all the medical facts given by your doctor within certain time limits to decide if this service is the best way to take care of you. Gateway’s doctors and nurses make a decision on whether the care is medically necessary and appropriate for you. There is no extra payment given to these doctors and nurses no matter what they decide about your care. Doctors and nurses are not rewarded for reducing the amount of care approved.

Some of the services that need to be approved before you have them are listed below:

- Hospital admission
- The use of a short procedure unit in a hospital for a dental operations
- The use of a short procedure unit in a hospital for certain medical operations
- Medical equipment for your home (Some covered items under $500 only require your doctor’s prescription.)
- Nurses to come to your home
- Physical therapy, occupational therapy or speech therapy
- MRI and CT scan (testing)
- Using a doctor or other provider not in Gateway’s network
- Ambulance service, except for emergencies
- Chiropractic services (except for the first visit)
- Hospice (care for the terminally ill or dying)
• Nursing home or rehabilitation admissions
• Surgery

There may be other services that need to be approved by Gateway first. Your PCP or other doctor must contact Gateway to get prior authorization for certain services. If you do not have approval from Gateway before getting these services, you may have to pay the bill.

If you need to have tests or an operation, your doctor will call Gateway to have the services approved. Gateway will suggest a place for treatment.

If a service is not covered under the plan, your doctor can ask Gateway for an exception. Gateway does not guarantee that all exception requests will be approved or covered.

If Gateway denied payment for a service that you already had, your doctor may ask for a “retrospective review” to change the decision. A retrospective review is a detailed look at your records and information to determine if the services were necessary to keep you healthy. This is done by Gateway’s Health Services division.

If you are admitted to the hospital and your doctor feels that you may need more days of care, a “concurrent review” may happen. A concurrent review is a detailed review while you are still admitted. This is also done by Gateway’s Health Services division to determine if the services are necessary to get you healthy.

You may request a copy of the criteria for medical necessity on which the decision was based by sending a written request to:

Gateway HealthSM
Member Services Department
Four Gateway Center
444 Liberty Ave, Suite 2100
Pittsburgh, PA 15222-1222

Out of Network Care

Many doctors and hospitals participate with Gateway. They are called the “network.” There may be a time when you need to use a doctor or hospital that is not a part of Gateway’s network. If this happens, your PCP can call Gateway to make this request. The Health Services division will check to see if there is a doctor or hospital within Gateway’s network that can give you the same care. If there is a doctor or hospital within the network, Health Services will let your doctor know.

New Gateway members have the right to keep seeing an out of network doctor to finish a course of treatment. The doctor must agree to Gateway’s guidelines. If you have been getting ongoing care from a doctor that is not a Gateway doctor, and you need to stay with this same doctor to finish a course of treatment, please call Member Services at 1-800-392-1147 (TTY/TDD users: 711) for help. Please keep in mind that any services received from providers not in our network must be approved by Gateway; otherwise you may have to pay for them.

If a request to use a doctor or hospital outside of Gateway’s network is denied, you can file a complaint with Gateway by calling Member Services at 1-800-392-1147 (TTY/TDD users: 711). If you receive services from a provider that is not in Gateway’s network without approval, that provider may be allowed to bill you.
When Out of Town

Gateway services many counties within Pennsylvania. Gateway is offered in:
- Adams
- Allegheny
- Armstrong
- Beaver
- Bedford
- Berks
- Blair
- Butler
- Cambria
- Cameron
- Clarion
- Clearfield
- Crawford
- Cumberland
- Dauphin
- Elk
- Erie
- Fayette
- Forest
- Franklin
- Fulton
- Greene
- Huntingdon
- Indiana
- Jefferson
- Lancaster
- Lawrence
- Lebanon
- Lehigh
- McKean
- Mercer
- Northampton
- Perry
- Potter
- Somerset
- Venango
- Warren
- Washington
- Westmoreland
- York

If you or your family members are out of Gateway’s service area and have a medical emergency, such as a heart attack or a car accident, go to the nearest emergency room. Make sure that you or your authorized representative calls your PCP as soon as possible.

Sometimes you will need to get care for things that may not be considered a medical emergency, such as a cold or flu. If you become sick when you are out of Gateway’s service area and it is not a medical emergency, call Member Services at 1-800-392-1147 (TTY/TDD users: 711). Member Services can connect you to your PCP at no cost to you. All of Gateway’s doctor offices have a doctor on call 24 hours a day. If the office is closed when you call, you will be able to leave a message with an answering service or on a machine, and the doctor will call you back. It is important to leave the phone number where you can be reached while out of town. If it is during normal office hours, you will speak to the office staff. The office staff will talk to the doctor about your problem and then tell you what to do. If you are not able to speak with a doctor, Member Services may also help you get the care you need.

Emergency Services

Your PCP or an on-call physician, is available 24 hours a day, 7 days a week, for whenever you need medical care. If you are having an emergency and must get immediate medical care, go to the nearest emergency room. If you do not need immediate emergency attention, call your PCP first. Your doctor will tell you what to do. If your doctor is not in, an answering service will give your doctor a message to call you back.

You should only go to the hospital emergency room for emergency care. An emergency is a sudden start of a medical condition or severe pain that an average person with no medical training feels:

1. Places the person’s health (or with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy.
2. Would result in serious harm to bodily functions.
3. Would result in serious harm to an organ or body part.

Every situation is different. If you or your family has an emergency, go to the nearest emergency room or 24-hour care center. Dial 911 or the phone number for your local ambulance service.

The hospital should provide appropriate medical screening to determine whether or not an emergency medical condition exists regardless of your ability to pay for treatment, your citizenship, or the legality of your presence in the United States.
Emergency medical condition means a medical condition that could reasonably expected to result in (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

There are times when it is hard to know what a real emergency is. If you call your PCP before going to the emergency room, the doctor can tell you what to do.

Here are some examples of times when you should use the emergency room:

- Blackouts
- Car accident
- Chest pain or heart attack
- Choking
- Criminal attack (i.e. mugging or rape)
- Danger of losing limb or life
- Difficulty in breathing
- Heavy bleeding
- Loss of speech
- Overdose of medicine or drugs
- Paralysis (not able to move)
- Poisoning
- Possible broken bones
- Seizures
- Vomiting (throwing up) blood

Here are some examples of when you probably do not need to go to the emergency room. At these times, if you call your PCP, the doctor can tell you what you should do.

- Bruises or swelling
- Cold or cough
- Cramps
- Small cuts or burns
- Earache

- Rash
- Sore throat
- Vomiting (throwing up)

Your PCP should arrange all follow-up care after an emergency room visit. Do not go back to the emergency room for bandage changes, removal of stitches, cast checks, or more testing. Do not return to the emergency room unless you have another emergency.

Transportation for Medical Services

If you need help getting a ride to a medical service other than an emergency, each county provides transportation through the Medical Assistance Transportation Program. Each county provides transportation services directly or hire a transportation provider depending on the resources available in the county. The transportation provided may be:

- Tickets or tokens to ride public transportation;
- Mileage reimbursement for use of a private car;
- Para-transit services (for example, in a van)

A list of phone numbers by county is on pages 45 & 46 of this Handbook. You can also call Member Services at 1-800-392-1147 (TTY/TDD users: 711), and you will be connected to the Medical Assistance Transportation Program (MATP) in your county.
Covered Benefits

Some of the services that are covered by Gateway at no cost to you include:

- Visits to your PCP
- Visits to the doctor while you are pregnant
- Yearly physical examination
- Well child care, including regular check-ups and shots
- Non-emergency dental care, if eligible for non-emergency dental care under Medical Assistance
- Topical fluoride varnish treatments
- Braces for teeth for members under age 21, if medically necessary
- Eye exams
- Contraceptives (birth control), insulin, insulin syringes, vitamins and certain over-the-counter medicines when prescribed by a doctor and covered by the approved drug list
- Drugs for members under age 21 when prescribed by a doctor and covered by the approved drug list
- Orthopedic shoes and hearing aids for members under age 21, if medically necessary
- Emergency care 24 hours a day, 7 days a week
- 24-hour toll-free member telephone service for non-emergency and urgent needs, through Member Services
- Surgery and anesthesia, if medically necessary
- EPSDT expanded services for members under age 21
- Extended home nursing services for members under age 21, if medically necessary
- Nursing facility care (limited to 30 days), if medically necessary
- Home health care visits, if medically necessary and ordered by your doctor
- Molded shoes, if medically necessary
- Any other medical services for members under age 21 determined to be medically necessary
- Laboratory Services
- Tobacco Cessation Counseling

Some of the services that are covered by Gateway that may require you to pay a co-payment include:

- Visits to specialists with a referral from your PCP
- Allergy tests and shots with a referral from your PCP
- Drugs for members age 18 and older, if eligible for medicine coverage under Medical Assistance, prescribed by a doctor and covered by the approved drug list
- Foot care
- Hospitalization, if medically necessary, including semi-private rooms (a private room is covered if needed for a medical condition), inpatient drug and doctor services
- Cardiograms, as ordered by your doctor
- X-rays, when medically necessary and ordered by your doctor
- Physical therapy, if medically necessary
- Occupational and speech therapy, if medically necessary
- On-going chiropractic services, if medically necessary

Co-payments do not apply to any member who is under age 18, in a nursing home or pregnant (plus...
60-days after pregnancy ends through the end of the month the 60-days ends) and women in the Breast and Cervical Cancer Prevention and Treatment (BCCPT) program.

Your provider will tell you the amount of your co-payment when you present your ID card and any other insurance ID cards that you may have. Your caseworker at your local county assistance office (CAO) determines if you are MA or GA eligible. If you have any questions about the amount of your co-payment, talk with your provider or call Member Services at 1-800-392-1147 (TTY/TDD users: 711).

You cannot be denied a service or drug if you cannot pay the co-payment. Tell your provider if you cannot afford to pay. Your provider may bill you later and has the right to collect for co-payments not paid at the time of service.

Co-payment does not apply to:

- Services or items provided to a terminally ill individual who is receiving hospice care
- Services provided to individuals of any age eligible under Titles IV-B and IV-E Foster Care and Adoption Assistance
- Services provided in emergency situations
- Family planning services and supplies
- Home health agency services
- Renal dialysis services
- Blood and blood products
- Oxygen
- Rental of Durable Medical Equipment
- Outpatient services when the MA Fee is under $2.00
- Medical exams requested by the Department
- More than one of a series of a specific allergy test provided in a 24 hour period
- Targeted case management services
- Members under 18 or any member who is pregnant (through the post-partum period beginning on the last day of the pregnancy and extending through the end of the month in which the 60-day period following termination of the pregnancy ends) or in a nursing home
- Members covered under the MA Adult benefit category do not have a copayment for the following kinds of drugs:
  - Drugs, including immunizations, that you get in the doctor’s office
  - Anti-hypertensive agents
  - Anti-diabetic agents
  - Anti-convulsants
  - Cardiovascular preparations
  - Anti-psychotic agents, except those that are also schedule C-IV anti-anxiety agents
  - Anti-neoplastic agents
  - Anti-glaucoma drugs
  - Anti-parkinson drugs
  - Drugs used only to treat HIV/AIDS

The pharmacy will inform the member of any applicable co-pay for a prescription. Members cannot be denied a service if they are unable to pay their co-pay.

**The yearly limits will start again on July 1st of every year. Providers or members may request an exception to approve services above the yearly limits based on medical necessity.**
Benefit Limits

Some members age 21 and older have limits to the services they can receive. To find out if benefit limits apply to you, talk with your physician or call Member Services at 1-800-392-1147 (TTY/TDD users: 711).

Benefit Limit Exceptions

Benefit limits do not apply if you are under age 21 or are pregnant. If benefits limits do apply to you and you or your provider feel you need services above these limits, your provider can ask Gateway to approve additional services for you. This is called an exception.

All exception requests are reviewed for medical necessity and can be granted if:

• You have a serious chronic illness or other serious health condition and without the additional service your life would be in danger; or

• You have a serious chronic illness or other serious health condition and without the additional service your health will get much worse; or

• You would need more costly services if the exception is not granted; or

• You would have to go into a nursing home or institution if the exception is not granted; or

• You need the exception approved to agree with State regulations.

Requests received after the service has been rendered will receive a response within 30 days of the date on which Gateway received the request. A retrospective request for an exception must be submitted no later than sixty (60) days from the date that Gateway rejects a claim due to a service being over the benefit limit. Retrospective exception requests made after sixty (60) days will be denied.

If your exception request is denied, you or your doctor may appeal the denial.

Your doctor may not bill you for services over the limits unless both of the following conditions are met:

• Your doctor has requested an exception to the limit and Gateway denied the request.

• Your doctor told you before the service was provided that you are responsible for payment if the exception is not granted.

To ask for an exception, you or your doctor can call Member Services at 1-800-392-1147 (TTY/TDD users: 711).

You and your doctor will receive written notice of the approval or denial of the request for exception. For prospective exception requests, if you or your doctor are not notified of the decision within 21 days the request is received, the decision will be automatically granted.

Any exception request received prior to the service being provided will get a response within 21 days of the date on which Gateway received the request. Prospective urgent exception requests will receive a response within 48 hours of the date and time on which Gateway received the request.
Medicines

If you are eligible for drug coverage, your prescriptions can be filled at any pharmacy (drug store) that is part of Gateway’s pharmacy network. Members that are not eligible for drug coverage can get contraceptives (birth control) and vitamins. Diabetic members that are not eligible for drug coverage from Medical Assistance can get insulin and syringes (needles) from Gateway. Members must get prescriptions from their PCP for insulin, syringes, contraceptives, and vitamins. The prescription may be taken to a pharmacy in Gateway’s network. You may be charged a co-payment depending upon your eligibility and the prescription being filled. If you need help finding a pharmacy that is in the network or have questions on drug coverage, please call Member Services at 1-800-392-1147 (TTY/TDD users: 711).

Gateway uses an approved drug list, called a drug formulary, to determine if your drug is covered. The drug formulary has FDA approved products from every major drug category, including vitamins and all over-the-counter medicines covered by Medical Assistance.

Can the Formulary change?

Gateway may make certain changes to our formulary during the year. These changes must first be approved by the Department of Public Welfare. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescriptions. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations (prior approval), quantity limits (limits the amount of drug you can have filled), and/or step-therapy restrictions (you must try certain drugs before you can fill a prescription for some drugs) on a drug

Utilization Management

Gateway has additional requirements for coverage or limitations of certain formulary drugs. Our formulary book will tell you which drugs may have any additional requirements or limits on them. The online formulary found at http://www.gatewayhealthplan.com/members/look-medication will also tell you this information. These requirements and limits help us be sure that our members use these drugs in a safe and effective manner while helping to control drug plan costs. A team of doctors and/or pharmacists work to develop these requirements and limits for Gateway to help provide quality coverage to our members. The requirements for coverage or limits on certain drugs are listed as follows:

- **Prior Authorization:** Gateway requires prior authorization (prior approval) for certain drugs. Some drugs on the formulary require additional information from your doctor to make sure the drug is being used safely and will work well in treating your condition. This means that your doctor will need to get approval from Gateway before you fill your prescription. If they don’t get prior approval, Gateway will not cover the drug.

- **Quantity Limits:** For certain drugs, Gateway has established quantity limits that the FDA has approved to be safe and effective. A quantity limit is the maximum amount of the drug Gateway will cover per prescription of over a defined period of time. For example, we will provide up to 28 tablets per prescription for the antibiotic, ciprofloxacin, every 30 days.
• **Step Therapy:** Some medications on Gateway’s formulary require specific drugs to be tried before you can receive a step therapy medication that treats your medical condition first. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

• **Generic Substitution:** When there is a generic version of a brand-name drug available, Gateway requires the generic drug be given to you. If your doctor prescribes a brand name drug, our network pharmacies will automatically give you the generic version. If your doctor feels you must take the brand name drug, he or she must contact Gateway’s pharmacy services to have that request reviewed.

If you would like a copy of the approved drug formulary, or have any questions on drug coverage, please call Member Services at 1-800-392-1147 (TTY/TDD users: 711). Members can also notify Gateway if they feel a new drug should be placed on the formulary.

If you are on a drug that is not on Gateway’s approved drug formulary, talk to your doctor to see if your drug can be switched to a drug from the formulary that has the same or similar effect. If your doctor feels that the drug you take now is medically necessary and cannot be switched, your doctor can call Gateway to request an exception. If the exception is approved, Gateway will cover your current drug. Gateway will approve for your pharmacy to give you enough of the drug for up to 96 hours if a decision on the exception cannot be made within 24 hours, and you need the drug.

You have the right to appeal any decision made about your drug coverage. Call Member Services toll-free at 1-800-392-1147 (TTY/TDD users: 711), 24 hours a day, 7 days a week.

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### Six Prescription Benefit Limit

You can get up to 6 prescriptions each month. This rule **does not apply** to you if:

- You are under 21 years of age; or
- You are pregnant; or
- You live in a nursing home or an intermediate care facility

In some instances Gateway can approve more than 6 prescriptions. This is called a benefit limit exception. Gateway can grant a benefit limit exception if:

- You have a serious chronic illness or health condition and without the additional service, your life would be in danger; or
- You have a serious chronic illness or health condition and without the additional service, your health would get much worse; or
- You would need more expensive services if the exception is not granted; or
- It would be against federal law for Gateway to deny the exception

Some exceptions can happen at the pharmacy. A benefit limit exception can be made at the pharmacy if your prescription is for one of the drugs listed below:
Drugs to treat:
- Abnormal or irregular heartbeat
- Angina
- Asthma or COPD (chronic obstructive pulmonary disease)
- Bipolar disease
- Cancer
- Chronic kidney disease
- Depression
- Diabetes
- Enzyme deficiencies
- Glaucoma
- Gout
- Hemophilia
- Hepatitis
- High blood pressure
- High cholesterol
- HIV/AIDS
- Immune deficiency
- Infection
- Multiple sclerosis
- Nausea and vomiting
- Opiate dependency
- Parkinson’s disease
- Pulmonary hypertension
- Serious mental illness
- Thyroid disorders

Drugs to prevent:
- Blood clots
- Pregnancy
- Seizures

Drugs to:
- Reduce stomach acid
- Stop migraine headaches
- Suppress the immune system
- Provide immunity (vaccines)

If your prescription is not approved at the pharmacy, your doctor or provider who prescribed the drug must call the pharmacy prior notification service and the give our staff person:

- Your name, address, date of birth, and Gateway Health ID number
- Provider name, address, telephone and fax number, medical license number and National Provider Identifier number
- Information about the drug being prescribed, your diagnosis and why you need the exception

Once Gateway has the needed information, we will respond to the request within 24 to 72 hours. You and your doctor will get a written notice of the decision.

If you need the drug right away, your pharmacist may give you up to a 5 day emergency supply.

If a request for an exception is denied, you and your doctor will get a written notice of the decision. The written notice will explain how to appeal. The written notice will explain how and when to ask for a Fair Hearing with the Department of Public Welfare or file a complaint or grievance with Gateway Health if your request for a benefit limit exception is denied. If you need help filing an appeal you can call Member Services at 1-800-392-1147 (TTY/TDD users: 711).

Eye Exams and Eyeglasses

Regular eye exams are very important. That is why Gateway gives this benefit to all Gateway members. Each Gateway member is eligible for two eye examinations every calendar year (there
are no benefit limits for members under age 21, if medically necessary). There is no waiting period to get your vision benefit.

You must go to an eye doctor who is part of Gateway’s vision network. You do not need a referral. Be sure to show your ID card and say that you are a Gateway Health member.

Members age 21 and older will also be covered for one pair of standard eyeglasses (one frame and two lenses) or one pair of contact lenses from a Gateway’s network provider, per calendar year. Members under age 21 are eligible for two standard pairs of eyeglasses (two frames and four lenses), or two pairs of contact lenses or one each from within Gateway’s network each calendar year, as well as replacement, if medically necessary.

Some examples of covered lenses would be:
- Single Vision lenses (standard, plastic, glass or oversize)
- Bifocal lenses (standard, plastic, glass or oversize)
- Trifocal lenses (standard, plastic, glass or oversize)
- Aphakic/Lenticular lenses (standard, plastic, glass or oversize)
- Contact lens prescription and fitting
- Standard Contact Lenses (two lenses) (such as daily wear/spherical)
- Disposable/Replacement contacts - $75.00 member credit.
- Polycarbonate lenses for members under 21 years of age.

Designer Frames from the Davis Vision Collection are covered in full or you may receive a $20.00 retail allowance for a provider supplied frame. You will be responsible for the amount over $20.00.

There are special provisions for members 21 and older with Cataracts or Aphakia. To learn more, call Member Services.

If you choose value-added options for your lenses that are beyond the standard eyeglass lenses, such as tinting or special coatings, you may be charged an additional fee which may not be covered by Gateway. Some examples of options and services that are not covered are:

- Special lens designs or coatings other than those described in the benefit plan
- Non-prescription (Plano) lenses
- Replacement of lost/stolen eyewear if not authorized by Gateway
- Any refractive surgical procedures, including Lasik
- Medical treatment of eye disease or injury as this may be covered by your Gateway medical benefits
- Low vision aids
- Low vision devices
- Visual therapy
- Services not performed by licensed personnel

You can call Member Services at 1-800-392-1147 (TTY/TDD users: 711) for a list of participating eye doctors or if you have questions about your vision benefits.
**BENEFITS AND SPECIAL SERVICES**

**Dental Care**

Children under the age of 21 are eligible to receive all medically necessary dental services. Your child can go to any dentist that is a part of Gateway’s network. You can find a dentist in your area by using our online provider directory at gatewayhealthplan.com or by calling Member Services at 1-800-392-1147 (TTY/TDD users: 711). Your child does not need a referral for a dental visit. However, your child’s PCP may refer children age 3 and above to a dental home as part of their regular EPSDT well child screens.

Dental services that are covered for children under the age of 21 include the following, when medically necessary:

- Anesthesia
- Orthodontics (braces)*
- Check-ups
- Periodontal services
- Cleanings
- Fluoride Treatments
- Root canals
- Crowns
- Sealants
- Dentures
- Dental surgical procedures
- Dental emergencies
- X-rays
- Extractions (tooth removals)
- Fillings

* If braces were put on before the age of 21, services will be covered, until they are completed, or age 23, whichever comes first, as long as the patient remains eligible for Medical Assistance.

Adult members may get the following dental services each year from any Gateway participating dentist:

Members with Limited Medicaid Benefits (as determined by the Department of Public Welfare):
- One exam in an office setting
- One (1) cleaning in an office setting
- X-rays, cleanings and exams in a hospital setting are covered only if determined to be medically necessary

Members with Full Medicaid Benefits (as determined by the Department of Public Welfare):
- Two exams
- Two (2) cleanings
- X-rays

In your lifetime you can get:
1. One partial upper denture or one full upper denture; and
2. One partial lower denture or one full lower denture

You can get the following services only if you get special approval, called a benefit limit exception:
1. Crowns and related services;
2. Root canals and other endodontic services; and
3. Periodontal services

For more information on your child’s dental benefits, please call Member Services at 1-800-392-1147 (TTY/TDD users: 711).
How do I get a benefit limit exception?

Your dentist must ask for the exception. This can happen before the services start or after they are finished. Your dentist can ask for an exception up to 60 days after your dental services are finished. Your dentist must send a written request by mail to:

United Concordia Companies, Inc.
Benefit Limit Exception
PO Box 69427
Harrisburg, PA 17106-9427

The benefit limit exception submitted by your dentist must include:

- Your name, address and Member ID number
- The dental service that is needed
- The reason the exception is needed
- The dentist’s name and phone number

Mental Health, Drug & Alcohol Services

Services for mental health care such as depression, or drug and alcohol abuse are available to you. Please see the last page of this handbook for the phone numbers for your county.

If you need help accessing these services, you can call Member Services at 1-800-392-1147 (TTY/TDD users: 711).

Care Management

If you have a special healthcare need, the Care Management Department can help. Nurses, social workers, and other healthcare staff are available to work with you to make sure you get the medical care that you need. They can assist you with any problems you have in getting your care.

Care Managers can also provide you with:

- Information about programs in your community such as food banks, utility assistance, HIV, or nutrition and weight loss programs.
- Assistance with complex case management, for members with specific, specialized needs.
- Assistance with transition management, to help you understand your discharge instructions, and what you need to do once you get home from the hospital.

Call Member Services at 1-800-392-1147 (TTY/TDD users: 711) if you would like to talk to a Care Manager.

Gateway to Lifestyle Management℠

Gateway has programs to help you manage Asthma, COPD, Heart Disease and Diabetes. There is also a program to help you have a healthy pregnancy. You do not have to do anything to enroll. If you have one of these conditions you are automatically enrolled in Gateway to Lifestyle Management℠ and will receive educational information in the mail. A Care Manager may contact you to see how you are doing and answer any questions to help you improve your health and the care you receive from your health care team.

Asthma Program

Do asthma symptoms interfere with your life? If so, you may want to join our Asthma Program. This program is offered to Gateway members 2 years of age and older. A Care Manager can help you manage your asthma. This can help you to have less disruption in your life so that you can do the things that you want to do.
Here are a few reminders for managing your COPD:

• Quit smoking. This is the most important change you can make. You can get help by calling 1-800-QUIT-NOW (1-800-784-8669).

• Avoid air pollution, second-hand smoke and fumes because they can make your breathing worse.

• Take your breathing medicine as your doctor ordered. Your medicine can help you breathe easier and may help prevent a hospital visit.

• Get a yearly flu shot. Ask your doctor about a pneumonia shot if you have not had one.

• Talk to your doctor about an exercise program. Daily exercise can help you to breathe better.

• Make sure you use your oxygen if it was ordered for you. It can help you to be more active.

• Avoid going outside when pollution levels are high. Air pollution can make your breathing worse. Pay attention to alerts on the radio and television.

• If you are admitted to the hospital, remember to get all of your breathing medicines filled when you go home. Don’t forget to make a doctor appointment within 2 weeks of leaving the hospital.

If you would like more information on the Gateway to Lifestyle Management™ Asthma Program, call 1-800-642-3550 (TTY/TDD users: 711) then press 3. The care managers are available to answer your call Monday through Friday between 8:30 am and 4:30 pm.

Chronic Obstructive Pulmonary Disease (COPD) Program

Living with chronic obstructive pulmonary disease (COPD) can be overwhelming. Gateway Health wants to help! If you are at least 21 years of age and are living with COPD, you may benefit from our COPD program. A care manager can help you to learn how to manage your symptoms so that you can be more active and enjoy life.

Here are a few reminders for managing your COPD:

• Stop smoking and avoid second-hand smoke. Get help to quit smoking by calling 1-800-QUIT-NOW (1-800-784-8669).

• Take your long-term control medicine every day. Your control medicine helps to prevent symptoms and treats swelling in your airways.

• Use your rescue inhaler when you have wheezing or trouble breathing. Tell your doctor if you need to use your rescue inhaler more than 2 days a week. This means that your asthma is not controlled.

• Uncontrolled asthma may cause scarring and permanent narrowing of the airways. So it is important to tell your doctor, as you may need a change in your medicine.

• Visit your doctor at least twice a year. It is important that your doctor monitors your asthma.

• Ask your doctor about an Asthma Action Plan. This will help you understand what to do when you are sick.

• If you are admitted to the hospital, make an appointment to see your doctor within 2 weeks of discharge.

If you want to speak to a care manager about our Gateway to Lifestyle Management™ COPD Program call 1-800-642-3550 (TTY/TDD users: 711) and press #3. Care managers are available Monday through Friday between 8:30 am and 4:30 pm.
**Cardiac Program**

Gateway Health members age 21 or older with heart disease or heart failure may benefit from the Cardiac Program. A specially trained care manager is available and can help you and your doctor better manage your heart disease. You will get the support you need to take an active role in staying healthy.

Understanding a heart healthy lifestyle decreases the chances of flare ups and hospital stays. Care managers are available by phone between 8:30 am and 4:30 pm and look forward to hearing from you.

Here are a few important reminders for managing your heart problems:

- Take your medicine the way your doctor ordered. If you can’t, let your doctor know. Wait to hear from your doctor’s office before you stop taking your pills.
- Some pills have to be slowly stopped over several days so don’t just stop taking a pill. You can have uncomfortable side effects if you do.
- Visit your doctor at least twice a year. If you are admitted to the hospital make an appointment to see your doctor within 2 weeks of discharge.
- If you are admitted to the hospital, be sure to ask which medicines you should take. Medicines may have different names for the same pill. Don’t assume that you are to take the medicines that you have at home and make sure you understand what each of your pills is for.
- Know the signs and symptoms for when to notify your doctor when you don’t feel well.
- Ask your doctor which blood tests you need to control your heart disease.
- Stop smoking and avoid second-hand smoke. Get help to quit smoking by calling 1-800-QUIT-NOW (1-800-784-8669).

If you would like more information on the Gateway to Lifestyle Management Cardiac Program call 1-800-642-3550 (TTY/TDD users: 711) and press #3. Care managers are available to answer your call Monday through Friday between 8:30 am and 4:30 pm.

**Diabetes Program**

Gateway HealthSM members of any age who are living with Diabetes may benefit from the Diabetes Program. A specially trained care manager is available to help you learn about:

- How to keep blood sugars under control to help prevent diabetic complications like heart disease, blindness, amputations and kidney problems.
- How taking your medications, testing your blood sugar and having labs done as recommended by your doctor can help you stay on top of your diabetes.

Here are a few reminders about managing your diabetes:

- Take your blood sugar readings the way your doctor ordered them and know your goals.
- Make sure you get these tests at least once a year or more often if your doctor tells you to:
  - A1c: a blood test that measures your average blood sugar for the past 2-3 months. It doesn’t replace checking your own blood sugar, which tells you what your blood sugar is only at the time you are checking.
  - LDL-c: (cholesterol) - a form of fat that can lead to a buildup of cholesterol in the
arteries. Keeping your LDL-C at your target is the most effective way to protect the heart and blood vessels.

- Urine test (microalbumin) - a simple urine test that checks for small amounts of protein in the urine. Protein in the urine can be an early indicator of kidney problems.
- Blood pressure: diabetes and high blood pressure raises your risk of heart attack, stroke, and eye and kidney disease. Knowing your goal and having it checked regularly can prevent delay problems.
- Dilated Retinal Eye Exam - this exam checks for eye disease, which is more common in people with diabetes. Tell your eye doctor you have diabetes. This exam isn’t the same as a vision exam for glasses or contacts. This can help identify eye problems early and prevent problems from developing.
- Stop smoking and avoid second-hand smoke. Get help to quit smoking by calling 1-800-QUIT-NOW (1-800-784-8669).

If you would like more information on the Gateway to Lifestyle Management® Diabetes Program call 1-800-642-3550 (TTY/TDD users: 711) and press #3. The care managers are available to answer your call Monday through Friday between 8:30 am and 4:30 pm.

**MOM Matters® Program**

Gateway has a special program for pregnant women called MOM Matters®. This program provides education and support to help you have a healthy pregnancy. You should try to remain with Gateway throughout your pregnancy to get the most of this program. Specially trained care managers can answer your questions or concerns about your pregnancy. The care managers can also help with community service referrals. You will also receive information on pregnancy and baby care in the mail.

Here are some helpful tips for your pregnancy:

- Keep all of your prenatal appointments. If you miss an appointment, call your doctor to reschedule. Do not wait until your next visit.
- Take the prenatal vitamins prescribed by your doctor. Prenatal vitamins are an important part of your prenatal care for both the health of you and your baby. There are many prenatal vitamins available that Gateway pays for.
- Avoid alcohol, illegal drugs and smoking. Second-hand smoke can harm you and your unborn child. Get help to quit smoking by calling 1-800-QUIT-NOW (1-800-784-8669).
- Never take any medicines without checking with your doctor first. This includes prescription medications and over the counter medications like aspirin, Tylenol and cough syrup.
- Eat at least 3 meals a day and choose healthy foods like fruit, meat, milk, vegetables, breads and cereals.
- Avoid foods like coffee, soda pop, fast foods, candy and doughnuts.
- Drink at least 6 to 8 glasses of water every day. Juice and milk are also healthy choices.
- Keep your teeth and gums healthy by brushing and flossing daily. Gum infections can increase the risk of preterm labor.
- Wear your lap and shoulder belts when you are in a car. The lap portion should be low under your belly and touching your thighs.
If you would like more information about the Gateway to Lifestyle Management®MOM Matters® Program, call 1-800-642-3550 (TTY/TDD users: 711) and press 2. The care managers are available to answer your call Monday through Friday between 8:30 am and 4:30 pm by phone.

**HIV/AIDS Services**

If you have HIV/AIDS you can call Gateway’s Care Management Department, 1-800-642-3550 (TTY/TDD users: 711), Option 1 to discuss services and resources that are available for you.

You may be eligible for additional home and community-based services if you have AIDS or symptomatic HIV. Services include additional nursing and home health aide visits, homemaker services, nutritional supplements, nutritional consultations, and medical supplies.

To get services, your doctor will need to write an order. Prior authorization is required for some services. Your doctor’s office can call Gateway’s Utilization Management Department at 1-800-392-1146 (TTY/TDD users: 711) to obtain prior authorization.

If you need help finding a PCP or specialist to treat you, call Gateway’s Member Services Department at 1-800-392-1147 (TTY/TDD users: 711).

**Women, Infants, and Children Program (WIC)**

WIC is a program that provides food vouchers, nutrition education and counseling, and referrals to health and other social services to pregnant women, post partum mothers, breastfeeding mothers and children under age five who are at nutritional risk, at no charge.

In addition to the foods normally available such as milk, eggs, cheese, cereal and juices, WIC may provide families with vouchers redeemable for many other nutritious foods, including whole wheat breads/rolls, brown rice, oats, whole wheat/corn soft tortillas, soymilk, tofu, fresh fruits/vegetables, jarred baby foods, canned beans, pink salmon or sardines.

Many grocery stores accept WIC food vouchers.

You can apply for WIC by calling 1-800-942-9467 or 1-800-WIC-WINS.

If you would like more information about WIC, call our Care Management Department at 1-800-642-3550 (TTY/TDD users: 711) and press 2. The care managers are available Monday through Friday between 8:30 am and 4:30 pm by phone.

**Growing Up with Gateway℠ Program**

Members under age 21 are eligible for a special program called Growing Up with Gateway℠. Growing Up with Gateway℠ includes all of the services recommended by the Pennsylvania Department of Welfare’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The purpose of the Growing Up with Gateway℠ program is to find children’s health problems early and to keep checking to be sure that children stay healthy.

Your child’s PCP will check on many areas of health during EPSDT exams and screenings. The doctor will check on your child’s heart, lungs,
eyesight, hearing and teeth. If your child’s doctor finds areas of concern, your child’s doctor will make a referral for other tests or to a specialist as needed. The doctor may refer children age 3 and above to a dental home as part of their regular EPSDT well child screens. For the EPSDT visit, the doctor could also give your child shots (immunizations) or ask about the child’s nutrition or diet. The doctor will also check other areas that are important to your child, by testing the child’s urine or testing the child’s blood for anemia and lead levels. The doctor will also ask questions about your child’s mental health, speech, social actions and behavior – the way your child relates to other kids their age. Finally, the doctor will ask questions to put together a family medical history.

During your child’s EPSDT exam the PCP will identify if your child is due for a dental referral based on his/her age. The PCP will advise you if the child is need of a referral. The PCP will also notify Gateway of the need for a dental referral as part of the Growing Up with GatewaySM Program. Gateway has Preventive Health staff that will contact you and offer assistance in setting up dental appointments if needed. Please remember dental health is very important even with very young children. Talk to your PCP about your child’s dental health at each EPSDT visit.

It is very important that you keep your EPSDT appointments with the doctor. These physical exams can sometimes be used as the exam your child needs to get into Head Start, or for school, or for a driver’s license physical.

Your child’s doctor may find that your child needs a medically necessary service or a piece of equipment to treat a problem found during a screening visit. If so, your child’s doctor can call Gateway to ask for the service or equipment, and it will be reviewed for approval.

If you need more information about the Growing Up with GatewaySM program, please call the Preventive Health Department at 1-800-642-3550 (TTY/TDD users: 711), and press 4. Preventive Health staff can also help you set up an appointment for your child, assist you with dental appointments or help you get a ride for these appointments.

**Early Intervention Services**

Gateway participates in Early Intervention Services by identifying infants, toddlers and preschool children who have special needs due to developmental delays or disabilities. PCP and school districts may also help identify members in need of Early Intervention Services. When a member is identified, the parent is contacted and given the CONNECT Helpline at 1-800-692-7288. The CONNECT staff will answer questions and refer a family to the appropriate local agency for a developmental assessment.

**Stop Smoking**

You CAN Quit Smoking – We CAN Help

**Do you want help to stop smoking?**

Gateway wants to help you, whether this is your first try at quitting or even if you have tried before and started smoking again. Gateway wants to help you become smoke free.

**Medicines:**

Gateway covers the following medications to help you quit smoking: Nicotine gum, nicotine patch, nicotine lozenge, nicotine inhaler, Nicotrol NS and buproprion. To get medicines to help you stop smoking, call your doctor for an appointment.
**Counseling services:**
*Gateway* covers counseling to help you quit smoking. To get counseling, start by calling the Pennsylvania Free Quitline at 1-877-724-1090

Even if medicine or counseling did not work before, that doesn’t mean they will never work for you.

The Pennsylvania Department of Health also wants you to succeed in your quit attempt. That’s why they created the Pennsylvania Free Quitline. If you are considering quitting smoking, call the Pennsylvania Free Quitline today.

For help, call Pennsylvania’s Free Quitline at 1-877-724-1090

Remember: People often try to quit several times before they succeed.

Just because you have tried before, does not mean it isn’t time to try again.

**Family Planning**

Family planning (birth control) services are available to Gateway Health members. You do not need a referral from your PCP for family planning services. You can see any doctor that offers family planning. If you would like more information on a doctor in Gateway’s network, please call 1-800-392-1147 (TTY/TDD users: 711). However, you may choose to use a family planning clinic that is not part of Gateway’s network (for routine gynecology or non-family planning visits, you must use an OB/Gynecologist that is part of Gateway’s network). There is no cost for these services. When you go to a family planning provider, just show your ID card.

Treatment for infertility (cannot have a baby) is not covered by Gateway.

**Chiropractic Services**

Gateway Health members can get chiropractic care. You may go to a chiropractor from Gateway’s list of participating doctors on your own for the first visit, or your PCP can call Gateway before you go. After your first visit, the chiropractor must talk to a Gateway nurse about your treatment plan, and the nurse may approve more visits, if medically necessary.

**Services not Covered**

There are some services not covered by Gateway. Limitations and most exclusions do not apply to members under age 21. Services not covered include:

- Braces for teeth (called orthodontics) for members age 21 and older
- Cosmetic Surgery (also called plastic surgery), unless medically necessary
- Custodial care including Personal Care Homes
- Experimental procedures, unless prior approval from Gateway is received
- Nursing home care for more than 30 days. If you need to stay in a nursing home for more than 30 days, you will be switched back to the traditional Medical Assistance Fee for Service Program (also called ACCESS)
- Personal items or services such as television or a telephone while you are in the hospital
- Prescription drugs for members age 21 and older that are not eligible for Medical Assistance drug benefits (other than vitamins, insulin, syringes, and birth control)
BENEFITS AND SPECIAL SERVICES

- Prescription drugs not listed on the approved drug list, unless an exception is made
- Drugs designated as less than effective by the Food and Drug Administration (FDA). These are also known as DESI for the Drug Efficacy Study Implementation drugs
- Drugs prescribed for the treatment of erectile dysfunction
- Treatment for infertility (cannot become pregnant)
- Home modifications
- Respite care
- Services that are not covered by the Medical Assistance program
- Non-medical items or services
- Surgery, medication or any other medical procedures or services related to sex-change

Shift nursing services are not covered for members age 21 and older. This applies to members who began receiving these services when they were under age 21. You may be eligible for a Home and Community Based Waiver through Medical Assistance to provide shift nursing services beyond the age of 21. If you are interested in obtaining information regarding Home and Community Based Waivers, please call 1-800-642-3550 (TTY/TDD users: 711), press 1.

There may be other services that are not covered by Gateway. If you are not sure if the service you need is covered, call Member Services at 1-800-392-1147 (TTY/TDD users: 711). Some services, such as transportation and Behavioral Health services, are not covered by Gateway but may be covered by your ACCESS card. You may have to pay for services that are not covered by Gateway or your ACCESS card or for services not provided by a Pennsylvania Medical Assistance participating provider. A Care Manager will provide you with information regarding waivers and important phone numbers that you will need. If you are interested, the Care Manager can also send you “The Transition to Adulthood” brochure that includes information about various aspects of transitioning to adulthood, and services that are available.

Remember, in most cases, Gateway will only cover those services that are ordered by your PCP, except in a medical emergency.
Adding New Members to Gateway

When you have a new baby or add a new member to your family, you should call Member Services at 1-800-392-1147 (TTY/TDD users: 711). It is also important to let your caseworker at the County Assistance Office know about your baby’s birth. If you don’t tell Gateway and your caseworker, your new family member’s Gateway insurance may be delayed.

When You Move

If you move, it is very important to tell your caseworker at the County Assistance Office. Gateway can only update your address and phone number after your caseworker updates your Department of Public Welfare file. Your new address and phone number are needed so that Gateway can send you information about your health plan. If you move out of the counties that Gateway services, you cannot keep your Gateway coverage. Call Member Services at 1-800-392-1147 (TTY/TDD users: 711) to let Gateway know you moved.

Other Insurance

You or one of your family members might have other types of insurance. Call Member Services at 1-800-392-1147 (TTY/TDD users: 711) if you or any member of your family is covered by Gateway and another insurance plan. Your caseworker at the County Assistance office also needs to know this information. If you have health, dental or vision insurance through another insurance company, you must use that insurance coverage first as a primary insurance. Gateway is always the last payer to other insurance coverage you may have. It is important to show your healthcare providers all of your insurance cards.

Claims – What Do I Do With a Bill?

Pennsylvania Medical Assistance providers cannot charge you for services that are covered by Gateway. If you get a bill from your doctor or the hospital by mistake, do not pay the bill. Please call Member Services at 1-800-392-1147 (TTY/TDD users: 711) with the billing information and a representative will help you.

Changes in Benefits or Services

Gateway will let you know if there are changes in your benefits or the way you receive your services. An example of a change would be if your PCP or specialist were no longer part of Gateway’s list of participating doctors, called the “network.” Member Services will call you or send a letter to give you a chance to pick a new doctor, so there will not be a problem or delay for you to get the care you need. It is important to note that changes in your medical assistance benefit package or general eligibility status are made by the County Assistance Office.

Changing Health Plans

If you would like to enroll with Gateway or change your health plan from Gateway to another plan at any time, call Pennsylvania Enrollment Services at 1-800-440-3989 (TTY/TDD: 1-800-618-4225) or enroll online at www.enrollnow.net.

Pennsylvania Enrollment Services is responsible for enrollment activities. Pennsylvania Enrollment Services employs trained, professional staff called Enrollment Specialists (ES). The ES's primary responsibility is to enroll MA consumers into the plan that best meets their needs. The ES assists consumers by providing objective information so
they can choose a physical health plan for their medical needs and a Primary Care Physician (PCP) to manage their care.

Other responsibilities of Pennsylvania Enrollment Services include, but are not limited, to the following:

- Provide education and information to MA consumers to enable them to make informed choices of a physical health plan
- Enroll MA consumers in the physical health plan of their choice
- Assist with the selection of a Primary Care Physician (PCP)
- Provide information about Behavioral Health Services and how to access those services

If you are hearing impaired and use a TTY/TDD (Telecommunication Device for the Deaf) service, you can call toll-free number, 1-800-618-4225 to enroll with Gateway or change your health plan from Gateway to another plan.

**Involuntary Disenrollment**

An “involuntary disenrollment” is when your Gateway membership ends without you asking for the change. Your Gateway membership will end if your case is “closed” by the Pennsylvania Department of Public Welfare.

If your case is “closed” for less than 6 months and then opens up again, you will automatically be put back on Gateway.

If your case is “closed” for more than 6 months and then opens up again, the Pennsylvania Department of Public Welfare will not put you back on Gateway Health automatically.

- If you want to become a Gateway member again, you must call Pennsylvania Enrollment Services 1-800-440-3989 (TTY/TDD: 1-800-618-4225) or enroll online at www.enrollnow.net.

If you do not contact Pennsylvania Enrollment Services to choose a plan, the Pennsylvania Department of Public Welfare will automatically choose a plan for you.

It will take 4-6 weeks for your new membership to start.

**When You Stop Being a Gateway Health Member**

You will stay a member of Gateway Health unless:

- You want to change health plans
- You move outside of Gateway’s service area
- The Pennsylvania Department of Public Welfare closes your case
**Member Rights**

As a Gateway Health Member, you have the right to:

1. Get information about Gateway, the services Gateway provides, doctors and other healthcare providers giving you care, and your rights and responsibilities as a Gateway member
2. Be treated with respect and recognition of dignity and right for privacy when receiving healthcare
3. Work with your doctor or other healthcare providers in making decisions about your healthcare and to express preferences about future treatment decisions
4. Openly discuss, without any limitations by Gateway, appropriate or medically necessary treatment choice for your condition with a doctor or other healthcare provider, including treatment options, risks of treatment, alternative therapies and consultations or tests that may be self administered, regardless of the cost or if it is a benefit
5. Receive your medical and nursing care without regard to marital status, race, color, religion, sex, sexual preference, handicap, age, national origin, whether you have an advance directive
6. Remain free from seclusion used as a means of coercion, discipline, convenience or retaliation
7. Pick your own doctor from Gateway’s network of doctors
8. Refuse care from certain doctors
9. File a complaint or grievance about Gateway or the care it provides
10. Make recommendations regarding Gateway’s members’ rights and responsibilities policies
11. Request a fair hearing from the Department of Public Welfare
12. Prepare a Living Will and/or an Advance Directive
13. See, or have your medical record copied, within Federal and State laws, and to request that your medical record be changed or corrected within Federal laws
14. Have your medical records kept private and confidential

Your choice to exercise these rights will not adversely affect the way Gateway, its providers or any State agency will treat you.

**Member Responsibilities**

As a Gateway Health Member, you have a responsibility to:

1. Give information to your doctor, other healthcare provider, or Gateway so they can provide care to you
2. Follow the instructions and treatment plans that you agreed on with your doctor or other healthcare provider
3. Provide consent to healthcare providers and Gateway to help them manage your care, to improve your health or for research
4. Understand your health problems. As much as you can, take part in making a plan for treatment goals with your doctor or other healthcare providers
5. See the doctor you picked on a regular basis
6. Treat the people giving you medical care with the same respect and kindness you expect for yourself
When should I file a first level complaint?

You must file a complaint within **45 days of getting a letter** telling you that

- Gateway has decided that you cannot get a service or item you want because it is not a covered service or item.
- Gateway will not pay a provider for a service or item you got.
- Gateway did not decide a complaint or grievance you told us about within 30 days.

You must file a complaint **within 45 days of the date you should have gotten a service or item** if you did not get a service or item.

You may file **all other complaints at any time**.

What happens after I file a first level complaint?

After you file your complaint, you will get a letter from Gateway telling you that we have received your complaint, and about the first level complaint review process.

You may ask Gateway to see any relevant information we have about your complaint. You may also send information that may help with your complaint to Gateway.

You may attend the complaint review if you want to. You may come to our offices at Four Gateway Center, 444 Liberty Ave, Suite 2100, Pittsburgh, PA 15222-1222 or be included by phone or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect our decision.
A committee of one or more Gateway staff who have not been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

What to do to continue getting services:
If you have been receiving services or items that are being reduced, changed or stopped and you file a complaint that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you, the service or items will continue until a decision is made.

What if I don’t like Gateway’s decision?

SECOND LEVEL COMPLAINT
If you do not agree with our first level complaint decision, you may file a second level complaint with Gateway.

When should I file a second level complaint?
You must file your second level complaint within 45 days of the date you receive the first level complaint decision letter. To file a second level complaint, you can:

- call Gateway at 1-800-392-1147 TTY/TDD 711 and tell us your second level complaint
- write down your second level complaint and send it to us at:
  
  Gateway HealthSM
  Four Gateway Center
  444 Liberty Ave, Suite 2100
  Pittsburgh, PA  15222-1222

What happens after I file a second level complaint?
You will receive a letter from Gateway telling you that we have received your complaint, and telling you about the second level complaint review process.

You may ask Gateway to see any relevant information we have about your complaint. You may also send information that may help with your complaint to Gateway.

You may attend the complaint review if you want to. You may come to our offices at Four Gateway Center, 444 Liberty Ave, Suite 2100, Pittsburgh, PA or be included by phone or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee made up of three or more people, including at least one person who is not an employee of Gateway who have not been involved in the issue you filed your complaint about, will review your complaint and make a decision. Your complaint will be decided no later than 45 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.
What to do to continue getting services:
If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file a second level complaint that is hand-delivered or postmarked within 10 days of the date on the first level complaint decision letter, the services or items will continue until a decision is made.

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, Pennsylvania 17120
Telephone Number: 1-877-881-6388

If you send your request for external review to the wrong department, it will be sent to the correct department.

The Department of Health or the Insurance Department will get your file from Gateway. You may also send them any other information that may help with the external review of your complaint.

You may be represented by an attorney or another person during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

What to do to continue getting services:
If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file a second level complaint that is hand-delivered or postmarked within 10 days of the date on the first level complaint decision letter, the services or items will continue until a decision is made.

What can I do if I still don’t like Gateway’s decision?

EXTERNAL COMPLAINT REVIEW
If you do not agree with Gateway’s second level complaint decision, you may ask for an external review by either the Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve Gateway’s policies and procedures.

You must ask for an external review within 15 days of the date you received the second level complaint decision letter. If you ask, the Department of Health will help you put your complaint in writing.

You must send your request for external review in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, PA 17120-0701
Telephone Number: 1-888-466-2787

or

What to do to continue getting services:
If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file a second level complaint that is hand-delivered or postmarked within 10 days of the date on the first level complaint decision letter, the services or items will continue until a decision is made.
**Grievances**

**What is a grievance?**

When Gateway denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a letter (notice) telling you Gateway’s decision.

A grievance is when you tell us you disagree with Gateway’s decision.

**What should I do if I have a grievance?**

**FIRST LEVEL GRIEVANCE**

To file a grievance, you can:

- call Gateway at 1-800-392-1147 (TTY/TDD users: 711) and tell us your grievance, or
- write down your grievance and send it to us at:
  
  Gateway Health℠
  Four Gateway Center
  444 Liberty Ave, Suite 2100
  Pittsburgh, PA  15222-1222
- your provider can file a grievance for you if you give the provider your consent in writing to do so.

NOTE: If your provider files a grievance for you, you cannot file a separate grievance on your own.

**When should I file a first level grievance?**

You have 45 days from the date you receive the letter (notice) that tells you about the denial, decrease, or approval of a different service or item, to file your grievance.

**What happens after I file a first level grievance?**

After you file your grievance, you will get a letter from Gateway telling you that we have received your grievance, and about the first level grievance review process.

You may ask Gateway to see any relevant information we have about your grievance. You may also send information that may help with your grievance to Gateway.

You may attend the grievance review if you want to. You may come to our offices Four Gateway Center, 444 Liberty Ave, Suite 2100, Pittsburgh, PA or be included by phone or by videoconference. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee of one or more Gateway staff, including a licensed doctor, who have not been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 30 days after we received your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

**What to do to continue getting services:**

If you have been receiving services or items that are being reduced, changed or stopped and you file a first level grievance that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you the services or items will continue until a decision is made.
COMPLAINTS, GRIEVANCES, AND FAIR HEARINGS

What if I don’t like Gateway’s decision?

SECOND LEVEL GRIEVANCE

If you do not agree with our first level grievance decision, you may file a second level grievance with Gateway.

When should I file a second level grievance?

You must file your second level grievance within 45 days of the date you receive the first level grievance decision letter. To file a second level grievance, you can:

• Call Gateway at 1-800-382-1147 (TTY/TDD users: 711) and tell us your second level grievance

• Write down your second level grievance and send it to us at:

  Gateway Health℠
  Four Gateway Center
  444 Liberty Ave, Suite 2100
  Pittsburgh, PA 15222-1222

What happens after I file a second level grievance?

You will receive a letter from Gateway telling you that we have received your grievance, and telling you about the second level grievance review process.

You may ask Gateway to see any relevant information we have about your grievance. You may also send information that may help with your grievance to Gateway.

You may attend the grievance review if you want to. You may come to our offices at Four Gateway Center, 444 Liberty Ave, Suite 2100, Pittsburgh, PA or be included by phone or by videoconference. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee of three or more people including a doctor and at least one person who is not an employee of Gateway, who have not been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 45 days after we receive your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

What can I do if I still don’t like Gateway’s decision?

EXTERNAL GRIEVANCE REVIEW

If you do not agree with Gateway’s second level grievance decision, you may ask for an external grievance review.

You must call or send a letter to Gateway asking for an external grievance review within 15 days of the date you received our grievance decision letter. To ask for an external grievance review, you can:

What to do to continue getting services:
If you have been receiving services or items that are being reduced, changed or stopped and you file a second level grievance that is hand-delivered or postmarked within 10 days of the date on the first level grievance decision letter, the services or items will continue until a decision is made.
COMPLAINTS, GRIEVANCES, AND FAIR HEARINGS

- Call Gateway at 1-800-392-1147 (TTY/TDD users: 711) and tell us your grievance or
- Write down your grievance and send it to us at:

  Gateway HealthSM
  Four Gateway Center
  444 Liberty Ave, Suite 2100
  Pittsburgh, PA  15222-1222

We will then send your request to the Department of Health.

The Department of Health will notify you of the external grievance reviewer’s name, address and phone number. You will also be given information about the external grievance review process.

Gateway will send your grievance file to the reviewer. You may provide additional information that may help with the external review of your grievance to the reviewer within 15 days of filing the request for an external grievance review.

You will receive a decision letter within 60 days of the date you asked for an external grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

What to do to continue getting services:
If you have been receiving services or items that are being reduced, changed or stopped and you request an external grievance review that is hand-delivered or postmarked within 10 days of the date on the second level grievance decision letter, the services or items will continue until a decision is made.

You may call Gateway’s toll-free telephone number at 1-800-392-1147 (TTY/TDD users: 711) if you need help or have questions about complaints and grievances, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

What can I do if my health is at immediate risk?

Expedited Complaints and Grievances

If your doctor or dentist believes that the usual timeframes for deciding your complaint or grievance will harm your health, you or your doctor or dentist can call Gateway at 1-800-392-1147 (TTY/TDD users: 711) and ask that your complaint or grievance be decided faster. You will need to have a letter from your doctor or dentist faxed to 412-255-4503 explaining how the usual timeframe for deciding your complaint or grievance will harm your health.

If your doctor or dentist does not fax Gateway this letter, your complaint or grievance will be decided within the usual timeframes.

EXPEDITED COMPLAINT

The expedited complaint will be decided by a licensed doctor, who has not been involved in the issue you filed your complaint about.

Gateway will call you with our decision within 48 hours of when we receive the letter from your doctor or dentist explaining how the usual timeframe for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review,
COMPLAINTS, GRIEVANCES, AND FAIR HEARINGS

whichever is sooner. You will also receive a letter telling you the reason(s) for the decision and how to file an external complaint, if you don’t like the decision.

EXPEDITED GRIEVANCE AND EXPEDITED EXTERNAL GRIEVANCE

A committee of three or more people, including a licensed doctor and at least one Gateway member, will review your grievance. The licensed doctor will decide your expedited grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your grievance about.

Gateway will call you with our decision within 48 hours of when we receive the letter from your doctor or dentist explaining how the usual timeframe for deciding your grievance will harm your health or within 3 business days of your request for an expedited (faster) grievance review, whichever is sooner. You will also receive a letter telling you the reason(s) for the decision and how to file an expedited external grievance, if you don’t like the decision.

If you want to ask for an expedited external grievance review by the Department of Health, you must call Gateway at 1-800-392-1147 (TTY/TDD users: 711) within 2 business days from the date you get the expedited grievance decision letter. Gateway will send your request to the Department of Health within 24 hours after receiving it.

What kind of help can I have with the complaint and grievance processes?

If you need help filing your complaint or grievance, a staff member of Gateway will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review. For legal assistance you can contact your local legal aid office at 1-800-322-7572.

At any time during the complaint or grievance process, you can have someone you know represent you or act on your behalf. If you decide to have someone represent or act for you, tell Gateway, in writing, the name of that person and how we can reach him or her.

You or the person you choose to represent you may ask Gateway to see any relevant information we have about your complaint or grievance.

Persons whose primary language is not English

If you ask for language interpreter services, Gateway will provide the services at no cost to you.

Persons with Disabilities

Gateway will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed. This help includes:

• providing sign language interpreters;
• providing information submitted by Gateway at the complaint or grievance review in an alternative format. The alternative format version will be given to you before the review; and
• providing someone to help copy and present information.

NOTE: For some issues you can request a fair hearing from the Department of Public Welfare in addition to or instead of filing a complaint or grievance with Gateway.

See below for the reasons you can request a fair hearing.

**COMPLAINTS, GRIEVANCES, AND FAIR HEARINGS**

- **Department of Public Welfare Fair Hearings**

  In some cases you can ask the Department of Public Welfare to hold a hearing because you are unhappy about or do not agree with something Gateway did or did not do. These hearings are called “fair hearings”. You can ask for a fair hearing at the same time you file a complaint or grievance or you can ask for a fair hearing after Gateway decides your first or second level complaint or grievance.

  **What kind of things can I request a fair hearing about and by when do I have to ask for my fair hearing?**

<table>
<thead>
<tr>
<th>If you are unhappy because…</th>
<th>You must ask for a fair hearing…</th>
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<tbody>
<tr>
<td>Gateway decided to deny a service or item because it is not a covered service or item</td>
<td>within 30 days of getting a letter from Gateway telling you of this decision</td>
</tr>
<tr>
<td>Gateway decided to not pay a provider for a service or item you got and the provider can bill you for the service or item</td>
<td>within 30 days of getting a letter from Gateway telling you of this decision</td>
</tr>
<tr>
<td>Gateway did not decide within 30 days, a complaint or grievance you told Gateway about before</td>
<td>within 30 days of getting a letter from Gateway telling you that we did not decide your complaint or grievance within the time we were supposed to</td>
</tr>
<tr>
<td>Gateway decided to deny, decrease or approve a service or item different than the service or item you requested because it was not medically necessary</td>
<td>within 30 days of getting a letter from Gateway telling you of this decision or within 30 days of getting a letter from Gateway telling you its decision after you filed a complaint or grievance about this issue</td>
</tr>
<tr>
<td>Gateway did not provide a service or item by the time you should have received it.</td>
<td>within 30 days from the date you should have received the service or item</td>
</tr>
</tbody>
</table>
How do I ask for a fair hearing?

You must ask for a fair hearing in writing and send it to:

Department of Public Welfare
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair Hearings
PO Box 2675
Harrisburg, PA 17105-2675

Your request for a fair hearing should include the following information:

- member name;
- member social security number and date of birth;
- a telephone number where you can be reached during the day;
- if you want to have the fair hearing in person or by telephone; and
- any letter you may have received about the issue you are requesting your fair hearing for.

What happens after I ask for a fair hearing?

You will get a letter from the Department of Public Welfare’s Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing.

What to do to continue getting services:
If you have been receiving services or items that are being reduced, changed or stopped and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that Gateway has reduced, changed or denied your services or items or telling you Gateway decision about your first or second level complaint or grievance, your services or items will continue until a decision is made.
What can I do if my health is at immediate risk?

**Expedited Fair Hearing**

If your doctor or dentist believes that using the usual timeframes to decide your fair hearing will harm your health, you or your doctor or dentist can call the Department of Public Welfare at 1-800-798-2339 and ask that your fair hearing be decided faster. This is called an expedited fair hearing. You will need to have a letter from your doctor or dentist faxed to 717-772-6328 explaining why using the usual timeframes to decide your fair hearing will harm your health. If your doctor or dentist does not send a written statement, your doctor or dentist may testify at the fair hearing to explain why using the usual timeframes to decide your fair hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within 3 business days after you ask for the fair hearing.

If your doctor does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date you asked for the fair hearing.

If your doctor sent a written statement or testifies at the hearing, the decision will be made within 3 business days after you asked for the fair hearing.

You may call Gateway’s toll-free telephone number at 1-800-392-1147 (TTY/TDD users 711) if you need help or have questions about fair hearings, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.
**Advance Directives**

If you are admitted as a patient to a hospital, you will be asked if you have any Advance Directives. An Advance Directive is any instructions you give about your medical care before medical services are done. Advance Directives are only followed in the future when you are unable to say what medical care you want.

There are two kinds of Advance Directives. One is called a “living will” and the other is called a “durable power of attorney.”

A “living will” spells out what kind of life-sustaining care you want to get in a terminal condition or permanent state of coma.

A “durable power of attorney” for healthcare lists someone who can make healthcare decisions for you. This would be if you could not make and tell people your decisions.

An Advance Directive might be used when a person is in a coma and cannot tell the doctor what type of care he or she wants.

It is your legal right to make Advance Directives about your medical care. It is also something you may want to talk to your doctor about.

Gateway can send you information about policies and the current Pennsylvania law regarding the Patient Self Determination Act. This is the law that covers Advance Directives. Call Member Services at 1-800-392-1147 (TTY/TDD users: 711) for a copy.

Gateway will notify you, by letter, of any changes in Pennsylvania law about Advance Directives within 90 days of the change.

If you believe that a doctor or hospital has not followed the instructions of your Advance Directive you may contact Gateway to find out how to file a complaint with Gateway or with the Department of Health.

**HealthChoices Clinical Sentinel Hotline**

The Clinical Sentinel Hotline (CSH) is operated by The Department of Public Welfare (DPW) to make sure that your requests for medically necessary care and services sent to Gateway and your Behavioral Health MCO are responded to in a timely manner. The CSH helps all Medical Assistance consumers who are enrolled in the HealthChoices Program.

The CSH allows members to speak to nurses who work for DPW. If you or your health care provider request medical care or services, and Gateway or your Behavioral Health MCO has not responded in time to meet your needs, call the CSH. You can also call the CSH if Gateway or your Behavioral Health Plan has denied you medically necessary care or services and will not accept your request to file a grievance. You can also call the CSH if you are having trouble getting shift home health services that have been authorized by Gateway.

You can call the CSH Monday through Friday between 9:00 am and 5:00 pm. To reach the CSH, call 1-800-426-2090. The CSH cannot provide or approve urgent or emergency medical care. If you believe you need urgent or emergency care, you should call your PCP or go to your local hospital.
Suggestions for Changes

If you would like to suggest changes to any of Gateway’s Policies and Procedures, please call Member Services at 1-800-392-1147 (TTY/TDD users: 711).

Fraud and Abuse

If you think that someone is using your or another member’s Gateway Health ID card to get medical or prescription drug benefits, call Gateway’s Fraud and Abuse Hotline at 412-255-4340 (TTY/TDD users: 711). Your name will be kept private unless Gateway is required to share that information. If you are not in the (412) area code, call Member Services at 1-800-392-1147 (TTY/TDD users: 711) to report this activity.

You may also report this information to the Department of Public Welfare’s Medical Assistance Provider Compliance Hotline at 1-866-DPW-TIPS (1-800-379-8477). You can report any provider (for example a doctor, dentist, therapist or hospital) for suspected fraud or abuse for services provided to anyone with an Access card.

Some common examples of fraud and abuse are:

- Billing or charging you for services that your health plan covers
- Offering you gifts or money to receive treatment or services for your Access number
- Giving you treatment or services that you don’t need
- Physical, mental or sexual abuse by medical staff

You can call the Hotline and speak to someone Monday through Friday 8:30 am to 3:30 pm. You may leave a voice mail message at other times. If you don’t speak English, an interpreter will be made available. If you are hearing impaired, you can call the hotline using your TTY device.

You do not have to give your name and if you do give your name, the provider will not be told you called.

You can also report suspected fraud and abuse by using the website: http://www.dpw.state.pa.us/omap or email omap-tips@state.pa.us. This has been set up so you do not have to give your name also.

Recipient Restriction Program

Gateway Health and the Department of Public Welfare have the right to restrict members to specific provider types when it has been determined that the member has abused his or her healthcare benefits.

The member may appeal the restriction by submitting to the Department of Public Welfare a written request for a Fair Hearing within 30 days from the date of the letter.

A request for a DPW Fair Hearing must be in writing, signed by the member and sent to:

Department of Public Welfare
Division of Program and Provider Compliance
Bureau of Program Integrity
Recipient Restriction Section
PO Box 2675
Harrisburg, Pennsylvania 17110
Requests by the member, pharmacy or physician for a restriction change must be in the form of a written request that is sent to the Gateway Restriction Liaison. Once the request is received and reviewed, the person requesting the change will be notified of Gateway’s decision.

New Technology: Is it Covered?

Gateway evaluates new technology to decide if it should be included as a covered benefit. New technology means any skills, equipment or know-how of doing something better.

A committee of Gateway physicians evaluates information on new technology. If they recommend that a new technology be included in Gateway’s benefits package, the recommendation will be shared with Gateway’s Senior Management for more evaluation and approval. The committee may recommend that the new technology be approved on a case-by-case basis.

Gateway has pharmacists and physicians who look at new drugs and new uses for drugs four times a year. New drugs are added to the formulary list on an on-going basis. Drugs may be removed from the formulary four times per year.

Other Information

If you would like any information about Gateway including who sits on the Board of Directors, what the education of your doctor is or the way we plan to improve the care and services to our members through Gateway’s Quality Improvement Program, call Member Services at 1-800-392-1147 (TTY/TDD: 711).

Eligibility

The Department of Public Welfare decides if you qualify for Medical Assistance. They also decide what healthcare benefits you get based on your level of assistance. You should call your caseworker at your local County Assistance Office (CAO) if you have any questions about your Medical Assistance coverage of healthcare package.
## Important Phone Numbers for Mental Health, Drug, & Alcohol Services

Members are able to get mental health, drug, and alcohol services through agencies in your county.

<table>
<thead>
<tr>
<th>County Name</th>
<th>Behavioral Health Managed Care Organizations</th>
<th>Drug &amp; Alcohol Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>CCBH (Community Care Behavioral Health) 717-771-9618 or 1-800-441-2025</td>
<td>717-771-9618 or 1-800-441-2025</td>
</tr>
<tr>
<td>Allegheny</td>
<td>CCBH (Community Care Behavioral Health) 1-800-553-7499</td>
<td>412-350-3857</td>
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<tr>
<td>Armstrong</td>
<td>VBH (Value Behavioral Health) 1-877-688-5969</td>
<td>724-354-2746</td>
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<tr>
<td>Beaver</td>
<td>VBH (Value Behavioral Health) 1-877-688-5970</td>
<td>724-847-6220</td>
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<tr>
<td>Bedford</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-877-773-7891</td>
<td>814-623-5009</td>
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<tr>
<td>Berks</td>
<td>CCBH (Community Care Behavioral Health) 610-478-3271</td>
<td>610-375-4426</td>
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<tr>
<td>Blair</td>
<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
<td>814-693-3023</td>
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<td>Butler</td>
<td>VBH (Value Behavioral Health) 1-877-688-5971</td>
<td>724-284-5114</td>
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<td>Cambria</td>
<td>VBH (Value Behavioral Health) 1-877-404-4562</td>
<td>-888-647-4814</td>
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<td>Cameron</td>
<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
<td>814-642-9541</td>
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<td>Clarion</td>
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<td>814-226-5888</td>
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<td>Clearfield</td>
<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
<td>814-371-9002</td>
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<td>Crawford</td>
<td>VBH (Value Behavioral Health) 1-866-404-4561</td>
<td>814-724-4100</td>
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<td>Cumberland</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646</td>
<td>717-240-6300</td>
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<tr>
<td>Dauphin</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646</td>
<td>717-255-2984</td>
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<tr>
<td>County Name</td>
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<td>Drug &amp; Alcohol Services</td>
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<td>Erie</td>
<td>CCBHO (Community Care Behavioral Health Organization) 1-855-224-1777</td>
<td>814-451-6877</td>
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<td>Elk</td>
<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
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<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
<td>814-726-2100</td>
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<tr>
<td>Franklin</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-877-773-7917</td>
<td>717-263-1256</td>
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<td>Fulton</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-877-773-7917</td>
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<tr>
<td>Greene</td>
<td>VBH (Value Behavioral Health) 1-877-688-5973</td>
<td>724-852-5276</td>
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<td>Huntingdon</td>
<td>CCBH (Community Care Behavioral Health) 1-866-878-6046</td>
<td>717-242-1446</td>
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<td>Indiana</td>
<td>VBH (Value Behavioral Health) 1-877-688-5974</td>
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<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
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<td>Lancaster</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646</td>
<td>717-299-8023</td>
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<td>Lawrence</td>
<td>VBH (Value Behavioral Health) 1-877-688-5975</td>
<td>724-658-5580</td>
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<td>Lebanon</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646</td>
<td>717-274-0427</td>
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<td>Lehigh</td>
<td>Magellan Behavioral Health 1-866-238-2311</td>
<td>610-782-3555</td>
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<td>McKean</td>
<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
<td>814-642-9541</td>
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<tr>
<td>Mercer</td>
<td>VBH (Value Behavioral Health) 1-866-404-4561</td>
<td>724-662-1550</td>
</tr>
<tr>
<td>Northampton</td>
<td>Magellan Behavioral Health 1-866-238-2312</td>
<td>610-997-5800</td>
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<tr>
<th>County Name</th>
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<th>Drug &amp; Alcohol Services</th>
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<tr>
<td>Perry</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646</td>
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<tr>
<td>Potter</td>
<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
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<td>Somerset</td>
<td>CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-877-773-7891</td>
<td>814-445-1530</td>
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<td>Venango</td>
<td>VBH (Value Behavioral Health) -866-404-4561</td>
<td>814-432-9744</td>
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<td>Warren</td>
<td>CCBHO (Community Care Behavioral Health Organization) 1-866-878-6046</td>
<td>814-726-2100</td>
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<tr>
<td>Washington</td>
<td>VBH (Value Behavioral Health) 1-877-688-5976</td>
<td>724-223-1181</td>
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<tr>
<td>Westmoreland</td>
<td>VBH (Value Behavioral Health) 1-877-688-5977</td>
<td>1-800-220-1810</td>
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<td>York</td>
<td>CCBH (Community Care Behavioral Health) 717-771-9618 or 1-800-441-2025</td>
<td>1-800-441-2025</td>
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If you need transportation for a medical service other than an emergency, each county can provide transportation through the Medical Assistance Transportation Program. Call Member Services at 1-800-392-1147 (TTY/TDD: 711), and a representative will help you get transportation through the Medical Assistance Transportation Program in your county.

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<tr>
<th>County</th>
<th>Local Telephone Number</th>
<th>Toll Free Number</th>
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<tr>
<td>Adams</td>
<td>717-337-1345</td>
<td>800-830-6473</td>
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<td>Allegheny</td>
<td>412-350-4484</td>
<td>888-547-6287</td>
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<td>Armstrong</td>
<td>724-548-3405</td>
<td>800-468-7771</td>
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<td>Beaver</td>
<td>724-728-5633</td>
<td>800-262-0343</td>
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<td>Bedford</td>
<td>814-623-9129</td>
<td>800-323-9997</td>
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<td>610-921-2361</td>
<td>800-383-2278</td>
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<tr>
<td>Blair</td>
<td>814-946-1235</td>
<td>800-245-3282</td>
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<tr>
<td>Butler</td>
<td>724-545-3669</td>
<td>866-638-0598</td>
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<td>Cambria</td>
<td>814-536-9031</td>
<td>888-647-4814</td>
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<td>Cameron</td>
<td>866-282-4968</td>
<td>866-282-4968</td>
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<td>Clarion</td>
<td>814-226-7012</td>
<td>800-672-7116</td>
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<td>Clearfield</td>
<td>814-765-1551</td>
<td>800-822-2610</td>
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<td>Crawford</td>
<td>814-333-7090</td>
<td>800-210-6226</td>
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<td>Cumberland</td>
<td>717-240-6340</td>
<td>800-315-2546</td>
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<td>Dauphin</td>
<td>717-232-7009</td>
<td>800-309-8905</td>
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<td>Erie</td>
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<td>Fayette</td>
<td>724-628-7433</td>
<td>800-321-7433</td>
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<td>Forest</td>
<td>814-927-8266</td>
<td>800-222-1706</td>
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<tr>
<td>Franklin</td>
<td>717-264-5225</td>
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<td>Fulton</td>
<td>717-485-0931</td>
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<td>Greene</td>
<td>724-627-6778</td>
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### County Local Telephone Number Toll Free Number

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<th>County</th>
<th>Local Telephone Number</th>
<th>Toll Free Number</th>
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<tr>
<td>Huntingdon</td>
<td>814-641-6408</td>
<td>800-817-3383</td>
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<td>Indiana</td>
<td>724-463-3235</td>
<td>888-526-6060</td>
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<tr>
<td>Jefferson</td>
<td>814-938-3302</td>
<td>800-648-3381</td>
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<tr>
<td>Lancaster</td>
<td>717-291-1243</td>
<td>800-892-1122</td>
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<td>Lawrence</td>
<td>724-652-5588</td>
<td>888-252-5104</td>
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<tr>
<td>Lebanon</td>
<td>717-273-9328</td>
<td>Same as Local</td>
</tr>
<tr>
<td>Lehigh</td>
<td>610-253-8333</td>
<td>888-253-8333</td>
</tr>
<tr>
<td>McKean</td>
<td>866-282-4968</td>
<td>866-282-4968</td>
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<tr>
<td>Mercer</td>
<td>724-662-6222</td>
<td>800-222-8797</td>
</tr>
<tr>
<td>Northampton</td>
<td>610-253-8333</td>
<td>888-253-8333</td>
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<tr>
<td>Perry</td>
<td>717-567-2490</td>
<td>877-800-7433</td>
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<tr>
<td>Potter</td>
<td>814-544-7315</td>
<td>800-800-2560</td>
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<tr>
<td>Somerset</td>
<td>814-445-9628</td>
<td>800-452-0241</td>
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<td>Venango</td>
<td>814-432-9767</td>
<td>877-836-4699</td>
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<td>Warren</td>
<td>814-723-1874</td>
<td>877-723-9456</td>
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<td>Washington</td>
<td>724-223-8747</td>
<td>800-331-5058</td>
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<tr>
<td>Westmoreland</td>
<td>724-832-2706</td>
<td>800-242-2706</td>
</tr>
<tr>
<td>York</td>
<td>717-845-7553</td>
<td>800-632-9063</td>
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IMPORTANT NOTE: Here is your Member Handbook. Your Gateway HealthSM membership card is being mailed in a separate envelope.

1-800-392-1147
MEMBER SERVICES