

Congratulations

On choosing the road to better health!

Dear New Gateway Health Plan Member,

Congratulations on choosing the road to better health! As President of Gateway Health Plan, I welcome you to your new health care program through Gateway.

Gateway Health Plan is a managed health care plan. This means that Gateway members pick a doctor, called a Primary Care Physician (PCP), to care for their total health care needs. As part of caring for the member's total health care needs, a Primary Care Physician (PCP) may arrange for care to be given at Gateway hospitals or specialty doctor offices.

Keeping Gateway members as healthy as possible is Gateway Health Plan's goal. Some of the ways Gateway does this include: members choosing Primary Care Physicians (PCP), providing extra benefits to Gateway members, and helping members get complete care, such as childhood shots, lead screenings, and prenatal care.

Your Member Handbook explains the services you get with Gateway and tells you about how Gateway Health Plan works. **Gateway Health Plan may not cover all your health care costs. Read this Member Handbook carefully to find out which health care services are covered.** Keep your Member Handbook in a safe place in case you need to use it later.

I encourage you to use your Gateway Health Plan benefits and get the care that you need to stay healthy. Your Gateway Health Plan coverage is based on your eligibility for Medical Assistance. If you have any questions about your Gateway Health Plan coverage, or need information about how to use your benefits, please call the Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988). Member Services is open 24 hours a day, 7 days a week for your calls.

*Sincerely,
C. Michael Blackwood
President/CEO
Gateway Health Plan*

Questions? Need Help?

Call Member Services at

1-800-392-1147

(TTY/TDD 1-800-654-5988)

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Services for members

Member Services

The Gateway Health Plan Member Services Department can help answer your questions. You may want to ask about a covered service, or you may need to talk to someone about a problem. Member Services can help you find a doctor and tell you about your doctor's training.

You can call Member Services 24 hours a day, 7 days a week. The phone number is 1-800-392-1147 (TTY/TDD 1-800-654-5988). The call is free, and Member Services would like to hear your ideas on making Gateway Health Plan better. You may also visit Gateway's website at www.gatewayhealthplan.com.

Gateway Health Plan Notice of Privacy Practices

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

Gateway Health Plan ("Gateway") is required to protect the privacy of your personal medical and non-public personal information. Also, Gateway is required to give you this notice about how Gateway uses or gives out ("discloses") medical and personal ("non-public") information held by Gateway.

Gateway will use and give your medical information:

- To you or someone who acts for you (your personal representative)
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- When required by law.
- To meet your medical needs, to pay for your healthcare and to operate the Gateway benefit program, for example:
 - To give information to help the doctors or other healthcare providers who care for you.
 - To make sure you and other Gateway members get quality health care, to provide member services to you, or to resolve any complaints you have.
 - To pay or deny your claims or to share payments and payment information with your other insurer(s).

Gateway may also use or give your medical information:

- To state and federal agencies that have the legal right to receive such data,
- For public health activities (such as reporting disease outbreaks),
- For government health care oversight activities (such as fraud investigations),
- For judicial and administrative proceedings (such as in response to a court order),
- For law enforcement purposes (such as providing limited information to locate a missing person),
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- To avoid a serious and likely threat to health or safety,
- To contact you about new or changed benefits,
- To contact you for appointment reminders or for disease management programs and alternative treatments that may interest you, and

- To create a collection of information that can no longer be traced back to you.

Gateway must have your written permission (an “authorization”) to use or give out your medical information for any purpose that is not listed in this notice. You may take back (“revoke”) your written permission at any time, except if Gateway already took action based on your permission.

You have the right to:

- Ask for your medical information by writing to Gateway or by calling Gateway to request a form for this purpose.
- Ask Gateway to change your medical information if you can show that it is wrong or that information is missing by writing to Gateway or by calling Gateway to request a form for this purpose. If Gateway disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a list of who received your medical information within a six-year period by writing to Gateway or by calling Gateway to request a form for this purpose. You must tell Gateway the dates for which you are requesting the list. The list will not cover information given out before April 14, 2003, information that was given to you or your personal representative, or information given for healthcare payments, for Gateway operations or for law enforcement needs.
- Ask Gateway to communicate with you in a different manner or at a different place (for example, by sending material to a P.O. Box instead of your home address), by writing to Gateway or by calling Gateway to request a form for this purpose. Gateway must have written reason(s) for your request(s) and may not be able to honor your request.
- Ask Gateway to limit the way your personal medical information is used or given to others, by writing to Gateway or by calling Gateway to request a form for this purpose. Please note that Gateway may not be able to do what you request.
- Call or write to Gateway to ask for a separate paper copy or e-mail copy of this Notice.

What is the non-public information that Gateway Health Plan collects about you?

- It is personal information but is non-medical, for example, the information you completed on your enrollment application that identifies who you are and how you can be contacted.
- It is information collected for a request for services by you or your doctor.
- Also, it is information collected to answer a question or concern from you.

Can anyone receive your non-public information?

- Gateway does not give out your non-public information, except if required or permitted by law.
- Gateway does not give out your non-public information to anyone unrelated to providing your care under the health plan unless you or your representative give permission

How does Gateway protect your non-public information?

- Gateway does not make your non-public information available to anyone other than those necessary to provide medical or health plan services to you.
- You have the right to give or withhold permission for other uses or disclosures of this information, except as required by law.

If you believe Gateway has violated your privacy rights as stated in this notice, you may file a complaint at the following address:

Privacy Officer
Gateway Health Plan
Regulatory, Compliance and Legal Affairs
600 Grant Street, 41st Floor
Pittsburgh, PA 15219

Filing a complaint will not affect your benefits. You may also file a complaint with the Secretary of the Department of Health and Human Services. For more information on filing a complaint or your rights stated in this notice, you may call Gateway's Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

Gateway is required to follow the terms in this privacy notice. Gateway has the right to change the way your medical information is used and given out. If Gateway makes any changes, you will get a notice by mail within sixty (60) days of the change.

These privacy practices went into effect April 14, 2003.

Hearing and Sight 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 AT&T TDD Service at 1-800-654-5988 and asking to be transferred to Gateway Health Plan Member Services at 1-800-392-1147.

Gateway Health Plan offers the Member Handbook and other Gateway information in large print, Braille, on cassette tape, or computer diskette at no cost to the member. Please call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988) to ask for these other formats.

Non-English Speaking Members

If you do not speak English, call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988), and an interpreter will be provided. Please also call if you need your Gateway information translated.

SPANISH: LLAME A SERVICIOS PARA MIEMBROS, AL TELEFONO 800-392-1147 (TTY/TDD 1-800-654-5988) Y SE LE FACILITARÁ UN INTÉRPRETE Y SI NECESITA QUE LE TRADUZCAN SU INFORMACIÓN GATEWAY, LLAMENOS AL MISMO NÚMERO.

CAMBODIAN: បើសិនលោកអ្នកមិននិយាយភាសាអង់គ្លេស សូមទូរស័ព្ទមក សេវាកម្មសមាជិកតាមទូរស័ព្ទលេខ ១-៨០០-៣៩២-១១៤៧ (TTY/TDD 1-800-654-5988) ហើយអ្នកបកប្រែនឹងបកប្រែជូន ។ សូមទូរស័ព្ទមក បើសិនលោកអ្នកត្រូវការព័ត៌មានបកប្រែ Gateway របស់លោកអ្នក ។

CHINESE: “如果您不会讲英语，请拨打会员服务热线 1-800-392-1147 (TTY/TDD 1-800-654-5988)，我们会为您提供口译。另外，如果您需要翻译您的入口(Gateway)信息，也请致电我们。”

CROATIAN: Ako Vi ne govorite engleski, nazovite Usluzne Clanove na 1-800-392-1147 (TTY/TDD 1-800-654-5988), 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 1-800-654-5988) 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 1-800-654-5988), 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 minh.

Gateway Health Plan ID Card

Gateway Health Plan members will receive a green plastic (ID) identification cards for every member of the family in Gateway Health Plan.

You can start using your Gateway ID card on the “effective” date that is printed on the upper left hand corner of your card. The card is good for as long as you stay on Medical Assistance, and remain a member of Gateway Health Plan. Your Gateway 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 Health Plan service. Use your ACCESS Card for MA services that are not the responsibility of Gateway such as WIC, Medical Assistance Transportation Program (MATP), Mental Health, and Drug and Alcohol services. If your Gateway ID card is lost or stolen, call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988). If your ACCESS card is lost or stolen, call your caseworker at your local County Assistance office.

Primary Care Physicians (PCP) *and specialty care*

Primary Care Physician (PCP)

When you enrolled in Gateway Health Plan, you picked a Primary Care Physician (PCP). Your doctor will arrange your health care needs and work with Gateway to make sure that you get the care you need. You can have the same doctor for the whole family, or a different doctor for each family member. If you need an appointment, call your doctor. The doctor's phone number is on your Gateway ID card, and there is no charge for visits to your Primary Care Physician (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.

Your Primary Care Physician (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. (For more information on emergency services, see page__) If you do not need immediate emergency attention, call your Primary Care Physician (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.

If you need a list of Gateway doctors, hospitals, dentists, or other special providers, call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988). You can also visit our website at www.GatewayHealthPlan.com for a list of providers. It is important for your doctor to be able to see you when you need care. Gateway has appointment guidelines that Primary Care Physicians (PCP) and Specialists are asked to follow. These appointment guidelines are different for the reason you need to be seen:

New member appointment for your first examination...

members with HIV/AIDS

members who receive Supplemental Security Income (SSI)

members under age 21

all other members

Members who are pregnant:

You should have an appointment ...

with Primary Care Physicians (PCP) or specialist no later than 7 days after you become a member in Gateway unless a Primary Care Physicians (PCP) or specialist is already treating you.

with Primary Care Physicians (PCP) or specialist no later than 45 days after you become a member of Gateway unless a Primary Care Physicians (PCP) or specialist is already treating you.

with Primary Care Physicians (PCP) for an EPSDT screen no later than 45 days after you become a member in Gateway unless a Primary Care Physicians (PCP) or specialist is already treating you

with Primary Care Physicians (PCP), no later than 3 weeks after you become a member in Gateway.

You should have an appointment ...

pregnant women in their first trimester	with OB/GYN within 10 business days of Gateway learning you are pregnant.
pregnant women in their second trimester	with OB/GYN within 5 business days of Gateway learning you are pregnant.
pregnant women in their third trimester	with OB/GYN within 4 business days of Gateway learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN within 24 hours of Gateway learning you are pregnant.

Appointment with Primary Care Physician (PCP)... You should have an appointment...

urgent medical condition	within 24 hours
routine medical appointment	within 10 business days
health assessment/general physical examination	within 3 weeks

Specialists (with referral)... You should have an appointment ...

urgent medical condition	within 24 hours of referral
routine medical appointment	within 10 business days of referral

How Can I Change My Doctor?

If you want to change your Primary Care Physician (PCP) for any reason, call the Gateway Health Plan Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988). Member Services will help you make the change and will tell you when you can start seeing the new doctor. Changing your doctor can take from 2 to 5 weeks to be done, depending on the time of the month you call to ask for the change. You will get a new ID card, which will have your new doctor’s name and phone number. The front of the card will also have an effective date to let you know when you can start seeing the new doctor.

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 Primary Care Physician (PCP) cannot give you, your doctor may send you to a specialist for care. This is called a “referral.” Your Primary Care Physician (PCP) and the specialist will work together for your total health care needs. If you go to a specialist without your Primary Care Physician’s (PCP) referral, you may have to pay the specialist’s bill.

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 Primary Care Physician (PCP). You can go to any Gateway Health Plan doctor for the services listed below without a referral:

- Obstetrical and gynecological visits
(pelvic exams, PAP tests, mammograms, pregnancy care, woman care)
- Routine eye care
- Dental visits
- Your first chiropractor visit
(further visits must be authorized)

For Family Planning services, you can go without a referral to any doctor, whether the doctor is a Gateway doctor or not. See page__ under the Family Planning section.

You do not need a referral for behavioral health services including mental health care (depression) or drug and alcohol abuse. See pages__ for the phone numbers you can call for help.

Gateway Health Plan's goal is for you to be seen by the specialist that can best treat you. If there are not at least two specialists in the list of Gateway doctors that can treat you, Gateway must approve a visit to a specialist that is not on the Gateway list. Your Primary Care Physician (PCP) will arrange this.

If you have been seeing a specialist for an ongoing problem, the doctor can choose to be your Primary Care Physician (PCP). Please call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988) for help in getting your specialist to be your Primary Care Physician (PCP).

How Can I Get a Second Opinion?

You may want to be seen by a different doctor, other than the one you have been seeing, for a second opinion. Your Primary Care Physician (PCP) can refer you to another Gateway doctor for a second opinion. If you have any questions, please call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

Arranging Your Care

There are some services that Gateway Health Plan 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 Department. 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 as defined by the Department of Public Welfare. There is no extra payment given to these doctors and nurses no matter what they decide about your care.

If you need a service that must be approved by Gateway Health Plan before it is done, your doctor will call Gateway's Health Services Department to get an approval. The doctors and nurses in Gateway's Health Services department 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.

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 medical or dental operation
- Medical equipment for your home (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

There may be other services that need to be approved by Gateway Health Plan first. Call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988) to see if the service you need requires approval before getting it.

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

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

If Gateway Health Plan 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 by Gateway's Health Services Department at your records and information to determine if the services were necessary to keep you healthy.

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 Department 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 Health Plan
Member Services Department
US Steel Tower-Floor 41
600 Grant Street
Pittsburgh, PA 15219-2704**

Out of Network Care

Gateway Health Plan has many doctors and hospitals that 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 Primary Care Physician (PCP) can call Gateway to make this request. The Health Services Department 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 Health Plan 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 1-800-654-5988) for help.

If a request to use a doctor or hospital outside of Gateway’s network is denied, you can file a complaint with Gateway Health Plan by calling Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

Other Medical Staff in Your Doctor’s Office

Some medical offices may have other types of staff treating you besides doctors and nurses. These types of medical staff are called Physician Assistants and Nurse Practitioners. They are specially trained to work in your doctor’s office and to examine you. Your doctor will always oversee any treatment that you get. Some offices also have doctors working there, called “Residents,” who are finishing their training. Medical Residents work with your regular doctor to take care of you.

More Information About Your Doctor

If you would like to know more about the education and training of your doctor, or anyone else treating you, call Gateway’s Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

Hospital Care

Your Primary Care Physician (PCP) or specialist will arrange all of your admissions to the hospital. You should not be admitted to a hospital without your doctor’s orders, unless it is an emergency as described below. If a doctor other than your Gateway doctor admits you to the hospital, you should call your Primary Care Physician (PCP) within 24 hours of being admitted. If you cannot call, ask someone to call for you.

If a doctor other than your Primary Care Physician (PCP) or specialist admits you to a hospital for a problem that is not an emergency, you may have to pay your own hospital bills.

Call the Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988) if you have any questions on hospital services.

Emergency Services

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 U.S.

There are times when it is hard to know what a real emergency is. If you call your Primary Care Physician (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 Primary Care Physician (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 Primary Care Physician (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.

When Out of Town

Gateway Health Plan services many counties within Pennsylvania. Gateway is offered in:

- Adams
- Allegheny

- Armstrong
- Beaver
- Berks
- Blair
- Butler
- Cambria
- Carbon
- Clarion
- Columbia
- Cumberland
- Dauphin
- Erie
- Fayette
- Franklin
- Greene
- Indiana
- Jefferson
- Lackawanna
- Lancaster
- Lawrence
- Lebanon
- Lehigh
- Luzerne
- Mercer
- Monroe
- Montour
- Northampton
- Northumberland
- Perry
- Pike
- Schuylkill
- Somerset
- Susquehanna
- Washington
- Westmoreland
- Wyoming
- York

If you or your family members are out of the Gateway Health Plan 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 someone you know, call your Primary Care Physician (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 outside of the service area, and it is not a medical emergency, call the Gateway Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988). Member Services can connect you to your Primary Care Physician (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.

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. A list of each phone number by county is on the back cover of this Handbook. You can also call Gateway's Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988), and you will be connected to the Medical Assistance Transportation Program (MATP) in your county.

Benefits *and special services*

Covered Benefits

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

- Visits to your Primary Care Physician (PCP)
- Visits to the doctor while you are pregnant
- Yearly physical
- Well child care, including regular check-ups and shots
- Emergency dental care
- Non-emergency dental care, if eligible for non-emergency dental care under Medical Assistance (See page __ under Dental Care for more information.)
- 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 the Gateway Member Services Department
- Surgery and anesthesia, if medically necessary
- EPSDT expanded services for members under age 21 (see page __)
- 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
- Medically necessary services for members under age 21

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

- Visits to specialists with a referral from your Primary Care Physician (PCP)
- Allergy tests and shots with a referral from your Primary Care Physician (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 (see page__ under Medicines for more information)
- 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
- Laboratory tests and 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 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.

Your provider will tell you the amount of your co-payment when you present your Gateway Health Plan ID Card and any other insurance ID cards that you may have. General Assistance (GA) recipients cannot be charged more than \$180.00 worth of co-payments in a six month period and Medical Assistance (MA) recipients cannot be charged more than \$90.00 worth of co-payments in a six month period. Your caseworker at your local county assistance office (CAO) determines if you are MA or GA eligibility (for more information on eligibility see page_). If you have any questions about the amount of your co-payment or how to be reimbursed, talk with your provider or call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

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.

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 1-800-654-5988).

Benefit Limit Exceptions

If benefits limits do apply to you and you or your provider feel you need services above these limits, your provider can ask Gateway Health Plan 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.

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

Requests received after the service has been rendered will receive a response within 30 days of the date from 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 is 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 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 Gateway Health Plan at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

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.

Medicines

If you are under 21, or age 21 or over and eligible for drug coverage, your prescriptions can be filled at any pharmacy (drug store) that is part of Gateway Health Plan'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 Primary Care Physician (PCP) for insulin, syringes, contraceptives, and vitamins. Then the prescription can 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 1-800-654-5988).

Gateway Health Plan 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. 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 1-800-654-5988). Members can also notify Gateway Health Plan of their desire to have a new medication 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 72 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 the Member Services Department toll-free at 1-800-392-1147 (TTY/TDD 1-800-654-5988), 24 hours a day, 7 days a week.

Eye Exams and Eyeglasses

Regular eye exams are very important. That is why Gateway Health Plan gives this benefit to all Gateway members. Each Gateway member is eligible for eye examinations every calendar year. There is no waiting period to get your vision benefit.

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

Members age 21 and older will also be covered for one pair of standard eyeglass lenses or contact lenses per calendar year. In addition, members age 21 and older will be covered for one pair of eyeglass frames from the Gateway approved collection each calendar year. Members age 21 and older who choose frames outside of the Gateway approved collection may receive \$20.00 toward the purchase of frames each calendar year.

Members under age 21 are eligible for two standard pairs of eyeglasses (frames and lenses) and one pair of contact lenses from within Gateway's network each calendar year and replacement pairs, if medically necessary. Members under age 21 who choose frames outside of the Gateway approved collection may receive \$20.00 toward the purchase of frames each calendar year.

If you have a medical condition such as cataracts, you will also be covered for glasses or contacts to treat your condition.

If you choose options for your lenses beyond what your doctor prescribed, you may be charged an additional fee.

You can call Gateway's Member Services at 1-800-392-1147 or 1-800-654-5988 (TTY) for a list of participating eye doctors or if you have questions about your vision benefits.

Dental Care

All Gateway members may get the following dental services each year from any Gateway Health Plan participating dentist:

- One exam
- 2 Cleanings
- X-rays

All members under the age of 21 and some members age 21 and over have benefits for more dental services than are listed above. Call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988) with questions about your dental coverage or to get a list of Gateway Health Plan dentists. You can go to any Gateway dentist to get your services.

Special Needs

If you have a special health care need, the Special Needs Case Management Unit can help. Nurses, social workers, and other health care staff help to make sure you get the medical care that you need. They can assist you with any problems you have in getting your care.

If you would like information about programs in your community such as food banks or HIV programs, the Special Needs Case Managers will help you. Call the Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988) if you would like to talk to the Special Needs Case Management Unit.

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 1-800-654-5988).

Asthma Help Is Here at Gateway Health Plan

Gateway Health Plan has a program for members between the ages of 2 years and 56 years with asthma called "AIR" Gateway. This program will help you understand how to take care of your asthma. Your asthma can be managed and should not be stopping you from doing things you like. As part of the program, a specially trained asthma nurse may call you on the telephone. The nurse will help you understand the

difference between your long term control medicine and rescue medicine. She will help you understand peak flow monitoring and how to use an asthma action plan. You will also receive information on asthma in the mail.

Here are a few reminders for managing your asthma:

- Take your long term control medicine every day as your doctor tells you even when you feel good.
- The quick relief medicine helps you when you are having trouble breathing. **This medicine should not be used everyday.** If you are using them everyday, **call your doctor.**
- Visit your doctor at least twice a year. Your doctor needs to see you to make sure your asthma is in control so you can do things you like to do.
- ♥ Stop smoking and avoid second hand smoke. Get help to quit smoking by calling Pennsylvania's Quitline at 1-877-724-1090

If you would like more information on "AIR" Gateway, call 1-800-642-3550 and press #3. The nurses are available Monday through Friday between 8:30 am and 4:30 pm by phone.

Help Your Heart Cardiac Program

If you are a Gateway member age 21 or older who has congestive heart failure, or had a heart attack, stents or bypass surgery you might like to join the Help Your Heart Program. This program helps you understand how to take care of your heart so you can live a healthy life. This program has specially trained nurses available by phone between 8:30am and 4:30pm. The nurses help you understand what has happened to your heart. They will teach you about a proper diet, exercise and how to take your medicines. They will teach you warning signs to look out for.

Here are a few reminders for managing your heart problems:

- Take your medicine the way your doctor ordered. If you can't, call the office and tell them. Wait to hear from the office before you stop taking your pills.
- Some heart pills have to be stopped over several days. Do not just stop taking a pill. You can have complications if you do. Follow your doctor's directions.
- Make sure you visit your doctor at least twice a year for a check up. If you are admitted to the hospital make an appointment to see your doctor within 2 weeks of discharge.
- Ask your doctor which lab tests you need to control your heart disease.
- ♥ Stop smoking and avoid second hand smoke. Get help to quit smoking by calling Pennsylvania's Quitline at 1-877-724-1090

If you would like more information on the Help Your Heart Program, call 1-800-642-3550 and press #3. The nurses are available Monday through Friday between 8:30 am and 4:30 pm by phone.

Healthy Returns Diabetes Program

If you are a Gateway member with diabetes, you might want to join the Healthy Returns Diabetes Program. Diabetes can cause problems for your heart, eyes, kidneys and circulation before you even know it. Diabetes can lead to heart failure. It is also the leading cause for amputations. Many people who are getting kidney dialysis are diabetics. Gateway offers a diabetic program that teaches you what symptoms to look for. As part of this program, specially trained nurses may call you on the telephone. The nurses teach you about the simple blood and urine tests you should have that warn you of some of the problems BEFORE you even know it's a problem!

The nurses are available all day long, seven days a week for this program. Monday through Friday between 8:30am and 4:30pm dieticians and pharmacists are able to talk to you about your diet and medicines.

Here are a few reminders about managing your diabetes:

- Take your blood sugar readings the way your doctor ordered them.
- Make sure you get these tests at least every year and more often if the doctor tells you to: HbA1c, LDL-c, urine test. These will help to show kidney or heart problems.
- Go to your eye doctor and tell them you are a diabetic. You need a retinal eye exam at least every year. Your doctor can tell if diabetes is damaging your eyes during this test. Glasses cannot fix all eye problems caused by diabetes.
- Ask your doctor which lab tests you need to keep your diabetes under control.
- ♥ Stop smoking and avoid second hand smoke. Get help to quit smoking by calling Pennsylvania's Quitline at 1-877-724-1090.

If you would like to learn more about how to care for your diabetes, please call the Gateway Healthy Returns Diabetes Program twenty four hours a day at 1-866-366-9415.

MOM Matters™ Program

Gateway Health Plan has a special program for pregnant women called MOM Matters™. This program provides education and support to help you have a healthy pregnancy. Specially trained nurses can answer your questions or concerns about your pregnancy. The nurses 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.
- ♥ Avoid alcohol, illegal drugs and smoking. Second hand smoke can harm you and your unborn child. Get help to quit smoking by calling Pennsylvania's Quitline at 1-877-724-1090
- ♥ 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 MOM Matters™ Program, call 1-800-642-3550 and press #2. The nurses are available Monday through Friday between 8:30 a.m. and 4:30 p.m. by phone.

Early Intervention

Gateway Health Plan participates in Early Intervention Services by identifying infants, toddlers, and preschool children who have special needs due to developmental delays or disabilities. Primary Care Physicians (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.

Family Planning

Family planning (birth control) services are available to Gateway Health Plan members. You do not need a referral from your Primary Care Physician (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 1-800-654-5988). However, you may choose to use a family planning clinic that is not part of Gateway's network. There is no cost for these services. When you go to a family planning provider, just show your Gateway Health Plan ID card.

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

Chiropractic Services

Gateway Health Plan members can get chiropractic care. You may go to a chiropractor from Gateway's list of doctors on your own for the first visit, or your Primary Care Physician (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 Health Plan. 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, except those approved by Gateway Health Plan (see page – under Experimental Treatments)
- 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)
- Prescription drugs not listed on the approved drug list, unless an exception is made
- 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

Extended home nursing services, private duty nursing, shift nursing care, and EPSDT home health 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.

There may be other services that are not covered by Gateway Health Plan. If you are not sure if the service you need is covered, call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988). You may have to pay for services that are not covered by Gateway Health Plan or services not provided by a Pennsylvania Medical Assistance participating provider.

Remember, in most cases, Gateway will only cover those services that are ordered by your Primary Care Physician (PCP), except in a medical emergency.

Administrative Policies *and procedures*

Adding New Members to Gateway

When you have a new baby or add a new member to your family, you should call Gateway Health Plan Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988). A newborn will automatically be added to the mother's health plan at the time of birth. 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 Health Plan 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 (see page _), you cannot keep your Gateway coverage. Call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988) to let Gateway know you moved.

Other Insurance

You or one of your family members might have other types of insurance. Call the Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988) 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 coverage is always the last payer to other insurance coverage you may have.

Claims-What Do I Do With a Bill?

Pennsylvania Medical Assistance providers cannot charge you for services that are covered under your Gateway plan. 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 1-800-654-5988) with the billing information and a representative will help you.

Changes in Benefits or Services

Gateway Health Plan 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 Primary Care Physician (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.

Changing Health Plans

If you would like to enroll with Gateway Health Plan or change your health plan from Gateway to another plan at any time, call the ACS Enrollment Services at 1-800-440-3989 (TTY/TDD 1-800-618-4225)

The Independent Enrollment Assistance Program (IEAP) contractor is responsible for enrollment activities. The IEAP contractor 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 the IEAP contractor 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.

When You Stop Being a Gateway Member

You will stay a member of Gateway Health Plan unless:

- You want to change health plans.
- You move from a HealthChoices to a non-HealthChoices county.
- You move outside of Gateway's service area.
- The Pennsylvania Department of Public Welfare closes your case.

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 Health Plan.

If your case is "closed" for more than 6 months, and then opens up again, and you live in the following HealthChoices counties, the Pennsylvania Department of Public Welfare will not put you back on Gateway Health Plan automatically.

- If you want to become a Gateway Health Plan member again, you must call 1-800-440-3989 (TTY/TDD 1-800-618-4225).

If you do not call the HealthChoices Hotline 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.

Rights and Responsibilities

Member Rights

As a Gateway Member, you have the right to:

1. Get information about Gateway, the services Gateway provides, doctors and other health care 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 health care.
3. Work with your doctor or other health care providers in making decisions about your health care 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 health care 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 or any other basis prohibited by law.
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 Plan member, you have a responsibility to:

1. Give information to your doctor, other health care 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 health care provider.
3. Provide consent to health care 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 health care 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.

Complaints, Grievances, and Fair Hearings

If a provider or Gateway Health Plan does something that you are unhappy about or do not agree with, you or your representative can tell Gateway Health Plan or the Department of Public Welfare that you are unhappy or you disagree with what the provider or Gateway Health Plan has done. This section describes what you can do and what will happen.

You may call Gateway Health Plan's toll-free Member Services telephone number at 1-800-392-1147 (TTY/TDD 1-800-654-5988) if you need help or have questions about complaints, grievances or fair hearings, you may also request utilization review and clinical practice guidelines. You can contact your local legal aid office or call the Pennsylvania Health Law Project at 1-800-274-3258. If you need help getting the local legal aid telephone number, please call Gateway's toll-free Member Services telephone number listed above.

COMPLAINTS

What is a complaint?

A complaint is when you tell Gateway Health Plan you are unhappy with Gateway or your provider or do not agree with a decision by Gateway.

Some things you or your representative may file a complaint about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Gateway approved.

What should I do if I have a complaint?

First Level Complaint

To file a complaint, you or your representative can:

- Call Gateway Health Plan at 1-800-392-1147 (TTY/TDD 1-800-654-5988) to tell your complaint, or write down your complaint and send it to Gateway at:
Gateway Health Plan
US Steel Tower Floor 41

600 Grant St.
Pittsburgh, PA 15219-2704

or your provider or your representative can file a complaint for you if you give the provider or your representative your consent in writing to do so.

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

This is called a first level complaint.

When should I file a first level complaint?

1. You or your representative must file a complaint within 45 days of getting a letter telling you that:
 - Gateway Health Plan has decided that you cannot get a service or item you want because it is not a covered service or item
 - Gateway Health Plan will not pay a provider for a service or item you got.
 - Gateway Health Plan did not decide a complaint or grievance that you had reported within 30 days.
2. You or your representative 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. See page _ for appointment guidelines.
3. You or your representative may file all other complaints at any time.

What happens after I file a first level complaint?

After you or your representative file your complaint, you will get a letter from Gateway Health Plan telling you that Gateway has received your complaint, and about the first level complaint review process.

You or your representative may ask Gateway Health Plan to see any information Gateway has about your complaint. You or your representative may also send information that may help with your complaint to Gateway.

You or your representative may attend the complaint review if you want to. You or your representative may come to Gateway Health Plan's offices 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 Gateway's decision.

A committee of one or more Gateway Health Plan staff who has not been involved in the issue will review your complaint and make a decision within 30 days after Gateway receives 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.

If you need more information about help during the complaint process, see page _
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What to do to continue getting services during the First Level Complaint:

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 the first level complaint decision, you or your representative may file a second level complaint with Gateway.

When should I file a second level complaint?

You or your representative must file your second level complaint within 45 days of the date you receive the first level complaint decision letter. Use the same address or phone number you used to file your first level complaint.

What happens after I file a second level complaint?

You will receive a letter telling you that Gateway has received your complaint, and telling you about the second level complaint review process.

You or your representative may ask Gateway to see any information Gateway Health Plan has about your complaint. You may also send information that may help with your complaint to Gateway.

You or your representative may attend the complaint review if you want to. You or your representative may come to Gateway Health Plan's offices 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 Gateway's decision.

A committee made up of three or more people, who have not been involved in the issue, will review your complaint and make a decision. At least one third of the second level review committee may not be employees of the plan or of a related subsidiary or affiliate. Your complaint will be decided within 45 days after Gateway receives 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.

If you need more information about help during the complaint process, see page _

What to do to continue getting services during the Second Level Complaint:

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.

External Complaint Review

If you do not agree with Gateway's second level complaint decision, you or your representative 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 or your representative must ask for an external review within 15 days of the date you received the second level complaint decision letter. If you or your representative ask, the Department of Health will help you put your complaint in writing.

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

Department of Health
Bureau of Managed Care
Attention: Complaint Appeals
P.O. Box 90
Harrisburg, PA 17108-0090
Phone: 1-888-466-2787

Or Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120
Phone: 1-877-881-6388

If you or your representative 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 or your representative may also send Gateway any other information that may help with the external review of your complaint.

An attorney or another person may represent you 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 during the External Complaint Review:

<p>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 request for an external complaint review that is hand-delivered or postmarked within 10 days of the date on the second level complaint decision letter, the services or items will continue until a decision is made.</p>
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GRIEVANCES

What is a grievance?

When Gateway Health Plan 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 Gateway you disagree with the decision.

What should I do if I have a grievance?

First Level Grievance

To file a grievance, you or your representative can:

Call Gateway at 1-800-392-1147 (TTY/TDD 1-800-654-5988) to file your grievance, or

Write down your grievance and send it to Gateway at
Gateway Health Plan
US Steel Tower Floor 41
600 Grant St.
Pittsburgh, PA 15219-2704

or your provider or your representative can file a grievance for you if you give the provider or your representative 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 or your representative 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 or your representative file your grievance, you will get a letter telling you that Gateway has received your grievance and about the first level grievance review process.

You or your representative may ask Gateway to see any information Gateway Health Plan has about your grievance. You or your representative may also send information that may help with your grievance to Gateway.

You or your representative may attend the grievance review if you want to. You or your representative may come to Gateway's offices 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 Gateway's decision.

A committee of one or more Gateway Health Plan staff, including a licensed doctor or dentist, 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 Gateway receives 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.

If you need more information about help during the grievance process, see page _

What to do to continue getting services during the First Level Grievance review:

If you have been receiving services or items that are being reduced, changed or stopped, and you file a 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 being reduced, changed or stopped, the services or items will continue until a decision is made.

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

Second Level Grievance

If you do not agree with the first level grievance decision, you or your representative may file a second level grievance with Gateway.

When should I file a second level grievance?

You or your representative must file your second level grievance within 45 days of the date you receive the first level grievance decision letter. Use the same address or phone number you used to file your first level grievance.

What happens after I file a second level grievance?

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

You or your representative may ask Gateway to see any information Gateway Health Plan has about your grievance. You or your representative may also send information that may help with your grievance to Gateway.

You or your representative may attend the grievance review if you want to. You or your representative may come to Gateway's offices 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 Gateway's decision.

A committee of three or more people including a doctor or dentist who have not been involved in the issue you filed your grievance about, will review your grievance and make a decision. At least one third of the second level review committee may not be employees of the plan or of a related subsidiary or affiliate. Your grievance will be decided no later than 45 days after Gateway receives 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.

If you need more information about help during the grievance process, see page _

What to do to continue getting services during the Second Level Grievance review:

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.

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 or your representative may ask for an external grievance review.

You or your representative must call or send a letter to Gateway asking for an external grievance review within 15 days of the date you received the second level grievance decision letter. Use the same address and phone number you used to file your first level grievance. Gateway 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 review process.

Gateway will send your grievance file to the reviewer. You or your representative 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 during the External Grievance Review:

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.

If you need more information about help during the grievance process, see page _

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 Health Plan at 1-800-392-1147 (TTY/TDD 1-800-654-5988) 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, this letter is called a Provider certification.

If your doctor or dentist does not include a Provider certification with an expedited complaint or grievance, Gateway will notify you that this certification was not received and is needed to explain the reasons why the expedited review is needed. If Gateway is unable to obtain a Provider certification from your doctor or dentist within forty-eight (48) hours or your request for an expedited complaint or grievance, your complaint or grievance will be decided within the usual timeframes.

Expedited Complaint

A licensed doctor or dentist, who has not been involved in the issue you filed your complaint about, will decide the expedited complaint.

Gateway Health Plan will call you within 3 business days of when Gateway receives your request for an expedited (faster) complaint review with Gateway's decision. You will also receive a letter telling you the reason(s) for the decision and how to file a second level complaint, if you don't like the decision. For information on how to file a second level complaint, see page __.

An expedited complaint decision may not be requested after a first level complaint decision has been made on the same issue.

Expedited Grievance and Expedited External Grievance

A committee of three or more people, including a licensed doctor or dentist, will review your grievance. The licensed doctor or dentist 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 Health Plan will call you within 48 hours from receiving the provider's certification or 3 business days of when Gateway receives your request for an expedited (faster) grievance review with the decision. You will also receive a letter telling you the reason for the decision and, that you can ask for an expedited external grievance review, if you don't like the decision.

If you or your representative want to ask for an expedited external grievance review by the Department of Health, you must call Gateway Health Plan at 1-800-392-1147 (TTY/TDD 1-800-654-5988) 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.

An expedited grievance decision may not be requested after a second level grievance decision has been made on the same issue.

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

If you need help filing your complaint or grievance, a staff member of Gateway Health Plan 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 by calling 1-800-440-3989. If you need help getting the local legal aid telephone number, please call Gateway’s toll-free Member Services telephone number at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

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 Health Plan, 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 Health Plan to see any information Gateway has about your complaint or grievance.

Persons whose primary language is not English

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

Persons with Disabilities

Gateway Health Plan 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;
- 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 Health Plan.

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

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 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 when do I have to ask for my fair hearing?

If you are unhappy because Gateway ...	You must ask for a fair hearing...
1) denied a service/item requested because it is not medically necessary;	1) within 30 days of getting a letter from Gateway telling you of this decision
2) denied a service/item requested because it is not a covered benefit;	2) within 30 days of getting a letter from Gateway telling you of this decision
3) denied or approved only a limited	3) within 30 days of getting a letter from

<p>authorization for a service/item requested;</p> <p>4) reduced, suspended or terminated approval for a previously authorized service/item;</p> <p>5) denied the requested service/item but approved an alternate service/item;</p> <p>6) did not provide a service/item requested in a timely manner;</p> <p>7) did not decide a complaint or grievance you told Gateway about over 30 days ago;</p> <p>8) denied payment for a service/item which was delivered without authorization or by a non-participation provider.</p> <p>9) denied payment for a service/item which was already delivered because it is not a covered benefit.</p>		<p>Gateway telling you of this decision</p> <p>4) within 30 days of getting a letter from Gateway telling you of this decision</p> <p>5) within 30 days of getting a letter from Gateway telling you of this decision</p> <p>6) within 30 days of getting a letter from Gateway telling you of this decision</p> <p>7) within 30 days of getting a letter from Gateway telling you that Gateway did not decide your complaint or grievance within the time Gateway was supposed to.</p> <p>8) within 30 days from the date you should have received the service or item</p> <p>9) within 30 days from the date you should have received the service or item</p>
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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.

Gateway will also participate in the fair hearing to explain why the decision was made or explain what happened.

If you ask, Gateway must give you (at no cost to you) any records, reports and other information Gateway has that is relevant to what you requested your fair hearing about.

When will the fair hearing be decided?

If you ask for a fair hearing after a first level complaint or grievance decision, the fair hearing will be decided no more than 60 days after the Department of Public Welfare gets your request.

If you ask for a fair hearing and did not file a first level complaint or grievance, or if you ask for a fair hearing after a second level complaint or grievance decision, the fair hearing will be decided within 90 days from when the Department of Public Welfare gets your request.

If your fair hearing is not decided within 90 days from the date that the Department of Welfare receives your request, you may be able to get interim assistance until the decision is made.

What to do to continue getting services during the Fair Hearing:

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 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 your fair hearing was held.

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 health care lists someone who can make health care 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 Gateway’s Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988) 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 (See page ___) or with the Department of Health.

HealthChoices Clinical Sentinel Hotline

The Medical Director for the Office of Medical Assistance Programs at the Department of Public Welfare (DPW) set up the Clinical Sentinel Hotline (CSH). The CSH was developed to ensure that the HealthChoices managed care medical plans and behavioral health plans honor your right to have your request for medically necessary care and services responded to in a timely manner. The CSH helps all Medical Assistance recipients who are enrolled in the HealthChoices Program

If you live in one of the following counties, you may call the Clinical Sentinel Hotline at the Department of Public Welfare at 1-800-426-2090:

- Adams
- Allegheny
- Armstrong
- Beaver
- Berks
- Butler
- Indiana
- Lancaster
- Lawrence
- Lebanon
- Lehigh
- Northampton

- Cumberland ● Perry
- Dauphin ● Washington
- Fayette ● Westmoreland
- Greene ● York

Nurses who work for DPW answer the CSH. If you or your medical providers have requested medical care or services, and your managed care medical plan or behavioral health plan has not responded in time to meet your needs, call the CSH. The CSH will work along with the medical plan or behavioral health plan responds to your request soon enough to meet your needs. You can also call the CSH if your medical plan or behavioral health plan has denied you medically necessary care or services and won't accept your request to file a grievance.

The CSH operates Monday through Friday between 9am and 5pm. Call 1-800-426-2090.

The CSH cannot provide or approve urgent or emergency care. If you believe you have an urgent or emergency medical situation, you should seek the care you need with your Primary Care Physician (PCP) or local hospital.

If you have questions about your care or Gateway services, and you live outside of the above listed counties, call Gateway Health Plan's Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

Suggestions for Changes

If you would like to suggest changes to any Gateway Health Plan Policies and Procedures, please call the Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

Fraud and Abuse

If you think that someone is using your Gateway Health Plan identification (ID) card to get medical or prescription drug benefits, call Gateway's Fraud and Abuse Hotline at 412-255-4340 (TTY/TDD 1-800-618-4225). Your name will be kept private. If you are not in the (412) area code, call the Gateway Member Services Department at 1-800-392-1147 (TTY/TDD 1-800-654-5988) 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 8:30AM to 3:30PM. 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 omaptips@state.pa.us. This has been set up so you do not have to give your name also.

Recipient Restriction Program

Gateway Health Plan (GHP) 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 health care 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
P.O. 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 Health Plan 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 four times a year, and drugs are removed from the formulary list two times a year.

Other Information

If you would like any information about Gateway Health Plan 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 Health Plan's Quality Improvement Program, call Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988).

Eligibility

The Department of Public Welfare decides if you qualify for Medical Assistance. They also decide what health care 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 health care package.

Important Notice

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.

County Name	Mental Health Services	Drug & Alcohol Services
Adams	CCBH (Community Care Behavioral Health) 1-866-738-9849	1-717-771-9618
Allegheny	CCBH (Community Care Behavioral Health) 1-800-553-7499	412-350-3857
Armstrong	VBH (Value Behavioral Health) 1-877-688-5969	1-724-354-2746
Beaver	VBH (Value Behavioral Health) 1-877-688-5970	1-724-847-6220
Berks	CCBH (Community Care Behavioral Health) 1-866-292-7886	1-610-376-8669
Blair	1-814-693-3023	1-814-693-3023
Butler	VBH (Value Behavioral Health) 1-877-688-5971	1-724-284-5114
Cambria	1-814-534-2800	1-814-536-5388
Carbon	1-570-420-1900	1-570-421-3669 1-570-421-1960
Clarion	1-814-226-1081	1-814-226-1080
Columbia	1-570-275-5422	1-570-275-5422
Cumberland	CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646	1-717-240-6300
Dauphin	CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646	1-717-255-2984
Erie	1-814-451-6800	1-814-451-6870
Fayette	VBH (Value Behavioral Health) 1-877-688-5972	1-724-438-3576
Franklin	1-717-264-5387	1-717-263-1256
Greene	VBH (Value Behavioral Health) 1-877-688-5973	1-724-852-5276
Indiana	VBH (Value Behavioral Health) 1-877-688-5974	1-724-354-2746
Jefferson	1-814-265-1060	1-814-371-9002
Lackawanna	1-570-346-5741	1-570-963-6820
Lancaster	CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646	1-717-299-8023
Lawrence	VBH (Value Behavioral Health) 1-877-688-5975	1-724-658-5580

Lebanon	CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646	1-717-274-0427
Lehigh	Magellan 1-866-238-2312	1-610-782-3555
Luzerne	1-570-825-9441	1-570-826-8790
Mercer	1-724-662-1550	1-724-662-1550
Monroe		
Montour	1-570- 275-5422	1-570-275-5422
Northampton	Magellan 1-866-238-2312	1-610- 997-5800
Northumberland	1-570- 988-4434	1-570-988-4420
Perry	CBHNP (Community Behavioral Healthcare Network of Pennsylvania) 1-888-722-8646	1-717-240-6300
Pike	1-570-420-1900	1-570-421-3669
Schuylkill	1-570-628-1180	1-570-621-2890
Somerset	1-814-443-4891	1-814-445-1530
Susquehanna	1-570-265-2211	1-717- 278-1000
Washington	VBH (Value Behavioral Health) 1-877-688-5976	1-724-223-1181
Westmoreland	VBH (Value Behavioral Health) 1-877-688-5977	1-724-684-9000
Wyoming	1-570-825-9441	1-570-826-8790
York	CCBH (Community Care Behavioral Health) 1-866-542-0299	1-717-771-9618

Medical Assistance Transportation

Phone numbers

If you need transportation for a medical service other than an emergency, each county can provide transportation through the Medical Assistance Transportation Program. Call Gateway Health Plan Member Services at 1-800-392-1147 (TTY/TDD 1-800-654-5988), and a representative will help you get transportation through the Medical Assistance Transportation Program in your county.

Adams County	1-717-337-1345 or 1-717-337-1346 1-717-337-1494 or 1-888-830-6473
Allegheny County	412-350-4476 or 1-888-547-6287
Armstrong County	1-724-548-3405 or 1-800-468-7771
Beaver County	1-724-728-5633 or 1-800-262-0343
Berks County	1-800-383-2278 or 1-610-921-2361
Blair County	1-814-946-1235 or 1-800-245-3282
Butler County	1-866-638-0598
Cambria County	1-814-536-9031 or 1-888-647-8414
Carbon	1-800-990-4287
Clarion County	1-814-226-7012 or 1-800-672-7116
Columbia County	1-570-784-8807 or 1-888-868-2320
Cumberland County	1-888-315-2546 or 1-717-697-0371 x6340
Dauphin County	1-717-232-6100
Erie County	1-814-455-3330 or 1-800-323-5579
Fayette County	1-724-430-4600 or 1-800-321-7433
Franklin County	1-717-864-5225
Greene County	1-724-627-6778 or 1-877-360-7433

Indiana County	1-724-463-3235 or 1-888-526-6060
Jefferson County	1-800-648-3381 or 1-814-938-3302
Lackawanna	1-570-963-6482
Lancaster County	1-717-291-1243 or 1-800-892-1122
Lawrence County	1-724-652-5588 or 1-888-252-5104
Lebanon County	1-717-274-9469
Lehigh County	1-610-435-3200
Luzerne	1-570-288-8420 or 1-800-679-4135
Mercer County	1-724-662-6222 or 1-800-570-6222
Monroe	
Montour County	1-570-271-0833
Northampton County	1-610-432-3200 or 1-610-253-8833
Northumberland County	1-570-644-4463 or 1-570-644-4464 1-800-479-2626
Perry County	1-877-800-7433 or 1-717-567-2490
Pike County	1-570-775-5550 or 1-570-775-5555 1-800-223-8911
Schuylkill County	1-570-628-1425 or 1-888-656-0700
Somerset County	1-814-445-9628 or 1-800-452-0241
Susquehanna County	1-570-853-4510 x284
Washington County	1-724-223-8747 or 1-800-331-5058
Westmoreland County	1-800-242-2706 or 1-724-832-2706

Wyoming County	1-570-288-8420 or 1-800-679-4135
York County	1-800-524-2766 or 1-717-845-7553