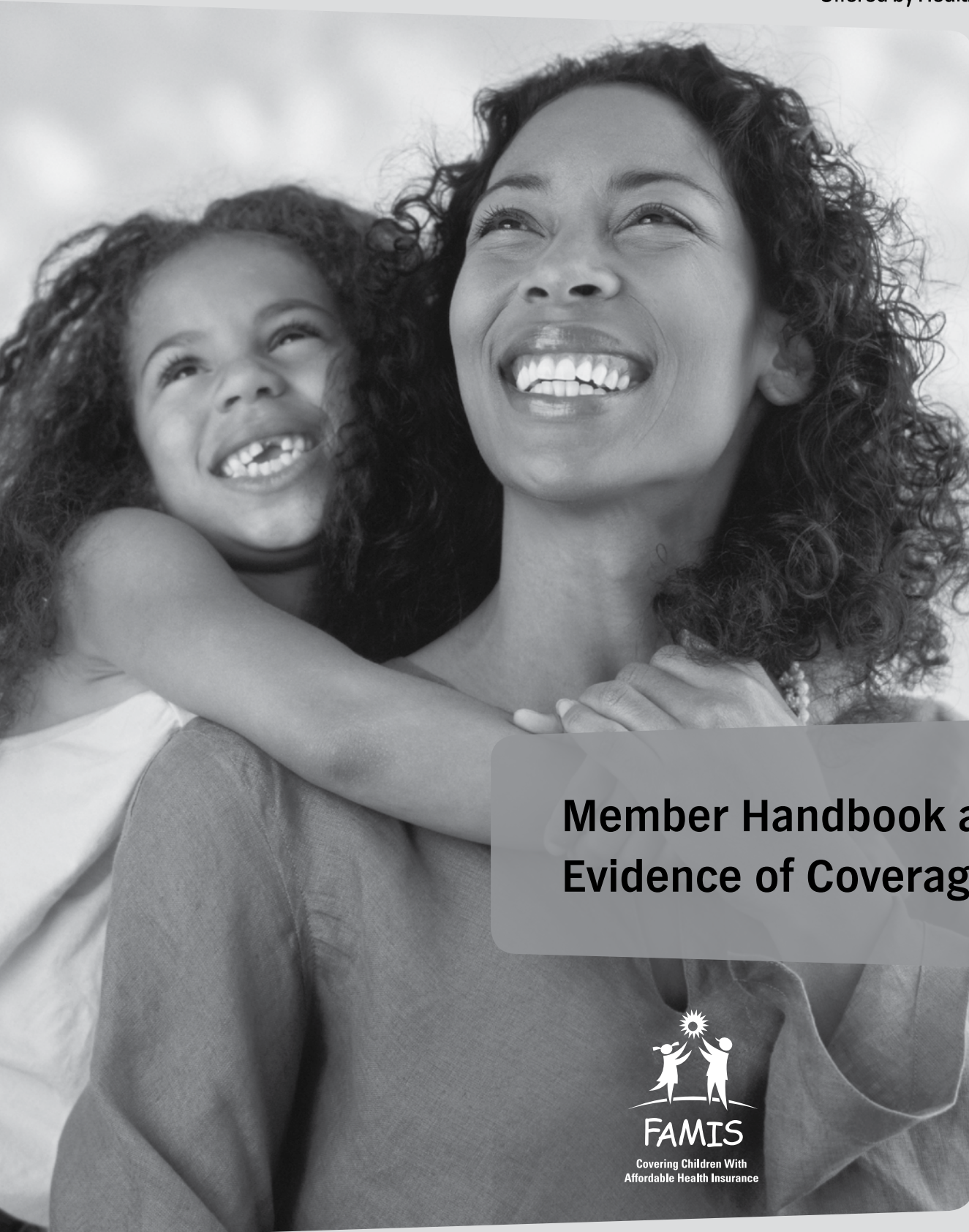




**Anthem** HealthKeepers Plus  
Offered by HealthKeepers, Inc.



## Member Handbook and Evidence of Coverage





**Anthem** HealthKeepers Plus  
Offered by HealthKeepers, Inc.

# Anthem HealthKeepers Plus Member Handbook and Evidence of Coverage

[www.anthem.com/vamedicaid](http://www.anthem.com/vamedicaid)

Member Services  
1-800-901-0020 (TTY 711)



**FAMIS**  
Covering Children With  
Affordable Health Insurance

AVA-MHB-0018-17

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# Welcome

Welcome to your Anthem HealthKeepers Plus plan. Our team is ready to help you and your family stay on top of your health care. We help you get your child's Family Access to Medical Insurance Security Plan (FAMIS) benefits and services 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 child's health care plan works.
- Find out how you can get your child medical care.

**Please read this handbook carefully.**

## How to get in touch with us

If you need to talk with someone about your child's benefits or health plan, contact us:

- Call Member Services toll free at **1-800-901-0020**. If you're 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 child's 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 Member Services!

If you move, contact us right away, and we'll update your address with the state. If you don't, your child could lose his or her benefits during the annual renewal process. Update your address in one of these ways:

- Call Member Services at 1-800-901-0020 (TTY 711). We're available Monday through Friday from 8 a.m. to 6 p.m.
- Log in to your secure account on our website at [www.anthem.com/vamedicaid](http://www.anthem.com/vamedicaid) to update your address and information online.
- Contact your local social services caseworker.

## **Other resources**

- Learn more about your child's dental benefits by calling Smiles for Children at **1-888-912-3456 (TTY 711)**.

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

## **Translation and interpreter services**

No-cost translation and interpreter services are available if your child is a member and you don't speak English. If you have vision loss or you need your child's Anthem HealthKeepers Plus 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 child's health plan. We look forward to helping you get your child's health care.

**Call toll free for translation or oral interpretation at no cost/Llame a la línea gratuita para servicios de traducción o interpretación sin cargo: 1-800-901-0020 (Medallion Medicaid, FAMIS); 1-855-323-4687 (CCC Plus); TTY 711.**

**[www.anthem.com/vamedicaid](http://www.anthem.com/vamedicaid)**

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## Section I: Benefit quick reference guide

We're here to help you get your child's FAMIS benefits and services. The chart below tells you about the benefits covered by your child's health plan. This chart is a summary only. Please refer to **Section III: Benefits** for a full list of Anthem HealthKeepers Plus benefits.

For some services, you may need a referral from your child's 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.

Benefit	Coverage	Copays/Limits
<b>Ambulance services</b>  You don't need an authorization from your child's PCP or us for emergency transportation.	Emergency transport is used to get medical care and treatment in a true emergency. We cover: <ul style="list-style-type: none"><li>• Ground ambulance</li><li>• Air ambulance</li><li>• Transport between local hospitals when medically needed</li><li>• Transport to provider's office or outpatient hospital department ONLY if:<ul style="list-style-type: none"><li>– The member can't safely ride in a car due to his or her health condition</li><li>– It's prearranged by the member's PCP and approved by us</li></ul></li></ul> However, transportation services aren't provided for routine access to and from providers for covered medical services.	Copay applies
<b>Chiropractic services</b>  Chiropractic services require an authorization from us.	We cover medically necessary outpatient chiropractic services for musculoskeletal conditions.	Copay applies  Limited to \$500 per member per calendar year.

Benefit	Coverage	Copays/Limits
<p><b>Dental and oral surgery services</b></p> <p>Routine pediatric dental services are covered through the Smiles for Children Program through the Dental Benefit Administrator (DBA) that is under contract with DMAS.</p>	<p>We cover medically necessary services for:</p> <ul style="list-style-type: none"> <li>• External trauma from dental accidents that results in damage to the hard or soft tissue of the oral cavity</li> <li>• Procedures to the mouth where the main purpose is not to treat or help the teeth like: <ul style="list-style-type: none"> <li>– Cleft palate repair</li> <li>– Preparation of the mouth for radiation therapy</li> <li>– Maxillary or mandibular frenectomy when not related to a dental procedure</li> <li>– Orthognathic surgery to attain functional capacity (TMJ)</li> <li>– Surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures</li> </ul> </li> <li>• Anesthesia and hospitalization services when required to provide dental care</li> <li>• Dental fluoride varnish provided by a nondental medical provider</li> </ul>	<p>For information on services covered by DMAS, call DentaQuest/Smiles for Children program at 1-888-912-3456.</p> <p>Dental fluoride varnish is for members 0-3 years of age. The service may be given every six months up to a maximum of six applications.</p>
<p><b>Diabetic services, equipment and supplies</b></p>	<p>We cover:</p> <ul style="list-style-type: none"> <li>• All FDA-approved equipment</li> <li>• Insulin pumps</li> <li>• Home blood glucose monitors, lancets, blood glucose test strips, syringes and needles</li> <li>• Outpatient self-management training and education</li> </ul>	<p>Copay applies</p>

Benefit	Coverage	Copays/Limits
<p><b>Durable medical equipment (DME) and supplies</b></p> <p>All custom-made DME requires an authorization from us; some other DME may require an authorization from us.</p>	<p>Medically necessary equipment and supplies, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Medical and surgical supplies</li> <li>• Wheelchairs</li> <li>• Traction equipment</li> <li>• Walkers</li> <li>• Crutches and canes</li> <li>• Ventilators</li> <li>• Oxygen</li> <li>• Prosthetic and orthotic devices</li> <li>• Hearing aids and accessories (limited to two hearing aids every five years)</li> <li>• Diabetes supplies</li> <li>• Enteral and total parenteral nutrition supplies and equipment</li> </ul>	<p>DME must be obtained from the designated network provider for this health service. Copays may apply for medical equipment.</p> <p>Orthotics will be covered for all members when the orthotic is part of an approved intensive rehabilitation program.</p> <p>Orthotic and prosthetic equipment must be obtained from the designated network provider for this service.</p>
<p><b>Early Intervention (EI) services</b></p> <p>Early Intervention services are covered by DMAS within its coverage criteria and guidelines.</p>	<p>We will cover other medically necessary rehabilitative or developmental therapies when medically necessary, including EI children where appropriate. Services include:</p> <ul style="list-style-type: none"> <li>• Speech and language therapy</li> <li>• Occupational therapy</li> <li>• Physical therapy</li> <li>• Assistive technology services and devices</li> </ul>	<p>Available to members 0-3 years of age who are certified as eligible for services under Part C of the Individuals with Disabilities Act.</p>
<p><b>Emergency and urgent care services</b></p> <p>You don't have to call for permission if your child needs emergency care.</p>	<p>All emergency services received in the United States are covered. You don't need an authorization from your PCP or us for any of these services.</p> <p>Urgent care services aren't an emergency, but need medical attention within 48 hours.</p> <p>Urgent care appointments can be made with your child's PCP within 24 hours of your request. Your child may also go to an in-network urgent care center (clinic) for treatment.</p>	<p>Copay applies</p> <p>We cover emergency room services received outside of the network (and state), but within the United States.</p>



<b>Benefit</b>	<b>Coverage</b>	<b>Copays/Limits</b>
<b>Family planning services</b>  Your child may see any licensed family planning provider; the provider doesn't have to be part of our network.	We cover: <ul style="list-style-type: none"> <li>• Health education and advice</li> <li>• Counseling</li> <li>• Physical exam</li> <li>• Annual cervical cancer screenings</li> <li>• Birth control</li> <li>• Follow-up care</li> <li>• Lab and pregnancy tests</li> <li>• Tests for sexually transmitted infections (STIs)</li> <li>• HIV screening, testing and counseling for at-risk members as well as referrals for treatment</li> <li>• Services, drugs and devices for individuals of childbearing age which delay or prevent pregnancy</li> </ul>	Copay applies  We don't cover elective abortion services. We do pay for medically needed follow-up care related to these services.  We don't cover services to treat infertility or to promote fertility.
<b>Health education</b>	Health education services are covered when authorized or furnished by us.	
<b>Home health care</b>  Home health care requires an authorization from us.	We cover: <ul style="list-style-type: none"> <li>• House calls by your PCP</li> <li>• Skilled nursing visits</li> <li>• Home infusion therapy</li> <li>• Medical supplies</li> <li>• Physical, occupational, speech and inhalation therapy</li> <li>• Personal care services</li> </ul>	Copay applies  We don't cover custodial care.  Home health care services are limited to a combined cumulative total of 90 visits per member per calendar year.

Benefit	Coverage	Copays/Limits
<p><b>Hospice</b></p> <p>Hospice requires an authorization from us.</p>	<p>We cover:</p> <ul style="list-style-type: none"> <li>• Skilled nursing care</li> <li>• Home infusion therapy drugs for palliative care and pain management</li> <li>• A home health aide or homemaker</li> <li>• A medical social worker</li> <li>• Physical, occupational or speech therapy</li> <li>• Durable medical equipment</li> <li>• Routine medical supplies</li> <li>• Counseling, including nutritional counseling, with respect to the member's care and death</li> <li>• Bereavement counseling for immediate family members both before and after the member's death</li> <li>• Short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management</li> </ul>	<p>Hospice care is for members diagnosed with a terminal illness with a life expectancy of six months or less.</p> <p>Respite care may be provided only on an intermittent, nonroutine and occasional basis and may not be provided for more than five days every 90 days.</p>

Benefit	Coverage	Copays/Limits
<p><b>Hospital services — Inpatient</b></p> <p>Services require an authorization from us; your child doesn't need an authorization from us in an emergency or for a routine delivery.</p>	<p>We cover:</p> <ul style="list-style-type: none"> <li>• A semiprivate room</li> <li>• General nursing services</li> <li>• Meals and special diets</li> <li>• Services in special units</li> <li>• Delivery rooms</li> <li>• Special treatment rooms</li> <li>• Operating rooms</li> <li>• Surgical procedures</li> <li>• Anesthesia</li> <li>• Lab and other diagnostic tests</li> <li>• Drugs the hospital staff gives you during your stay</li> <li>• Blood and blood products</li> <li>• Physical, occupational and speech therapy</li> <li>• Radiation therapy</li> <li>• Inhalation therapy</li> <li>• Chemotherapy</li> <li>• Dialysis treatment</li> <li>• Discharge planning</li> <li>• All covered services rendered by network physicians and network provider hospital personnel that are authorized and provided while you're admitted to a network provider hospital as a registered bed patient</li> </ul>	<p>Copay applies</p> <p>We don't cover:</p> <ul style="list-style-type: none"> <li>• A private room unless it is medically necessary</li> <li>• Comfort items such as: <ul style="list-style-type: none"> <li>– Telephone</li> <li>– Television</li> <li>– Visitor meals</li> </ul> </li> </ul> <p>Limited to 365 days per confinement.</p>
<p><b>Hospital services — Outpatient</b></p> <p>Some services require an authorization from us.</p>	<p>We cover:</p> <ul style="list-style-type: none"> <li>• Emergency room use</li> <li>• Diagnostic services to find out what is wrong with your child</li> <li>• Surgical care that doesn't require an overnight stay in the hospital</li> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• Speech therapy</li> <li>• All covered diagnostic, treatment and surgical services rendered by network providers authorized by your PCP</li> </ul>	<p>Copay applies</p>

Benefit	Coverage	Copays/Limits
<b>Immunizations</b>	<p>Children under 6 years of age get immunizations in accordance with the most current Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics Advisory Committee recommendations.</p> <p>In addition, members 6 years of age and older may receive the following immunizations:</p> <ul style="list-style-type: none"> <li>• Influenza</li> <li>• Pneumonia</li> <li>• Chickenpox</li> <li>• Tetanus booster</li> <li>• Hepatitis B</li> </ul>	<p>FAMIS-eligible members don't qualify for the free Vaccines for Children program, though immunizations covered by FAMIS don't have a copay.</p>
<b>Mental health and substance abuse services</b>  Some services require an authorization from us.	<p>We cover medically necessary:</p> <ul style="list-style-type: none"> <li>• Inpatient mental health and substance abuse services given by a network provider</li> <li>• Mental health and substance abuse services given during the day at a network hospital (Partial Day Treatment Services)</li> <li>• Outpatient individual, family and group behavioral health (mental health and substance abuse treatment) services given by a network provider</li> <li>• Inpatient psychiatric services in a psychiatric unit of a general acute care hospital for 365 days per confinement</li> </ul> <p>We also cover mental health and substance abuse medicine (specifically atypical antipsychotic medicine developed for treatment of schizophrenia).</p>	<p>Copay applies</p> <p>Services rendered in freestanding psychiatric hospitals to members up to age 19 aren't covered.</p> <p>DMAS makes some services available that aren't covered by us, including:</p> <ul style="list-style-type: none"> <li>• Intensive in-home services for children and adolescents</li> <li>• Substance abuse case management</li> <li>• Therapeutic day treatment for children and adolescents</li> <li>• Case management for children who need services for a serious emotional disturbance.</li> </ul>

Benefit	Coverage	Copays/Limits
<b>Obstetrical/ gynecological services</b>	<p>We cover:</p> <ul style="list-style-type: none"> <li>• Maternity care, including pregnancy-related care and postpartum services</li> <li>• Hospital services</li> <li>• Anesthesia</li> <li>• Lab services</li> </ul> <p>Except inpatient services and outpatient surgery received from an OB/GYN in the care of or related to the female reproductive system and breasts, services don't require authorization (an OK).</p>	<p>We don't cover diagnosis and treatment of infertility.</p> <p>Eligibility for newborn children is subject to the conditions set forth in Section VI: Terms and Conditions.</p>
<b>Organ and tissue transplants</b>  Transplants require an authorization from us.	<p>We cover the following organ and tissue transplants:</p> <ul style="list-style-type: none"> <li>• Heart transplants</li> <li>• Single lung transplants</li> <li>• Liver transplants</li> <li>• Pancreas transplants</li> <li>• Tissue transplants</li> <li>• Autologous, allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue for children with lymphoma and myeloma</li> <li>• Kidney transplants for patients with dialysis-dependent kidney failure</li> </ul>	<p>Copay applies</p> <p>We don't cover any transplant which is considered experimental or investigational. Scheduled transplantations authorized by DMAS will be honored.</p> <p>Services to identify donors who are immediate blood-related family members are limited to \$25,000 per member.</p>
<b>Outpatient rehabilitative services</b>  No authorization is required.	<p>We cover:</p> <ul style="list-style-type: none"> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• Speech therapy</li> <li>• Audiology</li> </ul>	<p>Copay applies. Requested services must meet these criteria:</p> <ul style="list-style-type: none"> <li>• They're medically necessary.</li> <li>• They're performed by a network provider.</li> </ul>

Benefit	Coverage	Copays/Limits
<p><b>Pharmacy and over-the-counter products</b></p> <p>Some prescription drugs require an authorization from us.</p> <p>Generic drugs will be dispensed unless your doctor obtains an authorization from us for a brand-name drug.</p>	<p>Services provided under the pharmacy benefit include, but aren't limited to:</p> <ul style="list-style-type: none"> <li>• All medically necessary FDA-approved prescription drugs</li> <li>• Some over-the-counter medications (when prescribed by the member's provider from our Preferred Drug List)</li> <li>• Diaphragms and birth control pills</li> <li>• Insulin, syringes and needles for the administration of insulin</li> <li>• Glucometer</li> </ul>	<p>Copay applies</p> <p>Extra costs may apply if your provider asks for authorization from us for a medically needed brand-name drug when a generic is available.</p> <p>We don't cover:</p> <ul style="list-style-type: none"> <li>• Drugs used primarily for cosmetic purposes</li> <li>• Drugs for the treatment of erectile dysfunction</li> <li>• More than one glucometer within a two-year period</li> <li>• Drugs and medications not approved by the FDA for the purpose prescribed</li> </ul>
<p><b>Preventive services</b></p>	<p>We cover:</p> <ul style="list-style-type: none"> <li>• Well-baby care from birth</li> <li>• Periodic health assessments</li> <li>• Immunizations</li> <li>• Vision and hearing screenings</li> <li>• Mammograms</li> <li>• Tobacco cessation and drug counseling for pregnant women</li> <li>• Annual gynecological exams including: <ul style="list-style-type: none"> <li>– Breast exam</li> <li>– Pelvic exam</li> <li>– Pap smear</li> </ul> </li> </ul>	<p>Services must be performed by your PCP.</p> <p>A woman may see any network OB/GYN provider for her annual well-woman exam.</p>

Benefit	Coverage	Copays/Limits
<b>Private duty nursing</b>  Private duty nursing requires an authorization from us.	We cover private duty nursing only if the following criteria are met: <ul style="list-style-type: none"> <li>• Services are provided by a registered nurse (RN) or a licensed practical nurse (LPN).</li> <li>• Services are medically necessary.</li> <li>• The nurse may not be a relative or member of the member's family.</li> <li>• The member's provider must explain why the services are required.</li> <li>• The member's provider must describe the medically skilled services provided.</li> <li>• The services are preauthorized.</li> </ul>	Copay applies
<b>Provider services</b>  Out-of-network services, including Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), require authorization from us.	We cover routine well-baby and well-child care, including: <ul style="list-style-type: none"> <li>• Routine office visits with health assessments and physical exams</li> <li>• Routine lab work</li> <li>• Age-appropriate immunizations</li> <li>• Medically necessary: <ul style="list-style-type: none"> <li>– Preventive services</li> <li>– Diagnostic services</li> <li>– Therapeutic services</li> <li>– Rehabilitative services</li> <li>– Palliative services</li> <li>– Renal dialysis services</li> </ul> </li> </ul>	
<b>Skilled nursing facility services</b> These services require an authorization from us.	We cover: <ul style="list-style-type: none"> <li>• Room and board in a semiprivate room</li> <li>• Rehabilitative services</li> <li>• Drugs</li> <li>• Medical supplies</li> </ul>	Copay applies You must use a network provider skilled nursing facility or a skilled nursing bed in a network provider hospital. Limited to 180 days per confinement. We don't cover custodial or residential care in a skilled nursing facility or any other facility.

<b>Benefit</b>	<b>Coverage</b>	<b>Copays/Limits</b>
<b>Telehealth</b>	We cover the real time or near-real time two-way transfer of medical data and information using an interactive audio/video connection for medical diagnosis and treatment.	
<b>Vision services</b>	We cover: <ul style="list-style-type: none"> <li>• A routine eye examination once every 24 months</li> <li>• A pair of eyeglasses or contact lenses when medically necessary</li> </ul>	Copay applies  Services must be received from your network provider.
<b>Well-baby and well-child visits</b>	We cover well-baby and well-child visits provided at home, a doctor's office and other outpatient facilities. We follow the American Academy of Pediatrics recommended periodicity schedule (see the schedule on the next page).	

HealthKeepers, Inc. will pay only for covered services that are medically necessary. We'll also provide medically necessary follow-up services after 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 to get an authorization for medical care, call Member Services at 1-800-901-0020 (TTY 711).

No copays will be charged to or for the following:

- Native Americans or Alaska Natives
- Lab or X-ray services performed as part of a physician office visit
- Supplies used with covered durable medical equipment



Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3<sup>rd</sup> ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE <sup>1</sup>	Prenatal <sup>2</sup>	Newborn <sup>3</sup>	3-5 d <sup>4</sup>	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index <sup>5</sup>												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure <sup>6</sup>		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision		★	★	★	★	★	★	★	★	★	★	★	★	● <sup>7</sup>	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		● <sup>8</sup>	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental Screening <sup>9</sup>								●			●		●																			
Autism Screening <sup>10</sup>											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment <sup>11</sup>																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening <sup>12</sup>																						●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION <sup>13</sup>		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES <sup>14</sup>																																
Newborn Blood Screening <sup>15</sup>		←→	●	→																												
Critical Congenital Heart Defect Screening <sup>16</sup>		●																														
Immunization <sup>17</sup>		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin <sup>18</sup>						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening <sup>19</sup>							★	★	● or ★ <sup>20</sup>		★	● or ★ <sup>20</sup>		★	★	★	★															
Tuberculosis Testing <sup>21</sup>				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening <sup>22</sup>												★			★		★		★	←→	●	→	★	★	★	★	★	★	★	←→	●	→
STI/HIV Screening <sup>23</sup>																					★	★	★	★	★	★	←→	●	→	★	★	★
Cervical Dysplasia Screening <sup>24</sup>																																●
ORAL HEALTH <sup>25</sup>							★	★	● or ★		● or ★	● or ★	● or ★	●			●															
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement “The Prenatal Visit” (<http://pediatrics.aappublications.org/content/124/4/1227.full>).

3. Every infant should have a newborn evaluation within 3 to 5 days of birth, and breastfeeding should be encouraged (and instruction and support should be offered).

4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement “Breastfeeding and the Use of Human Milk” (<http://pediatrics.aappublications.org/content/129/3/e827.full>). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement “Hospital Stay for Healthy Term Newborns” (<http://pediatrics.aappublications.org/content/125/2/405.full>).

5. Screen, per the 2007 AAP statement “Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report” ([http://pediatrics.aappublications.org/content/120/Supplement\\_4/S164.full](http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full)).

6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

7. If the patient is uncooperative, rescreen within 6 months, per the 2007 AAP statement “Eye Examination in Infants, Children, and Young Adults by Pediatricians” (<http://pediatrics.aappublications.org/content/111/4/902.abstract>).

8. All newborns should be screened, per the AAP statement “Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs” (<http://pediatrics.aappublications.org/content/120/4/898.full>).

9. See 2006 AAP statement “Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening” (<http://pediatrics.aappublications.org/content/118/1/405.full>).

10. Screening should occur per the 2007 AAP statement “Identification and Evaluation of Children with Autism Spectrum Disorders” (<http://pediatrics.aappublications.org/content/120/5/1183.full>).

11. A recommended screening tool is available at <http://www.ceasar-boston.org/CRAFTT/index.php>.

12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at [http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH\\_ScreeningChart.pdf](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf).

13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement “Use of Chaperones During the Physical Examination of the Pediatric Patient” (<http://pediatrics.aappublications.org/content/127/5/991.full>).

14. These may be modified, depending on entry point into schedule and individual need.

15. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf>), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.

16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease” (<http://pediatrics.aappublications.org/content/129/1/190.full>).

17. Schedules, per the AAP Committee on Infectious Diseases, are available at: <http://aapredbook.aappublications.org/site/resources/izschedules.xhtml>. Every visit should be an opportunity to update and complete a child’s immunizations.

18. See 2010 AAP statement “Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)” (<http://pediatrics.aappublications.org/content/126/5/1040.full>).

19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention” ([http://www.cdc.gov/nceh/lead/ACCLPP/Final\\_Document\\_030712.pdf](http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)).

20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.

21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.

22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, “Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents” ([http://www.nhlbi.nih.gov/guidelines/cvd\\_ped/index.htm](http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm)).

23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (<http://pediatrics.aappublications.org/content/128/5/1023.full>) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

24. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement “Gynecologic Examination for Adolescents in the Pediatric Office Setting” (<http://pediatrics.aappublications.org/content/126/3/583.full>).

25. Refer to dental home, if available. If not available, perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>) if primary water source is deficient in fluoride, consider oral fluoride supplementation. For those at high risk, consider application of fluoride varnish for caries prevention. See 2008 AAP statement “Preventive Oral Health Intervention for Pediatricians” (<http://pediatrics.aappublications.org/content/122/5/1387.full>), and 2009 AAP statement “Oral Health Risk Assessment Timing and Establishment of the Dental Home” (<http://pediatrics.aappublications.org/content/111/5/1113.full>).

## **Section II: Using your Anthem HealthKeepers Plus benefits**

### **Member Services**

**Call Member Services if you have questions or want to learn more about your child's health care benefits. You can call Member Services at 1-800-901-0020 (TTY 711). They're available Monday through Friday from 8 a.m. to 6 p.m. Eastern time.**

Our Member Services team can help you with your questions about:

- The information in this member handbook.
- Member ID cards.
- Your child's primary care provider (PCP) and other doctors or specialists your child sees, including names, specialties, addresses, phone numbers and professional qualifications.
- PCP visits for your child.
- How to find information about types of care we don't cover.
- Health care benefits for your child.
- 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 move, because you need to let the state know your child's new mailing address (call the local Department of Social Services (DSS) if your child's case is assigned through a worker).
- 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 child's 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.
- We will 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 doctor)

Your child's primary care provider (PCP) is the main doctor who will take care of your child. A PCP can be a family practice, general practice, internal medicine or pediatric doctor. A Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that performs primary care functions may also serve as a PCP. If your child is identified as American Indian, an Indian Health Provider can be his or her PCP. Your child's PCP will coordinate all his or her medical needs.

If your child has special health care needs, you may ask that your child's PCP is a specialist. We will review the request and work with the chosen specialist to make sure your child gets routine screening and preventive services like immunizations and dental services.

A woman can choose an OB/GYN as her PCP.

To choose a PCP, call Member Services. A representative will help you find a PCP for your child. If you don't call, a PCP will be assigned to your child. If you would like information about the professional qualifications of a provider (including provider specialty, location or board certification status), please call Member Services.

If you're not happy with the PCP assigned to your child, you may request a new PCP at any time. Just call Member Services to ask for a PCP change. You will receive a new ID card in the mail with your child's new PCP listed.

If your child's provider leaves our network, we'll let you know and send you a new ID card for your child. It will have the name of your child's new PCP. If you want to find a different PCP for your child, call Member Services. We'll help you and mail a new ID card with the PCP you choose.

## Appointments

Each time your child needs to go to the PCP, you'll need to make an appointment. Please keep your child's scheduled appointments. If you can't keep the appointment, call your child's PCP's office to cancel at least 24 hours before the 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 14 days.
- Urgent care (as defined in **Section VIII** of this EOC) appointments within 24 hours.
- Emergency care (as defined in **Section VIII** of this EOC) 24 hours a day, seven days a week at your local hospital or a hospital close to you if you're out of the area.
- Maternity care appointments must be scheduled:
  - First trimester: within 14 calendar days of your request
  - Second trimester: within seven calendar days of your request
  - Third trimester: within five business days of your request

- High-risk pregnancies: within three business days of your request
- If an emergency exists: Immediately

## Types of care

Preventive care includes yearly wellness exams, tests and screenings 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 child's health is important — and there are lots of things you can do to stay focused on it. Follow these tips to make sure your child stays healthy:

- Go to all your child's regular checkups.
- Be sure your child is taking medicines as instructed.
- Take small steps to help your child be more active. Your child's doctor can help you come up with an exercise plan to improve his or her overall health.
- Make sure you and your child have 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 child's PCP seven days a week, 24 hours a day. For 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 child's 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.

## Your identification (ID) card

You must present your child's Anthem HealthKeepers Plus member ID card whenever your child gets covered services. The ID card must be carried at all times to ensure prompt receipt of covered services.

Your child will receive only one ID card. If the ID card is lost or stolen, please call Member Services at 1-800-901-0020 immediately. We'll send a new ID card for your child.

You'll also get a plastic identification card from the Department of Medical Assistance Services (DMAS). This is your child's permanent identification card. **Do not throw this card away.** You should keep this card even if your child loses eligibility.

You should present BOTH the Anthem HealthKeepers Plus ID card and the plastic ID card from DMAS whenever your child gets covered services.

ID cards remain the property of HealthKeepers, Inc. and must be returned upon our request.

**Anthem HealthKeepers Plus**  
Offered by HealthKeepers, Inc.

Identification Number: 12345678901234567890

Group No. 12345678901234567890  
BC/BS Plan 923  
Rx Bin Num. 610575

PCP/Specialist \$0/\$0  
Outpatient \$0  
Inpatient \$0  
Emergency \$0  
Rx \$0/\$0

**Anthem HealthKeepers Plus**  
Offered by HealthKeepers, Inc.

www.anthem.com/vamedicaid

Member Services: 1-800-901-0020  
Provider Services: 1-800-901-0020  
TDD (Hearing Impaired): 1-800-855-2880  
24/7 Nurse Line: 1-800-901-0020  
Mental Health Services: 1-800-901-0020  
Rx Services: 1-800-824-0898  
Authorization: 1-800-901-0020  
Smiles for Children: 1-888-912-3456

\*Contracts directly with group

HealthKeepers, Inc.  
P.O. Box 27401  
Mall Drop VA2002-N500  
Richmond, VA 23279

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.

Claims Filing Address:  
Post Office Box 27401  
Richmond, Virginia 23279  
VA22 11/13

Depending on the type of coverage your child has, there may be a different copay amount than that shown in the above sample ID card. Your child's ID card shows your child's:

- ID number
- Name
- PCP
- Copays

It also has the HealthKeepers, Inc. address and a list of phone numbers to call for Member Services, the 24/7 NurseLine, pharmacy services, dental services and more. If you have questions about the ID card, please call Member Services.

## Prior authorization

Your child's PCP or specialist will need to get a prior authorization (an approval for services) from us for some services to make sure they're covered. This means that HealthKeepers, Inc. and your child's PCP or specialist need to agree the services are medically necessary.

"Medically necessary" means appropriate and needed 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.

Once we get the PCP's request for a prior authorization for a service for your child, we'll decide within:

- 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 child's provider asks for an extension
- We justify the need for more information and the extension is in your child's best interest

See Section III: Benefits to check service limits. Your child's PCP can tell you more about this.

If you don't agree with the decision to extend the time frame, you may file a grievance for your child. See Section VI: Terms and Conditions for more information about the grievance and appeals process and the DMAS appeals process.

We may or may not authorize payment for a service you or your doctor asks for. If we don't, we'll send you and your child's doctor a letter that tells you why we won't cover the service. The letter will also tell you how you can 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 child's doctor may call our Member Services department toll free at 1-800-901-0020 (TTY 711). Or you may write to us at:

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

Some services don't need an authorization from us or your child's PCP. Services your child can get without a referral from your PCP include:

- Emergency services
- Family planning services
- Immunizations
- Vision services

## **Making coverage decisions**

We care about your child's health. Your child's doctors will work with you to decide what's best for your child's health. Doctors or primary care providers (PCPs) and other health care workers must decide about your child's health based on whether or not the care is right for the health issue. Your child's 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 your child has.

We don't pay doctors or other health care workers who make utilization management decisions to:

- Deny your child care.
- Say your child doesn't have coverage.
- Approve less care than your child needs.

To learn more about how medical coverage decisions are made, call our toll-free Member Services or TTY number (for those with hearing or speech loss).

## 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. We decide 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
- Plan 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're not 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.

Read the *How we pay providers* section for more information on how we work with providers in our network.

We make sure that UM staff takes calls about utilization management issues at least eight hours a day on normal business days. You can speak with someone in the UM department by calling Member Services and asking to be transferred to the Utilization Management department. Translation services are available to our non-English-speaking members when you call Member Services at 1-800-901-0020. For those with hearing or speech loss, call TTY 711.

## Specialist care

Your child's PCP may send your child to a network specialist for certain types of care or treatment. Please note:

- Your child's PCP will work with you to choose a specialist to provide needed care.
- Your child's PCP's office can help you set up a time for your child to see the specialist.
- You need to tell your child's PCP and the specialist as much as you can about your child's health. That way, all of you can decide what is best.
- A specialist may treat your child for as long as he or she thinks it is needed, and certain services may need authorization from HealthKeepers, Inc.

If you would like to learn more about specialty care, talk to your child's 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 child's illness or the care the PCP says your child needs. You may want to get a second opinion from another doctor if:

- You have questions about a recommended treatment or a diagnosis.
- Your child's PCP is unable to diagnose your child's condition or the diagnosis is in doubt due to test

results that conflict with each other.

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

Your child's PCP will help you ask for a second opinion from a qualified health care provider in our network. If there is not a qualified health care provider in the network to give you a second opinion, your child's PCP can call HealthKeepers, Inc. 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 child's provider may:

- Be paid each time he or she treats your child (Fee-For-Service)
- Be paid a set fee each month for your child whether or not he or she actually gets services (capitation)
- Participate in the Physician Incentive Plan

These kinds of pay may include ways to earn more money and:

- Is based on different things like how happy a member is with the care or quality of care
- Is also based on how easy it is to find and get care

We don't:

- Offer providers rewards, money or other incentives to deny care or services to our members
- 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 to learn more about how our network providers 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



## Section III: Benefits

All benefits are subject to the terms, conditions, definitions, limitations and exclusions described elsewhere in this evidence of coverage (EOC). Only medically necessary covered services will be provided by HealthKeepers, Inc. Also, we will pay only the charges incurred when your child is actually eligible for the covered services received.

You **MAY BE responsible for payment** to the provider for noncovered services in any one of the following situations:

- Your child was not enrolled in the FAMIS program at the time the services were rendered.
- Services your child received were nonemergency and the provider was nonparticipating with us and the Virginia FAMIS program.
- The provider was participating with us or the Virginia FAMIS program and notified you prior to the services being provided that the nonemergency services would not be covered. You signed a document listing the specific services and why they aren't covered along with the estimate of the cost and that you agreed to pay for those services.

You **WILL NOT be responsible for payment** to the provider for noncovered services in any one of the following situations:

- Your child's provider who participates with us or with Virginia FAMIS did NOT notify you prior to the nonemergency services being provided that the services would not be covered.
- Your child's provider did notify you prior to the nonemergency services being provided that the services would not be covered, but you did NOT sign a document listing the specific services and why they're not covered along with the estimate of the cost and that you agreed to pay for those services.
- You CANNOT be held liable for payment for emergency services regardless of whether your child received services from a participating or nonparticipating provider.

If you get a bill for services and you shouldn't be held responsible based on these guidelines, please call Member Services at 1-800-901-0020 (TTY 711).

Before receiving services, it is a good idea to always ask your child's provider if they participate with us and the FAMIS program, and if the services are FAMIS-covered services so that you can avoid being billed for services.

If your child is covered by more than one health benefit plan, you should file all your claims with each plan.

### A. Abortions

Elective abortions, including any related services performed at the immediate time of the abortion, aren't covered under this plan, but may be covered by the Department of Medical Assistance Services (DMAS) as a carved-out service where the life of the mother is endangered. We'll provide coverage for any

medically necessary follow-up care that may be needed in relation to the abortion services.

## **B. Ambulance services**

Ambulance services will be provided if the services are:

- Medically necessary.
- Prearranged by your primary care provider (PCP).
- Authorized by us.

**In an emergency, you don't need an authorization from us.**

Professional ambulance services are covered when used locally or from a covered facility or provider office when medically necessary. Air ambulance services are also covered when preauthorized or in cases of an emergency. In emergency cases with life-threatening conditions, only such air ambulance services required to take your child to the closest hospital with the capability of treating your condition will be covered.

Transportation services aren't provided for routine access to and from providers of covered, routine medical services.

## **C. Chiropractic services**

Medically necessary chiropractic services are covered up to \$500 per calendar year for musculoskeletal conditions.

## **D. Dental and oral surgery services**

Dental services are provided through Smiles for Children by DentaQuest, a Dental Benefit Administrator contracted with the DMAS. The toll-free number for Smiles for Children is 1-888-912-3456.

We cover medically necessary services resulting from a dental accident or for medically necessary procedures to the mouth where the main purpose is not to treat or help the teeth.

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 members enrolled in HealthKeepers, Inc. from 0-3 years of age. This service can be rendered every six months up to a maximum of six applications. Providers may include physicians (pediatric/family practice), nurse practitioners (pediatric/family practice), local health departments, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) contracted with HealthKeepers, Inc.

## **E. Diabetic services, equipment and supplies**

If your child has diabetes, medical supplies, equipment and education for diabetes care is covered. This

includes coverage for the following:

- All FDA-approved equipment
- Insulin pumps
- Home blood glucose monitors, lancets, blood glucose test strips, syringes and needles when received through a retail pharmacy
- 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

For equipment and supplies, you will need to pay any copays that apply. The copay listed on your child's copay schedule will apply for these services given in person by a certified, registered or licensed health care professional (such as PCP or other specialty providers):

- Outpatient self-management training
- Education
- Medical nutrition therapy

## **F. Disease management (care management program)**

We have a Disease Management Centralized Care Unit (DMCCU) program. If your child is enrolled in a care management program, a team of licensed nurses and social workers, called DMCCU case managers, will educate you and your child about the condition and help you learn how to manage your child's care. Your child's primary care provider (PCP) and our team of DMCCU case managers will assist you with your child's health care needs.

DMCCU case managers provide support over the phone for members with:

- |                                |   |
|--------------------------------|---|
| • Diabetes                     | • Heart conditions                      |
| • HIV/AIDS                     | – Coronary artery disease               |
| • Behavioral health conditions | – Congestive heart failure              |
| – Bipolar disorder             | – Hypertension                          |
| – Major depressive disorder    | • Lung conditions                       |
| – Substance use disorder       | – Asthma                                |
| – Schizophrenia                | – Chronic obstructive pulmonary disease |

We offer weight management services. DMCCU case managers work with you and your child to create health goals and help develop a plan to reach them.

As a member in the program, your child will benefit from having a case manager who:

- Listens and takes the time to understand your child's needs
- Helps you and your child make a care plan to reach health care goals
- Gives you and your child the tools, support and community resources that can help improve your child's quality of life
- Provides health information to help your child make better choices
- Helps coordinate care with your child's providers

As a member, your child has certain rights and responsibilities when getting health care services. You

also have a responsibility to take an active role in your child's care. As your child's health care partner, we're committed to making sure your child's rights are respected while providing needed health care benefits. That also means giving you and your child access to our network providers and the information needed to make the best decisions for your child's health and welfare.

**These are your child's rights and responsibilities when participating in the DMCCU program.**

**You and your child have the right to:**

- Get information about us, including programs and services provided on our behalf, our staff and staff qualifications, and any contractual relationships
- Opt-out of (cancel) DMCCU services
- Ask for and get information about managing DMCCU services as well as how to request a change
- Be supported by us to make health care decisions interactively with your child's PCP
- Be informed of all DMCCU-related treatment options included or mentioned in clinical guidelines (even if a treatment is not covered), and to discuss options with your child's PCP
- Have personal identifiable data and medical information kept confidential, know what entities have access to this information, and know procedures used by the organization to ensure security, privacy, and confidentiality
- Be treated courteously and respectfully by our staff
- Communicate complaints to the organization and receive instruction on how to use the complaint process, including our standards of timeliness for responding to and resolving issues of quality and complaints
- Receive information that is clear and understandable

**You and your child have the responsibility to:**

- Follow care advice offered by us and your child's PCP
- Provide us with information necessary to carry out services
- Notify us and your child's PCP if you decide to disenroll your child from the DMCCU program

If your child has one of these conditions or you'd 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. Eastern time. If you're deaf or hard of hearing, please call TTY 711. Ask to speak with a DMCCU case manager. You can also visit our website at [www.anthem.com/vamedicaid](http://www.anthem.com/vamedicaid) to learn more.

## **G. Durable medical equipment and supplies**

Rental of medically necessary durable medical equipment is covered if authorized by HealthKeepers, Inc. (or purchase if it is less than rental cost as determined by us).

The prescribing physician must obtain authorization for some services from us. Durable medical equipment (DME) must be obtained from a network provider for this health service. Maintenance and needed repairs of DME will be covered. Medically necessary supplies are also covered.

Damaged equipment due to neglect or abuse won't be repaired or replaced. We don't cover supplies and devices that are for comfort or convenience only, including but not limited to:

- Air conditioning
- Air filters
- Air purifiers
- Room humidifiers
- Spas
- Furniture or appliances not defined as medical equipment
- Home or vehicle modifications

We cover medically necessary prosthetic services and devices that include artificial arms, legs and their necessary supportive attachments. Medically necessary orthotic services and devices are covered for eligible members when part of an approved intensive rehabilitation program. Orthotic and prosthetic equipment must be obtained from a network provider for this health service.

**Medical nutritional supplements and supplies:** Coverage of nutritional supplements for the general network population, which doesn'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. Sole source is defined as the inability of the individual to handle (swallow or absorb) any other form of oral nutrition. The exception is for members under age 21 where the supplement must be the primary source of nutrition. Primary source means the nutritional supplements are medically indicated for the treatment of the member's condition.

Coverage is available for nutritional supplements regardless of whether the supplement is administered orally or through a nasogastric or gastrostomy tube. We cover supplies and equipment necessary to administer enteral nutrition.

The enteral nutrition/medical foods benefit for members under age 21 is not covered by HealthKeepers, Inc. Coverage of enteral nutrition and total parenteral nutrition doesn't include the provision of routine infant formula. Specialized infant formula for children under age 5 is reimbursed by DMAS.

## **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. These services include:

- 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're 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 includes services that can enhance functional ability without resulting in a cure.

If your child needs special services, your child's 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. Early Intervention services are covered by DMAS within its coverage criteria and guidelines.

## **I. Emergency care services**

If your child has an emergency, you should **call 911** or go to the nearest hospital emergency room right away. Your child should be able to see a provider right away for emergency care.

A true emergency means the sudden start of a medical condition with symptoms so severe (including acute pain) that, without immediate medical care, could be expected by a prudent layperson who has 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

We'll cover payment for emergency services that are medically necessary until:

- The clinical emergency is stabilized
- Your child can be safely discharged or transferred

Coverage includes treatment that may be needed to assure within reasonable medical probability that no material deterioration of your child's condition is likely to result from or occur during discharge or transfer to another facility. All our network hospitals provide emergency and post-stabilization care.

Prior authorization is not needed for urgent, emergency or post-stabilization services (services you get 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.

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

### **1. Within the service area**

- If the emergency is such that immediate action is demanded, your child 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.
- You should contact your child's PCP within 48 hours after going to the emergency room to make an appointment for follow-up care.

### **2. Outside the service area**

- Emergency services outside the service area are given to help your child if he or she sustains an injury or becomes ill while temporarily away from the service area. This means benefits for these services are limited to care that is required immediately and unexpectedly. Elective care and care required as a result of circumstances that could reasonably have been foreseen prior to departure from the service area are not covered.
- If an emergency situation occurs when your child is temporarily outside the service area, your child should be taken to the nearest appropriate medical facility or **call 911**.
- Benefits for follow-up care must be set up in advance by your child's PCP and must follow the rules in this EOC. After your child's emergency or urgent care situation is stabilized, if additional services are not pre-approved, follow-up care must be provided by a network provider. But if you can't reach us for authorization or we don't respond to a request for post-stabilization care services within one hour after being requested, we'll still cover those services.

### **3. Notification**

- In the event of an emergency that needs hospitalization or if outpatient emergency services are needed, you or your child's representative must tell your child's PCP within 48 hours after care began or on the next business day. This applies to services your child receives within or outside the service area.

## **J. Urgent care services**

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, your child can go to an in-network urgent care center for treatment if you believe care is needed right away. If you're not sure, you can also call your child's PCP to find out if your child should come in for an urgent visit or go to another office to get care right away.

In some cases, your child's PCP may tell you to go to the emergency room at a hospital for care. Your child should be able to see his or her PCP within 24 hours for an urgent care appointment.

**1. Within the service area**

Your child may go to an in-network urgent care center for treatment if you believe your child needs care right away.

**2. Outside the service area**

Urgent care and services outside the service area are provided to help treat your child if he or she has an injury or becomes ill while temporarily away from the service area. This means benefits for these services are limited to care that is required immediately and unexpectedly. Elective care and care required as a result of circumstances that could reasonably have been foreseen prior to departure from the service area are not covered.

**3. Notification**

If you seek treatment for your child at an in-network urgent care center, please follow up with your child's PCP within 48 hours or on the next business day to get an appointment for any needed follow-up care.

For medical advice 24 hours a day members can call our 24/7 NurseLine at 1-800-901-0020. This service is offered at no-cost and can help answer your medical questions promptly, by a registered nurse.

## **K. Health education**

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

## **L. Home health care**

**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 child's PCP and us:

- Nursing care
- Personal care
- Rehabilitative services
- Home health aide services
- Physical, occupational, speech and hearing therapy
- Inhalation therapy



- Medical supplies
- Other medically necessary services and supplies
- House calls determined to be medically necessary by a network physician

These home health services are allowed up to 90 visits per calendar year.

The following home health services are not covered:

- Medical social services
- Services that would not be paid for if provided to an inpatient of a hospital
- Community food service delivery arrangements
- Domestic or housekeeping services that are unrelated to patient care
- Custodial care that primarily requires protective services rather than definitive medical and skilled nursing care services
- Services related to cosmetic surgery

## **M. Hospice services**

Hospice care, as we authorize, will be covered for members diagnosed with a terminal illness with a life expectancy of six months or less. Hospice care is available at the same time as care being received for treatment of the condition.

Covered hospice services include the following:

- Skilled nursing care
- Home infusion therapy drugs for palliative care and pain management
- Services of a medical social worker
- Services of a home health aide or homemaker
- Physical, speech or occupational therapy
- Durable medical equipment
- Routine medical supplies
- Counseling, including nutritional counseling, with respect to the member's care and death
- Bereavement counseling for immediate family members both before and after the member's death

Short-term inpatient care is also covered and includes both respite care and procedures needed for pain control and acute chronic symptom management. Respite care means nonacute inpatient care for the member in order to provide the member's primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, nonroutine and occasional basis and may not be provided for more than five days every 90 days.

## **N. Immunizations**

Immunizations that are rendered in accordance with the most current Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics Advisory Committee recommendations for children under the age of 6 are covered.

The following additional immunizations are covered for members age 6 and over:

- Influenza
- Pneumonia
- Chickenpox
- Tetanus booster
- HPV
- Hepatitis B

## **O. Individual case management**

Case management is a voluntary program designed to help you coordinate health care benefits for your child's medical conditions or chronic care needs with a goal to help improve health. Case management services are provided to your child at no cost to you.

Along with the covered services listed in this EOC, we may choose to offer benefits for services through an approved alternative treatment plan for your child.

We'll provide such alternative benefits:

- At our sole discretion.
- Only when and for so long as we decide the alternative services are medically needed and cost-effective.
- When the total benefits paid for such services don't exceed the maximum benefits the member would otherwise get under this EOC in the absence of alternative benefits.

If we decide to provide alternative benefits for your child in one instance:

- It doesn't mean we'll provide the same or similar benefits for in any other instance
- It shouldn't be taken as a waiver of our right to administer this EOC in strict agreement with its express terms

## **P. Hospital services**

Your child's coverage provides benefits for the hospital services when your child is treated on an **inpatient basis** because of illness, injury or pregnancy or on an **outpatient basis**.

Your child must go to an in-network hospital unless it is an emergency. Special rules apply if it is an emergency. (Read **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 child's PCP or admitting physician and approved in advance by HealthKeepers, Inc.** We also reserve the right to decide whether the continuation of any hospital admission is medically necessary (needed for health reasons). (Read **Paragraph R.** in this section to learn more about OB/GYN services.)

Hospital admissions for:

- Covered breast cancer surgery (radical or modified radical mastectomy) shall be approved for a period of no less than 48 hours
- A covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours
- A covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours
- A covered vaginal hysterectomy shall be approved for a period of no less than 48 hours

Your child may stay in the hospital for at least 48 hours following a vaginal delivery or for at least 96 hours following a cesarean delivery.

**2. Benefits:** Hospital services may include:

- A semiprivate room and board (or private room when medically needed and ordered by a network doctor)
- General nursing care and the items below when prescribed by network doctors:
  - 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, occupational and speech therapy, radiation therapy, chemotherapy, and inhalation therapy
  - Administration of whole blood and blood plasma and other medically necessary services
  - As an inpatient, all covered services of our network doctors and network provider hospital personnel are provided while your child is admitted to a network provider hospital as a registered bed patient.
  - Inpatient hospital stays are covered in general acute care and rehabilitation hospitals for all members up to 365 days.
  - As an outpatient, all covered diagnostic, treatment and surgical services of our network providers are provided, including clinical services that are defined as:
    - Preventive, diagnostic or therapeutic
    - Rehabilitative or palliative services that are provided to outpatients and are provided by a licensed facility or formally approved as a hospital facility that is not part of a hospital but is organized and operated to provide medical care to outpatients are covered
    - Observation bed services and facility charges are to be covered when reasonable and needed to evaluate a medical condition to determine appropriate level of treatment or nonroutine observation for underlying medical complications
    - Outpatient services, including emergency, surgical, diagnostic and professional provider services (facility charges also covered)

## **Q. Behavioral health services**

Inpatient services require an approval from HealthKeepers, Inc. Inpatient and outpatient mental health and substance abuse services include:

- Diagnostic services
- Detoxification
- Individual psychotherapy and group therapy
- Counseling with family members to assist in the member's treatment
- Partial day treatment services
- Psychological testing
- Electroconvulsive therapy

### **Addiction and Recovery Treatment Services (ARTS) are part of your benefits with us**

If your child is struggling with using substances, including drugs and alcohol, there are a variety of services to help you as part of your child's Anthem HealthKeepers Plus benefits. We cover services like:

- Inpatient treatment – when medically necessary and when given by a doctor in your plan. We also cover 365 days per confinement in a psychiatric unit for medically necessary services. Members 19 and over who get care in a free-standing psychiatric hospital aren't covered.
- Outpatient treatment – when medically necessary and given by a doctor in your plan. You need to get prior approval for psychological testing and neuropsychological testing.
- Community-based treatment
- Medication-assisted treatment
- Peer support services
- Case management
- Smoking-cessation counseling

The Department of Medical Assistance Services (DMAS) makes some services available that aren't covered by HealthKeepers, Inc. These include:

- Intensive in-home services and therapeutic day treatment for children and adolescents
- Case management for children who need services for a serious emotional disturbance

## **R. 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

**There are no copays for pregnancy-related care.**

- 2. New Baby, New Life<sup>SM</sup> (prenatal, postpartum and newborn care for members of childbearing age):** Give your baby the best start in life by seeking prenatal care early in your pregnancy. When you enroll in the program, you'll get health information and rewards for getting prenatal and postpartum care for your child.

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.

With the New Baby, New Life<sup>SM</sup> program, your child will get an education packet that includes:

- Prenatal flier with information on the program
- Planning a Healthy Pregnancy, a book that helps your child take care of herself during pregnancy
- Labor, Delivery and Beyond, a booklet about the third trimester and what to expect during labor
- Having a Healthy Baby brochure with information and resources to help keep your child and her baby healthy
- Information about our Warm Health program\* where you can get weekly messages via phone, text or smartphone app
- Reward forms to send us after your child completes key prenatal appointments during the first trimester or within 42 days of enrollment

If you think your child is pregnant:

- Call the doctor right away. Your child does not need a referral form from her PCP to see an OB/GYN doctor.
- Call Member Services if you need help finding an OB/GYN doctor.

If you'd like to speak with a nurse or have questions, call Member Services and they'll connect you with the case management team.

After your child has the baby, we'll send a postpartum education packet with:

- Information on taking care of your child and a new baby
- Postpartum depression booklet
- Reward forms to send us after your child completes key postnatal appointments

It's important for your child to see her PCP or OB/GYN when her baby is between three and eight weeks old for a postpartum checkup. She may feel well and think she is healing, but it takes the body at least six weeks to mend after delivery.

If your child has to have surgery to have the baby by cesarean section, her PCP or OB/GYN may ask her to come back for a two-week post-surgery checkup; she will still need to go back and see them for a postpartum checkup.

**3. Family planning:** We offer private family planning services and benefits to fit your child's life and goals for the future. These services include:

- Prescription contraceptive devices and birth control medications.
- Norplant implant system.
- The insertion, reinsertion and removal of implantable contraceptive capsules.
- Long-acting reversible contraceptives (LARCs). LARCs are a birth control option your child doesn't need to keep track of taking every day. You can set up a visit with your child's doctor to talk about this option or schedule the procedure.

These services:

- May also include FDA-approved drugs and devices to delay or prevent pregnancy.
- Don't include services to treat infertility or to promote fertility.

Family planning services can be provided by network provider or non-network provider.

**4. Services from OB/GYN:** All female members may receive services in the care of or related to the female reproductive system and breasts from an obstetrician/gynecologist or nurse-midwife who is a network provider without authorization from the PCP. The obstetrician/gynecologist or nurse-midwife must obtain authorization us for inpatient hospital services and outpatient surgery. Any services related to infertility diagnosis and treatment won't be covered. Although not required to do so, members can ask in advance if such a service will be covered by calling their PCP or us.

**5. Tobacco-cessation services:** Pregnant members can get tobacco-cessation services, counseling and drugs. There is no copay for these services.

## **S. Organ and tissue transplants**

The following organ and tissue transplants are covered when medically necessary and according to industry treatment standards:

- Heart transplants
- Single-lung transplants
- Liver transplants
- Pancreas transplants
- Tissue transplants
- Autologous, allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue for

children with lymphoma and myeloma

- Kidney transplants for patients with dialysis-dependent kidney failure

We'll also cover procurement or donor-related services. Scheduled transplants authorized 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.

We won't cover donor searches of potential donors who are not immediate blood-related family members (parent, child or sibling). Services to identify donors who are immediate blood-related family members are limited to \$25,000 per member.

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 can get 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

## **T. Outpatient prescription drug services**

### **What can my child's doctor prescribe?**

We use a chosen list of drugs called a Preferred Drug List (PDL) from which your child's primary care provider (PCP) can order drugs. 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 child's PCP thinks your child needs to take a drug that is not on this list, the PCP will need to call us to ask for an approval before your child can get the drug.

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 our Member Services department at 1-800-901-0020 (TTY 711). You and your child's PCP can work together to decide which drug is best for your child.

Even though a drug is on the list, your child's doctor may not order it for him or her. Some drugs need an approval from us ahead of time, or they may have limits based on medical need.

When you get your child's prescription filled, you won't get more than a 31-day supply. Your child's PCP may write that your child can get refills. The pharmacy staff can call your child's PCP to check if

you can get refills.

We'll review and decide on these requests within one working day. If we say no, we'll send you a letter that lets you know why and what other drugs or treatments your child can try.

You also may appeal if we deny the drug request. We can mail you a grievance or appeal form. To learn more, see Section VI: Terms and Conditions or call our toll-free Member Services department at 1-800-901-0020 (TTY 711).

A pharmacist or hospital emergency room may give your child a 72-hour emergency supply of a drug if they think it is needed. We'll pay for the emergency supply.

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

### **Where can I get my prescription filled?**

Our Provider Directory lists drugstores that are in the Anthem HealthKeepers Plus pharmacy network. You must receive your child's 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 the Anthem HealthKeepers Plus pharmacy network.

If your child has an emergency, and you can't go to a drugstore in the Anthem HealthKeepers Plus 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 your child 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 Anthem HealthKeepers Plus members. The network provides the special care needed when a specialty drug is dispensed. Your child must use an in-network specialty pharmacy authorized to dispense specialty medications to get your child's specialty drugs. As of November 2015, the specialty pharmacies in the Anthem HealthKeepers Plus network are Accredo and Acaria Health.

- Accredo 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 child's



doctor can work together to decide which drug is best for your child.

### **What is covered?**

We'll cover your child's drugs if they're:

- Ordered by your child's PCP or another network 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)

All FDA-approved medically necessary prescription drugs and over-the-counter medications (when prescribed by a network provider) 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 child's PCP asks for a brand-name drug for your child and there is a generic version available, the generic drug will be dispensed unless the PCP gets a prior authorization (an approval or OK) from HealthKeepers, Inc. for the brand-name drug.**

Your child's PCP must document the medical reason why a brand-name drug is required. For each prescription, we'll cover up to a 31-day supply. You may ask for a brand-name drug and pay the difference between the brand-name drug and the generic drug, in addition to the copay.

We'll cover:

- Injectable insulin and syringes and needles for the administration of the insulin
- Diabetic glucose test strips
- Lancets

No more than one glucometer will be approved within a two-year period.

We **do not 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 when prescribed by your child's PCP
2. Drugs and medications for conditions excluded in this EOC
3. Any other drug deemed not medically necessary by HealthKeepers, Inc.
4. Any drug not included in our Preferred Drug List, except as provided below (we may add or delete drugs from the PDL 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 won't 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 these standard references:
  - The American Hospital Formulary Service Drug Information
  - The National Comprehensive Cancer Network’s Drugs & Biologics Compendium
  - The Elsevier’s Gold Standard Clinical Pharmacology

Also, benefits won’t be denied for any drug prescribed to treat a covered condition as long as:

- 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.

### **Prior authorization for prescription drugs**

We have a process that allows your child to get a specific, medically necessary prescription drug if the covered drug is determined by us, after reasonable investigation and consultation with the prescribing doctor, to be an appropriate therapy for your child’s medical condition. We’ll act on such requests within two working days of getting all the information we need.

A prior authorization written request must include:

- 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, ID number, date of birth and applicable medical records

Your child’s PCP or treating doctor may fax the request to 1-800-359-5781 or call Provider Services at 1-800-901-0020 with any questions.

You and your child’s 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 child’s medicines and health services work together in a way that won’t harm his or her 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 medicines. This tool uses an electronic system to monitor the dispensing of Schedule II, III, and IV controlled substance prescription drugs.

If your child is chosen for PUMS, you may be locked into only using one pharmacy or only going to one provider to get certain types of medicines for your child. 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 your child should continue the program. If your child is placed in PUMS and you don't think he or she should be in the program, you can appeal. You must appeal to us within 30 days of when you get the letter saying that your child has been put into PUMS.

If your child is 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 your child 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.

## **U. Preventive services**

The following preventive health services are covered. Except as noted, all preventive health services must be performed by your child's primary care provider (PCP):

- Well-child care from birth as recommended by the American Academy of Pediatrics Advisory Committee
- Periodic health assessments for children, including screening X-rays, lab services and lead testing
- Immunizations, defined as diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, pneumococcal conjugate and other immunizations like annual flu vaccine, in accordance with recommendations of the American Academy of Pediatrics and as may be prescribed by the Virginia Commissioner of Health
- The HPV vaccine (covered for eligible males and females)
- Mammograms as ordered by a network doctor
- Vision screenings (assessment of visual acuity through use of the Snellen chart and the detection of color blindness)
- Hearing screenings (assessment of your child's monaural threshold and the ability to locate the source of pure tones through the use of a pure tone, air-only audiometer)
- An annual gynecological examination, which consists of a breast exam, pelvic and Pap smear (This can be done by an OB/GYN; no PCP referral is necessary.)

## **V. Private duty nursing**

Private duty nursing services are covered only if:

- The services are provided by a registered nurse (RN) or licensed practical nurse (LPN).
- The services are medically necessary.
- The nurse is not a relative or member of your family.
- Your child's provider must explain why the services are required.
- Your child's provider must describe the medically skilled service provided.
- We have authorized the services.

We don't cover private duty nursing in a school setting.

## **W. Rehabilitative services**

We cover short-term medically necessary rehabilitative services such as:

- Physical therapy
- Speech therapy
- Occupational therapy
- Inhalation therapy
- Intravenous therapy
- Other medically necessary rehabilitative services when they meet these criteria:
  - They're required for medical conditions to treat or promote recovery from an illness or injury
  - They're rendered on an inpatient or outpatient basis
  - They're performed by a network provider
  - Your child's PCP authorizes the service with us

Your child's PCP and HealthKeepers, Inc. must authorize rehabilitation services for members under 3 years of age.

## **X. Services in skilled nursing facilities (SNF)**

The following items and services will be provided to you as an inpatient in a skilled nursing bed of a network provider hospital when authorized by us:

- Room and board in semiprivate accommodations
- Rehabilitative services
- Drugs, biologicals and supplies
- Other medically necessary services and supplies
- Coverage for up to 180 days per confinement

Custodial or residential care in a SNF or any other facility is not covered.

## **Y. Telehealth services**

You have coverage for 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.

## **Z. Value-added Benefits**

Here are some of the services, discounts and extra benefits you can access for your child:

- Our New Baby, New Life<sup>SM</sup> program to help you have a healthy pregnancy with services like toll-free access to a care manager to answer your questions and tools to help you and your child's doctor see possible risks

- No-cost retail coupons with special discounts to local retailers
- No-cost sports physicals (age 19 and younger)

## **AA. Vision services**

These services are covered when you use an approved eye care provider. Contact our Member Services line at 1-800-901-0020 for a list of providers near you and more details about this service. It includes:

- A routine eye examination once every 24 months
- Eyeglasses (one pair of frames and one pair of lenses) or contact lenses prescribed as medically necessary

## **BB. Benefits you can get from the state**

The state Medicaid program offered through DMAS covers some benefits for your child 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 and mental health services, including:
  - Intensive in-home services
  - Therapeutic day treatment
  - Mental health crisis intervention
  - Mental health case management

Check your benefits quick reference guide to find out more about your child's benefits from the state. You can call DMAS at any time if your child needs these services.

## Section IV: Limitations

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

### **Chiropractic services**

Limited to \$500 per member per calendar year.

### **Durable medical equipment**

Limited to two hearing aids every five years.

### **Home health care services**

Limited to a combined cumulative total of 90 visits per member per calendar year.

### **Inpatient hospital**

Limited to 365 days per confinement.

### **Skilled nursing facility**

Limited to 180 days per confinement.

### **Special limitations**

If we can't provide or arrange health services for your child as a result of a natural, manmade or unforeseen event not within our control, we'll make a good faith effort to provide or arrange for your child's care.

We'll take into account the event and how practical it will be to provide or arrange for such care based on our best judgment.

Us and our 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.

### **Transplants**

Services to identify donors who are immediate blood-related family members are limited to \$25,000 per member.

### **Women, Infants and Children program**

The Women, Infants and Children program, or WIC, helps make sure eligible children age five and younger, pregnant women, women who breastfeed or women who have just had a baby get the nutrition they need. To find out more about who may qualify for the program:

- Call WIC at 1-888-942-3663
- Visit WIC online at: <http://www.vdh.virginia.gov/ofhs/dcn/wic/>

## Section V: Exclusions

You'll be responsible for the cost of any noncovered services you get.

**Under this Explanation of Coverage (EOC), we won't cover:**

- Services not listed or described as eligible for reimbursement.
- Services of non-network providers, except for emergencies, family planning, immunizations or when authorized in writing in advance by the network Medical Director. Services you get that aren't prearranged by your child's primary care provider (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 that was not authorized in advance by us or prearranged by your child's PCP. Notwithstanding this exclusion, any provider shall be permitted by us to continue rendering health services to a pregnant member who has entered the third trimester of pregnancy at the time of such provider's termination of participation as a network provider, except when such provider is terminated by us for cause and/or excluded from participation in federal health care programs. Such treatment shall, at your option, continue through the provision of postpartum care directly related to the delivery.

Further, notwithstanding this exclusion, any provider shall be permitted by us to keep giving health services to any member diagnosed with a terminal illness with a life expectancy of six months or less at the time of such provider's termination of participation as a network provider, except when such provider is terminated for cause or is excluded from participation in federal health care programs. Such treatment shall, at the member's option, continue for the rest of the member's life for care directly related to the treatment of the terminal illness.

- Routine vision and hearing care, except as defined in Paragraphs U. and AA. of **Section III**.
- Services for radial keratotomy.
- 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.
- Your child's coverage doesn't include benefits for or related to cosmetic surgery or procedures, including complications that result from such surgeries and/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 child's 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); and 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, returned checks, stop payment on checks and other such clerical charges.
- Services for rest cures or domiciliary, residential or convalescent care.
- Examinations required specifically for insurance, employment, school, sports 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. 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 for which federal, state or local law require to 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 benefits insurance. The cost of health services covered under the Medicare programs or other insurance. Care for military service-connected disability and conditions for which you're 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'll 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 are not treated.
- Corrective shoes.
- Services for biofeedback.
- Services for weight control, including, but not limited to surgery and other procedures done mostly for the purpose of weight loss for members who are not morbidly obese.
- Experimental/investigative medical or surgical procedures and drugs, as defined by DMAS. However, clinical trials are not always considered to be experimental or investigational, and will be evaluated on a case-by-case basis.
- Services for elective abortions are not covered by us. This service may be covered as a DMAS



“carved-out” service where the life of the mother is in danger.

- Services of Christian Science nurses.
- Services that are not medically necessary, as determined by us in our sole discretion.
- Any types of health services, supplies or treatments not specifically provided herein. The term “services” as used in the exclusions includes supplies or medical items.
- High dose chemotherapy and/or high dose radiation, any resulting medical complications, and any supporting allogeneic or syngeneic bone marrow transplants or other forms of allogeneic or syngeneic stem cell rescue (those with a donor other than the patient) are covered only when used to treat lymphoma and melanoma with bone marrow involvement. The term “high dose,” when used to describe chemotherapy or radiation, means a dose so high as to predictably require stem cell rescue.
- High dose chemotherapy and/or high dose radiation, any resulting medical complications, and any supporting autologous bone marrow transplants or other forms of autologous stem cell rescue (those in which the patient is the donor) are covered only when used to treat the following:
  - Hodgkin’s disease, which has come back after an initial complete remission or is in first remission with poor prognostic factors, with no bone marrow involvement
  - Non-Hodgkin’s lymphoma, which has come back after an initial complete remission or is in first remission with poor prognostic factors, with no bone marrow involvement
  - Multiple myeloma

The term “high dose,” when used to describe chemotherapy or radiation, means a dose so high as to predictably require stem cell rescue.

- Paternity tests.
- Genetic testing other than fetal screenings. Services for potential illnesses that may result from genetic predisposition are not covered in the absence of signs or symptoms.
- Acupuncture therapy.
- Transportation other than covered ambulance services.
- Psychiatric residential treatment services (RTS).
- Services for obesity or in connection with weight reduction or dietary control, except covered facility or provider’s services to treat morbid obesity.
- Chiropractic treatment or services not authorized by your child’s PCP and us. Chiropractic services not covered include but are not limited to:
  - Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders
  - Conjunctive therapy not associated with spinal or joint adjustment
  - Laboratory tests
  - X-rays
  - Adjustments
  - Physical therapy
  - Any other chiropractic services not documented as medically necessary and appropriate

- Any treatment classified as experimental or in the research state
- Thermography.
- Educational programs.
- Nonmedical self-care, self-help, or any self-help physical exercise training or related diagnostic testing.

## 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 Explanation of Coverage (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.

### B. Copays

Copays for certain covered services are outlined in the Copay Schedule included in your child's new member packet. These amounts are your financial responsibility and should be paid at the time a covered service is rendered. The Copay Schedule lists the annual copay limit in terms of a benefit year family maximum.

When the total of all copays paid by you and other FAMIS enrollees in your immediate family in a benefit year reach the annual copay limit, you and your immediate family members who are FAMIS enrollees will no longer be required to make copays for the remainder of that benefit year. In order for this to occur, you must provide copay receipts for yourself and your immediate family members enrolled in any FAMIS programs up to the amount of the annual family copay limit specified in the Copay Schedule. We aren't responsible for administering this process.

These receipts should be sent to:

Cover Virginia  
P.O. Box 1820  
Richmond, VA 23218-1820

Toll-free phone:

1-855-242-8282

Hours of operation:

8 a.m. to 7 p.m., Monday-Friday

9 a.m. to noon, Saturday

Once Cover Virginia receives and verifies the copay receipts, they will notify us if you and other FAMIS enrollees in your immediate family have reached the annual copay limit. We will then issue a new ID card to you and any of your immediate family members enrolled in the FAMIS program indicating that no additional copays are required for the rest of the benefit year.

You should present your child's new ID card to providers who are rendering covered services in order to avoid additional copay responsibility.

## **C. Seeing other providers**

You don't need to get a referral from your child's PCP for your child to get care from other Anthem HealthKeepers Plus network providers.

Coverage for your child does require that you use only network providers unless you receive prior approval from us for your child to see a provider outside of the Anthem HealthKeepers Plus network.

You should talk with your child's PCP or call Member Services to make sure your child's provider is in our network.

Some services, such as inpatient services, require prior authorization from HealthKeepers, Inc. Please ask your child's PCP about these services. He or she should oversee all aspects of your child's health care, so please tell the PCP about other health care providers who are treating your child.

## **D. Eligibility**

No person is eligible to be enrolled in FAMIS unless approved by the Department of Medical Assistance Services (DMAS).

### **Newborn children dependents**

As a member, your newborn will be enrolled in the Anthem HealthKeepers Plus plan for his or her birth month plus the two following months. The newborn's continued enrollment with our plan doesn't depend on your enrollment. This means even if you don't stay enrolled, your newborn will still be covered for the first three months.

To make sure your newborn stays a member, you must call Cover Virginia at 1-855-242-8282. Cover Virginia will determine eligibility for your newborn. Infants born to mothers enrolled with FAMIS who don't get a FAMIS ID number before the end of the third month of age will no longer be eligible for continued coverage.

## **E. Enrollment**

DMAS tells HealthKeepers, Inc. about newly enrolled members and members who are disenrolled from the plan each month. New members are covered starting on the first day of the first month of the enrollment period. A newborn is covered starting at birth for the birth month plus two additional months, unless the parent decides to change the newborn's plan.

For the first 90 days after enrolling, you may disenroll your child from one plan and move the child to another plan without cause. If you don't disenroll your child during this period, you may not change your child's plan for the rest of the enrollment period. You may change plans each year during the open enrollment period. You may also disenroll your child from one health plan to another at any time for good cause. To learn more about disenrolling for good cause, call Cover Virginia at 1-855-242-8282.

## **F. Effective date of coverage**

Coverage is effective at midnight on the first day of the month after DMAS tells us your child is enrolled as an Anthem HealthKeepers Plus member. Disenrollments are effective at 11:59 p.m. on the last day of the month of enrollment. If you disenroll for good 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.**

## **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 child's coverage will end if:**

1. DMAS disenrolls the child.
2. You permit the use of your child's identification card by any other person or use another member's card; we may recall the card and terminate your child's coverage upon 31 days' written notice.
3. Your child loses eligibility for FAMIS through the commission of fraud or if enrollment would be harmful to your child's interest, the child will be disenrolled with us. You may be responsible for repayment of capitation premium payments if your child loses eligibility due to failure to report truthful or accurate information when applying for FAMIS.
4. The agreement between us and DMAS may be terminated by DMAS or by us. In this event, coverage by us will end for all members as of the effective date of termination.
5. If a member becomes incarcerated; we will notify DMAS within 48 hours of being informed, and the member will be disenrolled. (Individuals on house arrest are not considered incarcerated.)

## **H. Relationship of contracting parties**

Network doctors maintain the doctor-patient relationship with you and your child and are solely responsible for all medical services. The relationship between us and our providers of covered services is an independent contractor relationship. Network providers of covered services aren't employees or agents of ours and neither us nor any of our employees are employees or agents of any network provider.

For the purposes of this EOC, no member is the agent or representative of ours, 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 are entitled to get (from any provider of covered services to your child) all information necessary for 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 child's care and treatment and physical condition and permit copying of records by us.

Information from your child's 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 child's medical records at any time from your child's 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 child's 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.

## L. Notices

- 1. From us to you.** A notice sent to you from us is considered "given" when mailed to your child's last known address as shown in our enrollment records. Notices include any information that we may send you, including ID cards. **If your address changes, please call the local Department of Social Services as well as Member Services to let us know.**
- 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 child's name and ID number are included

in the notice.

## **M. Agreement**

The “agreement” means the agreement between us and the Virginia Department of Medical Assistance Services (DMAS), of which this EOC is a part. We have entered into an agreement with DMAS for the provision of the benefits outlined in this EOC.

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 direct specific questions related to the agreement between us and DMAS to DMAS.

## **N. Grievance and appeals process and DMAS appeals process**

We care about the quality of care that you get from us and your child’s health care providers. If you have a problem with your child’s health care, we would like to know about it. We can help you with problems you may have with your child’s health care services, such as:

- Access to health care services
- Provider care and treatment
- Administrative issues
- A decision made by us

If you have any questions or concerns, you may call Member Services toll free at 1-800-901-0020 (TTY 711). 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**

A grievance is a complaint about dissatisfaction with availability, delivery or quality of services. A grievance is not an appeal. You or someone you choose to represent you may file a grievance with us over the phone or in writing. You need to file a grievance within 30 calendar days from the date the problem took place.

If you have questions or concerns about your child’s care, try to talk to your child’s primary care provider (PCP) 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 child’s health care benefits, you need to file an appeal instead of a grievance. Please see the part called “Appeal process” later in this chapter.

If you need help filing a grievance, a Member Services representative can help you at 1-800-901-0020. 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 the TTY phone number at 711.

You have two ways to file a grievance with us. You can:

- Call Member Services toll free at 1-800-901-0020
- 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

If you write a grievance letter, please attach any documents that will help us look into the problem. Send the completed letter to:

Central Appeals Processing  
HealthKeepers, Inc.  
P.O. Box 62429  
Virginia Beach, VA 23466-2429

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 the grievance, we'll review it and investigate it. We will send you an acknowledgment letter within five calendar days.

We will send you a letter with our decision within 30 days from the date we got the grievance. If you're not happy with the grievance resolution, you have the right to file a complaint with the DMAS Managed Care Helpline at 1-800-643-2273 (TTY 1-800-817-6608).

For expedited grievances, you or the person you choose to represent you may ask us to handle the grievance faster if your child's health needs it. You or the person you choose to represent you with written consent can submit written or verbal appeals. Verbal appeals must be followed up in writing. We answer problems that need to be taken care of right away within 48 hours. We will call you or send you a letter with our decision within 48 hours after we get the expedited grievance. The letter will let you know about our decision.

### **Appeal process**

If you're not 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 30 calendar days from the date on the Notice of Action letter. You can do this by calling Member Services at 1-800-901-0020 or writing us a letter. You may send an appeal in writing to:

Central Appeals Processing  
HealthKeepers, Inc.  
P.O. Box 62429  
Virginia Beach, VA 23466-2429

You may also file an appeal by calling TTY 711 if you:

- Are deaf or hard of hearing
- Have a visual or other communicative impairment

We can help you through the appeal process.

Please see the “Expedited appeals process” section later in this chapter to learn more about faster appeals.

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 child’s behalf.

When we receive the appeal, we will review it and investigate it. We will send you an acknowledgment letter when we receive the appeal. The letter will tell you that we got the appeal request. We will make a decision about the appeal within 30 calendar days after we get it.

Once the appeal is resolved, we’ll send you a letter to tell you what we decide about the decision.

The letter will explain:

- The decision we reached on the appeal
- The reason we reached our decision
- The policies and procedures we used to make our decision
- Additional appeal rights you have, including how to request an external review
- How to contact the Virginia Department of Health if you have concerns about the appeal

**For expedited appeals**, you or the person you choose to represent you may ask us to handle the appeal faster if your child’s health needs it. We will acknowledge the appeal within 24 hours from the time we got it. We will make a decision within 72 hours.

Your child may keep benefits while waiting for the appeal if you asked for the appeal within the right time frame. Call Member Services at 1-800-901-0020 (TTY 711) to ask if your child can keep getting benefits. You may have to pay for the care your child gets while you wait for an answer about the appeal if the final decision is not what you wanted.

### **External review process**

If you have a problem with what we decide after completing our appeal process, you can ask for an **external review**.

If you don't agree with a coverage or appeal decision, you or your child's authorized representative may send an appeal request to KEPRO. You may ask for an external review if we:

- Said "no" to paying for a service you wanted for your child
- 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 your child access to a service fast enough

To ask for an external review, this request must be sent in writing and be signed within 30 days of receipt of our Appeal Notice of Action resolution letter and sent to:

FAMIS External Review Request  
c/o KEPRO  
2810 N. Parham Rd., Suite 305  
Henrico, VA 23294  
[www.dmas.kepro.com](http://www.dmas.kepro.com)

This right is only available to you when you have completed our appeal process. If you have concerns about the appeal that you feel have not been addressed, you have the right to register the complaint with the Virginia Department of Health Professions at 1-800-533-1560. You may also register complaints with the Managed Care Helpline at 1-800-643-2273.

You may also write them at:

Office of Licensure and Certification  
Virginia Department of Health  
9960 Mayland Drive, Suite 401  
Richmond, VA 23233  
Hotline: 1-800-955-1819  
Richmond Metropolitan Area: 1-804-367-2106 or 1-804-367-2102  
Fax: 1-804-527-4502  
Email: [MCHIP@vdh.virginia.gov](mailto:MCHIP@vdh.virginia.gov)  
Web page: [www.vdh.virginia.gov](http://www.vdh.virginia.gov)

You may also call Cover Virginia at 1-855-242-8282 to register your complaints.

### **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 at 1-800-901-0020.

For members with vision loss or who need any Anthem HealthKeepers Plus written materials in an alternative format, please call Member Services 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 child's EOC are personal. You may not assign your child's right to receive covered services.

You may not assign your child's 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 of 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 a network employee, officer or director concerning the EOC or the benefits available

## **R. Limitation on damages**

In the event you or your child's 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, the damages shall be limited to the amount of the 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 child's representative of any noncontractual damages to which you or your child's representative may otherwise be entitled.

## **S. Our continuing rights**

On occasion, we may not insist on strict performance on all terms of this member handbook. Failure to apply terms or conditions doesn't mean we waive or give up any future rights we may have under this member handbook.

## **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 that is collected about you. For more information, contact Member Services.
- A more complete notice of our information practices is available upon request.

## **U. Filing of 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 are not network providers and some prescription drug claims.

You may obtain claim forms from your child's Member Services representative. Claims should be sent to us at the following address:

Operations  
Anthem HealthKeepers Plus  
P.O. Box 27401  
Richmond, VA 23279

We will 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 service.

## **V. Coordination of benefits**

All benefits provided under this EOC are subject to this provision. Benefits won't be increased by virtue of this provision.

If your child is 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 that 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.

In no instance will the combined payments of both plans exceed our allowable charge for such covered service. You must cooperate fully in providing information about your child's other group health benefits plans to us. A delay in our receipt of this information will result in a delay in the payment of claims.

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

- Any person 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.

## **W. Reporting member or provider waste, abuse or fraud**

If you suspect a member (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 member waste, abuse or fraud include, but are not limited to:

- Loaning of 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:

Medicaid Special Investigations Unit  
Anthem HealthKeepers Plus  
P.O. Box 62509  
Virginia Beach, VA 23462  
Telephone: 1-800-368-3580

When reporting a person who receives benefits, provide these:

- 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 these:

- Name, address and telephone number of the provider
- Name and address of the facility (hospital nursing home or home health agency)
- The provider or facility FAMIS number (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
- Date(s) of events
- Summary of what happened

You may also report fraud directly to the Medicaid Fraud Control Unit Hotline at 1-800-371-0824 and 1-888-323-0587 or by email at [MFCU\\_mail@oag.state.va.us](mailto:MFCU_mail@oag.state.va.us).

## **X. Information available to members on an annual basis**

As a member of HealthKeepers, Inc., you will get, or can ask for:

- Member materials, such as a new member handbook, your child's member rights and responsibilities, information on our policies, and any member mailing.
- Names, addresses, telephone numbers of network providers and the languages they speak (other than English)
- The provider directory for our network
- Names of providers who are not accepting new patients, including PCPs, specialists and hospitals in your child's service area
- Any limits to your child's freedom of choice among network providers
- Information on complaint, appeal and external review procedures
- The amount, duration and scope of benefits offered under the FAMIS program in enough detail to make sure that you understand your child's covered benefits
- How to get benefits, such as our OK

- 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 is 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 OK ahead of time (prior authorization) is not required for emergency care.
  - How to obtain emergency care, including the use of **911** or a local emergency number.
  - Your child's 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 child's PCP, such as the practice guidelines of the managed care organization

## **Y. 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 the 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 a patient's health

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

If your child's 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 child's doctor know if the treatment is medically necessary and if we approve it.

## **Z. 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 and your child have certain rights and responsibilities when your child gets health care. You and your child also have a responsibility to take an active role in your child's care. As your child's health care partner, we're committed to making sure your child's rights are respected while providing health care benefits. That also means giving your child access to our network providers and the information needed to make the best decisions for your child's health and welfare.

### **These are your rights and responsibilities:**

**You have the right to get the information you need to help make sure your child gets the most from his or her 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 choose a primary care provider (PCP) for your child.** 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 child's health as long as that PCP is accepting new patients. PCPs specialize in the areas of general practice, family practice, internal medicine 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 your child a new PCP, but you have the right to change your child's PCP if you're not satisfied with the PCP assignment we make.

If a network provider other than your child's 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 receive prompt treatment and service for your child.** You and your child should always be treated with respect and dignity. Likewise, when you have questions or need help with plan benefits, you should always get prompt and courteous service from our employees.

**You have the right to speak freely and privately with your child's doctor about all health care options and treatment needed for your child's condition, no matter what the cost or whether it is covered under your plan.** You have the right to get this information in a manner that you can understand.

**You have a right to work with your child's doctors in making choices about his or her health care.** You also have the right to refuse treatment for your child (subject to any applicable legal limitations). You may obtain a copy of our Clinical Practice Guidelines by calling Member Services for assistance.



**Your child has the right to be free from any form of restraint or seclusion.** While your child is enrolled as our member, he or she has the right to be free from any form of restraint or seclusion (isolation) used as a means of coercion, discipline, convenience or retaliation, as specified in other state or federal regulations on the use of restraints and seclusion.

**You have the right to expect us to keep private your child's personal health information. This is as long as it follows state and federal laws and our privacy policies.**

Any medical information about your child that we receive, including his or her medical records from health care professionals or hospitals, will be kept confidential and, except as permitted by law, won't be made available to anyone without your written permission.

You can review any personal information collected about your child by us, and corrections can be made at your request. (See the HIPAA Notice of Privacy Practices in your member packet.)

You have the right to make a complaint or file an appeal about:

- Your child's health care plan
- Any care your child gets
- Any covered service or benefit ruling that your health plan makes

Our Member Services staff can resolve most of your concerns if you're ever dissatisfied with us or the care your child received from a participating health care professional.

**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 information.** While your child is enrolled as our member, you have the right to request certain information about the health plan and its services, the health care professionals who contribute to his or her care, and your rights and responsibilities. We also may periodically send you information on how to use the benefits and features of the health plan. If you should ever have any questions or concerns, you may contact our Member Services department at **1-800-901-0020**.

**You have the right to request and receive a copy of your child's medical records and request that they be amended or corrected.**

**You have the right to ask for member materials on an annual basis.** While your child is enrolled as our 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 make recommendations regarding the rights and responsibilities set forth here.** Being a partner in your child's health care means remaining involved in and informed about the decisions that affect their health. At HealthKeepers, Inc., we welcome all suggestions regarding what your rights and responsibilities should be, as well as what our rights and responsibilities as your child's

health plan should be. If you should have any questions, comments or suggestions, please contact Member Services.

**You have the right to freely exercise your rights.**

**You have the right to assure that your child is furnished health care services in accordance with federal law.**

**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 the member should use to access benefits (different from what is explained in this EOC).**

## **Member responsibilities**

**You're responsible for selecting your child's primary care provider (PCP).** You should select a PCP when you enroll and maintain a designated PCP as long as your child is 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. Please see **Section II** of this EOC for more information on how to choose a PCP.

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

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

**You have the responsibility of understanding your child's health problems and working with the doctors to make a treatment plan that you all agree on.** Take the necessary steps to have your child's previous medical records and any updates transferred to all current doctors. You also have the responsibility to give us and the doctors the information needed to help you get the best possible care.

If you have any questions or disagree with your child's treatment plan, discuss it with the provider. You should also be sure to understand the medications your child is taking and whether he or she is 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 the provider can see your child.

**You have the responsibility to make your copays at the time of your visit.** Please be prepared to make your appropriate copay when you receive your services.

**You have the responsibility to understand your child's identification (ID) card.** You should be familiar with your child's ID card, carry it with you at all times and present the card whenever you receive covered services. Only your child may use his or her ID 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 the 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 child's doctors.** It is important for you to work as a partner in your child's health care to maintain good health. You have the responsibility for notifying us and Department of Medical Assistance Services (DMAS) if your child has other health insurance or if other health insurance coverage changes.

**You have the responsibility for notifying us, DMAS and your local Department of Social Services (DSS) if your family size changes, if your address changes, if you move out of the service area or if you obtain other insurance.**

If you would like additional information regarding your rights and responsibilities, you may call Member Services. Members with hearing or speech loss may call the TTY line at 711.

## Section VIII: Definitions

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

**Adverse Action** means the delay, denial, reduction, suspension or termination of health services, in whole or part.

**Agreement** means the agreement between us and the Virginia Department of Medical Assistance Services (DMAS) of which this EOC is a part.

**Allowable charge** means our 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.

**Appeal** means a request made by a member (or provider on behalf of a member) to review an adverse action taken by us that results in the delay, reduction, suspension or termination of health services in whole or in part. Review of an adverse action made by us must be conducted by a person or agent who has not been directly involved in the adverse action under review.

**Capitation payment** means a payment made to us on behalf of each member enrolled under a contract for the provision of medical services, regardless of whether the particular member receives services during the period covered by the fee.

**Care coordination** means the process of learning about patient needs, followed by a plan of care to help the member get quality, cost-effective health care.

**Complaint** means a grievance.

**Confinement** means the period from a member’s admission into a facility up to the day the member is discharged. When days of inpatient care are provided “per confinement,” all inpatient stays less than 90 days apart are considered the same confinement. In other words, a new admission to a facility must follow the most recent discharge from a facility by 90 days or more in order for the new admission to be considered a different confinement.

The number of days of care for which a member is covered as an inpatient are subtracted from those available in this way:

- The day admitted is subtracted.
- Each day up to the day of discharge is subtracted.
- The day of discharge is not subtracted.

Members must be discharged by the established discharge hour. If a member stays beyond the established discharge hour, benefits will be provided for these additional inpatient services only if the

longer stay was medically necessary.

**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 FAMIS is the payer of last resort.

**Copay** is an amount of money, which a provider may collect from a member, for a covered benefit at the time the service is given.

**Covered services** means those medically needed hospital and medical services that are covered in this EOC and which are performed, prescribed or directed by a network provider.

**Department of Social Services** means the agency that determines whether or not an individual is eligible for FAMIS.

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

**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.

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.

**Evidence of Coverage (EOC)** includes this document as well as any amendment or related document sent with this document to explain covered services and benefits you're entitled to.

**Experimental/Investigative** means any service or supply that is determined to be experimental or investigative in our sole discretion.

We will apply the following four criteria in exercising its discretion:

- Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration (FDA).
- There must be sufficient information in the peer-reviewed medical and scientific literature to enable us to make conclusions about safety and efficacy.
- The available scientific evidence must demonstrate a beneficial effect on health outcomes outside a research setting.
- 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 or investigative if we determine that any one of the four criteria is not satisfied. New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered experimental/investigative.

**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.

**HMO or MCO** means health maintenance organization or managed care organization. HealthKeepers, Inc. is an HMO or MCO.

**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 us or its designee to provide covered services to members. A list of network providers is provided 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.

**Individuals with Disabilities Education Act Early Intervention Services (IDEA-EIS) program**  
The Virginia Department of Behavioral Health and Developmental Services directs the IDEA-EIS program. We may refer you to the program if your infant or toddler has physical, cognitive, communication, social or emotional, or adaptive development disabilities.

**Inpatient** means a member who has been admitted to a hospital or skilled nursing facility, is confined to

a bed there, and receives meals and other care in that facility.

**Medical Director** means a duly licensed physician or his or her designee who has been designated by us 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 are not provided only as a convenience. Services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

**Member** means a child eligible for FAMIS 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 or skilled nursing facility.

**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 practitioner who provides preventive and primary medical care for eligible members and who certifies prior authorization and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists and specialists who perform primary care functions such as surgeons, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

**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.

**Your child** refers to the covered member.



HealthKeepers, Inc. follows Federal civil rights laws. We don't discriminate against people because of their:

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

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

### **Communicating with you is important**

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

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

To get these services, call the Member Services number on your ID card at 1-800-901-0020 (Medallion Medicaid, FAMIS) or 1-855-323-4687 (CCC Plus); 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 (Medallion Medicaid, FAMIS) or 1-855-323-4687 (CCC Plus); TTY 711.

Fax: 1-855-832-7294

Email: [grievancesandappeals-hkp@anthem.com](mailto: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>
- **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)

For a complaint form, visit **[www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html)**.

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

Podemos traducir esto gratuitamente. Llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación (ID Card).

*Spanish*

نستطيع ترجمة هذه المواد مجاناً. اتصل بخدمات الاعضاء، باستخدام رقم الهاتف المدون على بطاقة الاعضاء لديك.

*Arabic*

Մենք կարող ենք անվճար թարգմանել սա: Զանգահարեք հաճախորդների սպասարկման բաժին ձեր անդամաքարտում (ID card) նշված հեռախոսահամարով:

*Armenian*

ဤအရာကို ကျွန်ုပ်တို့ အခမဲ့ ဘာသာပြန်ပေးနိုင်ပါသည်။ သင့် ID ကတ်ပါ ဝယ်ယူသုံးစွဲသူ ဝန်ဆောင်မှုနံပါတ်ကို ဖုန်းဆက်ပါ။

*Burmese*

我們可以免費為您提供翻譯版本。請撥打您 ID 卡上所列的電話號碼洽詢客戶服務中心。

*Chinese*

ما می توانیم این را به رایگان برایتان ترجمه کنیم. به شماره خدمات مراجعین ما که پشت کارت شناسایی تان (ID) درج شده، تلفن بزنید.

*Farsi*

Nous pouvons traduire ceci gratuitement. Appelez le numéro du service après-vente sur votre carte d'identification.

*French*

Nou ka tradwi sa la pou okenn pri. Pélé nimero sèvis kliyantèl la sou tôle kat didantité.

*Fr. Creole*

Wir können das gerne kostenlos übersetzen. Bitte wenden Sie sich an die Kundenservice-Hotline auf Ihrer ID-Karte.

*German*

Μπορούμε να σας μεταφράσουμε το παρακάτω χωρίς χρέωση. Καλέστε τον αριθμό του Τμήματος Εξυπηρέτησης Πελατών που θα βρείτε στην κάρτα ταυτοποίησής σας.

*Greek*

અમે આનું ભાષાંતર કોઈપણ ખર્ચ લીધા વિના કરી શકીએ છીએ. તમારા ID કાર્ડ પર આપેલ ગ્રાહક સેવા નંબર પર ફોન કરો.

*Gujarati*

אנחנו יכולים לתרגם את זה ללא עלות. התקשר למספר של שירות הלקוחות הנמצא על גבי כרטיס הזיהוי שלך.

*Hebrew*

हम इसका अनुवाद निशुल्क कर सकते हैं। अपने ID कार्ड पर दिए गए ग्राहक सेवा नंबर पर फोन करें।

*Hindi*

Peb txhais tau qhov ntawm no dawb. Hu rau lub chaw haujlwm pab cov neeg siv peb cov kev pab tus xovtooj uas nyob ntawm koj daim npav ID rau tus tswv cuab.

*Hmong*

Possiamo effettuare la traduzione gratuitamente. Contatti il numero dell'assistenza clienti riportato sulla Sua tessera identificativa.	<i>Italian</i>
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。	<i>Japanese</i>
យើងអាចបកប្រែជូនដោយឥតគិតថ្លៃអ្វីទេ ។ សូមទូរស័ព្ទទៅផ្នែកសេវាអតិថិជន តាមលេខមាននៅលើប័ណ្ណ ID របស់អ្នក ។	<i>Khmer</i>
저희는 이것을 무료로 번역해 드릴 수 있습니다. 가입자 ID 카드에 있는 고객 서비스부 번호로 연락하십시오.	<i>Korean</i>
ພວກເຮົາສາມາດແປອັນນີ້ໃຫ້ທ່ານໄດ້ຟຣີ. ໃຫ້ໂທຫາຝ່າຍບໍລິການລູກຄ້າທີ່ມີເປັນຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.	<i>Laotian</i>
Możemy to przetłumaczyć bez żadnych kosztów. Zadzwoń pod numer obsługi klienta za pomocą karty ID.	<i>Polish</i>
Podemos traduzir isto gratuitamente. Ligue para o serviço de atendimento ao cliente que consta no seu cartão de identificação.	<i>Portuguese</i>
Мы можем это бесплатно перевести. Позвоните в отдел обслуживания по телефону, приведенному на вашей идентификационной карточке участника плана.	<i>Russian</i>
Možemo to prevesti besplatno. Pozovite na broj korisničkog servisa s Vaše identifikacione kartice (ID).	<i>Serbian</i>
Maaari namin ito isalin-wika nang walang bayad. Mangyaring tawagan ang numero ng customer service sa inyong ID card na pang miyembro.	<i>Tagalog</i>
เราสามารถแปลได้โดยไม่มีค่าใช้จ่ายใดๆ ติดต่อหมายเลขโทรศัพท์ของฝ่ายบริการลูกค้าบนบัตรประจำตัวของคุณ	<i>Thai</i>
ہم اس کا ترجمہ مفت کر سکتے ہیں۔ اپنے ID کارڈ پر دیے گئے کسٹمر سروس کے نمبر پر کال کریں۔	<i>Urdu</i>
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.	<i>Vietnamese</i>
מ'ר קענען דאס איבערזעצן פון אפצאל. רופט דעם קאסטומער סערוויס נומער אויף אייער אידענטיטעט קארטל.	<i>Yiddish</i>



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