Anthem HealthKeepers Plus
Member Handbook and Evidence of Coverage
www.anthem.com/vamedicaid

Member Services
1-800-901-0020
TTY 711
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Dear Member:

Thanks for being a member of Anthem HealthKeepers Plus offered by HealthKeepers, Inc. We want to let you know about some changes to your member handbook. Please keep this insert with the handbook so you have the most up-to-date information.

Please read this carefully if you use behavioral health or substance abuse benefits in your Anthem HealthKeepers Plus plan. Here’s what’s changing:

**More benefits**
Your plan now includes behavioral health and substance abuse services, like:

- Halfway house and group home treatment
- Residential treatment
- Residential detox
- Peer supports (effective July 1, 2017)

You still get the same services as before, too, like:

- Inpatient mental health, including temporary detention orders from local courts in urgent and acute situations
- Outpatient mental health and substance abuse office visits to licensed behavioral health providers
- Psychiatrists (doctors who can prescribe medicine), psychologists (can’t prescribe medicine) and social workers
- Traditional one-on-one sessions with your doctor
- Psychological testing
- Rides to all behavioral health services

**More provider choices**
Magellan used to manage some of your benefits. Starting April 1, 2017, we’ll manage them. And that means there are more doctors and other providers in your plan to choose from. If you need help finding a place to get services:

- Visit www.anthem.com/vamedicaid to use our Find a Doctor tool.
- Call Member Services at 1-800-901-0020 (TTY 711) Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

If you used to contact Magellan about the services listed above, you’ll contact us instead.

**If you take Suboxone**
Managing substance use disorder is important, and we’re here to help you stay on top of it. If you take Suboxone to help with this, you can still get it as an Anthem HealthKeepers Plus member. Some rules are changing, though:

- You can only get it from one drugstore
• You can only get it from one doctor
• You can’t combine it with painkillers

If you take Suboxone, you’ll get a letter with your doctor and pharmacy information. If you don’t get this letter, call Member Services.

Questions? We’re a click or call away.
• Visit our website at www.anthem.com/vamedicaid.
• Call Member Services at 1-800-901-0020 (TTY 711) Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

Thank you for being our member.

Sincerely,

HealthKeepers, Inc.

www.anthem.com/vamedicaid

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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

Podemos traducir esta información sin costo. Llame al número de Servicios a Miembros que figura en su tarjeta de identificación de miembro.
Welcome

Welcome to your Anthem HealthKeepers Plus plan. Our team is ready to help you stay on top of your health care. We help you get your Medicaid benefits as a contractor of the Department of Medical Assistance Services (DMAS).

Use this member handbook and Evidence of Coverage (EOC) to:
- Guide you to helpful benefits.
- Learn about how your health care plan works.
- Find out how to get medical care when you need it.

Please read this handbook carefully.

How to get in touch with us
If you need to talk with someone about your benefits or health plan, contact us:

- Call Member Services toll free at 1-800-901-0020. If you are deaf or hard of hearing, call the TTY line at 711. We’re open Monday through Friday from 8 a.m. to 6 p.m. Eastern time.
- Have health questions after hours? Call our 24/7 NurseLine at 1-800-901-0020 (TTY 711) to talk with a nurse, day or night, even on weekends and holidays.
- Have questions about your behavioral health (mental health and substance abuse) benefits? Call 1-800-901-0020 (TTY 711).
- Write to us at: Member Services
  Anthem HealthKeepers Plus
  P.O. Box 27401
  Mail Drop VA2002-N500
  Richmond, VA 23279

Address changing? Call Cover Virginia!
If you move, contact Cover Virginia or your local social services department right away to change your address. If you don’t, you could lose your benefits during the annual renewal process. Update your address in one of these ways:

- Call Cover Virginia at 1-855-242-8282 (TDD 1-888-221-1590). They’re available Monday through Friday from 8 a.m. to 7 p.m. and Saturday from 9 a.m. to 12 p.m. They speak English and Spanish. This is the easiest way to report your address change.
- Contact your local social services caseworker.

Other resources
- Learn more about your dental benefits by calling Smiles for Children at 1-888-912-3456 (TTY 711).
- Call for transportation services at 1-877-892-3988 (TTY 711).

If there are changes to your Medicaid-covered services or benefits, we’ll let you know in writing at least 30 days before the changes take place.

Member Services: 1-800-901-0020 (TTY 711)
Monday – Friday, 8 a.m. – 6 p.m. Eastern time
24/7 NurseLine: 1-800-901-0020
Translation and interpreter services

No-cost translation and interpreter services are available if you’re a member and don’t speak English. If you have vision loss or need your written materials in an alternate format, call Member Services at 1-800-901-0020 (TTY 711) for help.

Thank you for choosing us as your health plan. We look forward to helping you get your health care.
Section I: Benefit quick reference guide

We’re here to help you get your Medicaid benefits and services. The chart below tells you about the benefits covered by your health plan. This chart is a summary only. Please refer to Section III: Benefits for a full list of your benefits.

For some services, you may need a referral from your primary care provider (PCP) or prior authorization (that means you ask us at HealthKeepers, Inc. for an OK) ahead of time. Otherwise, we may not cover the service.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
<th>Limits</th>
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</thead>
<tbody>
<tr>
<td>Behavioral health services</td>
<td>Inpatient hospital services require prior authorization.</td>
<td>We don’t cover inpatient hospital services given in a state psychiatric</td>
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<tr>
<td></td>
<td>Inpatient behavioral services rendered in a free-standing psychiatric hospital are covered only for members over 64 years of age or under 21 years of age (when medically necessary, according to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards).</td>
<td>hospital.</td>
</tr>
<tr>
<td></td>
<td>Outpatient treatment provided by a provider in our network doesn’t require a prior authorization. This includes assessments for individual, family and group behavioral health services. This also applies to substance abuse assessments and treatment provided by a provider in our network.</td>
<td>The Department of Medical Assistance Services (DMAS) covers:</td>
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<td></td>
<td>This will include covered pharmacy prescriptions obtained at a contracted network pharmacy and transportation related to substance abuse. This will include prescriptions for opioid treatment obtained from a contracted network pharmacy.</td>
<td>- Behavioral health residential care</td>
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<td>- Day treatment (partial hospital program (PHP))</td>
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<td>- Intensive outpatient program (IOP)</td>
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<td></td>
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<td>- In-home services</td>
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<td></td>
<td>DMAS also covers substance abuse treatment for children and adults insured under Medicaid, including:</td>
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<td>- Emergency (crisis) services</td>
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<td>- Intensive outpatient treatment</td>
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<td></td>
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<td>- Day treatment</td>
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<td></td>
<td></td>
<td>- Substance abuse case management</td>
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<td></td>
<td></td>
<td>- Prescriptions for opioid treatment administered by a substance abuse provider</td>
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Member Services: 1-800-901-0020 (TTY 711)
Monday – Friday, 8 a.m. – 6 p.m. Eastern time
24/7 NurseLine: 1-800-901-0020
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
<th>Limits</th>
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<tbody>
<tr>
<td><strong>Dental and oral surgery services</strong></td>
<td><strong>Smiles for Children covers routine dental services.</strong></td>
<td><strong>For information on services covered by DMAS, call DentaQuest/Smiles for Children program at 1-888-912-3456.</strong></td>
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<td></td>
<td><strong>We cover medically necessary services for:</strong></td>
<td><strong>Dental fluoride varnish is for members up to 3 years of age.</strong></td>
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<td></td>
<td>• Dental accidents</td>
<td><strong>The service may be rendered every six months up to a maximum of six applications.</strong></td>
</tr>
<tr>
<td></td>
<td>• Procedures to the mouth where the main purpose is not to treat or help the teeth</td>
<td><strong>Smiles for Children also provides dental benefits to pregnant women age 21 and over.</strong></td>
</tr>
<tr>
<td></td>
<td>• Anesthesia and hospitalization services when required to provide dental care</td>
<td><strong>Dental services for pregnant women offered by Smiles for Children include:</strong></td>
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<td>• Dental fluoride varnish provided by a nondental medical provider</td>
<td>• X-rays and examinations</td>
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<td>• Cleanings</td>
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<td>• Fillings</td>
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<td>• Root canals</td>
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<td>• Gum-related treatment</td>
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<td></td>
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<td>• Crowns, bridges, partials and dentures</td>
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<td></td>
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<td>• Tooth extractions and other oral surgeries, and</td>
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<td></td>
<td></td>
<td>• Other appropriate general services</td>
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<td></td>
<td></td>
<td><strong>Orthodontic treatment is not included in the coverage.</strong></td>
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<td></td>
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<td><strong>Pregnant women will need to provide the dentist with the anticipated due date.</strong></td>
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<td><strong>The dental coverage for Medicaid-enrolled women who are pregnant includes coverage for 60 days after the baby is born.</strong></td>
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<td><strong>Durable medical</strong></td>
<td><strong>Medically necessary equipment and</strong></td>
<td><strong>Durable medical equipment must be</strong></td>
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<td></td>
<td><strong>For information on services covered by DMAS, call DentaQuest/Smiles for Children program at 1-888-912-3456.</strong></td>
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<td><strong>Dental fluoride varnish is for members up to 3 years of age.</strong></td>
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<td></td>
<td></td>
<td><strong>The service may be rendered every six months up to a maximum of six applications.</strong></td>
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<td><strong>Smiles for Children also provides dental benefits to pregnant women age 21 and over.</strong></td>
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<td><strong>Dental services for pregnant women offered by Smiles for Children include:</strong></td>
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<td>• Cleanings</td>
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<td>• Fillings</td>
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<td>• Root canals</td>
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<td>• Gum-related treatment</td>
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<td>• Tooth extractions and other oral surgeries, and</td>
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<td>• Other appropriate general services</td>
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<td><strong>Orthodontic treatment is not included in the coverage.</strong></td>
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<td></td>
<td><strong>Pregnant women will need to provide the dentist with the anticipated due date.</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>The dental coverage for Medicaid-enrolled women who are pregnant includes coverage for 60 days after the baby is born.</strong></td>
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<td>Benefit</td>
<td>Coverage</td>
<td>Limits</td>
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<tr>
<td>equipment (DME) and supplies</td>
<td>supplies, including, but not limited to:</td>
<td>obtained from the network provider for this health service.</td>
</tr>
<tr>
<td></td>
<td>• Medical and surgical supplies</td>
<td>We don’t cover hearing aids for members 21 years of age and older.</td>
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<tr>
<td></td>
<td>• Wheelchairs</td>
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<td>• Traction equipment</td>
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<td></td>
<td>• Walkers</td>
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<td></td>
<td>• Crutches and canes</td>
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<td></td>
<td>• Ventilators and oxygen</td>
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<tr>
<td></td>
<td>• Hearing aids and accessories</td>
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<td></td>
<td>• Diabetes supplies</td>
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<td></td>
<td>All custom-made DME requires an authorization from us.</td>
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<td></td>
<td>Some other DME may require an authorization from us.</td>
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<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Medically necessary preventive, screening and treatment services, including but not limited to:</td>
<td>EPSDT services are for members under 21 years of age.</td>
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<td></td>
<td>• Health and development history</td>
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<td></td>
<td>• Physical exam</td>
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<td></td>
<td>• Diagnostic services and treatment</td>
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<td></td>
<td>• Developmental assessment</td>
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<td></td>
<td>• Nutritional assessment</td>
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<td></td>
<td>• Vision and hearing screening</td>
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<td></td>
<td>• Dental screening</td>
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<td></td>
<td>• Lab tests including blood lead level</td>
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<td></td>
<td>• Appropriate vaccines</td>
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<td></td>
<td>• Teaching you about health topics</td>
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<td></td>
<td>• Tobacco cessation services, education and pharmacotherapy</td>
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</tr>
<tr>
<td>Early Intervention (EI) services</td>
<td>Rehabilitative services as necessary beyond state agency benefits for EI-enrolled members to include:</td>
<td>EI services are:</td>
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<tr>
<td></td>
<td>• Speech and language therapy</td>
<td>• Covered by DMAS within its coverage criteria and guidelines</td>
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<td></td>
<td>• Occupational therapy</td>
<td>• Available to members from birth to three years of age who are</td>
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<td></td>
<td>• Physical therapy</td>
<td>certified as eligible for services under Part C of the Individuals</td>
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<td></td>
<td>• Assistive technology services and devices</td>
<td>with Disabilities Act</td>
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<tr>
<td>Emergency and urgent care services</td>
<td>All emergency services received in the United States are covered.</td>
<td>We cover emergency room services received outside of the network</td>
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<tr>
<td></td>
<td>You don’t need an authorization from your PCP or the health plan for</td>
<td>(and state), but not outside of the United States.</td>
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<tr>
<td></td>
<td>any of these services.</td>
<td></td>
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<td></td>
<td>Urgent care services aren’t an emergency, but need medical attention</td>
<td>If you need medical advice, please call the 24/7 NurseLine at</td>
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<td></td>
<td>within 24 hours.</td>
<td>1-800-901-0020 or your PCP.</td>
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### Benefit

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
<th>Limits</th>
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<tbody>
<tr>
<td><strong>Family planning services</strong></td>
<td>We cover:</td>
<td>Sterilization is covered for members 21 years of age and older when:</td>
</tr>
<tr>
<td>You may see any licensed family planning provider. The provider doesn’t need to be in our network.</td>
<td>- Health education and advice</td>
<td>- Prior voluntary consent is obtained and documented</td>
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<td></td>
<td>- Counseling</td>
<td>- The individual is mentally competent</td>
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<td></td>
<td>- Physical exam</td>
<td>- The required 30-day waiting period is met</td>
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<td></td>
<td>- Annual cervical cancer screenings</td>
<td>We don’t cover elective abortion services. We do pay for medically</td>
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<td>- Birth control</td>
<td>needed follow-up care related to these services.</td>
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<td></td>
<td>- Follow-up care</td>
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<td></td>
<td>- Lab and pregnancy tests</td>
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<td></td>
<td>- Sterilization</td>
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<td></td>
<td>- Tests for sexually transmitted infections (STIs)</td>
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<td></td>
<td>- HIV screening, testing and counseling for at-risk members as well as referrals for treatment</td>
<td></td>
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<td></td>
<td>- Transportation to covered medical appointments</td>
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<tr>
<td><strong>Health education</strong></td>
<td>Health education services are covered when authorized or furnished by us.</td>
<td></td>
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<tr>
<td><strong>High-dose chemotherapy, High-dose radiation and Bone marrow transplants</strong></td>
<td>For members under 21 years of age, we cover:</td>
<td>These services are only covered for members over 21 years of age who are diagnosed with:</td>
</tr>
<tr>
<td>Some services may require an authorization from us.</td>
<td>- High-dose chemotherapy and/or high-dose radiation</td>
<td>- Myeloma</td>
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<td></td>
<td>- Any resulting medical complications</td>
<td>- Lymphoma</td>
</tr>
<tr>
<td></td>
<td>- Any supporting bone marrow transplants or other forms of stem cell rescue</td>
<td>- Leukemia</td>
</tr>
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<td></td>
<td>For members age 21 and over, we cover:</td>
<td>- Breast cancer</td>
</tr>
<tr>
<td></td>
<td>- High-dose chemotherapy and/or high-dose radiation</td>
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<tr>
<td></td>
<td>- Any resulting medical complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Any supporting bone marrow transplants or other forms of stem cell rescue</td>
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<td><strong>Home health care</strong></td>
<td>We cover:</td>
<td>We don’t cover:</td>
</tr>
<tr>
<td>Requires an authorization from us.</td>
<td>- House calls by your PCP</td>
<td>- Personal care services</td>
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<td>- Skilled nursing visits</td>
<td>- Custodial care</td>
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<td>- Medical supplies</td>
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<td>- Physical, occupational and speech therapy</td>
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<tr>
<td>Benefit</td>
<td>Coverage</td>
<td>Limits</td>
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<td><strong>Hospital services — Inpatient</strong></td>
<td>We cover:</td>
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<tr>
<td>Requires an authorization from us.</td>
<td>A semiprivate room</td>
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<tr>
<td>You don’t need an authorization from us in an emergency or for a routine delivery.</td>
<td>General nursing services</td>
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<td>Meals and special diets</td>
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<td>Services in special units</td>
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<td>Delivery rooms</td>
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<td>Maternity services</td>
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<td>Special treatment rooms</td>
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<td>Operating rooms</td>
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<td>Surgical procedures</td>
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<td>Anesthesia</td>
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<td>Laboratory and other diagnostic tests</td>
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<td>Drugs the hospital staff gives you during your stay</td>
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<td>Blood and blood products</td>
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<td>Physical, occupational and speech therapy</td>
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<td></td>
<td>Radiation therapy</td>
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<td>Inhalation therapy</td>
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<td>Chemotherapy</td>
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<td></td>
<td>Dialysis treatment</td>
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<td>Discharge planning (includes needed future care)</td>
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<td>All covered services are rendered by network physicians and provider hospital personnel, which are authorized by your PCP and provided while you are admitted to a network provider hospital as a registered bed patient.</td>
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<td>We don’t cover:</td>
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<td></td>
<td>A private room unless it is medically necessary</td>
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<td>Comfort items such as:</td>
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<td>Telephone</td>
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<td></td>
<td>Television</td>
<td></td>
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<td></td>
<td>Visitor meals</td>
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</tr>
</tbody>
</table>

<p>| Hospital services — Outpatient | We cover:  |
| Some services require an authorization from us. | Emergency room use  |
| | Diagnostic services to find out what is wrong with you  |
| | Surgical care that doesn’t require an overnight stay in the hospital  |
| | Physical therapy  |
| | Occupational therapy  |
| | Speech therapy  |
| | All covered diagnostic, treatment and surgical services rendered by network providers, which are authorized by your PCP  |</p>
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
<th>Limits</th>
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</thead>
</table>
| Medical transportation services             | Emergency transport is used to get medical care and treatment in a true emergency. We cover:  
  - Ground ambulance  
  - Air ambulance if necessary  
  We cover transportation for pharmacy services necessary for the treatment of behavioral health and substance abuse conditions. | Nonemergency transportation is provided when related to covered medical care. Please see Section III: Benefits for more information about nonemergency transportation. |
| Obstetrical/Gynecological services          | We cover:  
  - Maternity care, including pregnancy-related care and postpartum services for 60 days after the pregnancy ends  
  - Hospital services  
  - Certified midwife services  
  - Anesthesia  
  - HIV testing, treatment and counseling for HIV | Eligibility for newborn children is subject to the conditions set forth in Section VI: Terms and Conditions. |
| Organ and tissue transplants                | For members under 21 years of age, we cover:  
  - Any medically necessary transplant  
  For members age 21 and over, we cover bone marrow transplants for specific diagnoses only including:  
  - Myeloma  
  - Lymphoma  
  - Leukemia  
  - Breast cancer  
  For members (all ages), we also cover:  
  - Corneal transplants  
  - Heart transplants  
  - Kidney transplants (living or cadaver donor)  
  - Liver or liver lobe transplants (living or cadaver donor)  
  - Single or double lung or lung lobe transplants | We don’t cover for members 21 years of age or older:  
  - Pancreas transplants  
  - Intestinal transplants  
  - Any transplant which is considered experimental or investigational  
  - Small bowel with liver  
  - Heart and lung |
<table>
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<tr>
<th>Benefit</th>
<th>Coverage</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy and over-the-counter products</td>
<td>Services provided under the pharmacy benefit include but aren't limited to:</td>
<td>For each prescription, we will cover up to a 31-day supply.</td>
</tr>
<tr>
<td></td>
<td>• All medically necessary FDA-approved prescription drugs and over-the-counter medications</td>
<td>No more than one glucometer within a two-year period.</td>
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<tr>
<td></td>
<td>• Diaphragms and birth control pills</td>
<td>We don’t cover:</td>
</tr>
<tr>
<td></td>
<td>• Insulin, syringes and needles for the administration of insulin</td>
<td>• Drugs used primarily for cosmetic purposes</td>
</tr>
<tr>
<td></td>
<td>• Glucometer</td>
<td>• Drugs for the treatment of erectile dysfunction</td>
</tr>
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<td></td>
<td></td>
<td>• Drugs and medications not approved by the U.S. Food and Drug Administration (FDA) for the purpose prescribed</td>
</tr>
<tr>
<td>Podiatry services</td>
<td>We cover:</td>
<td>Services must be performed by a network provider.</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic, medical or surgical treatment of disease, injury or defects of the foot</td>
<td>We don’t cover toenail clipping unless you’re diabetic.</td>
</tr>
<tr>
<td>Practitioner services</td>
<td>We cover medically necessary:</td>
<td>We don’t cover immunizations for a job, school or camp program.</td>
</tr>
<tr>
<td></td>
<td>• Preventive services</td>
<td></td>
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<td></td>
<td>• Diagnostic services</td>
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<tr>
<td></td>
<td>• Therapeutic services</td>
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<td></td>
<td>• Rehabilitative services</td>
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<tr>
<td></td>
<td>• Palliative services</td>
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<tr>
<td></td>
<td>• Renal dialysis services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We also offer no-cost sports physicals for members age 19 and younger as part of our value-added benefits</td>
<td></td>
</tr>
<tr>
<td>Preventive services</td>
<td>For members under 21 years of age, we cover:</td>
<td>Services must be performed by your PCP. A woman may see any participating OB/GYN provider for her annual well-woman exam.</td>
</tr>
<tr>
<td></td>
<td>• Well-baby care from birth</td>
<td>We cover these tests as recommended by the American College of Gastroenterology and the American Cancer Society.</td>
</tr>
<tr>
<td></td>
<td>• Periodic health assessments</td>
<td></td>
</tr>
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<td></td>
<td>• Immunizations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Vision and hearing screenings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Annual gynecological exams including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Breast exam</td>
<td></td>
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<tr>
<td></td>
<td>- Pelvic exam</td>
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<tr>
<td></td>
<td>- Pap smear</td>
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<tr>
<td></td>
<td>For members over 21 years of age,</td>
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<tr>
<td>Benefit</td>
<td>Coverage</td>
<td>Limits</td>
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<tr>
<td></td>
<td>we cover:</td>
<td>Orthotics are covered for:</td>
</tr>
<tr>
<td></td>
<td>• Periodic health assessments</td>
<td>• Members 21 years of age and younger</td>
</tr>
<tr>
<td></td>
<td>• Annual gynecological exams including:</td>
<td>• All members when the prosthesis and/or orthotic is part of an approved intensive rehabilitation program</td>
</tr>
<tr>
<td></td>
<td>– Breast exam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Pelvic exam</td>
<td></td>
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<tr>
<td></td>
<td>– Pap smear</td>
<td></td>
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<tr>
<td></td>
<td>• Annual fecal occult blood tests</td>
<td></td>
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<tr>
<td></td>
<td>• Flexible sigmoidoscopy</td>
<td></td>
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<tr>
<td></td>
<td>• Colonoscopy</td>
<td></td>
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<tr>
<td></td>
<td>• Colorectal cancer screening and barium enemas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prostate cancer screening including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Prostate Specific Antigen (PSA) testing</td>
<td></td>
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<td></td>
<td>– Digital prostate exams</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prosthetics and orthotics</td>
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<td></td>
<td>Some services require an authorization from us.</td>
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<tr>
<td></td>
<td>we cover:</td>
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<tr>
<td></td>
<td>• Artificial arms and legs and the necessary supportive attachments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Internal body parts (implants)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breasts</td>
<td></td>
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<tr>
<td></td>
<td>• Eye prostheses when eyeballs are missing and regardless of the function of the eye</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Molded therapeutic shoes and inserts for diabetics with peripheral vascular disease (PVD)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reconstructive breast surgery</td>
<td></td>
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<tr>
<td></td>
<td>we cover:</td>
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<tr>
<td></td>
<td>• Reconstruction of the breast on which a mastectomy has been performed</td>
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<tr>
<td></td>
<td>• Surgery and reconstruction of the unaffected breast to produce a symmetrical appearance</td>
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<td></td>
<td>• Prostheses and physical complications of all stages of mastectomy, including lymphedema</td>
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<tr>
<td></td>
<td>• Rehabilitative services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some services require an authorization from us.</td>
<td>Requested services must be:</td>
</tr>
<tr>
<td></td>
<td>we cover:</td>
<td>• Required for a medical condition</td>
</tr>
<tr>
<td></td>
<td>• Physical therapy</td>
<td>• Performed on an outpatient basis at an outpatient facility or</td>
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<tr>
<td></td>
<td>• Occupational therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Speech therapy</td>
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<td>Benefit</td>
<td>Coverage</td>
<td>Limits</td>
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<tr>
<td><em>Audiology</em></td>
<td>• Audiology</td>
<td>at a comprehensive outpatient rehabilitative facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Performed by a network provider</td>
</tr>
<tr>
<td><strong>Vision services</strong></td>
<td>For members age 21 years and under, we cover:</td>
<td>Services must be received from your network provider.</td>
</tr>
<tr>
<td></td>
<td>• A routine eye exam once every 24 months</td>
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<td></td>
<td>• A pair of eyeglasses or contact lenses as medically necessary</td>
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<td></td>
<td>For members age 21 years and</td>
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<td></td>
<td>older, we cover:</td>
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</tr>
<tr>
<td></td>
<td>• A routine eye exam once every 24 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A discount offer on materials every 24 months</td>
<td></td>
</tr>
<tr>
<td><strong>X-ray and laboratory services</strong></td>
<td>We cover:</td>
<td>All CT, MRI, MRA, PET and SPECT require an authorization from your PCP and the health plan.</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic lab tests</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diagnostic X-rays</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mammography</td>
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<tr>
<td></td>
<td>• Electrocardiograms</td>
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<tr>
<td></td>
<td>Services must be received from your network provider.</td>
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</tbody>
</table>

We will only pay for covered services that are medically needed. We will also pay for medically necessary follow-up services only if they’re related to services covered by the Virginia Department of Medical Assistance Services (DMAS).

If you’re out of town or out of the Commonwealth of Virginia and need help getting an authorization for medical care, call us toll free at 1-800-901-0020 (TTY 711).
Section II: Using your Anthem HealthKeepers Plus coverage

Help us get you the care you need – fill out your health assessment

In your new member packet, you’ll see a health assessment. Please fill it out and mail it back to us as soon as you can. It helps us connect you with benefits and services to meet your needs. If you don’t fill it out, we may contact you to help you fill it out.

Member Services

Member Services is here to help you understand your health care benefits. You can call Member Services at 1-800-901-0020. We’re open Monday through Friday from 8 a.m. to 6 p.m. Eastern time. Members with hearing or speech loss may call TTY 711.

Member Services staff can help you with your questions about:

- The information in this member handbook
- Member ID cards
- Your primary care provider (PCP) and other doctors or specialists your child sees, including names, specialties, addresses, phone numbers and professional qualifications
- PCP visits
- How to find information about types of care we don’t cover
- Health care benefits
- Utilization or health care management processes
- Wellness care
- Special kinds of health care
- Healthy living
- Grievances and appeals
- Your rights and responsibilities

Call Member Services if:

- You change your phone number or address so we have your current information
- You want to ask for a copy of the member handbook in your preferred language at no charge
- You would like a copy of your medical records mailed to you at no charge

For members who don’t speak English:

- We can help in many different languages and dialects
- Call Member Services for more details
- Interpreter services are provided free of charge (let us know if you need an interpreter at least 48 hours before your appointment)

For members who are deaf or hard of hearing:

- Call 711 If you need it, we’ll set up and pay for you to have a person who knows sign language help you during your doctor visits (let us know if you need an interpreter at least 48 hours before your appointment)
We provide health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, race, age, religion, national origin, physical or mental disability or type of illness or condition.

**Primary care provider (your main health care practitioner)**

Your primary care provider (PCP) is the health care practitioner that will take care of you. A PCP can be a family practice, general practice, internal medicine or pediatric doctor. Your PCP will coordinate all your medical needs. Members with a special health care need may request that their PCP be a specialist. We'll review this request and authorize as medically necessary. A woman can choose an OB/GYN as her PCP. Members who identify themselves as Indian can choose an Indian Health Provider as their PCP.

To choose a PCP, call Member Services. A representative will help you. If you don’t call, a PCP will be assigned to you. If you would like information regarding the professional qualifications of a provider (including provider specialty, location or board certification status) or other information regarding providers, please call Member Services.

If you’re not happy with the PCP assigned to you, you may request a new PCP. Just call Member Services to request a physician change. You will get a new ID card in the mail with your new physician listed. If you call after the 10th of the month or you have seen the PCP listed on your ID card, the change will take effect on the first day of the following month.

**Appointments**

Each time you need to go to your PCP, you will need to make an appointment. Please keep your scheduled appointments. If you can't keep your appointment, call your PCP's office to cancel at least 24 hours before your appointment.

You can get:
- Preventive care appointments (such as mammograms and Pap smears) within 60 days of your call
- Routine/nonurgent care (such as sore throat and sinusitis) appointments within 30 days
- Urgent care (as defined in Section VII of this EOC) appointments within 24 hours
- Emergency care (as defined in Section VII of this EOC) 24 hours a day, seven days a week at your local hospital
- Maternity care appointments:
  - First trimester: within 14 calendar days of your request
  - Second trimester: within seven calendar days of your request
  - Third trimester: within five working days of your request
  - High-risk pregnancies: within three working days of your request or right away if there is an emergency

**Types of care**

Preventive care includes yearly wellness exams, tests and screenings you have done on a yearly basis like eye exams, mammograms, Pap smear or prostate screening. Routine/nonurgent care includes services done on a routine basis such as checking for high blood pressure, diabetes or thyroid.
Stay focused on health
Your health is important — and there are lots of things you can do to stay focused on it. Follow these tips to stay healthy:

- Go to all your regular checkups.
- Take all your medicines as instructed.
- Take small steps to be more active. Your doctor can help you come up with an exercise plan to improve your overall health.
- Eat a balanced diet. Check nutrition labels and add foods from each recommended group daily.
- Don’t smoke or use drugs, especially if you’re pregnant. Your baby can be healthier when you are, too. Ask your doctor if you need help quitting.

Access to care
Medical care is available through your PCP seven days a week, 24 hours a day. If you need care after regular hours, you may contact the on-call PCP or the 24/7 NurseLine.

For instructions on how to receive care, call your PCP or the 24/7 NurseLine at 1-800-901-0020. Members with hearing or speech loss may call the 24/7 NurseLine TTY line at 711.

If there are changes to your Medicaid covered services or benefits, we’ll let you know in writing at least 30 days before the change takes place.

Transportation
Transportation is available to medical appointments for covered services for members who don’t have their own transportation. Please call the transportation number shown on your Anthem HealthKeepers Plus ID card to schedule your ride for nonemergency services at least five days before your appointment or as soon before your appointment as possible. Bus tickets are also available. To obtain bus tickets, please call at least seven days before your appointment.

Gas reimbursement for those who assist you to medical appointments for covered services also may be provided. For gas reimbursement information, please call the transportation number on your Anthem HealthKeepers Plus ID card.

Your identification card
You should present your member identification (ID) card whenever you receive covered services. You must carry the ID card with you at all times to assure prompt receipt of covered services.

You will get only one ID card. If your card is lost or stolen, please call Member Services at 1-800-901-0020 immediately. We’ll send you a new ID card. You can also print new ID cards from the secure member web site.

You should present your ID card whenever you get covered services. Identification cards remain the property of HealthKeepers, Inc. and must be returned upon request.
Prior authorization (an authorization from HealthKeepers, Inc.)

Your PCP or specialist will need to get an authorization from us for some services to make sure they are covered. This means that both your PCP or specialist agree with us that the services are medically necessary.

“Medically necessary” means appropriate and necessary health care services which, according to generally accepted principles of good medical practice, are required for the diagnosis or direct care and treatment of an illness, injury or pregnancy-related condition and aren’t provided only as a convenience. Services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

Preauthorization requirements don’t apply to emergency care, family planning services, preventive services and basic prenatal care.

Once we get your PCP’s request for a prior authorization for a service, we will decide within:
- Fourteen (14) calendar days following the receipt of the request for service for a standard authorization decision
- Three calendar days for an expedited authorization decision

These time frames may be extended by up to 14 calendar days if you or your provider requests an extension or if we justify the need for additional information and the extension is in your best interest. See Section III: Benefits to check service limits. Your PCP can tell you more about this.

We may not authorize payment for a service you or your doctor asks for. We will send you and your doctor a letter that tells you why we would not cover the service. The letter also will let you know how to appeal our decision. See Section VI, Terms and Conditions for more information about the grievance and appeals process and the DMAS appeals process.

If you have questions, you or your doctor may call us at our toll-free Member Services or TTY number (for those with hearing or speech loss). Or you may write to us at:

Anthem HealthKeepers Plus Member Services
P.O. Box 27401
Mail Drop VA2002-N500
Richmond, VA 23279
Some services don’t need an authorization from your PCP or from us.

Services you can get without a referral from your PCP include:
- Emergency services
- Family planning services
- Immunizations
- Vision services

Making coverage decisions
We care about you and want to help you get the health care you need. Your doctors work with you to decide what’s best for your health. Your doctors and other health care workers must decide about your health based on whether or not the care is right for your health issue. Your doctor may ask us for an authorization to pay for a certain health care service.

We base our decision on two things:
- Whether or not the care is medically necessary
- What health care benefits you have

We don’t pay doctors or other health care workers who make utilization management decisions to:
- Deny you care
- Say you don’t have coverage
- Approve less care than you need

To learn more about how medical coverage decisions are made, call Member Services toll free. Members with hearing or speech loss should call TTY 711.

Utilization Management
Utilization Management (UM) is a process that helps decide if certain outpatient care services, inpatient hospital stays or procedures are medically needed and covered by the plan. Decisions are only based on what is right for each member and on the type of care and service.

We look at standards of care taken from:
- Medical policies
- National clinical guidelines
- Your health benefits

You should know:
- Employees, consultants or other providers aren’t rewarded or offered money or other incentives to deny care or service
- They aren’t rewarded for supporting decisions that result in the use of fewer services
- We don’t make decisions about hiring, promoting or firing these people based on the idea that they will deny benefits

See the How we pay providers section for more information on how we work with providers in our network.
We make sure that Utilization Management (UM) staff takes calls about UM issues at least eight hours a day on normal business days. You can call UM at our toll-free Member Services number and you will be transferred to the Utilization Management department. Translation services are available to our non-English-speaking members when you call the Member Services number. For those with hearing or speech loss, call TTY 711.

**Specialist care**

Your PCP may send you to one of our network specialists for some types of care or treatment. Please note:
- Your PCP will work with you to choose a specialist to give you the care you need.
- Your PCP’s office can help you set up a time to see the specialist.
- You need to tell your PCP and the specialist as much as you can about your health. That way, all of you can decide what is best.
- A specialist may treat you for as long as he or she thinks you need it; some services may need authorization from us.

If you'd like to learn more about specialty care, talk to your PCP. Specialists can use the precertification tool online or contact Member Services for help.

**Getting a second medical opinion**

You might have questions about your illness or the care your PCP says you need. You may want to get a second opinion from another doctor if:
- You have questions about a recommended treatment or diagnosis.
- Your PCP is unable to diagnose your condition or the diagnosis is in doubt due to test results that conflict with each other

You should speak to your PCP if you want a second opinion. You don’t need an authorization to see an in-network provider.

Your PCP will help you arrange a second opinion from a qualified health care provider in our network. If there isn’t a qualified health care provider in the network to give you a second opinion, your PCP can call us to arrange for a second opinion outside the network at no cost to you.

**How we pay providers**

We want you to know more about how we work with the providers in our network. Providers can include doctors, specialists or consultants. Different providers in our network have agreed to be paid in different ways by us. Your provider may:
- Be paid each time he or she treats you (Fee-for-Service)
- Be paid a set fee each month for each member whether or not the member actually gets services (capitation)
- Participate in the Physician Incentive Plan

These kinds of pay may include ways to earn more money. This kind of pay is based on different things like how happy a member is with the care or quality of care. It is also based on how easy it is to find and get care. We don’t:
• Offer rewards, money or other incentives to deny care or services to providers
• Reward providers for supporting decisions that result in the use of fewer services
• Make decisions about hiring, promoting or firing providers based on the idea that they will deny benefits

If you want more details about how our contracted providers or any other providers in our network are paid, please call Member Services toll free at 1-800-901-0020 (TTY 711). Or write to us at:

Anthem HealthKeepers Plus Member Services
P.O. Box 27401
Mail Drop VA2002-N500
Richmond, VA 23279

Services for children in Adoption Assistance and Foster Care
We cover health care services for foster care and adoption assistance children enrolled in our health plan.

For foster care children’s medical care, we’ll work with the social worker, foster care parent or group home/residential staff person. The social worker is responsible for any changes to a foster care child’s health plan selection. Foster care children aren’t restricted to their health plan choice after the initial 90-day period.

For children in adoption assistance medical care, we’ll work directly with the adoptive parent. The adoptive parent is also responsible for any changes to an adoption assistance child’s health plan selection.
Section III: Benefits

All benefits are subject to the terms, conditions, definitions, limitations and exclusions described elsewhere in this EOC. Only covered services will be provided by us. Additionally, we will pay only the charges incurred by you when you are actually eligible for the covered services received.

You may be responsible for the cost of services you receive that aren’t covered services:
- If your provider tells you in advance that the services aren’t covered, and
- If you sign specific documentation indicating that you understand that you may have to pay for those specific services.

A. Behavioral health and substance abuse treatment services — Traditional and nontraditional behavioral health service categories

We have coverage responsibilities for traditional treatment services, including:
- Inpatient, outpatient (individual, family, and group) therapies
- Temporary detention services
- Emergency custody order services

We don’t have coverage responsibility for nontraditional, community mental health rehabilitation services and substance abuse treatment services.

To access covered behavioral health care services, members should call Member Services at 1-800-901-0020 (TTY 711). Inpatient behavioral health services require prior authorization. The services should be obtained from network providers.

Psychiatric health services given in a free-standing hospital are covered only for members over 64 years of age or under 21 years of age. When a child is admitted to a free-standing hospital as the result of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening, a certificate of the need for care must be completed as required by federal law.

We won’t provide coverage for behavioral health services given in a state psychiatric hospital. We will cover inpatient and outpatient therapies as well as temporary detention and emergency custody order services.

DMAS will provide coverage for nontraditional and community mental health rehabilitation services through its Behavioral Health Services Administrator.

Outpatient behavioral health and substance abuse treatment, including an assessment, is covered when given by a designated network provider. Testing (psychological and neuropsychological testing) requires prior authorization. DMAS will cover:
- Mental health residential (RTC) treatment
- Day Treatment (Partial Hospital Program (PHP))
- Intensive Outpatient Program (IOP)
- In-home services
DMAS will cover substance abuse services such as:
- Emergency (crisis) services
- Intensive Outpatient Treatment (IOT)
- Day Treatment
- Substance abuse case management

Members on home- and community-based Medicaid waivers (Individual and Family Developmental Disabilities Supports/Family and Individual Supports, Intellectual disability/Community Living, Elderly or Disabled with Consumer Direction, Day Support/Building Independence, or Alzheimer’s, or as may be amended from time to time) shall receive acute and primary medical services from us and shall get waiver services and related transportation to waiver services via the DMAS fee-for-service program.

B. Dental and oral surgery services

Routine Dental services (cleanings, X-rays, cavity fills) are provided through Smiles for Children, a Dental Benefit Administrator contracted with the Department of Medical Assistance Services (DMAS). The toll-free number for Smiles for Children is 1-888-912-3456. We cover medically necessary services resulting from external trauma from a dental accident that results in damage to the hard or soft tissue of the oral cavity or for medically necessary procedures to the mouth where the main purpose is not to treat or help the teeth. We also cover medically necessary anesthesia and hospitalization services when required to provide dental care. We will be responsible for transportation and medication related to covered dental services.

Dental fluoride varnish provided by a nondental medical provider is covered in accordance with the American Academy of Pediatrics guidelines. This service is covered for enrolled members up to three years of age. This service can be rendered in six-month increments up to a maximum of six applications.

Your PCP should make an initial direct referral to a dentist when the child receives his or her six month/biannual screening. The referral should be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. When any screening, even as early as the neonatal examination, indicates a need for dental services at any earlier age, referral should be made for needed dental services.

Providers may include physicians (pediatric/family practice), nurse practitioners (pediatric/family practice), local health departments, Federally Qualified Health Centers and Rural Health Clinics contracted with us.

Dental services are also available through Smiles for Children for pregnant women age 21 and over. Those services include: X-rays and examinations, cleanings, fillings, root canals, gum-related treatment, crowns, bridges, partials and dentures, tooth extractions and other oral surgeries, and other appropriate general services. Orthodontic treatment is not included in the coverage. Pregnant women will need to provide the dentist with the anticipated due date. The dental coverage for women who are pregnant includes coverage for 60 days after the baby is born.

Dental treatment for nonpregnant adults (age 21 and older) is covered under certain circumstances through Virginia’s dental program, Smiles for Children. Adult dental services are limited to medically necessary oral surgery and associated diagnostic services, such as X-rays and surgical extractions. Preventive, restorative, endodontic and prosthetic services (cleanings, fillings, root canals and

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Monday – Friday, 8 a.m. – 6 p.m. Eastern time
24/7 NurseLine: 1-800-901-0020
dentures) aren't covered for adults. Dental conditions that may qualify for reimbursement are ones compromising a patient's general health and such conditions must be documented by the dentist or medical provider. Symptoms would include pain and/or infection.

Adult services require prepayment review by DentaQuest and providers have the option of requesting prior authorization. Benefit descriptions are available in Exhibit B of the Provider Office Reference Manual posted on the DMAS Smiles for Children website at https://govservices.DentaQuest.com. Click on Find a Dentist. Adult benefit questions also may be answered by contacting the DentaQuest Customer Service Department directly at 1-888-912-3456.

C. Disease Management Centralized Care Unit

We offer a Disease Management Centralized Care Unit (DMCCU) program. A team of licensed nurses and social workers, called DMCCU case managers, educate you about your condition and help you learn how to manage your health. Your primary care provider, or PCP, and our team of DMCCU case managers will assist you with your health care needs. DMCCU case managers give support over the phone for members with:

- Asthma
- HIV/AIDS
- Bipolar disorder
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance use disorder

DMCCU case managers work with you to create health goals and help you develop a plan to reach them. As a member in the program, you will benefit from having a case manager who:

- Listens to you and takes the time to understand your specific needs. Helps you create a care plan to reach your health care goals.
- Gives you the tools, support and community resources that can help you improve your quality of life.
- Gives health information that can help you make better choices.
- Assists you in coordinating care with your providers.

As an Anthem HealthKeepers Plus member enrolled in the DMCCU program, you have certain rights and responsibilities.

- You have the right to:
  - Have information about your health plan; this includes all plan programs and services as well as our staff's education and work experience. It also includes contracts we have with other businesses or agencies.
  - Refuse to take part in or disenroll from programs and services we offer.
  - Know which staff members arrange your health care services and who to ask for a change.
  - Have us help you make choices with your doctors about your health care.
o Learn about all DMCCU-related treatments; these include anything stated in the clinical guidelines, or rules, whether covered by us or not; you have the right to discuss all options with your doctors.
o Have personal and medical information kept private, know who has access to your information, and know what we do to keep it private.
o Be treated with courtesy and respect by our staff.
o File a grievance with us and be told how to file a grievance; this includes knowing about our standards of timely response to grievances and resolving issues of quality.
o Get information that you can understand.

- You are encouraged to:
o Follow health care advice offered by us.
o Provide us with information needed to carry out our services.
o Tell us and your doctors if you decide to disenroll from the DMCCU program.

If you have one of these conditions or would like to know more about our DMCCU, please call 1-888-830-4300 Monday through Friday from 8:30 a.m. to 5:30 p.m. local time. Ask to speak with a DMCCU case manager.

D. Diabetic services, equipment and supplies

If you have diabetes, you will have coverage for medical supplies, equipment and education for diabetes care. This includes the following:
- All FDA-approved equipment
- Insulin pumps
- Home blood glucose monitors, lancets, blood glucose test strips, syringes and needles when received from a network pharmacy or DME provider
- Outpatient self-management training and education performed in person, including medical nutrition therapy, when provided by an in-network certified, licensed or registered health care professional

E. Doctor services

1. Inpatient. All covered services of network physicians and provider hospital personnel that are authorized by your PCP while you are admitted to a network provider hospital as a registered bed patient are provided.

2. Outpatient. All covered diagnostic, treatment and surgical services of network providers that are authorized by your PCP are provided.

F. Durable medical equipment and supplies

Rental of medically necessary durable medical equipment is covered if authorized by us (or purchase if such purchase would be less than rental cost as determined by us). The prescribing physician must obtain authorization for some services from us.

Durable medical equipment must be obtained from the designated network provider for this health service. Maintenance and necessary repairs of durable medical equipment will be covered. Medically necessary supplies are covered. Equipment that has been damaged due to your neglect or abuse will not be repaired or replaced by us.

We don’t cover supplies and devices that are for comfort or convenience only. This includes but is not limited to:
- Air conditioning
- Air filters
- Air purifiers
- Furniture or appliances not defined as medical equipment
- Home or vehicle modifications
- Room humidifiers
- Spas
G. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a special program for members under the age of 21 that detects and treats health care problems early through:

- Regular medical, dental, vision and hearing checkups
- Diagnosis of problems
- Treatment of dental, eye, hearing and other problems, including nutritional issues discovered during checkups
- Treatment of defects and physical, mental and substance use illnesses and conditions as needed to help maintain the child’s level of function

Medically necessary tobacco cessation for members under age 21 includes:

- Anticipatory guidance
- Risk-reduction counseling during routine well-child checkups
- Additional counseling and drug therapy

EPSDT exams (checkups) are done by your child’s PCP and must include:

- A complete physical and behavioral health and developmental history
- A nutritional assessment
- An unclothed, whole-body physical exam including height/weight and Body Mass Index (BMI) assessment
- Health education
- A growth and development check
- Lab tests, including blood lead level (for high-risk groups, this includes hemoglobin/hematocrit, urinalysis and tuberculin tests)
- Shots/immunizations, as needed
- An eye checkup and eyeglasses (if medically necessary)
- An ear checkup to test your child’s hearing and speech abilities
- An oral inspection and dental fluoride varnish (this is not a substitute for a full dental checkup by a dentist; your child will be referred to a dentist for a full checkup by 3 years of age)

Use the following chart to find out when your child should receive regular checkups:

<table>
<thead>
<tr>
<th>Age</th>
<th>Checkup schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 (Infants)</td>
<td>Checkup needed for newborns, under 6 weeks, and at ages 2, 4, 6 and 9 months</td>
</tr>
<tr>
<td>1 to 2 (Toddlers)</td>
<td>Checkup needed at ages 12, 15 and 18 months</td>
</tr>
<tr>
<td>2 to 4 (Early Childhood)</td>
<td>Checkup needed at ages 2 years, 30 months, 3 years and 4 years</td>
</tr>
<tr>
<td></td>
<td>Schedule dental visits every 6 months after your child’s third birthday</td>
</tr>
<tr>
<td>5 to 10 (Late Childhood)</td>
<td>Checkup needed at ages 5, 6, 7, 8, 9 and 10 years</td>
</tr>
<tr>
<td>11-20 (Teens)</td>
<td>Checkup needed at ages 11, 12, 13,14, 15, 16, 17,18, 19 and 20 years</td>
</tr>
</tbody>
</table>

You should visit your child's PCP for checkups early and on a regular basis.
Be sure each of your child’s shots is recorded on a shot record. Take your child’s shot record with you to every checkup.

**Immunizations may be part of your checkup.** Use the chart below to find out when and what shots your child should receive:

<table>
<thead>
<tr>
<th>Age</th>
<th>Shot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 2 months</td>
<td>Hep B (hepatitis B), RV-1</td>
</tr>
<tr>
<td>1 to 4 months</td>
<td>Hep B, RV-2</td>
</tr>
<tr>
<td>2 months</td>
<td>DTaP (diphtheria, tetanus and pertussis), IPV (polio), Hib (Haemophilus influenza type b), PCV (pneumococcal conjugate)</td>
</tr>
<tr>
<td>4 months</td>
<td>DTaP, IPV, Hib, PCV</td>
</tr>
<tr>
<td>6 months</td>
<td>DTaP, Hib, PCV, RV-3</td>
</tr>
<tr>
<td>6 months to 18 years</td>
<td>Influenza shot yearly</td>
</tr>
<tr>
<td>6 to 18 months</td>
<td>Hep B, IPV (polio)</td>
</tr>
<tr>
<td>12 to 15 months</td>
<td>Hib, MMR (measles, mumps and rubella), PCV</td>
</tr>
<tr>
<td>12 to 18 months</td>
<td>Var (chickenpox). HepA-1</td>
</tr>
<tr>
<td>15 to 18 months</td>
<td>DTaP, HepA-2</td>
</tr>
<tr>
<td>Before starting school (4-6 years)</td>
<td>MMR, DTaP, IPV</td>
</tr>
<tr>
<td>11 to 12 years</td>
<td>MMR (if your child has not had the MMR shots)</td>
</tr>
<tr>
<td></td>
<td>Var (if your child has not had the chickenpox shot and has never had chickenpox)</td>
</tr>
<tr>
<td></td>
<td>Hep B (if your child has not had the hepatitis B shots)</td>
</tr>
<tr>
<td></td>
<td>HPV 1, 2, 3</td>
</tr>
<tr>
<td>11 to 16 years</td>
<td>Td (tetanus, diphtheria)</td>
</tr>
</tbody>
</table>

The HPV vaccine is covered for male and female members; 3 doses between 11 and 12 years of age.

There are services covered through EPSDT that aren’t normally covered by us.

If a treatment or service is needed to correct or prevent a problem from getting worse, talk with your child’s PCP. Your child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment.

If your child’s PCP finds a health problem during an EPSDT checkup, he or she may be able to take care of the problem or may refer you to another provider (specialist) who can take care of it. Private Duty Nursing (PDN) is covered when medically necessary for members under age 21. PDN care includes but is not limited to:

- Nursing level assessments
- Monitoring
- Skilled interventions

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**Member Services:** 1-800-901-0020 (TTY 711)
Monday – Friday, 8 a.m. – 6 p.m. Eastern time
24/7 NurseLine: 1-800-901-0020
Members who may qualify include those who need constant nursing care that can’t be met through home health. Home health nursing provides occasional, short-term care for members who qualify.

H. Early intervention services
Early intervention services are available for members from birth to age 3 who are certified as eligible for services under Part C of the Individuals with Disabilities Education Act. Early intervention services are covered by DMAS within its coverage criteria and guidelines. These services consist of these:
- Speech and language therapy
- Occupational therapy
- Physical therapy
- Assistive technology services and devices

Early intervention services are those services listed above that are determined to be medically necessary. They are designed to help a person attain or retain the capability to function age-appropriately within his/her natural environment to the maximum extent possible.

This will include services that enhance functional ability without resulting in a cure. For more information on services and eligibility, visit the Early Intervention Program website at [www.infantva.org](http://www.infantva.org) or call the toll-free number at 1-800-234-1448.

If your child needs special services, your PCP will direct you to a certified early intervention provider in your area to evaluate your child. Together with your PCP, the early intervention provider will develop a plan that will meet your child’s special needs.

I. Emergency and urgent care services
A true emergency means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain that without immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:
- Serious jeopardy to the mental or physical health of the individual
- Danger of serious impairment of the individual’s bodily function
- Serious dysfunction of any of the individual’s bodily organs
- In the case of a pregnant woman, serious jeopardy to the health of the fetus or the mother

Call 911 or go to the nearest emergency room for emergency care.

We will cover payment for emergency services that are medically necessary until the clinical emergency is stabilized and until you can be safely discharged or transferred. This includes payment for post-stabilization care or services provided subsequent to an emergency that a treating physician views as medically necessary after you receive services or your emergency has been stabilized.

Coverage includes treatment that may be necessary to assure within reasonable medical probability that no material deterioration of your condition is likely to result from or occur during your discharge or transfer to another facility.

All network hospitals provide emergency and post-stabilization care (services you receive after you leave the emergency room). You don’t need prior approval for emergency and post-stabilization services.
Post-stabilization care services preapproved by us or a provider in your plan, whether you get them in or outside of our network, will be covered. We'll also cover services not preapproved when:

- Care is given to maintain your stabilized condition within one hour of a request to us for preapproval of further post-stabilization care services.
- Care is given to maintain, improve or resolve your stabilized condition if:
  - We don’t give a response for preapproval within one hour.
  - We can’t be reached.
  - We can’t come to an agreement about your care with your doctor, and a plan doctor isn’t available for consultation. In this case, we'll:
    - Give the doctor treating you the opportunity to consult with a plan doctor.
    - Allow your doctor to continue with your care until a network doctor is reached or until one of the criteria listed below is met.

- Coverage for post-stabilization care services we haven’t preapproved ends when:
  1. A doctor in your plan with privileges at the treating hospital takes over your care.
  2. A doctor in your plan takes over your care through transfer.
  3. We reach an agreement with the treating doctor about your care.
  4. You’re discharged from care.

- For post-stabilization care you get outside of the network, we'll work with the provider outside of your plan to resolve payment issues whenever possible. We won’t charge you any more than what we would have paid for the services if you had gotten them within our network.

1. Within the service area

- Medical care is available through your PCP seven days a week, 24 hours a day. For instructions on how to receive care, call your PCP or 24/7 NurseLine.
- If the emergency is such that immediate action is demanded, you should be taken to the nearest appropriate medical facility or call 911.
- We cover services rendered by providers other than network providers when the condition treated is an emergency as that term is defined in this EOC.
- A telephone call from you to your PCP while at an emergency room will not be sufficient to ensure coverage by us for nonemergency services.

2. Outside the service area

- Urgent care and emergency services outside the service area are provided to assist you if you sustain an injury or become ill while temporarily away from the service area. Accordingly, benefits for these services are limited to care which is required immediately and unexpectedly. Elective care and care required as a result of circumstances which could reasonably have been foreseen prior to departure from the service area aren't covered.
- If an emergency situation occurs when you are temporarily outside the service area, you should be taken to the nearest appropriate medical facility or call 911.
- If an urgent care situation occurs when you are temporarily outside the service area, you should obtain care at the nearest appropriate medical facility. For urgent care situations, you or your representative is responsible for notifying your PCP within 48 hours or on the next business day.
• Benefits for continuing or follow-up treatment must be prearranged by your PCP and are subject to all provisions of this EOC. After your emergency or urgent care situation is stabilized, continuing or follow-up care must be provided in the service area by an in-network provider.

• If you are a covered member in the custody of the Virginia Department of Social Services in a designated Foster Care program, you are able to receive coverage for all covered services until you can be disenrolled and transferred to a health plan within your new service area.

3. Notification
• In the event of an emergency requiring hospitalization or for which outpatient emergency services are necessary, you or your representative must notify your PCP within 48 hours after care began or on the next business day. This applies to services you receive within or outside the service area.

Urgent care means care for a health problem usually marked by rapid onset of persistent or unusual discomfort associated with an illness or injury. These problems may include high fever, vomiting, sprains and minor cuts.

For urgent care, you should call your PCP. Your PCP will tell you if you should come in for a visit right away or go to another office to get immediate care. In some cases, your PCP may tell you to go to the emergency room at a hospital for care.

You may also go to an in-network urgent care center. You should be able to see your PCP within 24 hours for an urgent care appointment.

24/7 NurseLine
A helpful service, at no cost to you, is the use of our call-in nursing program called 24/7 NurseLine. Anytime, call 1-800-901-0020 to get important medical advice and information. This service can help you with questions, advise your options for care and also offer locations for urgent care centers.

J. Extra benefits
We provide you with access to all your Medicaid benefits, like doctor visits and transportation. But we also offer you extra benefits:
• No-cost retail coupons with special discounts to local retailers
• No-cost sports physicals (ages 19 and younger)
• Disease Management Programs for asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD), heart failure, Coronary Artery Disease (CAD), major depressive disorder, bipolar disorder, substance abuse disorder, schizophrenia, hypertension and HIV/AIDS
• New Baby, New Life℠ will assist you in having a healthy pregnancy. Some of the services include toll-free access to a care manager to answer your questions, tools to help you and your doctor see possible risks
• A no-cost cellphone with no-cost monthly minutes, data and text messages.

K. Health education
Health education services are covered when authorized or furnished by us. This includes outpatient self-management training and education therapy, including nutritional therapy, furnished in person to members with diabetes by a certified, registered or licensed health care professional.

We cover medically necessary tobacco cessation services, including education, counseling and pharmacotherapy, for children and adolescents under the age of 21.

L. High-dose chemotherapy, high-dose radiation and bone marrow transplants

Members under age 21
High-dose chemotherapy and/or high-dose radiation, any resulting medical complications and any supporting bone marrow transplants or other forms of stem cell rescue are covered if you are under age 21 when preauthorized by us. The term “high dose” when used to describe chemotherapy or radiation means a dose so high as to predictably require stem cell rescue.

Members age 21 and over
High-dose chemotherapy and/or high-dose radiation, any resulting medical complications and any supporting bone marrow transplants or other forms of stem cell rescue are covered if you are age 21 and over only when you have been diagnosed with myeloma, lymphoma, leukemia or breast cancer and when preauthorized by us. The term “high dose” when used to describe chemotherapy or radiation means a dose so high as to predictably require stem cell rescue.

M. Home health care

1. Home health services. The following items and services are provided in your home by a licensed or certified health care professional on a part-time or intermittent basis when authorized and periodically reviewed by your PCP and us: nursing care, rehabilitative services, home infusion therapy, physical, occupational or speech therapy, medical supplies and other medically necessary services and supplies.

Medical nutritional supplements and supplies. Coverage of nutritional supplements, which don’t include a legend drug, are limited to when the supplement is the sole source of nutrition and is necessary to treat a medical condition for members 21 years of age and older. Sole source is defined as the inability of the individual to handle (swallow or absorb) any other form of oral nutrition.

Coverage is available for nutritional supplements regardless of whether the supplement is administered orally or through a nasogastric or gastrostomy tube.

Coverage of nutritional supplements for individuals authorized through the EPSDT program is limited to when the supplement is at least the primary source of nutrition and is necessary to treat a medical condition. Primary source is defined as being medically indicated for the treatment of your condition if you are unable to tolerate nutrients.

If a member is 21 years of age or younger, enteral nutrition/medical foods/specialized infant formula will be covered by DMAS within the DMAS-established criteria and guidelines. We cover supplies and equipment necessary to administer enteral nutrition. We don’t cover routine infant formula.

House calls. House calls determined to be medically necessary by your PCP are provided.

N. Hospital services
Your coverage provides benefits for hospital services when you are treated on an inpatient basis because of illness, injury or pregnancy, or on an outpatient basis. You must go to an in-network hospital unless it is an emergency. Special rules apply in emergencies. Refer to Paragraph I in this section to learn more about these special rules.

1. **Admissions.** All hospital admissions except routine deliveries and emergencies must be arranged by your PCP or admitting physician and approved in advance by us. We reserve the right to determine whether the continuation of any hospital admission is medically necessary. Refer to Paragraph Q in this section to learn more about OB/GYN services.

**Required Minimum Approvals for Hospital Admissions:**

You may stay in the hospital for:
- Covered breast cancer surgery (radical or modified radical mastectomy) at least 48 hours.
- A covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer at least 24 hours.
- A covered laparoscopy-assisted vaginal hysterectomy for at least 23 hours.
- A covered vaginal hysterectomy for at least 48 hours.

You may stay in the hospital at least 48 hours following a vaginal delivery or for at least 96 hours following a Cesarean delivery.

2. **Benefits.** Hospital services include semiprivate room and board (or private room when medically necessary and ordered by a network physician), general nursing care and the following additional facilities, services and supplies prescribed by network physicians and received by you:
- Meals and special diets
- Use of operating room and related facilities, use of intensive care or cardiac care units and services
- X-ray services
- Laboratory and other diagnostic tests, drugs, medications, biological, anesthesia and oxygen services
- Physical therapy, radiation therapy, inhalation therapy, chemotherapy, occupational and speech therapy
- Administration of whole blood and blood plasma and other medically necessary services

**O. Individual case management**

Registered Nurses and Licensed Clinical Social Workers are available to assist with medical or coverage questions/concerns for all age groups. They are also available to help with alternative options to noncovered services. Case managers work with the primary care physician of record to ensure high quality cost-effective care, at the right time and right place. Case managers assist with finding resources within the community for additional services. The goal of Case Management is to assist with quality of care, which promotes healthier outcomes. Case management services are at no cost to the member, and it is a voluntary benefit. Case management services are available by contacting the customer service number on your ID card.

**P. Medical transportation services**

In an emergency, your PCP’s order is not required. For emergency transportation, call 911. Air ambulance services are also covered when preauthorized or in cases of threatened loss of life.
cases of threatened loss of life, only such air ambulance services required to take you to the closest hospital with the capability of treating your condition will be covered.

If a member age 21-64 is admitted to a free-standing psychiatric facility under a TDO, we will be responsible for reimbursing transportation to the facility.

Nonemergency medical transportation (including nonemergent ambulance trips) is provided when related to covered medical care. Please call 1-877-892-3988 to schedule your ride for nonemergency services at least five days before your appointment. Bus tickets are also available. To obtain bus tickets, please call at least seven days before your appointment.

Q. Obstetrical/Gynecological (OB/GYN) services

1. Pregnancy and childbirth. We cover:
   - Maternity care, including pregnancy-related care and postpartum services for 60 days after the pregnancy ends
   - Mother/newborn care coordination program
   - Hospital services
   - Physician services
   - Certified nurse-midwife services
   - Anesthesia
   - Injectables
   - X-ray and laboratory services
   - HIV testing and treatment and counseling for HIV
   - Inpatient services for at least 48 hours following a vaginal delivery or for at least 96 hours for a Cesarean delivery. If the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery, we will cover one early discharge follow-up visit.

Eligibility for newborn children is subject to the conditions set forth in Section VI of this EOC.

A pregnant minor is deemed an adult for the purpose of consenting for herself and her child to both survival and medical treatment relating to the delivery and treatment of the child.

2. New Baby, New LifeSM (prenatal, postpartum and newborn care) is our program for all pregnant members and their newborns. With this program, members receive health information and incentives for getting prenatal and postpartum care.
   Our program also helps pregnant members with high-risk pregnancies and complex health care needs. Nurse case managers work closely with these members to give:
   - Education
   - Emotional support
   - Help in following your doctor’s care plan
   - Needed community referrals and support

   Our nurses also work with doctors and help with other services members may need. The goal is to promote better health for members and the delivery of healthy babies.

   If you think you are pregnant:
   - Call your doctor right away. You don’t need a referral form from your PCP to see an OB/GYN doctor.
   - Call Member Services if you need help finding an OB/GYN doctor.
We will send you a pregnancy education packet. It will include:
- Prenatal flier with information on the New Baby, New Life program
- *Planning a Healthy Pregnancy*, a self-care book with information about your pregnancy
- *Labor, Delivery and Beyond*, a booklet that will provide information on your third trimester
- *Having a Healthy Baby* brochure that will provide you information and resources to help keep you and your baby healthy
- *Warm Health* flier that will provide you information on a text messaging program that provides you with education throughout your pregnancy and after you deliver your baby
- Incentive mailers that will tell you how to receive your gift cards for attending prenatal visits during your first trimester or within 42 days of enrollment and your third trimester.

After you have your baby, it is important to set up a visit with your PCP or OB/GYN for your postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.
- This visit should be done between three and eight weeks after you deliver.
- If you have to have surgery to have your baby by Cesarean section, your PCP or OB/GYN may ask you to come back for a two-week post-surgery checkup; you will still need to go back and see your provider within three to eight weeks for your postpartum checkup.

We will send you a postpartum education packet. It will include:
- Postpartum flier congratulating you on the birth of your baby
- Nurture book with information on taking care of yourself and your new baby
- Postpartum depression booklet
- Incentive mailers that will tell you how to receive your gift card for attending your postpartum appointment between the third and eighth week after delivery, as well as information on obtaining a gift card for your baby’s well-child visits.

3. **Family planning.** Confidential family planning services are provided to all members. These services include:
- Tubal ligations, vasectomies, prescription contraceptive devices and birth control medications
- Devices and medications include oral and injectable contraceptive drugs, intrauterine devices and prescription barrier methods
- The insertion, reinsertion and removal of implantable contraceptive capsules
- Long Acting Reversible Contraceptives may be available to be inserted while in the hospital in most cases, but requires prearrangement by your provider
- Sterilization if you are 21 and older when prior voluntary consent is obtained and documented, the individual is mentally competent, and the required 30-day waiting period is met

Family planning services can be provided by a network provider or a non-network provider of your choice.

4. **Services of an obstetrician/gynecologist physician.** Notwithstanding any provision in this EOC to the contrary, all services, except inpatient hospital services and outpatient surgery, received from an obstetrician/gynecologist in the care of or related to the female reproductive system and breasts, shall not require the authorization of your PCP. Although you aren’t required to do so, if you’d like to ask in advance if such a service will be covered, please call your PCP or the health plan.
R. Organ and tissue transplants
The following organ and tissue transplants are covered for all eligible members:
- Bone marrow and high-dose chemotherapy for adult members (age 21 and older) diagnosed with breast cancer, leukemia, lymphoma and myeloma
- Liver, heart and lung medically necessary transplants (all ages), including:
  - Coverage of partial or whole
  - Orthotopic or heterotopic liver transplantation
- Single or double lung or lung lobe transplants for children and adults
- Heart and lung transplants for children only
- Liver or liver lobe transplants (living or cadaver donor) for children and adults
- Pancreas transplants done at the same time as covered kidney transplants (children only)
- Tissue transplants
- Autologous, allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue for children
- Kidney transplants (living or cadaver donor) for children and adults
- Corneas for children and adults
- Small bowel for children only
- Small bowel with liver for children only
- Pancreas for children only

All transplants except corneas require preauthorization. Any medically necessary transplants that aren’t experimental or investigational are covered for children under 21 years of age, when preauthorized. Scheduled transplants by DMAS will be honored.

Charges related to the removal of a living organ or tissue from a donor and transportation costs of the organ or tissue will be covered.

When both the donor and recipient are members, each will be entitled to receive the covered services set forth in this EOC. When only the recipient is a member, both the recipient and the donor shall be entitled to receive the covered services set forth in this EOC, but the donor’s benefits are limited to those not available to the donor from any other source.

This includes but is not limited to:
- Other insurance coverage
- Other health maintenance organization coverage
- Any government program

S. Outpatient prescription drug services

What can my doctor prescribe?
We use a chosen list of drugs called a Preferred Drug List (PDL) from which your doctor can order drugs for you. Drugs chosen from the PDL are safe and effective. A group of doctors and pharmacists updates this list every three months. Updating this list helps to make sure that the drugs on it are safe and effective.

If your doctor thinks you need to take a drug that is not on this list, your doctor will need to call us to ask for an approval before the drug will be covered.
To find out if a drug is on this list or if you want us to send you a copy of the PDL, please call Member Services at **1-800-901-0020 (TTY 711)**. You and your doctor can work together to decide which drug is best for you.

When you get your prescription filled, you will not get more than a 31-day supply. Your doctor may write that you can get refills. The pharmacy staff can call your doctor to check if you can get refills. Even though a drug is on the list, your doctor may not order it for you.

Some drugs need an approval from us ahead of time, or they may have limits based on medical need. We will review and decide on these requests within one business day. If we say no, you will get a letter that lets you know why and what other drugs or treatments you can try. You also may appeal if we deny your drug request. We can mail you a complaint or appeal form. To learn more, see **Section VI: Terms and Conditions**. Or call our toll-free Member Services number at **1-800-901-0020 (TTY 711)**.

A pharmacist or hospital emergency room may give you a 72-hour emergency supply if they think you need it. We will pay for the emergency supply.

If you have a concern with a service from this health plan, call our toll-free Member Services or TTY phone number. We can help you. You may file a complaint to get an answer to a problem or concern you have with this health plan.

**Where can I get my prescription filled?**
Our Provider Directory lists drugstores that are in our pharmacy network. You must receive your prescription drugs from one of these pharmacies. (Additional requirements apply for specialty drugs.) We won’t cover drugs you get from a drugstore that aren’t in our pharmacy network.

If you have an emergency, and you can’t go to a drugstore in our pharmacy network, go to the nearest drugstore and ask the pharmacist to call us at **1-800-901-0020 (TTY 711)**.

**What are specialty drugs?**
Specialty drugs are drugs that require you to have special care while taking them. They usually require special handling, administration or monitoring. Specialty drugs are often used to treat chronic illnesses.

**Where can I get specialty drugs filled?**
HealthKeepers, Inc. has a specialty pharmacy network for its members. The network provides the special care needed when a specialty drug is dispensed. You must use an in-network specialty pharmacy authorized to dispense specialty medications to get your specialty drugs. As of November 2015, the specialty pharmacies in our network are Accredro and Acaria Health.

- Accredro Phone: 1-877-241-3489
- Acaria Health Phone: 1-800-511-5144
- Call us at **1-800-901-0020 (TTY 711)** if you have any difficulty obtaining your specialty medicines. We can help.

To find out if a drug is considered a specialty drug or if you want us to send you a copy of the specialty drug list, please call Member Services at **1-800-901-0020 (TTY 711)**. You and your doctor can work together to decide which drug is best for you.

**What is covered?**
You don’t have a copay or deductible for prescription drugs. We will cover drugs if they are:
Ordered by a doctor
For the care and/or treatment of an illness or injury
Approved by us when the drug is not on the Preferred Drug List (PDL)
Over-the-counter medications when you have a prescription from your doctor

All FDA-approved medically necessary prescription drugs and over-the-counter medications incidental to outpatient care are covered, including compound medications, of which at least one ingredient is a covered over-the-counter drug. Diaphragms and birth control pills are also covered. In most cases, only generic drugs will be dispensed.

If your physician requests a brand-name drug for you for which there is a generic equivalent available, the generic product will be dispensed unless your physician obtains prior authorization from us for a brand-name drug.
Your physician must document the medical reason why a brand-name drug is required. Specific classes of medications, antipsychotics and contraceptives don’t require use of generics. For these drugs, both brand-name drugs and generics will be covered.

For each prescription, we will cover up to a 31-day supply. We will cover injectable insulin and syringes and needles for the administration thereof, diabetic glucose test strips and lancets. No more than one glucometer will be approved within a two-year period.

We don’t provide coverage for any of the following:

1. Drugs prescribed primarily for cosmetic purposes, such as Retin-A when used for any purpose other than treatment for severe acne
2. Drugs and medications for conditions excluded in this handbook
3. Any other drug deemed not medically necessary by us
4. Any drug not included in our Preferred Drug List, except as provided below; we may add or delete drugs from its Preferred Drug List from time to time
5. Drugs for the treatment of erectile dysfunction (unless used to treat a condition other than sexual or erectile dysfunction as approved by the FDA)
6. Quantities of any drug or medication above the recommended maximum daily dose or duration established by the FDA, or any of the standard references listed in item 7 below
7. Drugs and medications not approved by the FDA for the purpose prescribed. Benefits will not be denied for any drug or medication approved by the FDA for use in the treatment of cancer:
   • On the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed.
   • Provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard references:
     a. The American Hospital Formulary Service Drug Information
     b. The National Comprehensive Cancer Network’s Drugs & Biologics Compendium
     c. The Elsevier Gold Standard’s Clinical Pharmacology

Also, benefits will not be denied for any drug prescribed to treat a covered condition so long as these apply:

• The drug has been approved by the FDA for at least one indication
• The drug is recognized for the treatment of the covered indication in any of the standard reference compendia listed above or in substantially accepted peer-reviewed medical literature
Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature doesn't include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

**Exceptions to the Preferred Drug List and prior authorization**
We have established a process to enable you to obtain a specific, medically necessary nonpreferred prescription drug if the covered drug is determined by us after reasonable investigation and consultation with the prescribing physician to be an appropriate therapy for your medical condition. We will act on such requests within one business day.

A prior authorization written request, including the drug name, quantity per day and strength, period of time the drug is to be administered, medical condition for which the drug is being prescribed, the patient’s name and date of birth must be faxed by your doctor along with applicable medical records to 1-800-359-5781. Your doctor may also call Provider Services at 1-800-901-0020 with any questions.

You and your doctor will be notified in writing when a prescription is denied for coverage.

**Patient Utilization & Safety Management Program (PUMS)**
The Patient Utilization & Safety Management Program (PUMS), required by DMAS, helps make sure your medicines and health services work together in a way that won’t harm your health. As part of this program, we may check the Prescription Monitoring Program (PMP) tool that the Virginia Department of Health Professions maintains to review your medicines. This tool uses an electronic system to monitor the dispensing of Schedule II, III, and IV controlled substance prescription drugs.

If you are chosen for PUMS, you may be locked into only using one pharmacy or only going to one provider to get certain types of medicines. We’ll send you a letter to let you know how PUMS works. The lock-in period is for 12 months. At the end of the lock-in period, we’ll check in with you to see if you should continue the program. If you are placed in PUMS and don’t think you should be in the program, you can appeal. You must appeal to us within 30 days of when you get the letter saying that you have been put into PUMS. You can also request a state fair hearing.

If you’re in the PUMS program, you can get prescriptions after hours if your selected pharmacy doesn’t have 24-hour access. You’ll also be able to pick a PCP, pharmacy or other provider where you want to be locked in. If you don’t select providers for lock-in within 15 days, we’ll choose them for you.

All data related to the PMP are exempt from Freedom of Information Act requests and is considered confidential information.

**T. Podiatry services**
We cover podiatry services such as diagnostic, medical or surgical treatment of disease, injury or defects of the foot when performed by a network provider.

**U. Provider services**
This includes Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC). Out-of-network services require an authorization from us. We cover medically necessary:

- Preventive services
- Diagnostic services
- Therapeutic services
- Rehabilitative services
- Palliative services
- Renal dialysis services

We don’t cover physicals or immunizations for a job, school or camp.

V. Preventive services

If you are under age 21
We cover these preventive health services when performed by your PCP:
- Well-baby care from birth
- Periodic health assessments
- Immunizations in accordance with accepted medical practices
- Vision screenings (to assess your visual acuity through the use of the Snellen chart and the detection of color blindness)
- Hearing screenings (to assess your monaural threshold and your ability to locate the source of pure tones through use of a pure tone, air-only audiometer)
- Annual gynecological exams which consist of a breast exam, pelvic exam and Pap smear

If you are age 21 or over
We cover these preventive health services when performed by your PCP (or OB/GYN):
- Periodic health assessments
- Annual gynecological exams which consist of a breast exam, pelvic exam and Pap smear

We also cover these as recommended by the American College of Gastroenterology and the American Cancer Society:
- Fecal occult blood tests
- Flexible sigmoidoscopies
- Colonoscopies
- Colorectal cancer screenings and barium enemas

W. Prostate exams
We cover annual Prostate Specific Antigen (PSA) testing and digital rectal examinations consistent with the guidelines published by the American Cancer Society for the purpose of screening for prostate cancer when performed by your PCP.

X. Prosthetics and orthotics
We cover orthotic and prosthetic services to the extent they are medically necessary, including:
- Molded, therapeutic shoes for diabetics with peripheral vascular disease.
- Prosthetics (arms, legs and their supportive attachments, breasts and eye prostheses).
- Orthotics when ordered by your PCP and authorized as medically necessary by us if you are under the age of 21 or for all members when part of an approved intensive rehabilitation program.

Orthotic and prosthetic equipment must be obtained from the designated network provider for this health service.

Y. Breast surgery
We cover mastectomies:
- At least a 48-hour hospital stay following a radical or modified radical mastectomy
- Not less than 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer
  You and the attending physician can determine if a shorter stay in the hospital is appropriate when you have these procedures.

We cover reconstructive breast surgery:
- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the unaffected breast to produce a symmetrical appearance
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas
- Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to re-establish symmetry between the two breasts

The procedure must be done in a manner determined in consultation with the attending physician and you.

Z. Rehabilitative services
Your PCP and the health plan must authorize the services for members under three years of age.
We cover medically necessary rehabilitative services such as physical, speech and occupational therapy, as well as audiology services, when they meet these criteria:
- They are required for medical conditions
- They are rendered on an outpatient basis either at an outpatient facility or at a comprehensive outpatient rehabilitative facility
- They are performed by a network provider

AA. Telehealth services
We cover medically necessary telehealth services performed for medical diagnosis and treatment. Telehealth service is defined as the real time or near-real time two-way transfer of medical data and information using an interactive audio/video connection.

BB. Vision services
If you are under age 21
These services are covered when you receive them from your network provider:
- A routine eye examination once every 24 months
- A pair of eyeglasses as medically necessary
- A pair of contact lenses as medically necessary and if it is medically necessary for you to have contact lenses rather than eyeglasses

If you are age 21 or over, a routine eye examination is covered once every 24 months.

CC. X-ray and laboratory
We cover X-ray and laboratory services when they are authorized in advance by us and your PCP, and they are performed by designated network providers. This includes all X-ray and laboratory tests, services and materials, including:
- Diagnostic X-rays
- Chemotherapy
- Fluoroscopy
• Electrocardiograms
• Mammography
• Therapeutic radiology services

Some services must be approved by us for medical necessity. Screening mammograms for female members age 40 and over are covered, consistent with the guidelines published by the American Cancer Society.

DD. Benefits you can get from the state
The state Medicaid program offered through DMAS covers some benefits that we don’t cover. These are called carved-out services. Some of these services include:

• Dental care
• Early intervention services
• School health services for special education including physical therapy, occupational therapy, speech language pathology and skilled nursing services
• Some behavioral health services

Check your benefits quick reference guide to find out more about your benefits from the state. You can call DMAS at any time if you need these services.
Section IV: Limitations

The following limitations apply to specific benefits described under the Benefits section:

Behavioral health services

Inpatient behavioral health services rendered in a free-standing psychiatric hospital.
We cover care given in a free-standing psychiatric hospital only for members whose conditions meet medical necessity criteria and are over the age of 64 or under the age of 21. This care must be approved by us.

When a child is admitted as a result of an EPSDT screening, a certification of the need for care must be completed as required by state and federal law.

Special limitations

If we can’t provide or arrange health services for you as a result of a natural, manmade or unforeseen event not within our control, we will make a good faith effort to provide or arrange for your care. We will take into account the event and how practical it will be to provide or arrange for such care based on our best judgment.

HealthKeepers, Inc. and our network providers will incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by such an event.
Section V: Exclusions

You will be responsible for the cost of any noncovered services you receive.

Under this Explanation of Coverage (EOC), we will not cover:

- Services of non-network providers, except for emergencies, family planning, immunizations or when authorized in writing in advance by the network Medical Director.

- Services received which aren’t prearranged by your PCP and authorized in advance by us, except for those services in this EOC that don’t require a referral or preauthorization. However, this exclusion shall not apply to the services of pathologists, radiologists or anesthesiologists that are related to a service you receive which was not authorized in advance by us or prearranged by your PCP.

- Routine vision and hearing care, including hearing aids if you are 21 and over, except for a routine eye examination as covered in Section III.

- Services for radial keratotomy.

- Benefits for or related to cosmetic surgery or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person’s appearance, including body piercing and tattooing. However, a cosmetic surgery or procedure doesn’t include any surgeries or procedures to correct deformity caused by disease, trauma or a previous therapeutic process. These services or procedures require medical necessity. In addition, cosmetic surgery doesn’t apply to congenital deformities or deformities due to recent injury. When surgery also restores or improves a physiological function, it is not considered cosmetic surgery. We won’t consider your mental state in deciding if the surgery is cosmetic.

- Supplies and devices that are for comfort or convenience only (such as radio, television, telephone and guest meals); private rooms, unless a private room is medically necessary and approved by us during inpatient hospitalization. Additionally, space condition equipment (room humidifiers), furniture or appliances not defined as medical equipment and home or vehicle modifications are excluded.

- Providers’ charges for telephone calls, form completion, copying and/or transfer of medical records, returned checks, stop payment on checks and other such clerical charges. (If you ask, we will provide you one copy of your medical record at no charge.)

- Services for rest cures, domiciliary, residential or convalescent care if you are age 21 and over.

- Private duty nursing (PDN) except as medically necessary if you are under 21 years of age when service need is identified as part of an EPSDT service. This doesn’t include PDN services received in a school setting.

- Personal care services in your home.

- Examinations required specifically for insurance, employment, school or camp, and immunizations required for travel and work.
• Reversal of voluntarily induced sterility and complications incidental to such procedures. Procedures, services and supplies related to sex transformations. Sterilization services if you are under the age of 21 aren’t covered. Infertility medications and procedures aren’t covered, including in-vitro fertilization, services to promote fertility and embryo transplants.

• Except as provided by federal law, the cost of care for conditions that federal, state or local law require be treated in a public facility, or services or supplies provided or arranged by a governmental facility for which no charge would be made if you had no health insurance benefits. The cost of health services covered under the Medicare programs or other insurance. Care for military service-connected disability and conditions for which you are legally entitled to health services and for which facilities are reasonably accessible to you.

• Routine foot care, such as the removal of corns or calluses, the trimming of nails, other hygienic foot care such as cleaning and soaking the feet, and any other services that aren’t medically necessary aren’t covered. However, we will cover “corrective” trimming, performed to prevent further complications in a patient who has a systemic condition that has resulted in severe circulating embarrassment or areas of desensitization in the legs or feet. The “corrective” trimming of nails for systemic condition must be medically necessary and is limited to once every 60 days. Routine palliative trimming of corns, warts, or calluses (including plantar warts) is generally not covered. This service will be covered if the removal of the corn, wart, or callus is necessitated by the presence of an associated pathological condition that has resulted in severe circulating embarrassment or areas of desensitization of the legs or feet, or any disease whereby the patient’s life or limb may be jeopardized if such lesions aren’t treated.

• Treatment of flat feet and subluxations, dislocations, strains, imbalance and other structural misalignment not requiring surgery is not covered except as may be the general medical practice for the correction of a congenital defect identified through the EPSDT program.

• Spinal manipulation, acupuncture therapy, services rendered by chiropractors and related services.

• Services for biofeedback; weight control, including but not limited to surgery and other procedures done mostly for the purpose of weight loss for members who aren’t morbidly obese.

• School-based services or services on school property. School-based services include physical therapy, occupational therapy, speech therapy, skilled nursing services, medical assessments, audiology services, personal care services and medical evaluation services. Services rendered in a school setting or on school property may be reimbursed by DMAS.

• Experimental/investigative medical or surgical procedures and drugs except as medically necessary for members under 21 years of age when the service need is identified as part of an EPSDT service.

• Services for elective abortions including any related services performed at the immediate time of the abortion. This service may be covered by Fee-for-Service Medicaid if the life of the mother is endangered. Coverage is provided for any necessary follow-up medical care that may be needed in relation to the abortion services performed.
• Services related to assisted suicide, euthanasia, or mercy killings, or any action that may secure, fund, cause, compel, or assert/advocate a legal right to such services.

• Services of Christian Science nurses. However, Christian Science Sanatoria are covered with no limitations.

• Services for skilled nursing facility care.

• Services for hospice care.

• Inpatient behavioral health services rendered in a state psychiatric hospital.

• Intensive behavioral dietary counseling for adults with risk factors for diet-related chronic diseases.

• Your coverage doesn’t include benefits for services or supplies deemed not medically necessary by us. Notwithstanding this exclusion, all wellness services described in this EOC are covered.

• This exclusion shall not apply to services you receive on any day of inpatient care that is determined by us to be not medically necessary if such services are received from a professional provider who doesn’t control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist or anesthesiologist. Additionally, this exclusion shall not apply to inpatient services rendered by your admitting or attending doctor other than inpatient evaluation and management services provided to you, notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending doctor for purposes such as reviewing patient status, test results and patient medical records. Inpatient evaluation and management visits don’t include surgical, diagnostic or therapeutic services performed by your admitting or attending doctor. Also, in the event that we determine an outpatient procedure is not medically necessary, this exclusion shall not apply to the services of pathologists, radiologists and anesthesiologists related to such outpatient procedure. Nothing in this exclusion shall prevent you from appealing our decision that a service is not medically necessary.

Refer to Section VI for more information on appeals, types of health services, supplies or treatments not specifically provided herein. The term “services” as used in the exclusions includes supplies or medical items.

• Regular assisted living services provided to residents of adult care residences.

• Services covered under Medicaid but not through us. For a list of these services and information on how they may be accessed, please contact Member Services.

• Services of medical social workers.

• Specialized infant formula. Formula may be available through Medicaid or the Virginia Department of Health (VDH) WIC Program.

• Any service not covered under the Fee-for-Service program that is not listed as covered.
• Community mental health rehabilitative services, including:
  – Crisis intervention and crisis stabilization
  – Intensive in-home, therapeutic day treatment for children under age 21
  – Day treatment/partial hospitalization for adults
  – Mental health skill-building services
  – Psychosocial rehabilitation
  – Intensive community treatment
  – Mental health and substance abuse-targeted case management and treatment
  – Foster care case management
  – Substance abuse residential treatment for pregnant women
  – Substance abuse day treatment for pregnant women
  – Substance abuse intensive outpatient
  – EPSDT behavioral therapy
  – Residential treatment for children under age 21 (Levels A, B, and C)

• Level C Residential Treatment Facility (RTF) programs when authorized by the Department, as this will result in the disenrollment of the member from services.

• School health services which are defined as medical and/or mental health services through the child’s individualized education program (IEP), including:
  – Physical therapy
  – Occupational therapy
  – Speech therapy
  – Psychological and psychiatric services
  – Nursing services
  – Medical evaluation services
  – IEP-related transportation on specifically adapted school buses
  – Services rendered in a public school setting and included on the child’s IEP
  – All school health services rendered in a public school setting or on school property, (including Head Start) and included on the child’s IEP

• Targeted case management services provided to:
  – Seriously mentally ill adults and emotionally disturbed children
  – Youth at risk of serious emotional disturbance
  – Individuals with intellectual disability
  – Individuals with intellectual disability and related conditions participating in home- and community-based care waivers
  – The elderly
  – Members of Auxiliary Grants

• Waiver services and related transportation to waiver services for participants in the Home- and Community-Based Services
Section VI: Terms and Conditions

A. Availability of benefits
Except in the case of an emergency, family planning, immunizations or as otherwise specified in this 
EOC, you must obtain covered services only from network providers unless authorized in advance by 
us. Failure to abide by these procedures will result in denial of coverage for the applicable services by 
us.

B. Seeing other providers
There is no requirement that you get a referral from your PCP to receive care from other network 
providers. Your coverage does require that you use only network providers unless you receive prior 
approval from us to see a non-network provider. You should talk with your PCP or contact Member 
Services to assure that the provider you are visiting is a network provider.

Some services, such as inpatient services, require prior authorization from us. Please ask your PCP 
about these services. Your PCP should oversee all aspects of your health care, so please inform your 
PCP about other health care providers that are treating you.

C. Eligibility
Once you’re enrolled, you’ll receive a letter from Virginia Medicaid Management Information System 
(VAMMIS) that tells you how to choose an MCO (a health care plan like ours) You can choose a plan or 
one can be chosen for you. After you’re assigned a plan, you’ll receive a letter from VAMMIS to confirm 
your plan. If you change your mind, you may call and change your plan for the first 90 days after you 
are enrolled and each year during the open enrollment period.

D. Effective date of coverage
Coverage is effective at 12 a.m. (midnight) on the first day of the month following DMAS notification of 
enrollment. Disenrollments are effective at 11:59 p.m. on the last day of enrollment. If the disenrollment 
is for cause, it may be effective any day during the month. In the event of disenrollment, a request for 
proof of coverage can be made to DMAS.

E. Enrollment
The Virginia Medicaid Management Information System (VAMMIS) notifies us of newly enrolled 
members and members who are being disenrolled each month.

For the first 90 days following the effective date of enrollment, members who aren’t Foster Care 
children will be permitted to disenroll from one health plan to enroll with another. You may also enroll 
with another health plan during the open enrollment period for their regions without cause. If you don’t 
disenroll during the first 90 days of enrollment or during open enrollment, you may not change plans 
without cause for the remainder of the enrollment period. However, you may disenroll from one health 
plan to another at any time for good cause as defined by DMAS by calling the Managed Care Helpline 
at 1-800-643-2273 or by writing DMAS at:

Attn: Managed Care, Good Cause 
Department of Medical Assistance Services 
600 E. Broad St. 
Richmond, VA 23219

Members who are in Foster Care have flexibility with enrolling and disenrolling from our plan.
Important: If you move or change your phone number

When you move or change your phone number, please tell your caseworker at your local Department of Social Services (DSS) to make sure your information is up-to-date.

Enrollment of newborn children dependents for Medicaid members

Newborn children of Medicaid and FAMIS Plus members may be enrolled with us. Coverage for newborn children:

- Is effective on the date of birth
- Includes the birth month plus two months, unless the parent or legal guardian changes the newborn’s health plan

To keep health care coverage for the newborn after the birth month plus two month period, a parent or legal guardian must:

- Notify the Department of Social Services (DSS) of the child’s birth
- Go to DSS to get a Medicaid number for the newborn

If these standards aren’t met, the child could be disenrolled from HealthKeepers, Inc. We’ll notify the parent or legal guardian in writing of the effective date of disenrollment.

F. Medicaid Home- and Community-Based Care Services (HCBS) waivers:

Individuals in the Health and Acute Care Program (HAP) may be enrolled with us. This includes managed-care eligible members in Home- and Community-Based Care Services waiver programs, including the waivers for Elderly or Disabled with Consumer Direction (EDCD), Intellectual Disability, Alzheimer’s, Individual and Family Developmental Disabilities Support (DD), and Day Support.

If you are enrolled or become enrolled in a waiver program and need nonwaiver services (medical acute and primary care services) as described in this handbook, please use your Anthem HealthKeepers Plus ID card. If you need to use the HCBS waiver services, please use your DMAS Medicaid ID card (blue and white) to receive these services.

Home- and Community-Based Waivers (HCBW)

Long-term care services are covered and paid for through DMAS in accordance with Medicaid-established coverage criteria and guidelines, and include Individual and Family Developmental Disabilities Support, Intellectual Disability, Elderly or Disabled with Consumer Direction, Day Support or Alzheimer’s. These individuals shall receive acute and primary medical services from us.

If you are enrolled in the HCBW Technology Assisted waiver, you will not be enrolled with us.

G. Termination of coverage

All rights to benefits, including inpatient services, shall cease as of the effective date of termination, except for specially manufactured DME that was authorized in advance by us. Your coverage will end if:

1. DMAS disenrolls you.
2. You permit the use of your identification card by any other person or use another member’s card.
3. You lose your eligibility for Medicaid through the commission of fraud, such as:
• Failure to report truthful or accurate information when applying for Medicaid (you could be responsible for repaying capitation premium payments if your enrollment is discontinued for this reason)
• Failure to report required changes in your family size or income
• The agreement between us and DMAS is terminated by DMAS or us. You may be transitioned to another health plan if the agreement with us and DMAS is terminated.

4. You are an individual other than a student who permanently lives outside your area of residence for more than 60 consecutive days, unless you are placed there to receive medically necessary services funded by us or another Medicaid plan.

H. Relationship of contracting parties
Network doctors maintain the doctor-patient relationship with you and are solely responsible for all medical services. The relationship between us and network providers of covered services is an independent contractor relationship. Network providers of covered services aren't employees or agents of our health plan and neither us nor our employees are an employee or agent of any network provider.

For the purposes of this EOC, no member is the agent or representative of HealthKeepers, Inc., and no member shall be liable for any acts or omissions of the health plan, our agents or employees, or any other person or organization with which we have made or hereafter shall make arrangements for the provision of covered services.

I. Medical information
We're entitled to get (from any provider of covered services to you) the information necessary in connection with the administration of this EOC but subject to all applicable confidentiality requirements. By accepting coverage under this EOC, you authorize every provider rendering services hereunder to disclose all facts pertaining to your care and treatment and physical condition and permit copying of records by us.

Information from your medical records and information from doctors, surgeons or hospitals incidental to the doctor-patient relationship shall be kept confidential and, except as permitted by any applicable state and federal law, may not be disclosed without your consent.

You may request your medical records at any time from your provider. We can assist you in getting medical records from network providers. For more information, please call Member Services.

J. Policies and procedures
We may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of coverage under this EOC.

K. Modifications
Any provision, term, benefit or condition of coverage and this EOC may be amended, revised or deleted in accordance with the terms of the agreement between us and DMAS. DMAS is required to approve such actions. This may be done without your consent or concurrence. An amendment that specifies any change in benefit will be sent to you prior to implementation.

We may from time to time waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management and disease management) if in our discretion such change is in the best interest of you or your plan or is in furtherance of the provision of cost effective and/or quality services. In addition, we may select qualifying providers to participate in a
program that exempts them from certain procedural or medical management processes that would otherwise apply. We also may exempt your claim from medical review if certain conditions apply.

L. Notices
1. From us to you. A notice sent to you by us is considered “given” when mailed to your last known address as shown in our enrollment records. Notices include any information that we may send you, including identification cards.

2. From you or DMAS to us. Notice by you or DMAS is considered “given” when actually received by us. We won’t be able to act on this notice unless your name and identification number are included in the notice.

M. Group enrollment agreement
HealthKeepers, Inc. and DMAS have entered into an agreement for the provision of the benefits outlined in this EOC. Under this agreement, DMAS will contribute 100% of the premiums required. In the event of any inconsistency between the information contained in this EOC and the agreement between us and DMAS, the agreement will control. You may contact Member Services regarding questions related to the agreement between us and DMAS.

N. Grievance and appeal process and DMAS appeals process
We care about the quality of care that you get from us and your health care providers. If you have a problem with us, we would like to know about it. We can help you with problems you may have with your health care services, such as:
- Access to health care services
- Provider care and treatment
- Administrative issues
- A decision made by us

If you have a problem, you may call our toll-free Member Services or TTY 711 (for those with hearing or speech loss) if you have questions or concerns. A Member Services representative will be happy to help you with any problems or complaints.

We will take care of the problem or complaint when we get it, or we will send it to the right place for an answer. A decision will be made within 30 calendar days. We will tell you what decision was made by phone or in writing.

Grievance process
You or someone you choose to represent you may file a grievance with us over the phone or in writing. You need to file your grievance within 30 calendar days from the date the problem took place.

If you have questions or concerns about your care, try to talk to your primary care provider first. If you still have questions or concerns, call us. We can help you. You won’t be treated differently for filing a grievance.

If your problem has to do with the denial of your health care benefits, you need to file an appeal instead of a grievance. Please see the part called “Appeals process” later in this chapter.

If you need help filing your grievance, a Member Services representative can help you. If you don’t speak English, we can get an interpreter for you. Or if you have a visual or other communicative
impairment, we can help you through the grievance process. Please call our toll-free TTY phone number.

You have three ways to file a grievance with us. You can:
- Call our toll-free Member Services or TTY number (for those with hearing or speech loss)
- Complete a grievance form by calling Member Services and asking us to send you the form
- Write us a letter to tell us about the problem

Here are the things you need to tell us as clearly as you can:
- Who is involved in the grievance
- What happened
- When did it happen
- Where did it happen
- Why you aren’t happy with the care you got

Attach any documents that will help us look into the problem. Send your completed form or letter to:

Anthem HealthKeepers Plus
P.O. Box 62429
Virginia Beach, VA 23464

If you can’t mail the form or letter, you or the person you choose to represent you may call our toll-free Member Services or TTY number. When we receive your grievance, we will review it and investigate it. We will send you an acknowledgment letter within five calendar days if you sent us your grievance in writing.

We will send you a letter with our decision within 30 calendar days from the date we got your grievance if you sent us your grievance in writing. If you called us to file your grievance, we will respond to you in-kind and will not follow up our decision with you in writing, unless you or the person you chose to represent you requests it.

If you aren’t happy with the grievance resolution, you have the right to file a complaint with the DMAS Managed Care Helpline at 1-800-643-2273.

If you aren’t happy with your care, you have the right to file a complaint about your provider with the Department of Health Professionals at 1-800-533-1560.

If you suspect fraud, you have the right to register your concern with the Medicaid Fraud Control Unit of the Office of the Virginia Attorney General at 1-800-371-0824.

Appeals process
If you aren’t happy with a decision we made, you or someone you choose to represent you may file an appeal with us over the phone or in writing. The legal representative of a deceased member’s estate may also file an appeal or be a party to an appeal.

You may ask for an appeal if we:
- Said “no” to paying for a service you wanted.
- Said “OK” to a service, but then we put limits on it.
- Ended payment for a service that we said “OK” to before.
- Did not give you access to a service fast enough.
To file an appeal, you or someone you choose to represent you must ask for an appeal within 90 calendar days from the date on the Notice of Action letter by calling or writing us a letter. You may send your appeal in writing to:

Grievance and Appeals Department  
HealthKeepers, Inc.  
P.O. Box 62429  
Virginia Beach, VA 23464

You may also file an appeal by calling our toll-free Member Services or Member Services TDD phone number (for those with hearing or speech loss). Or if you don’t speak English, we can get an interpreter for you. If you have a visual or other communicative impairment, we can help you through the appeal process. Please call our toll-free TTY phone number at 711.

You also must follow up on your oral appeal in writing within 10 business days after you file an appeal over the phone with us, unless you ask for an expedited appeal. Please see the part called “Expedited appeals process” later in this chapter.

If someone you choose to represent you files an appeal with us, you must provide written consent for the representative to file the appeal on your behalf.

When we receive your appeal, we will review it and investigate it. We will send you an acknowledgment letter when we received your appeal. The letter will tell you that we got your appeal request. The individuals who make the decisions on your appeal aren’t involved in any previous level of review or decision making, and they are health care professionals who have appropriate clinical expertise to make the decision.

We will make a decision about your appeal within 30 calendar days after we get it. If we can’t decide within 30 calendar days because we are waiting for additional information or need more time, we have extra time (up to 14 calendar days) to make a decision. If we do this, we will send you a letter to tell you why we need more time. Even in cases where we’re waiting for more information in order to make a decision on your appeal, we’ll make a decision no more than 45 calendar days from the initial receipt of your appeal request. If the time frame to resolve your appeal is extended, we’ll make an effort to let you know about any decision not wholly in your favor. We’ll give you an oral notification, and we’ll also follow up with a letter within two calendar days.

Once your appeal is resolved, we will send you a letter to tell you what we decide about the decision. The letter will explain:

- Our decision about your appeal
- The date we made our decision
- How to request a State fair hearing
- Your right to keep your benefits during the review
- That you may have to pay for care you get while you wait for the decision if the final decision is not favorable to you
- How to contact the Virginia Department of Health if you have concerns about your appeal

For expedited appeals, you or the person you choose to represent you may ask us to handle your appeal faster if your health needs it. We will acknowledge your appeal within 24 hours from the time we got it. We will make a decision within 72 hours of the appeal.
Keeping benefits while you appeal
You can keep your benefits while you’re waiting for your appeal if you asked for the appeal within the right time frame. You may have to pay for the care you get while you wait for an answer about the appeal if the final decision is not what you wanted.

State Fair Hearing
If you have a problem with what we decide after completing our appeal process, you can ask for a state fair hearing. You may ask for a state fair hearing before or at the same time you are asking for an appeal with us, after you have finished your appeal with us when the decision is not wholly in your favor, or instead of appealing to us. You may send your state fair hearing request to the Department of Medical Assistance Services (DMAS).

You may ask for a state fair hearing if we:
- Said "no" to paying for a service you wanted
- Said “OK” to a service, but then we put limits on it
- Ended payment for a service that we said “OK” to before
- Did not give you access to a service fast enough

To ask for a state fair hearing, the request must be sent in writing and be signed within 30 days of receipt of our Notice of Action or our Appeal Notice of Action resolution letter.

If a request for a state fair hearing is not made within 30 days of receipt of our Notice of Action or our Appeal Notice of Action, DMAS may make an exception for an acceptable reason. Acceptable reasons for delay shall include, but not be limited to, situations or events where:
- You were seriously ill and could not contact us.
- You did not receive notice of our decision.
- You sent the request for appeal to another government agency in good faith within the time limit.
- Unusual or unavoidable circumstances prevented a timely filing.
- You received a defective notice from us.

Send your request for a state fair hearing to:
Division of Appeals
Department of Medical Assistance Services
600 E. Broad St.
Richmond, VA 23219
Fax: 1-804-371-8491

At the state fair hearing, you may represent yourself or you can have someone you choose represent you.

You can keep your benefits while you’re waiting for your state fair hearing if you asked for the state fair hearing within the right time frame. You may have to pay for the care you get while you wait for an answer about the state fair hearing if the final decision isn’t what you wanted.

You also have the right to register your complaint with the Department of Health Professions at 1-800-533-1560 if you have concerns about your appeal you feel have not been addressed.
You also may send your complaint to the Virginia Department of Health at this address:

Virginia Department of Health  
Office of Licensure and Certification  
9960 Mayland Drive, Suite 401  
Richmond, VA 23233  
Complaint Hotline: **1-800-955-1819**  
Richmond Metropolitan Area: **1-804-367-2106**  
Fax: **1-804-527-4502**  
Email: MCHIP@vdh.virginia.gov

**Translation and interpreter services**
Translation services are available to our non-English-speaking members. This service is available to members at no cost. If you need help translating any materials in a language other than English or need to identify a health care provider that speaks a language other than English, please contact Member Services toll free at **1-800-901-0020** Monday through Friday, 8 a.m. to 6 p.m. Eastern time.

For members with vision loss or who need any written material in an alternative format, please call Member Services toll free at **1-800-901-0020** for assistance. Members with hearing or speech loss may call the TTY line at **711** for assistance.

**O. Assignment of benefits and payments**
The covered services available under your EOC are personal. You may not assign your right to receive covered services.

You may not assign your right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not constitute a waiver of or otherwise restrict our right to direct future payments to you or any other individual or facility. Notwithstanding any provision in this EOC to the contrary, however, we will reimburse directly any ambulance service provider to whom the member has executed an assignment of benefits.

**P. Services of nonparticipating providers**
We don’t anticipate a need for you to utilize providers other than network providers except in emergencies and urgent care out-of-area situations.

In the event, however, that you do receive properly authorized covered services from a non-network provider, then we reserve the right to make payment for such covered services directly to the non-network provider or any other person responsible for paying the non-network provider’s charges.

**Q. Time limit on legal action**
No action at law or suit in equity shall be brought against us more than one year after the date the cause of action first occurred with respect to any matter relating to:

- This EOC  
- Our performance under this EOC  
- Any statements made by an employee, officer or director of the health plan concerning the EOC or the benefits available
R. Limitation on damages
In the event you or your representative sues us or any of our directors, officers or employees acting in his or her capacity as director, officer or employee for a determination of what coverage and/or benefits, if any, exist under this EOC, your damages shall be limited to the amount of your claim for benefits.

The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. This EOC doesn’t provide coverage for punitive damages or damages for emotional distress or mental anguish; provided, however, this provision is not intended and shall not be construed to affect in any manner any recovery by you or your representative of any noncontractual damages to which you or your representative may otherwise be entitled.

S. The health plan’s continuing rights
On occasion, we may not insist on your strict performance on all terms of this EOC. Failure to apply terms or conditions doesn’t mean we waive or give up any future rights we may have under this EOC.

T. Use of personal information
- Personal information may be collected from persons other than an individual proposed for coverage.
- This information, as well as other personal or privileged information subsequently collected by us in accordance with the Virginia Privacy Protection Act and other federal and state confidentiality laws, in certain circumstances may be disclosed to third parties without authorization.
- You have a right to see and correct all personal information which is collected about you. For more information, please contact Member Services.
- A more complete notice of our information practices is available upon request.

U. Copays and deductibles
For Medicaid members, there are no copays and deductibles required for any covered service under this EOC.

V. HealthKeepers, Inc. insolvency
A network provider is prohibited from billing, charging, collecting a deposit from, seeking compensation, remuneration or reimbursement from or having any recourse against you for covered services provided in accordance with the terms of this EOC even in the event of our insolvency. If you receive a bill for authorized services, please call Member Services for assistance.

W. Filing claims
Most claims will be filed for you by network providers. You may have to file claims for out-of-area services, services rendered by providers who aren’t network providers and some prescription drug claims. You may obtain claim forms from your Member Services representative.

Claims should be sent to us at the following address:
Anthem HealthKeepers Plus Operations
HealthKeepers, Inc.
P.O. Box 27401
Richmond, VA 23279

We'll reimburse you up to our allowable charge for a medically necessary covered service paid for by you only if a completed claim (including receipt) has been received by us within 90 days of the date you received such services.
X. Coordination of benefits
All benefits provided under this EOC are subject to this provision. Benefits will not be increased by virtue of this provision. If you are covered by two group health benefits plans, one of the plans will be considered the primary plan and the other plan will be the secondary plan.

The primary plan is the plan which will process claims for benefits first (as though no other coverage exists), and the secondary plan will coordinate its payment as not to duplicate benefits provided by the primary plan. This health benefits plan will always pay secondary. Medicaid is the payer of last resort. In no instance will the combined payments of both plans exceed our allowable charge for such covered service. We will help coordinate any claims between the primary and secondary plans.

You must cooperate fully in providing information about your other group health benefits plans to us, to DMAS, and to your Department of Social Services caseworker. A delay in our receipt of this information will result in a delay in the payment of claims.

If we have overpaid benefits because of coordination of benefits, we shall have the right to recover the excess from the following as we shall determine:

- Any persons to, or for whom, such payments were made
- Any insurance company
- Any other organization

To ensure the best possible service, you should promptly inform us by mail or telephone of any additional coverage you may have.

Y. Living will or power of attorney (advance directive)
You have a right to decide what health care you will seek. You have a right to accept or reject health care treatment. You also have the right to plan and direct the types of health care you may get in the future in the event you can't tell someone your wishes.

An advance directive is a witnessed written document, voluntarily signed in accordance with the law or a witnessed oral statement, made subsequent to the time a person is diagnosed as suffering from a terminal condition in accordance with the law.

The Virginia Health Care Decisions Act allows you to make decisions about your health care in an advance directive. All health care declarations are unconditionally revocable at any time, effective immediately, upon notice to the physician or health care provider.

The first type of decision you can make tells people how to care for you if you ever are unable to make informed decisions for yourself. This document is often called a “living will.”

You may name someone to make treatment decisions — to accept or refuse medical care — for you if at some point you can't make them yourself. This type of advance directive is often called a “medical power of attorney,” a “durable power of attorney for health care” or a “health care proxy.”

This person can make all health decisions for you that you could have made for yourself. Or you may direct instead that he or she make only those decisions that you list. You may also name a person who will see that your organs or your body is donated, as you wish, after your death.
If the Virginia Health Care Decisions Act changes at any time, we will notify you as soon as possible, but no later than 90 days from the date the change takes effect.

**You may change or revoke your advance directive at any time.**

You can let your PCP know about your feelings and make a living will or power of attorney for health care. Contact your PCP or Member Services if you have questions about these rights.

**Z. Reporting client or provider waste, abuse or fraud**

If you suspect a client (a person who receives benefits) or a provider (such as a doctor or dentist) has committed waste, abuse or fraud, you have a responsibility and a right to report it.

Examples of client waste, abuse or fraud include but are not limited to:
- Loaning insurance ID cards.
- Using more than one provider to obtain similar treatments and/or medications.
- Frequent emergency room visits for nonemergency conditions.

Examples of provider waste, abuse or fraud include but are not limited to:
- Billing for services not provided.
- Billing professional services performed by untrained personnel.
- Altering medical records.

To report waste, abuse or fraud, gather as much information as possible. You can report providers or clients directly to your health plan at:

**Government Business Division Special Investigations Unit**
Anthem HealthKeepers Plus
P.O. Box 66407
Virginia Beach, VA 23462
Telephone: **1-800-368-3580**

When reporting a person who receives benefits, provide this information:
- The person’s name
- The person’s date of birth, Social Security number or case number, if possible
- The city where the person resides
- Specific details about the waste, abuse or fraud

When reporting a provider (doctor, dentist or counselor), provide this information:
- Name, address and telephone number of the provider
- Name and address of the facility (hospital, nursing home or home health agency)
- The Medicaid number of the provider or facility (if you know it)
- The type of provider (doctor, pharmacist or physical therapist)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

You may also report fraud directly to the Medicaid Fraud Control Unit at **1-800-371-0824** or by email: MFCU_mail@oag.state.va.us.
AA. Information available to members on an annual basis
As a member of our health plan, you can ask for and get the following information each year:
- Names, addresses, telephone numbers of network providers and the languages they speak (other than English)
- The Provider Directory for our network
- A new copy of this EOC
- Names of providers that aren’t accepting new patients. (The information provided will include PCPs, specialists and hospitals in your service area.)
- Any limits to your freedom of choice among network providers
- Your member rights and responsibilities
- Information on complaint/grievance, appeal and State fair hearing procedures
- The amount, duration and scope of benefits offered under the Medicaid program in enough detail to make sure that you understand your covered benefits
- How to get benefits, including our approval for services
- How to get benefits such as family planning services from out-of-network providers and/or the limits to those benefits
- How after-hours and emergency coverage are provided and/or the limits to those benefits, such as:
  - What makes up emergency medical conditions, emergency and post-stabilization care
  - The fact that our approval ahead of time (prior authorization) is not required for emergency care
  - How to obtain emergency care, including the use of 911 or your local emergency number
  - The locations of any emergency settings and other places where providers and hospitals give emergency services covered under this plan
  - Your right to use any hospital or other setting for emergency care
  - Post-stabilization rules
- Policy on referrals for specialty care and for other benefits not given by your PCP
- Our practice guidelines

BB. New technology and treatments
This is an exciting time in health care. There are new treatments all the time. We want you to benefit from them, so we review them on a routine basis.

A group of PCPs, specialists and medical directors decides if a new treatment meets these criteria:
- Is approved by the government
- Has shown in a reliable study how it affects patients
- Will help patients as much as or more than treatments now in use
- Will improve patients’ health

The review group looks at all the information. The group then decides if the treatment is medically necessary.

If your doctor asks us about a treatment that the review group has not looked at, our reviewers will learn about the treatment and then decide. They will let your doctor know if the treatment is medically necessary and if we approve it.

CC. Our company structure and operation
HealthKeepers, Inc. is a Virginia domiciled stock insurance company that is owned 92.51% by Anthem Southeast, Inc. ("Anthem Southeast") and 7.49% by UNICARE National Services, Inc. ("UNICARE"). Anthem Southeast is a wholly-owned subsidiary of Anthem, Inc. ("Anthem"), a publicly traded company. UNICARE National Services, Inc. is a wholly-owned subsidiary of Anthem Holding Corp. which is wholly-owned by Anthem, Inc. Anthem, Inc. is the ultimate parent company. The Medicaid and FAMIS business is conducted through HealthKeepers, Inc.'s Anthem HealthKeepers Plus product. The Virginia Medicaid and FAMIS business is part of Anthem, Inc.'s Government Business Division (GBD).
Section VII: Member Rights and Responsibilities

As a member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we’re committed to making sure your rights are respected while providing your health care benefits. That also means giving you access to our network providers and the information you need to help you make the best decisions for your health.

These are your rights and responsibilities:

You have the right to get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
- Our company and services
- Our network of doctors and other health care providers
- Your rights and responsibilities

You have the right to receive EPSDT services. Under Medicaid, your child may be eligible to receive certain otherwise noncovered services under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of Medicaid. EPSDT covers medically necessary services which will cure an illness or condition or at least keep it from getting worse. These benefits include, but aren’t limited to services for nursing care, individualized treatments specific to developmental issues, and accessing carve-out services. Please contact Member Services for more information about how these benefits may be accessed.

You have the right to choose a primary care provider (PCP). You have access to a full range of cost-effective health care providers and benefits. You may choose any PCP listed in our directory of providers to manage your health as long as that PCP is accepting new patients. PCPs specialize in the areas of general practice, family practice, internal medicine, obstetrics/gynecology and pediatrics.

If the PCP you selected terminates his or her relationship with us, you will be notified via letter prior to the effective date of termination. We will assign a new PCP to you, but you have the right to change your PCP at any time. If network provider other than your PCP terminates his or her relationship with us, all affected members will be notified by the network provider prior to the effective date of the termination.

You have the right to be treated with respect and to receive prompt treatment and service. You should always be treated with respect and courtesy. Likewise, when you have questions or need help with your plan benefits, you should always receive prompt and courteous service from our employees.

You have the right to speak freely and privately with your doctor about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your health plan. You have a right to work with your doctors in making choices about your health care. You also have the right to refuse treatment. Your doctor should provide you with information on available treatment options and alternatives in a way that you can understand. You may obtain a copy of our Clinical Practice Guidelines by calling the Member Services number and requesting Utilization Management for assistance.
You have the right to expect us to keep your personal health information private in accordance with state and federal laws and our privacy policies.

Any medical information about you that we receive, including your medical records from health care professionals or hospitals, will be kept confidential and, except as permitted by law, will not be made available to anyone without your written permission. You can review any personal information collected about you by us, and corrections can be made at your request.

You have the right to not be discriminated against on the basis of race, color, national origin, sex, age or disability in its health programs and activities. Members with Limited English Proficiency (LEP) have the right to meaningful access including qualified interpreter services. Members have the right to be treated consistently with their gender identity.

You have the right to make a complaint or file an appeal about:
- Your health care plan
- Any care you get
- Any covered service or benefit ruling that your health plan makes

Our Member Services staff can resolve most of your concerns if you are ever dissatisfied with us, or the care you’ve received from a participating health care professional.

You have the right to information. While you are enrolled as an Anthem HealthKeepers Plus member, you have the right to request certain information about the health plan, its services, the health care professionals who contribute to your care, and your rights and responsibilities. This includes information on our structure and operation and physician incentive plans. We also may periodically send you information on how to use the benefits and features of your health plan. If you should ever have any questions or concerns, you may contact Member Services.

You have the right to ask for member materials on an annual basis. While you are enrolled as an Anthem HealthKeepers Plus member, you may request a new member handbook, Provider Directory, your member rights and responsibilities, information on our policies and any member mailing.

You have the right to request and receive a copy of your medical records. You may request your medical records at any time from your provider. You have the right to request that your medical records be amended or corrected. We can assist you in getting medical records from network providers. Call Member Services at 1-800-901-0020 to ask for a copy of your medical records.

You have the right to make recommendations regarding the rights and responsibilities set forth here. Being a partner in your health care means remaining involved in and informed about the decisions that affect your health. We welcome all suggestions regarding what your rights and responsibilities as a member should be, as well as what our rights and responsibilities as your health plan should be. If you should have any questions, comments, or suggestions, please contact Member Services.

You have the right to be free from any form of restraint or seclusion. While you are enrolled as an Anthem HealthKeepers Plus member, you have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

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Member Services: 1-800-901-0020 (TTY 711)
Monday – Friday, 8 a.m. – 6 p.m. Eastern time
24/7 NurseLine: 1-800-901-0020
You have the right to free exercise of rights. While you are enrolled as an Anthem HealthKeepers Plus member, you have the right to free exercise of your rights, and the exercise of those rights doesn’t adversely affect the way we and our providers treat you.

You have the right to make an advance directive (“living will”).

You have the right to be furnished health care services in accordance with federal regulations. While you are enrolled as an Anthem HealthKeepers Plus member, you have the right to be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210 as described in this EOC.

You have the right to be told at least thirty (30) calendar days prior to their implementation when there are changes to covered services, benefits, or the process that you should use to access benefits (different than what is explained in this handbook).

Member responsibilities
You are responsible for selecting your primary care provider. You should select a PCP when you enroll and maintain a designated PCP as long as you are an Anthem HealthKeepers Plus member. If you choose not to select a PCP upon enrollment or if the PCP you previously selected terminates his or her relationship with us, we will select a PCP for you. You may choose another PCP at any time. Please refer to Section II of the EOC for more information on how to pick a PCP.

You have the responsibility of getting to know your PCP. Establishing a personal and continuous relationship with your PCP is an essential part of maintaining good health because it allows your physician to become more familiar with your individual health care needs.

You have the responsibility to use only your PCP and Anthem HealthKeepers Plus network providers. Because your PCP is responsible for managing your health, you should see your PCP before receiving nonemergency services from any health care provider. If you need care from a specialist, your PCP will refer you to an appropriate health care professional.

You have the responsibility to notify HealthKeepers, Inc., DMAS, and the Department of Social Services when:
- Your family size changes
- Your address changes
- You move outside of the Commonwealth of Virginia

You have the responsibility to notify HealthKeepers, Inc. and DMAS:
- When you have other health insurance
- If your other health insurance coverage changes

You have the responsibility of understanding your health problems and working with your doctors to make a treatment plan that you all agree on. It is important that you work together with providers and their staff to be a partner with your health care professional and their treatment staff by following their advice and the care they recommend. Take the necessary steps to have your previous medical records and any updates transferred to your current doctor. You also have the responsibility to give us and your doctors the information needed to help you get the best possible care.
If you have any questions or disagree with your treatment plan, discuss it with your provider. You should also be sure to understand the medications you are taking and whether you are scheduled for follow-up visits.

You have the responsibility to keep all diagnostic or treatment appointments as scheduled. Please consider the needs of others by being on time for appointments you schedule with health care professionals. And because giving patients the full attention they need doesn’t always allow providers to stay on schedule, please understand if you have to wait before your provider can see you.

You have the responsibility to understand your identification card. You should be familiar with your identification card, carry it with you at all times, and present the card whenever you receive covered services. Only you may use your identification card.

You have the responsibility to know what is considered emergency care and what is considered urgent care. Be familiar with when to use the emergency room for care (immediately for any life-threatening condition no matter where you are) and when to seek care from your PCP (non-life-threatening illnesses or injuries or urgent care). Your EOC includes more information on when and how to use emergency room services in Section III.

You have the responsibility of following the care plan that you have agreed on with your doctors. It’s important for you to work as a partner in your health care to maintain good health.

If you would like additional information regarding your rights and responsibilities, you may call Member Services at **1-800-901-0020**. Members with hearing or speech loss may call TTY 711.
Section VIII: Definitions

**Abuse** means member, provider or facility practices that are inconsistent with medical or business practices and result in an unnecessary cost to the Medicaid Program or in reimbursement for services that aren’t medically necessary or that fail to meet professionally recognized standards for health care.

**Advance directive** means a written instruction, recognized under state law (whether determined by law or rule, or as recognized by the state’s courts), relating to the provision of health care when the individual (member) is incapacitated. All health care declarations are unconditionally revocable at any time, effective immediately, upon notice to the physician or health care provider.

**Agreement** means the Medicaid Participation Attachment between the health plan and the Virginia Department of Medical Assistance Services (DMAS) of which this EOC is a part.

**Allowable charge** means the health plan allowance for a specified covered service or the provider’s charge for that service, whichever is less. We will never pay more than our allowable charge for any covered service.

**Contract year** is July 1 – June 30.

**Behavioral Therapy Services** are services:
- Provided by licensed practitioners within the scope of practice
- Are covered as remedial care to qualified members age 21 and younger through EPSDT

**Coordination of Benefits (COB)** means a method of integrating benefits payable under more than one form of health insurance coverage so that the covered member’s benefits from all sources don’t exceed 100 percent of the allowable medical expenses. COB rules also establish which plan is primary (pays first) and which plan is secondary, recognizing that Medicaid is the payer of last resort.

**Covered services** means those medically necessary hospital and medical services which are described as covered in this EOC and which are performed, prescribed or directed by a network physician.

**Cover Virginia** is the statewide customer service center and online website that:
- Can help you learn about and apply for programs like Medicaid or FAMIS, report any changes to your address or renew your child’s health care coverage at 1-855-242-8282
- Provides information on eligibility and how to apply for the FAMIS and Medicaid programs at www.coverva.org

**Department of Social Services** means the agency which determines whether or not an individual is eligible for Medicaid/FAMIS Plus.

**Disenrollment** means the process of changing enrollment from one MCO to another MCO or ending health care coverage.

**DMAS** refers to the Virginia Department of Medical Assistance Services.
**Emergency medical condition** means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- Serious jeopardy to the mental or physical health of the individual.
- Danger of serious impairment of the individual’s bodily functions.
- Serious dysfunction of any of the individual’s bodily organs.
- In the case of a pregnant woman, serious jeopardy to the health of the fetus or the mother.

Services of a nonparticipating provider are covered when delay in receiving care from a network provider could reasonably be expected to cause the member’s condition to worsen if unattended.

**Emergency services** means covered inpatient and outpatient services that are:

- Given by a qualified provider.
- Needed to evaluate or stabilize an emergency medical condition.

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** is a program of preventive health care and well-child examinations with appropriate tests and immunizations for children and teens under 21 years old with Medicaid. Medically necessary services which are required to correct or ameliorate defects and physical or behavioral illnesses that are discovered during a screening examination are covered as a part of the EPSDT program.

**Early Intervention (EI)** is a program called the Infant and Toddler Connection of Virginia. The services are available through EPSDT and can help meet developmental needs of children from birth to age 3 who:

- Have 25 percent development delays in at least one area
- Have atypical developments or diagnosed mental or physical conditions that are likely to result in developmental delays

**Evidence of Coverage (EOC)** includes this document as well as any amendment or related document issued in conjunction with this document, setting out the coverage and other rights to which you are entitled.

**Experimental/investigative** means any service or supply which is determined to be experimental or investigative in our sole discretion. We will apply the following four criteria in exercising its discretion:

1. Any supply or drug used must have received final approval to market by the United States Food and Drug Administration (FDA).
2. There must be sufficient information in the peer-reviewed medical and scientific literature to enable us to make conclusions about safety and efficacy.
3. The available scientific evidence must demonstrate a beneficial effect on health outcomes outside a research setting.
4. The service or supply must be as safe and effective outside a research setting as existing diagnostic or therapeutic alternatives.

A service or supply will be experimental and/or investigative if we determine that any one of the four criteria is not satisfied.

**FAMIS MOMS** is a program for uninsured pregnant female members who:
- Are not eligible for Medicaid
- Have a family income at or below 200 percent of the federal poverty level
- Are assigned and enrolled in the aid category

FAMIS MOMS members have access to the same services as Medicaid members.

**Grievance** means a complaint by a provider, member or member representative expressing dissatisfaction with the availability, delivery or quality of services provided. A grievance is not the same as an appeal.

**Health and Acute Care Program or HAP** is a Medicaid program that includes members receiving services concurrently under both the 1915(b) managed care waiver and 1915(c) home- and community-based waivers (HCBW). Members will receive medical acute and primary care services through Medicaid HMO, while long-term care waiver services will be paid under the Department of Medical Assistance Services (DMAS) Fee-for-Service system. Members enrolled in the HCBW Technology Assisted program will remain in DMAS's Fee-for-Service system for both medical and waiver services.

**HMO** means HealthKeepers, Inc.

**HMO physician** means a duly-licensed doctor of medicine or osteopathy who has contracted with the HMO to provide medical services to members.

**HMO provider** means a medical group, network physician, hospital, skilled nursing facility, pharmacy or any other duly-licensed institution or health professional who has contracted with the HMO or its designee to provide covered services to members. A list of our network providers is given to each member upon enrollment. A current list may be obtained from us. The list shall be revised by us from time to time as we deem necessary.

**Indian** means a person who has been determined eligible to get health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under Contract Health Services (CHS).

**Indian Health Care Provider (IHS)** means a health care program, including providers of CHS, operated by the IHS or by an Indian Tribe, Tribal Organization, or I/T/U.

**Inpatient** means a member who has been admitted to a hospital, is confined to a bed there, and receives meals and other care in that facility.

**Managed Care Organization (MCO) or health plan** means a managed care organization such as HealthKeepers, Inc. that contracts with DMAS for coverage of persons eligible for Medicaid and FAMIS Plus.

**Medical director** means a duly-licensed physician or his or her designee who has been designated by the health plan to monitor the provision of covered services to members.

**Medically necessary** or **medical necessity** means appropriate and necessary health care services which, according to generally accepted principles of good medical practice, are required for the diagnosis or direct care and treatment of an illness, injury or pregnancy-related condition and aren’t
provided only as a convenience. Services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

**Member** means a person eligible for Medicaid who is enrolled in the Anthem HealthKeepers Plus plan.

**Morbidly obese** refers to:
- A weight that is at least 100 pounds over or twice the ideal weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables.
- A body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes.
- A BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.

**Outpatient** means a member who is receiving care but who has not been admitted to a hospital.

**Post-stabilization care services** means covered services, related to an emergency medical condition, that are provided after you’re stabilized to maintain the stabilized condition or to improve or resolve your condition.

**Primary care provider (PCP)** means a health care provider who:
- Provides preventive and primary medical care for eligible members
- Certifies prior authorizations and referrals for all medically necessary specialty services

PCPs may include:
- Pediatricians
- Family and general practitioners
- Internists
- Obstetrician/gynecologists
- Specialists who perform primary care functions within certain provider classes, care settings or facilities, including but not limited to health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Health Departments and other similar community clinics

**Service area** means the geographic area within which covered services are available.

**Urgent care** means care for a health problem usually marked by rapid onset of persistent or unusual discomfort associated with an illness or injury. These problems may include high fever, vomiting, sprains and minor cuts. If you aren’t sure if you have an urgent care situation, you should call your PCP. Your PCP will tell you what to do. You can also call Member Services at **1-800-901-0020** or our 24/7 NurseLine at **1-800-901-0020** for help.

**Utilization Management (UM)** means the process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

**Visit** means a brief period during which you meet with a physician or another person whose services are eligible for coverage.
Waste means the rendering of unnecessary, redundant or inappropriate services and medical errors and incorrect claim submissions.

You, Your refers to a member.
HealthKeepers, Inc. follows Federal civil rights laws. We don’t discriminate against people because of their:

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

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

**Communicating with you is important**

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

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

To get these services, call the Member Services number on your ID card at 1-800-901-0020 (TTY 711).

**Your rights**

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

HealthKeepers, Inc. for Anthem HealthKeepers Plus
Attention: Civil Rights Coordinator for Discrimination Complaints
P.O. Box 62429
Virginia Beach, VA 23464
Phone: 1-800-901-0020 (TTY 711)
Fax: 1-855-832-7294
Email: grievancesandappeals-hkp@anthem.com

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

- **On the Web:**  [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)
- **By mail:**
  U.S. Department of Health and Human Services
  200 Independence Ave., SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- **By phone:**  1-800-368-1019 (TTY/TDD 1-800-537-7697)

**Multi-language Interpreter Services**

We can translate this at no cost.

*Call the customer service number on your member ID card.*

<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>Podemos traducir esto gratuitamente. Llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación (ID Card).</td>
</tr>
<tr>
<td>Arabic</td>
<td>نستطيع ترجمة هذه المواد مجانًا. اتصل بخدمات الأعضاء، باستخدام رقم الهاتف المدون على بطاقة الأعضاء لديك.</td>
</tr>
<tr>
<td>Armenian</td>
<td>Մեկնարկենք իբրաելերի բարեփոխումները այս համակարգերով իրավաբար կազմված ավանդական բնական երկիրը տեղափոխերեք (ID card) կարտի համաձայնագրակարգը.</td>
</tr>
<tr>
<td>Burmese</td>
<td>မင်္ဂလာပါ အင်္ဂလိပ် အမေရိကန် သို့မဟုတ် မြန်မာ ဘာသာဖြင့် ကျင်းပစ်မည်။ ကျန်းမာရေး လုပ်ငန်းများ ကို အခြေခံပါ။</td>
</tr>
<tr>
<td>Chinese</td>
<td>我們可以免費為您提供翻譯版本。請撥打您 ID 卡上所列的電話號碼洽詢客戶服務中心。</td>
</tr>
<tr>
<td>Farsi</td>
<td>ما می توانیم این را به رایگان برایتان ترجمه کنیم. به شماره خدمات مشاورین مراجعین ما که پشت کارت شناساییتان (ID) درج شده، تلفن بزنید.</td>
</tr>
<tr>
<td>Fr. Creole</td>
<td>Nou ka tradwi sa la pou okenn pri. Pélé nimo sevis kliyentel la sou tò kat didantité.</td>
</tr>
<tr>
<td>German</td>
<td>Wir können das gerne kostenlos übersetzen. Bitte wenden Sie sich an die Kundenservice-Hotline auf Ihrer ID-Karte.</td>
</tr>
<tr>
<td>Greek</td>
<td>Μπορούμε να σας μεταφράσουμε το παρακάτω χωρίς χρέωση. Καλέστε τον αριθμό του Τμήματος Εξυπηρέτησης Πελατών που θα βρείτε στην κάρτα ταυτοποίησής σας.</td>
</tr>
<tr>
<td>Gujarati</td>
<td>આમે આપણે સફળતા થી સફળતા માં કોઈ વિદ્યુતી કલી વિદ્યુતી ક્ષીણ તમારા એડ ક્રોક પર આપણે ઉપકરણ સેવા નંબર પર ભયો કરી.</td>
</tr>
<tr>
<td>Hebrew</td>
<td>אנו מצפים נוכחות תרגום איטgpu עלולות. התבקשון לחופה של שירוט הלקיחותה.</td>
</tr>
<tr>
<td>Hindi</td>
<td>हमं इसका अनुवाद निशुल्क कर सकते हैं। अपने ID कार्ड पर दिए गए ग्राहक सेवा नंबर पर फोन करें।</td>
</tr>
<tr>
<td>Hmong</td>
<td>Peb txhais tau qhov ntawm no dawb. Hu rau lub chaw haujliwm pab cov neeg siv peb cov kev pab tus xovtooj uas nyob ntawm koj daim npav ID rau tus tswv cuab.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italian</td>
<td>Possiamo effettuare la traduzione gratuitamente. Contatti il numero dell’assistenza clienti riportato sulla Sua tessera identificativa.</td>
</tr>
<tr>
<td>Japanese</td>
<td>私たちは、この文章を無料で翻訳することができます。ご自身のIDカードにあるカスタマーサービス番号へお電話ください。</td>
</tr>
<tr>
<td>Khmer</td>
<td>បានសម្រាប់ប្រការជាមួយអ្នកគ្រប់គ្រាន់៖ សូមប្រឈមឈើធ្វើការកុំព្យូទ័រនេះ ដោយ输入 ID ប៉ារ៉ាឡ៊ីក់ ។</td>
</tr>
<tr>
<td>Korean</td>
<td>저희는 이것을 무료로 번역해 드릴 수 있습니다. 가입자 ID 카드에 있는 고객 서비스부 번호로 연락하십시오.</td>
</tr>
<tr>
<td>Laotian</td>
<td>ແຂວງການធ្វើអំណាចនេះមិនមានព័ត៌មាន៖ សូមធ្វើការនេះដោយ输入 ID ប៉ារ៉ាឡ៊ីក់ក្នុងប្រព័ន្ធកិច្ចវិទ្យាសម្រាប់អតិថិជន ។</td>
</tr>
<tr>
<td>Polish</td>
<td>Możemy to przetłumaczyć bez żadnych kosztów. Zadzwoń pod numer obsługi klienta za pomocą karty ID.</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Podemos traduzir isto gratuitamente. Ligue para o serviço de atendimento ao cliente que consta no seu cartão de identificação.</td>
</tr>
<tr>
<td>Russian</td>
<td>Мы можем это бесплатно перевести. Позвоните в отдел обслуживания по телефону, приведенному на вашей идентификационной карточке участника плана.</td>
</tr>
<tr>
<td>Serbian</td>
<td>Možemo to prevesti besplatno. Pozovite na broj korisničkog servisa s Vaše identifikacione kartice (ID).</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Maaari namin ito isalin-wika nang walang bayad. Mangyaring tawagan ang numero ng customer service sa inyong ID card na pang miyembro.</td>
</tr>
<tr>
<td>Thai</td>
<td>เราสามารถแปลได้โดยไม่ต้องใช้จ่ายใด ๆ ติดต่อหมายเลขโทรศัพท์ของฝ่ายบริการลูกค้าที่ระบุข้างต้นของคุณ</td>
</tr>
<tr>
<td>Urdu</td>
<td>بس اس کا ترجمہ مفت کر سکتے ہیں۔ اب نے ID کارٹ کر دیا گیا کہ یہ ID کارٹ کر دیا گیا ہے۔</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Chúng tôi có thể phiên dịch tài liệu này miễn phí. Xin gọi dịch vụ khách hàng qua số điện thoại ghi trên thẻ ID hội viên của quý vị.</td>
</tr>
<tr>
<td>Yiddish</td>
<td>מיט קאַמען דאָס איבערשאָטן פּר&quot;א פּאַפּאַמצאַ. רוקח דער קאָסטמער סPagerויזאַ.</td>
</tr>
</tbody>
</table>
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