# Anthem. HealthKeepers Plus Offered by HealthKeepers, Inc.

# **Member Handbook**

**Medicaid Managed Care** Effective February 19, 2021

www.anthem.com/vamedicaid

# **MEDICAID MANAGED CARE**

# **Member Handbook**



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#### www.anthem.com/vamedicaid

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Effective February 19, 2021

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#### Help in Other Languages or Alternate Formats

This handbook is available in other languages and formats including on-line, large print, braille or audio CD at no cost to you. To request this handbook in an alternate format and/or language call Member Services at **1-800-901-0020** and it will be provided within 5 business days.

If you are having difficulty understanding this information, please contact our Member Services staff at **1-800-901-0020 (TTY 711)** for help at no cost to you.

Additionally, Members with alternative hearing or speech communication needs can dial 711 to reach a Telecommunications Relay Services (TRS) operator who will help you reach Anthem HealthKeepers Plus Member Services staff. Voice and TRS users can make a 711 call from any telephone anywhere in the United States at no cost to you.

**English: "If you do not speak English**, call us at **1-800-901-0020 (TTY 711)**. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language."

**Spanish:** Si no habla inglés, llámenos a **1-800-901-0020 (TTY 711)**. Tenemos acceso a servicios de intérprete y podemos ayudar a responder sus preguntas en su idioma de forma gratuita. También podemos ayudarle a encontrar un proveedor de atención médica que pueda comunicarse con usted en su idioma.

Korean: 영어로 말할 수 없다면 1-800-901-0020 (TTY 711). 로 전화하십시오. 저희는 통역 서비스를 이용할 수 있으며 귀하의 언어로 된 질문에 무료로 답변 할 수 있습니다. 우리는 또한 귀하의 언어로 의사 소통 할 수있는 의료 서비스 제공자를 찾도록 도울 수 있습니다. Vietnamese: Nếu bạn không nói được tiếng Anh, hãy gọi cho chúng tôi tại 1-800-901-0020 (TTY 711). Chúng tôi có quyền truy cập vào các dịch vụ phiên dịch và có thể giúp trả lời câu hỏi của bạn trong ngôn ngữ của bạn miễn phí. Chúng tôi cũng có thể giúp bạn tìm thấy một nhà cung cấp chăm sóc sức khỏe người có thể giao tiếp với bạn bằng ngôn ngữ của bạn.

Chinese: 如果您不会说英语,请致电1-800-901-0020 (TTY 711)。 我们可以使用 翻译服务,并可以用您的语言免费回答您的问题。我们还可以帮助您找到一个 能用您的语言与您沟通的医疗保健提供者。

Arabic: الثلاثون-الثلاثون على بنا اتصل الإنكليزية، يتكلمون لا كنت إذا 1-800-901-0020 (TTY 711) على الحصول (TTY 711) 0020-901-0020 معك التواصل يمكن الذين الصحية الرعاية موفر على العثور مساعدتك أيضا يمكننا بك الخاصة باللغة أسئلتك بك الخاصة باللغة

**Tagalog:** kung ikaw ay hindi nagsasalita ng ingles , mo sa amin lt ; **1-800-901-0020 (TTY 711)** ; . kami ay ng interpreter paglilingkod at makakatulong ang sagot sa tanong na ang wika ng katungkulan . at kami ay tulungan ka ng ng pangangalaga sa kalusugan nagkakaloob na ang pamamahagi sa inyo sa inyong mga wika.

#### Farsi:

اگر انگلیسی صحبت با ما تماس بگیرید در (TTY 711) 0020-901-000-1 . ما دسترسی به خدمات مترجم شفاهی و سئوالات زبان شما می تواند کمک کند. ما همچنین می توانید کمک ارائه دهنده مراقبت های بهداشتی است که می تواند ارتباط با شما زبان خود را پیدا کنید.

Amharic: እንግሊዝኛ ሙናንር የማይችሉ ከሆነ, **1-800-901-0020 (TTY 711)** ይደውሉልን. እኛ የአስተርዓሚ አንልግሎቶች መዳረሻ ያላቸው እና ከክፍያ ነጻ በራስዎ ቋንቋ ውስጥ የእርስዎን ጥያቄዎች መልስ ለማግኘት ይችላሉ. እኛ ደግሞ እንደ እናንተ የእርስዎን ቋንቋ ከአንተ *ጋ*ር መንናኘት የሚችል የጤና እንክብካቤ አቅራቢ እንዲያንኙ ሊረዱዎት ይችላሉ

Urdu: مترجم ہم .کریں کال ہمیں پر (TTY 711) 1-800-901-0020 تو بولتے، نہیں انگریزی آپ اگر Urdu: میں دینے جواب کا سوالات کے آپ میں زبان اپنی انچارج کے مفت اور ہے حاصل رسائی تک خدمات کی دیکھ کی صحت ایک سکتے کر چیت بات ساتھ کے آپ میں زبان کی آپ جو آپ بھی نے ہم .سکتے کر مدد دیکھ کی صحت ایک سکتے کر مدد میں تلاش کی فراہم بھال

**French:** Si vous ne parlez pas anglais, appelez-nous à **1-800-901-0020 (TTY 711)**. Nous avons accès à des services d'interprètes et pouvons vous aider à répondre à vos questions dans votre langue gratuitement. Nous pouvons également vous aider à trouver un fournisseur de soins de santé qui peut communiquer avec vous dans votre langue.

**Russian:** Если вы не говорите по-английски, позвоните нам по телефону **1-800-901-0020 (TTY 711)**. Мы имеем доступ к услугам переводчика и может помочь ответить на ваши вопросы на вашем языке бесплатно. Мы также можем помочь вам найти поставщика медицинских услуг, которые могут общаться с вами на вашем языке.

Hindi: आप अंग्रेजी नह ंबोलतेहैं, तो 1-800-901-0020 (TTY 711) पर कॉल करें। हम दभ ुाषिया सेवाओंके ललए उपयोग ककया हैऔर ननः श ुल्क अपनी भािा मेंआपके सवालों के जवाब कर सकतेहैं। हम यह भी मदद कर सकता हैआप एक स्वास््य देखभाल प्रदाता जो आपकी भािा मेंआप के साथ संवाद कर सकतेहैं।

**German:** Wenn Sie kein Englisch sprechen, rufen Sie uns unter **1-800-901-0020** (**TTY 711**) an. Wir haben Zugang zu Dolmetscherdiensten und können Ihnen helfen, Ihre Fragen in Ihrer Sprache kostenlos zu beantworten. Wir können Ihnen auch helfen, einen Arzt zu finden, der mit Ihnen in Ihrer Sprache kommunizieren kann.

Bengali: আপনি ইংরেনি বলরে পানে িা, োহরল 1-800-901-0020 (TTY 711) আমারেে সরে য াগার াগ করুি. আমো যোভাষীে পনেরষবাগুনলরে অ্যারেস আরে এবং নিখেচা আপিি ভাষায় আপিি প্রেরেে উত্তে সাহা য কেরে পারেি. আমো সাহা য কেরে পারেি একটি স্বারযযে ত্ন প্রোিকােী াো আপিি ভোষায় আপিিে সারে য াগার াগ কেরে পারেি.

**Portuguese:** Se você não fala inglês, ligue para **1-800-901-0020 (TTY 711)**. Temos acesso a serviços de intérprete e podemos ajudar a responder às suas perguntas no seu idioma gratuitamente. Também podemos ajudá-lo a encontrar um profissional de saúde que possa se comunicar com você em seu idioma.

# 1. Medicaid Managed Care plan

#### Welcome to the Anthem HealthKeepers Plus plan

Thank you for choosing us as your preferred Medicaid Managed Care plan. If you are a new member, we'll get in touch with you in the next few weeks to go over some very important information with you. You can ask us any questions you may have or get help making appointments. If you need to speak with us right away or before we contact you, call our Member Services team at **1-800-901-0020 (TTY 711)**, visit our website at **www.anthem.com/vamedicaid**, or call the Virginia Medicaid Managed Care Helpline at 1-800-643-2273 (TTY 1-800-817-6608) Monday–Friday, 8:30 a.m.–6 p.m. for help. This handbook is also available on our website.

#### How to use this handbook

This handbook will help you understand your benefits and how to get help from the Anthem HealthKeepers Plus plan. This handbook is a Medicaid and Anthem HealthKeepers Plus member guide that explains health care services, behavioral health coverage, prescription drug coverage, and other services and supports covered under the program. This guide will help you take the best steps to make our health plan work for you.

Feel free to share this handbook with a family member or someone who knows your health care needs. When you have a question or need guidance, please check this handbook, call Anthem HealthKeepers Plus Member Services at **1-800-901-0020** (**TTY 711**), visit our website at **www.anthem.com/vamedicaid**, or call Virginia Medicaid Managed Care Helpline free of charge at 1-800-643-2273 (TTY 1-800-817-6608) Monday through Friday, 8:30 a.m. to 6 p.m.

#### Your welcome packet

#### Member ID card

You should have received a welcome packet that included your Anthem HealthKeepers Plus member ID card. Your member ID card is used to access Medicaid Managed Care program health care services and supports at doctor visits and when you pick up prescriptions. You must show this card to get services or prescriptions. Below is a sample card to show you what yours will look like:

#### (Front)



#### (Back)



For FAMIS members, your ID card should look like:

#### (Front)



(Back)



If you haven't received your card, or if your card is damaged, lost or stolen, call the Member Services number located at the bottom of this page right away, and we'll send you a new card.

Keep your Commonwealth of Virginia Medicaid ID card to access services that are covered through the State, under the Medicaid fee-for-service program. These services are described in **section 10** of this handbook.

#### Provider and pharmacy directories

You should have received information about Anthem HealthKeepers Plus Provider and Pharmacy Directories. These directories list the providers and pharmacies that participate in **our** network. In most cases, while you are a member of our plan, you must use one of our network providers to get covered services.

You may ask for a paper copy of the Provider and Pharmacy Directory by calling Member Services at the number at the bottom of the page. You can also see or download the Provider and Pharmacy Directory at **www.anthem.com/vamedicaid**.

Use your provider directory to find:

- A primary care provider (PCP).
- Specialists.
- Doctors in your area.
- Doctors who speak your language.
- How to contact doctors you want to see.
- Pharmacies in the Anthem HealthKeepers Plus plan.

You can also search for doctors and other providers near you with our Find a Doctor tool online and on our mobile app. Search by location, provider type or specialty to find the provider you're looking for.

What is the Anthem HealthKeepers Plus service area?

We cover members anywhere in the Commonwealth of Virginia. Our service area includes the cities and counties listed below.

**Central region:** Accomack, Amelia, Brunswick, Caroline, Charles City, Chesterfield, Colonial Heights, Cumberland, Dinwiddie, Emporia, Essex, Franklin City, Fredericksburg, Goochland, Greensville, Hanover, Henrico, Hopewell, King and Queen, King George, King William, Lancaster, Lunenburg, Mathews, Mecklenburg, Middlesex, New Kent, Northampton, Northumberland, Nottoway, Petersburg, Powhatan, Prince Edward, Prince George, Richmond City, Richmond Co., Southampton, Stafford, Surry, Sussex, Westmoreland

**Tidewater region**: Chesapeake, Gloucester, Hampton, Isle of Wight, James City Co., Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach, Williamsburg, York

**Northern/Winchester region:** Alexandria, Arlington, Clarke, Culpeper, Fairfax City, Fairfax Co., Falls Church, Fauquier, Frederick, Loudoun, Manassas City, Manassas Park, Page, Prince William, Rappahannock, Shenandoah, Warren, Winchester

Western/Charlottesville region: Albemarle, Amherst, Appomattox, Augusta, Buckingham, Campbell, Charlotte, Charlottesville, Danville, Fluvanna, Greene, Halifax, Harrisonburg, Louisa, Lynchburg, Madison, Nelson, Orange, Pittsylvania, Rockingham, Staunton, Waynesboro

**Roanoke/Alleghany region:** Alleghany, Bath, Bedford City, Bedford Co., Botetourt, Buena Vista, Covington, Craig, Floyd, Franklin Co., Giles, Henry, Highland, Lexington, Martinsville, Montgomery, Patrick, Pulaski, Radford, Roanoke City, Roanoke Co., Rockbridge, Salem, Wythe

**Southwest region:** Bland, Bristol, Buchanan, Carroll, Dickenson, Galax, Grayson, Lee, Norton, Russell, Scott, Smyth, Tazewell, Washington, Wise

Only people who live in our service area can enroll with the Anthem HealthKeepers Plus plan. If you move outside of our service area, you can't stay in this plan. If this happens, you will receive a letter from Department of Medical Assistance Services (DMAS) asking you to choose a new plan. You can also call the Managed Care Helpline if you have any questions about your health plan enrollment. Contact the Managed Care Helpline at 1-800-643-2273 or visit the website at virginiamanagedcare.com.

As an Anthem HealthKeepers Plus member, you get access to your regular Medicaid benefits as well as some no-cost extras we offer, like:

Adult dental care — one cleaning, one exam and a set of bitewing X-rays per

year

≻ Our mobile app

- ➤ Sports physicals for kids
- ➢ GED assistance

➤ and more!

To find out more about the extra benefits we offer, see Section 8 of this handbook.

#### List of covered drugs

You can access or download the Provider and Pharmacy Directory at **www.anthem.com/vamedicaid** or receive a printed copy by calling Member Services at **1-800-901-0020 (TTY 711)**.

The Provider and Pharmacy Directory will tell you about doctors, specialists and pharmacies in our plan. You must use a pharmacy in our plan to fill your prescriptions. The directory will help you pick a PCP and a pharmacy that you prefer. You can access or download the Provider and Pharmacy Directory at www.anthem.com/vamedicaid or receive a printed copy by calling our Member Services team Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

For a list of drugs we cover, first look at our Preferred Drug List (PDL). The PDL is a list of preferred drugs that we pay for. Doctors must prescribe drugs on our PDL whenever possible. If you do not see your medication in our PDL, you can look to see if it is in our formulary. Our formulary is a comprehensive list of all the drugs we pay for.

All of the drugs on our PDL are in our formulary, but not all of the drugs in our formulary are preferred. If your medication is in our formulary but not on our PDL, we'll still pay for it — but you may need to get prior authorization (preapproval) in order for us to do so.

You can access or download our PDL and formulary anytime at www.anthem.com/vamedicaid. You can also request a printed copy by calling Member Services.

#### List of covered and non-covered services

See **section 8** of this handbook for a list of services we do and do not cover. You can access or download our covered services at www.anthem.com/vamedicaid or receive a printed copy by calling 1-800-901-0020 (TTY 711). For questions about transition of care,

see Section 2 of this handbook.

#### Information about eligibility

If you have questions about your Medicaid eligibility, contact your case worker at the Department of Social Services in the city or county where you live. If you have questions about the services you get under the Anthem HealthKeepers Plus plan, please call the Member Services number listed at the bottom of this page. You may also visit Cover Virginia at www.coverva.org, or call 1-855-242-8282 or TDD: 1-888-221-1590. **These calls are free.** 

#### Getting help right away

#### Anthem HealthKeepers Plus Member Services

Our Member Services Staff are available to help you if you have any questions about your benefits, services or procedures, or if you have a concern about how we're doing as your health plan.

CALL	<b>1-800-901-0020 This call is free</b> . <b>Monday-Friday from 8 a.m. to 8 p.m. Eastern time</b> We have free interpreter services for people who do not speak English.	
TTY	711 This call is free. Monday-Friday from 8 a.m. to 8 p.m. Eastern time This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.	
FAX	1-800-964-3627	
WRITE	Member Services HealthKeepers, Inc. P.O. Box 27401 Mail Drop VA2002-N500 Richmond, VA 23279	
WEBSITE	www.anthem.com/vamedicaid	

#### How to contact Anthem HealthKeepers Plus Member Services

#### How our Member Services representatives can help you:

- Answer questions about the plan and the information in this handbook.
- Answer questions about claims, billing or member ID cards.

- Find or check to see if a doctor is in our network and answer questions about doctor visits.
- Change your primary care provider (PCP) or find out information about other doctors and specialists, including names, specialties, addresses, phone numbers and professional qualifications
- Understand your benefits and covered services, including the amount that we'll pay so that you can make the best decisions about your health care.
- > Understand your rights and responsibilities.
- With appeals about your health care services (including drugs). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
- With complaints about your health care services (including prescriptions). You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you received to us or to the Managed Care Helpline at 1-800-643-2273.
- With questions about wellness care, special kinds of care and healthy living.

#### How to contact your case manager

If you have complex health issues, we'll connect you with a case manager. Case managers help make sure you receive the attention and quality of care your health issues demand. They'll work with your primary care provider (PCP) to design a care plan that reflects your specific needs and can help you find resources in your community for other services you might need.

Case management doesn't cost you anything. You can ask for case management services or opt out of them at any time. If you think case management services could help you, you or your provider can call our Member Services team at 1-800-901-0020 (TTY 711) Monday through Friday from 8 a.m. to 8 p.m. Eastern time and ask to be transferred to the Case Management department.

Once you are assigned a case manager, he or she will reach out to you with his or her contact information. Member Services can also connect you with the case management team if you have questions or concerns or if you want to change your case manager.

#### Medical Advice Line available 24 hours a day, seven days a week

You can reach a nurse or behavioral health professional 24 hours a day, seven days a week to answer your questions toll-free at **1-800-901-0020 (TTY 711)**. Just choose the prompt

for our **24/7 NurseLine** to get help with health questions, find out options for care and get advice on where to go when you need care.

CALL	<ul><li>1-800-901-0020 This call is free.</li><li>Available 24 hours a day, seven days a week</li><li>We have free interpreter services for people who do not speak English.</li></ul>
TTY	<b>TTY 711 This call is free.</b> This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

#### **Behavioral Health Crisis Line**

Contact us if you do not know how to get services during a crisis. We'll help find a crisis provider for you. Call **1-844-429-9620 (TTY 711)**. If your symptoms include thoughts about harming yourself or someone else, you should:

#### Get help right away by calling 911.

#### ➢ Go to the closest hospital for emergency care.

CALL	<b>1-844-429-9620 This call is free.</b> Available 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	<b>TTY 711 This call is free.</b> This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

#### **Other resources**

Smiles for	For questions or to find a dentist in your area, call Smiles For		
Children through	Children at 1-888-912-3456. Information is also available on the		
DentaQuest,	DMAS website at:		
<b>DMAS Dental</b>	http://www.dmas.virginia.gov/Content_pgs/dnt-home.aspx		
Benefits	or the <b>DentaQuest</b> website at:		
Administrator	http://www.dentaquestgov.com		
Transportation	1-877-892-3988 (TTY 711)		

DMAS Transportation Contractor for transportation to and from DD Waiver Services	1-866-386-8331 TTY 1-866-288-3133 Or dial 711 to reach a relay operator	
Magellan of Virginia; DMAS Behavioral Health Services Administrator	Toll-free:1-800-424-4046 TDD: 1-800-424-4048 Or dial 711 to reach a relay operator http://www.magellanofvirginia.com	
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019 or visit the website at <b>www.hhs.gov/ocr</b>	
Maximus	1-800-643-2273	

#### **Disease Management**

If you have a long-term health issue, you don't have to go it alone. Our Disease Management program can help you get more out of life. The program is voluntary, private and on hand at no cost to you. It's called the Disease Management (DM) program. A team of registered nurses, called DM case managers, are available to teach you about your health issue and help you learn how to manage your health. Your primary care provider (PCP) and our DM team are here to help you with your health care needs.

You can join the program if you have one of these conditions:

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

Our case managers assist with weight management and smoking cessation education.

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

Listens to you and takes the time to understand your specific needs.

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

As an Anthem HealthKeepers Plus member enrolled in the DM program, you have certain rights and responsibilities. You have the right to:

→ Have information about the Anthem HealthKeepers Plus plan; this includes all our programs and services as well as our staff's education and work experience; it also includes contracts we have with other businesses or agencies.

- > Refuse to take part in or leave programs and services we offer.
- ≻ Know who your case manager is and how to ask for a different case manager.
- > Have us help you to make choices with your doctors about your health care.

➤ Learn about all DM-related treatments; these include anything stated in the clinical guidelines, whether covered by us or not; you have the right to talk about all options with your doctors.

> Have personal data and medical information kept private.

> Know who has access to your information and know our procedures used to ensure security, privacy and confidentiality.

> Be treated with courtesy and respect by our staff.

> File complaints to the Anthem HealthKeepers Plus plan and get guidance on how to use the complaint process, including how long it will take us to respond and resolve issues of quality and complaints.

> Get information that is clear and easy to understand.

You are encouraged to:

➤ Follow health care advice offered by the Anthem HealthKeepers Plus plan.

➤ Give us information needed to carry out our services.

> Tell us and your doctors if you decide to disenroll from the DM program.

If you have one of these health issues or would like to know more about our DM program, please call 1-888-830-4300 Monday through Friday from 8:30 a.m. to 5:30 p.m. local

time. Ask to speak with a DM case manager. Or you can leave a private message for your case manager 24 hours a day.

You can also visit our website at www.anthem.com/vamedicaid or call the DM if you would like a copy of DM information you find online. Calling us can be your first step on the road to better health.

#### **Healthy Families program**

Healthy Families is a six-month program for members ages 7-17, designed to assist families in obtaining a healthier lifestyle. This program provides families with fitness and healthy behavior coaching, written nutrition information, online and community resources. For additional information or to enroll in the Healthy Families program, call us at 1-844-421-5661.

## 2. How Managed Care works

The program is a mandatory Managed Care program for members of Virginia Medicaid (12VAC30-120-370). The Department of Medical Assistance Services (DMAS) contracts with Managed Care Organizations (MCOs) to provide most Medicaid covered services across the state. The Anthem HealthKeepers Plus plan is approved by DMAS to provide person-centered care coordination and health care services. Through this person-centered program, our goal is to help you improve your quality of care and quality of life.

#### What makes you eligible to be a member?

When you apply for Medical Assistance, you are screened for all possible programs based on your age, income, and other information. To be eligible for a Medical Assistance Program, you must meet the financial and non-financial eligibility conditions for that program. Please visit the Virginia Department of Social Services' (VDSS) Medicaid Assistant Program page for eligibility details and/or VDSS Medicaid Forms and Applications page for application and other Medicaid form details.

You are found eligible for full Medicaid benefits from the local Department of Social Services, and you meet one of the following categories:

- ➢ Children under age 21
- ▶ Foster Care and Adoption Assistance Child under age 26
- Pregnant women, including two months post-delivery
- Parent Care-Takers

Medicaid eligible persons who do not meet certain exclusion criteria must participate in the program. Enrollment is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. For more information about exclusionary criteria and participation, please refer to 12VAC30-120-370.

#### What makes you NOT eligible to be a member?

You would not be able to participate if any of the following apply to you:

- ➤ You lose Medicaid eligibility.
- > You do not meet one of the eligible categories above.
- ➢ You meet exclusionary criteria 12VAC30-120-370.
- > You are hospitalized at the time of enrollment.
- > You are enrolled in a Home and Community Based (HCBS) waiver.
- > You are admitted to a free standing psychiatric hospital.

➢ You are receiving care in a Psychiatric Residential Treatment Level C Facility (children under 21).

- > You meet the criteria for another Virginia Medicaid program.
- ➢ Hospice
- Virginia Birth-Related Neurological Injury Compensation Act

#### Third party liability

#### **Comprehensive health coverage**

Members enrolled in Medicaid, determined by DMAS as having comprehensive health coverage, other than Medicare, will be eligible for enrollment in Medallion 4.0, as long as no other exclusion applies.

Members who obtain other comprehensive health coverage after enrollment in Medallion 4.0 remain enrolled in the program.

Members who obtain Medicare after Medallion 4.0 enrollment will be disenrolled and subsequently enrolled into the Commonwealth Coordinated Care Plus (CCC+) program.

MCOs are responsible for coordinating all benefits with other insurance carriers (as applicable) and follow Medicaid "payer of last resort" rules.

MCOs cover the member's deductibles and coinsurance up to the maximum allowable reimbursement amount that would have been paid in the absence of other primary insurance coverage.

When the TPL payer is a commercial MCO/HMO organization, the MCO is responsible for the full member copayment amount.

MCOs ensure that members are NOT held accountable for payments and copayments for any Medicaid covered service.

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:

- 1. Those services federally required to be provided at public expense as is the case for
  - a. Assessment/EI evaluation.
  - b. Development or review of the Individual Family Service Plan (IFSP).
  - c. Targeted case management/service coordination.
- 2. Developmental services.

3. Any covered early intervention services where the family has declined access to their private health/medical insurance.

#### Enrollment

Enrollment in the program is required for eligible individuals. DMAS and the Managed Care Helpline manage the enrollment for the program. To participate, you must be eligible for Medicaid. The program allows for a process which speeds up member access to care coordination, disease management, 24-hour nurse call lines and access to specialty care. This is especially important for Members with chronic care needs, pregnant women, and foster care children who quickly need access to care.

#### Health plan assignment

You received a notice from DMAS that included your initial health plan assignment. With that notice DMAS included a comparison chart of health plans in your area. The assignment notice provided you with instructions on how to make your health plan selection.

You may have chosen us to be your health plan. If not, DMAS may have assigned you to our health plan based upon your history with us as your managed care plan. For instance, you may have been enrolled with us before through Medicaid. You may also have been assigned to us if certain providers you see are in our network.

#### Changing your health plan

Assistance through the Managed Care Helpline can help you choose the health plan that is best for you. For assistance, call the Managed Care Helpline at 1-800-643-2273 or visit the website at **virginiamanagedcare.com**. The Managed Care Helpline is available Monday through Friday (except on State holidays) from 8:30 a.m. to 6 p.m. Operators can help you understand your health plan choices and/or answer questions about which doctors and other providers participate with each health plan, among many helpful items. The helpline services are free and are not connected to any health plan.

You can change your health plan during the **first 90 days** of your enrollment for any reason. You can also change your health plan once a year during **open enrollment** for any reason. You will get a letter from DMAS during open enrollment with more information. You may also ask to change your health plan for "good cause" at any time. The Helpline handles good cause requests and can answer any questions you have. Contact the Helpline at 1-800-643-2273, download and use the Virginia Managed Care mobile app or visit the website at **virginiamanagedcare.com**.

#### Automatic re-enrollment

If your enrollment ends with us and you regain eligibility for the program **within 60 days** or less, you will automatically be reenrolled with the Anthem HealthKeepers Plus plan. You will be sent a re-enrollment letter from the Department of Medical Assistance Services.

#### What are the advantages of choosing the Anthem HealthKeepers Plus plan?

#### Some of the advantages include:

You will have access to Anthem HealthKeepers Plus case managers. Your case manager works with you and with your providers to make sure you get the care you need.
 You will be able to take control over your care with help from our care team and case managers.

> The care team and case managers are available to work with you to come up with a care plan specifically designed to meet your health needs.

An on-call nurse or other licensed staff is available 24 hours per day, seven days per week to answer your questions. We are here to help you. You can reach us by calling 1-800-901-0020 (TTY 711) at any time.

#### When you choose us, you get more than just a health plan. You get:

A team who has served Virginians with Medicaid for more than two decades.

> All your health care benefits, no matter where you live. We offer Medallion Medicaid and FAMIS benefits statewide.

> Over 25,000 plan doctors, hospitals and specialists to choose from.

#### Plus, we offer no-cost extras like:

> Smartphone with monthly minutes, data, texts and unlimited calls to

Member Services.

➤ Mobile app — easily find health plan details on the go, plus search for nearby plan doctors, call the 24/7 NurseLine and more right from the app.

> Sports physicals for kids.

- > Boys & Girls Club memberships for kids (where available).
- GED assistance.
- ▶ Books for Babies books mailed right to your door for children up to 24 months.
- > HEPA Air Purifier need determined by your care coordinator.
- ➤ Weight Watchers<sup>®</sup> vouchers.

➢ Fitness Coach Program — access to online information, fitness and exercise classes. For more information, please go to www.choosehealthy.com/fitnesscoachanthem.

 $\triangleright$  No-cost rides to grocery stores and farmers markets.

#### What is a Health Risk Assessment?

Within the first few weeks after you enroll with us, a care coordinator will reach out to you to ask you some questions about your needs and choices. They will talk with you about any medical, behavioral, physical and social service needs that you may have. This meeting may be in-person or by phone and is known as a health risk assessment (HRA). An HRA is a complete assessment of your medical, psychosocial, cognitive and functional status.

The HRA is generally completed by a care coordinator **within the first 30 to 60 days** of your enrollment with **us** depending upon the type of services that you require. This assessment will enable your care coordinator to help you get the care that you need.

#### Transition of care period

If we're new for you, you can keep previously authorized and/or scheduled doctor appointments and prescriptions for the **first 30 days**. If your provider is not currently in our network, then you may be asked to select a new provider that is in our provider network. If your doctor leaves our network, we'll notify you **within 15 days** so that you have time to select another provider.

#### What if I have other coverage?

Medicaid is the payer of last resort. This means that if you have another insurance, are in a car accident, or if you are injured at work, your other insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicaid services when Medicaid is not the first payer. Let Member Services know if you have other insurance so that we can best coordinate your benefits. Our case managers will also work with you and your other health plan to coordinate your services.

## 3. How to get regular care and services

"Regular care" means exams, regular check-ups, shots or other treatments to keep you well, getting medical advice when you need it, and referring you to the hospital or specialists when needed. Be sure to call your primary care provider (PCP) whenever you have a medical question or concern. If you call after hours or on weekends, leave a message with where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

Your care must be **medically necessary**. The services you get must be needed:

- > To prevent, or diagnose and correct what could cause more suffering, or
- > To deal with a danger to your life, or
- > To deal with a problem that could cause illness, or
- > To deal with something that could limit your normal activities.

#### How to get care from a primary care provider (PCP)

A PCP is a doctor selected by you who meets state requirements and is trained to give you basic medical care. You will usually see your PCP for most of your routine health care needs. Your PCP will work with you to coordinate most of the services you get as a member of our plan.

Coordinating your services or supplies includes checking or consulting with other plan providers about your care.

If you need to see a doctor other than your PCP, you may need a referral (authorization) from your PCP. You may also need to get approval in advance from your PCP before receiving certain types of covered services or supplies. In some cases, your PCP will need to get authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Contact Member Services with any questions about referrals or prior authorizations.

#### **Provider Directory**

The provider directory includes a list of all of the doctors, specialty physicians, hospitals, clinics, pharmacies, laboratories, affiliations, accommodations for persons with physical disabilities, behavioral health providers, provider addresses, phone numbers, web site URLs and new patient acceptance (open or closed panels) who work with our plan. We can also provide you with a paper copy of the provider directory. You can also call our Member Services team at the number on the bottom of this page for assistance.

#### **Choosing your PCP**

If you do not have a PCP, we can help you find a highly-qualified PCP in your community. For help locating a provider you can use our on-line provider directory at **www.anthem.com/vamedicaid**.

You may want to find a doctor:

- > Who knows you and understands your health condition,
- ➢ Who is taking new patients,
- Who can speak your language, or
- Who has accommodations that you require.

If you have a disabling condition or chronic illnesses you can ask us if your specialist can be your PCP. We also contract with Federally Qualified Health Centers (FQHC). FQHCs

provide primary and specialty care. Another clinic can also act as your PCP if the clinic is a network provider.

Women can also choose an OB/GYN for women's health issues. These includes routine check-ups, follow-up care if there is a problem, and regular care during a pregnancy. **Women do not need a PCP referral to see an OB/GYN provider in our network.** 

If you do not select a PCP by the 25th of the month before the effective date of your coverage, we'll auto-enroll you with a PCP. We'll notify you in writing of the assigned PCP. You will need to call the Member Services number at the bottom of the page to select a new PCP.

If you need help finding a PCP, use our Find a Doctor tool online to search for PCPs near you at www.anthem.com/vamedicaid. You can search by ZIP code, specialty and more. If you need more help, call our Member Services team at the number below. We are here to help Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

#### If your current PCP isn't in our network

You can continue to see your current PCP for up to 30 days even if they are not in our network. During the first 30 days of your enrollment with the Anthem HealthKeepers Plus plan, your care coordinator can help you find a PCP in our network. At the end of the 30 day period, if you do not choose a PCP in our network, we'll assign a PCP to you.

#### How to get care from other network providers

Our provider network includes access to care 24 hours a day, seven days per week and includes hospitals, doctors, specialists, urgent care facilities, nursing facilities, home and community based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health and hospice providers, durable medical equipment providers and other types of providers.

We provide you with a choice of providers and they are located so that you do not have to travel very far to see them. There may be special circumstances where longer travel time is required; however, that should be only on rare occasions.

#### Medical advances and new technology

Our medical directors and the doctors we work with look at new medical advances and changes to existing technology in:

- Medical procedures.
- > Behavioral health procedures.
- Medicines.
- Medical devices.

They review new advances and technology and scientific literature to decide if:

- > These advances should be covered benefits.
- > The government has agreed the treatment is safe and effective.
- The results of the advances have the same or better outcomes than treatments we use now.

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

#### **Changing Your PCP**

You may call **our** Member Services team or go online to **www.anthem.com/vamedicaid** to change your PCP at any time to another PCP in our network. Please understand that it is possible your PCP will leave our network. We'll tell you within 30 days of the provider's intent to leave our network. We are happy to help you find a new PCP.

It's easy to change your PCP online. Our Find a Doctor tool is fast, convenient and available 24/7. To change your PCP online:

➢ Go to www.anthem.com/vamedicaid and log in to your secure account. Haven't set up an account yet? Follow the instructions on the login page — all you need is your Anthem HealthKeepers Plus member ID number.

➤ Use our Find a Doctor tool to search for a PCP.

> Follow the instructions to change your PCP right from your secure account.

If you need more help finding or changing your PCP, call Member Services at the number at the bottom of this page. If you choose to change your PCP, we'll send you a new member ID card with your new PCP's name on it.

#### Getting an appointment with your PCP

Your PCP will take care of most of your health care needs. Call your PCP to make an appointment. If you need care before your first appointment, call your PCP's office to ask for an earlier appointment. If you need help making an appointment, call Member Services at the number below.

#### Appointment standards

You should be able to get an appointment with your PCP within the same amount of time as any other patient seen by the PCP. Expect the following times to see a provider:

- ▶ For an emergency immediately.
- > For urgent care office visits with symptoms 24 hours of request.
- ▶ For routine primary care visit within 30 calendar days.

If you are pregnant, you should be able to make an appointment to see an OB/GYN as follows:

First trimester (first 3 months) — within fourteen (14) calendar days of request.

Second trimester (3 to 6 months) — within seven (7) calendar days of request.

> Third trimester (6 to 9 months) — within five (5) business days of request.

➢ High Risk Pregnancy — within three (3) business days or immediately if an emergency exists.

➢ If you are unable to receive an appointment within the times listed above, call Member Services at the number below and they will help you get the appointment.

#### Travel time and distance standards

We'll provide you with the services you need within the travel time and distance standards described in the table below. These standards apply for services that you travel to receive from network providers. These standards do not apply to providers who provide services to you at home. If you live in an urban area, you should not have to travel more than 30 miles or 30 minutes to receive services. If you live in a rural area you should not have to travel more than

Member Travel Time & Distance Standards		
Standard	Distance	Time
Urban		
• PCP	15 Miles	30 Minutes
<ul> <li>Specialists</li> </ul>	30 Miles	
Rural		
• PCP	30 Miles	60 Minutes
Specialists	60 Miles	45 Minutes

#### Accessibility

We want to make sure that all providers and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. If you have difficulty getting an appointment to a provider or accessing services because of a disability, contact Member Services at the telephone numbers below for assistance.

#### What if a provider leaves the Anthem HealthKeepers Plus network?

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that include the following:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we'll give you at least 15 days' notice so that you have time to select a new provider.
- We'll help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we'll work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out one of your providers is leaving our plan, please contact your case manager so we can assist you in finding a new provider and managing your care.

#### What types of people and places are network providers?

Anthem HealthKeepers Plus network providers include:

- Doctors, nurses, and other health care professionals that you can go to as a member of our plan.
- Clinics, hospitals, nursing facilities and other places that provide health services in our plan.
- Providers for children with special health care needs.
- > Behavioral Health and Substance Abuse practitioners, therapists, and counselors.

#### What are network pharmacies?

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our Members. Use the Provider and Pharmacy Directory to find the network pharmacy you want to use.

Call Member Services at the number at the bottom of the page for more information. We can give you the most up-to-date information about changes in our network pharmacies and providers. You can also look online at **www.anthem.com/vamedicaid**.

#### Services you can get without a referral or prior authorization

In most cases, you will need an approval from your PCP before seeing other providers.

This approval is called a referral.

You can get services like the ones listed here without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- ➢ Family Planning services and supplies.

➢ Routine women's health care services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.

➤ Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral.

## 4. How to get specialty care and services

#### What are specialists?

If you need care that your PCP can't provide, your PCP may refer you to a specialist. Most of the specialists are in our network. A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- > Oncologists care for patients with cancer.
- > Cardiologists care for patients with heart problems.
- > Orthopedists care for patients with bone, joint or muscle problems.

If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (known as a standing referral). If you have a standing referral, you won't need a new referral each time you need care. If you have a disabling condition or chronic illness you can ask us if your specialist can be your PCP.

#### How do I access a network specialist?

No referrals or authorizations (approval from us before getting a service or medication) are required to see a network specialist (specialist in our plan). Please see **section 8** of this handbook for information about which services require authorization.

#### How to get care from out-of-network providers

All visits to out-of-network doctors and specialists require an authorization from us. We authorize visits to out-of-network providers when there's an emergency, or when we don't have a doctor in the plan who can give you the service or procedure you need.

If we do not have a specialist in the Anthem HealthKeepers Plus network to provide the care you need, we'll get you the care you need from a specialist outside of our network. We'll also get you care outside of our network in any of the following circumstances:

- > When we've approved a doctor out of our established network;
- When emergency and family planning services are rendered to you by an out of network provider or facility;
- > When you receive emergency treatment by providers not in the network;
- > When the needed medical services are not available in our network;
- When we can't provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas;

- When the type of provider needed and available in our network does not, because of moral or religious objections, furnish the service you need;
- Within the first 30 calendar days of your enrollment, where your provider is not part of our network but he has treated you in the past; and,
- If you are in a nursing home when you enroll with us, and the nursing home is not in our network.

If your PCP or the Anthem HealthKeepers Plus plan refers you to a provider outside of our network, you are not responsible for any of the costs, except for your patient pay towards long term services and supports. See **section 14** of this handbook for information about what a patient pay is and how to know if you have one.

#### How to get care from out-of-state providers

We're not responsible for services you obtain outside Virginia except under the following circumstances:

- Necessary emergency or post-stabilization services
- Where it is a general practice for those living in your locality to use medical resources in another State; and,
- The required services are medically necessary and not available in-network and within the Commonwealth.

### 5. How to get emergency care and services

#### What is an emergency?

You are always covered for emergencies. An emergency is a sudden or unexpected illness, severe pain, accident or injury that could cause serious injury or death if it is not treated immediately.

#### What to do in an emergency

Call 911 at once! You do not need to call us first. Go to the closest hospital. Calling 911 will help you get to a hospital. You can use any hospital for emergency care, even if you are in another city or state. If you are helping someone else, please remain calm.

Tell the hospital that you are an Anthem HealthKeepers Plus member. Ask them to call us at the number on the back of your ID Card.

#### What is a medical emergency?

This is when a person thinks he or she must act quickly to prevent serious health problems. It includes symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you believe that it could cause:

- Serious risk to your health; or
- Serious harm to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

➢ In the case of a pregnant woman in active labor, meaning labor at a time when either of the following would occur:

• There is not enough time to safely transfer you to another hospital before delivery.

 $\circ$  The transfer may pose a threat to your health or safety or to that of your unborn child.

#### What is a behavioral health emergency?

A behavioral health emergency is when a person thinks about or fears they might hurt themselves or someone else.

#### **Examples of non-emergencies**

Examples of non-emergencies include colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. If you aren't sure, call your PCP or our 24/7 medical advice line at **1-800-901-0020 (TTY 711)**.

#### If you have an emergency when you're away from home

You or a family member may have a medical or a behavioral health emergency away from home. You may be visiting someone outside Virginia. While traveling, your symptoms may suddenly get worse. If this happens, go to the closest hospital emergency room. You can use any hospital for emergency care. Show them your member ID card. Tell them you are in the Anthem HealthKeepers Plus program.

#### What is covered if you have an emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. If you have an emergency, we'll talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is complete.

#### Notifying us about your emergency

Notify your doctor and the Anthem HealthKeepers Plus plan as soon as possible about the emergency within 48 hours if you can. However, you won't have to pay for emergency services because of a delay in telling us. We need to follow up on your emergency care. Your care coordinator will assist you in getting the correct services in place before you are discharged to ensure that you get the best care possible. Please call our Member Services team at **1-800-901-0020 (TTY 711)** Monday through Friday from 8 a.m. to 8 p.m. Eastern time. This number is also listed on the back of your member ID card.

#### After an emergency

We'll provide necessary follow-up care, including to out-of-network providers, until your physician says that your condition is stable enough for you to transfer to an in-network provider, or for you to be discharged. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible after your physician says you are stable. You may also need follow-up care to be sure you get better. Your follow-up care will be covered by our plan.

#### If you are hospitalized

If you are hospitalized, a family member or a friend should contact us as soon as possible. By keeping us informed, your care coordinator can work with the hospital team to organize the right care and services for you before you are discharged.

Your care coordinator will also keep your medical team including your home care services providers informed of your hospital and discharge plans.
### What if it wasn't a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care, and the doctor may say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it was not an emergency, we'll cover your additional care only if:

➢ You go to a network provider, or

> The additional care you get is considered "urgently needed care" and you follow the rules for getting urgently needed care. (See "Urgently needed care" in section 6 of this handbook.)

## 6. How to get urgently needed care

### What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have an existing condition that worsens and you need to have it treated right away. In most situations, we'll cover urgently needed care only if you get this care from a network provider. However, if you can't get to a network provider, we'll cover urgently needed care you get from an out-of-network provider.

You can find a list of urgent care centers we work with in our Provider and Pharmacy Directory, available on our website at **www.anthem.com/vamedicaid.** 

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

# 7. How to get prescription drugs

This section explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or drug store.

### Rules for Anthem HealthKeepers Plus Outpatient Drug Coverage

We'll usually cover your drugs as long as you follow the rules in this section.

- 1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
- 2. You must use a network pharmacy to fill your prescription.
- 3. Your prescribed drug must be on our List of Covered Drugs. If it is not on the Drug List, we may be able to cover it by giving you an authorization. Usually, your provider will request an authorization if they think you need a drug that is not on our List of Covered Drugs. If you wish to request an authorization yourself, call Member Services at the number listed at the bottom of the page.
- 4. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

### **Getting Your Prescriptions Filled**

In most cases, we'll pay for prescriptions only if they are filled at Anthem HealthKeepers Plus network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our Members. You may go to any of our network pharmacies.

To find a network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services at the number at the bottom of the page.

To fill your prescription, show your member ID card at your network pharmacy. The network pharmacy will bill us for the cost of your covered prescription drug. If you do not have your member ID card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If you need help getting a prescription filled, you can contact Pharmacy Member Services at 1-833-207-3120 (TTY 711).

### List of Covered Drugs

The Anthem HealthKeepers Plus plan has a List of Covered Drugs that we select with the help of a team of doctors and pharmacists. Our List of Covered Drugs also includes all of the drugs on the DMAS Preferred Drug List (PDL).

The List of Covered Drugs can be found at **www.anthem.com/vamedicaid**. It tells you which drugs are covered by **us** and also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get.

You can call Member Services to find out if your drugs are on the List of Covered Drugs or check on-line at **www.anthem.com/vamedicaid** or we can mail you a paper copy. The List of Covered Drugs may change during the year. To get the most up-to-date version, visit **www.anthem.com/vamedicaid** or call our Member Services team at 1-800-901-0020 (TTY 711) Monday through Friday from 8 a.m. to 8 p.m. Eastern time. They'll also send you a paper copy, free of charge, if you need one.

We'll generally cover a drug on our List of Covered Drugs as long as you follow the rules explained in this section. You can also get drugs that are not on the list when medically necessary. Your physician may have to obtain a service authorization from us in order for you to receive some drugs.

### Limits for coverage of some drugs

For certain prescription drugs, special rules limit how and when we cover them. In general, our rules encourage you to get a drug that works for your medical condition and that is safe and effective, and cost effective.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may need to request a service authorization for you to receive the drug. We may or may not agree to approve the request without taking extra steps. Refer to "Service authorization and benefit determination" and "Service authorizations and transition of care" in **section 11** of this handbook.

If the Anthem HealthKeepers Plus plan is new for you, you can keep getting your authorized drugs for the duration of the authorization or for **30 days** after you first enroll, whichever is sooner. Refer to "Transition of care period" in **section 11** of this handbook.

If we deny or limit coverage for a drug, and you disagree with our decision, you have the right to appeal our decision. Refer to "Your right to appeal" in **section 12** of this handbook. If you have any concerns, contact your care coordinator. They'll work with you and your PCP to make sure that you receive the drugs that work best for you.

### Getting approval in advance

For some drugs, you or your doctor must get a service authorization approval from us before you fill your prescription. If you don't get approval, we may not cover the drug.

### Trying a different drug first

We may require that you first try one (usually less-expensive) drug before we'll cover another (usually more-expensive) drug for the same medical condition. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, then we'll cover Drug B. This is called step therapy.

### **Quantity limits**

For some drugs, we may limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug your physician has prescribed, check the List of Covered Drugs. For the most up-to-date information, call Member Services or visit our website at **www.anthem.com/vamedicaid**.

### **Emergency supply**

There may be an instance where your medication requires a service authorization, and your prescribing physician can't readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit a service authorization request for the prescribed medication.

### Non-covered drugs

By law the types of drugs listed below are not covered by Medicare or Medicaid:

Drugs used to promote fertility;

> Drugs used for cosmetic purposes or to promote hair growth;

> Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra<sup>®</sup>, Cialis<sup>®</sup>, Levitra<sup>®</sup> and Caverject<sup>®</sup>, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;

> Drugs used for treatment of anorexia, weight loss, or weight gain;

➢ All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective, including prescriptions that include a DESI drug;

Drugs that have been recalled;

> Experimental drugs or non-FDA-approved drugs; and,

Any drugs marketed by a manufacturer who does not participate in the Virginia Medicaid Drug Rebate program.

### **Changing pharmacies**

If you need to change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy. If you need help changing your network pharmacy, you can contact Pharmacy Member Services at 1-833-207-3120 (TTY 711) or your care coordinator.

If the pharmacy you use leaves our network, you will have to find a new network pharmacy. To find a new network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website or contact Pharmacy Member Services at 1-833-207-3120 (TTY 711) or your care coordinator. Member Services can tell you if there is a network pharmacy nearby.

### What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. These prescriptions are called specialty drugs. They often need you to have special care while taking them. Specialty drugs are often used to treat chronic illnesses, and they usually require special handling, administration or monitoring.

We have a specialty pharmacy network for our members in case you need specialty drugs. These specialty pharmacies provide the special care needed when a specialty drug is dispensed. If you need specialty drugs, you must use a specialty pharmacy in our plan. The specialty pharmacies in our plan are IngenioRx Specialty and Acaria Health.

If you have questions regarding your specialty pharmacy or your specialty drugs, call:

- ▶ IngenioRx Specialty at 1-833-255-0646.
- Acaria Health at 1-800-511-5144.

Or you can call us at 1-833-207-3120 (TTY 711) if you have any difficulty obtaining your specialty medicines. We're here to help. Call us to find out if a drug is considered a specialty drug or to get a copy of the specialty drug list. You and your doctor can work together to decide which drug is best for you.

### Can you use mail-order services to get your prescriptions?

You cannot use mail-order services to get your prescriptions.

### Can you get a long-term supply of drugs?

You can get up to a 31-day supply of your drugs.

### Can you use a pharmacy that is not in our network?

In general, we will not pay for medicines you get at pharmacies that aren't in our plan.

### What is the Patient Utilization Management and Safety (PUMS) Program?

Some members who require additional monitoring may be enrolled in the Patient Utilization Management and Safety (PUMS) program. The PUMS program is required by DMAS and helps make sure your drugs and health services work together in a way that won't harm your health. As part of this program, we may check the Prescription Monitoring Program (PMP) tool that the Virginia Department of Health Professions maintains to review your drugs. This tool uses an electronic system to monitor the dispensing of controlled substance prescription drugs.

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We'll send you a letter to let you know how PUMS works. The inclusion period is for 12 months. At the end of the lock in period, we'll check in with you to see if you should continue the program.

If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to "Appeals, State Fair Hearings, and complaints" in **section 12** of this handbook.

If you're in the PUMS program, you can get prescriptions after hours if your selected pharmacy doesn't have 24-hour access. You'll also be able to pick a PCP, pharmacy or other provider where you want to be locked in. If you don't select providers for lock in within 15 days, we'll choose them for you. Members who are enrolled in PUMS will receive a letter from us that provides additional information on PUMS including all of the following information:

> A brief explanation of the PUMS program;

- > A statement explaining the reason for placement in the PUMS program;
- > Information on how to appeal to us if placed in the PUMS program;

➢ Information regarding how to request a State Fair Hearing after first exhausting the appeals process;

Information on any special rules to follow for obtaining services, including for emergency or after hours services; and

➤ Information on how to choose a PUMS provider.

Contact Member Services at the number below or your care coordinator if you have any questions on PUMS.

# 8. Benefits

### General coverage rules

To receive coverage for services you must meet the general coverage requirements described below.

1. Your services (including medical care, services, supplies, equipment and drugs) must be medically necessary. Medically necessary generally means you need the services to prevent, diagnose, or treat a medical condition or prevent a condition from getting worse.

2. In most cases, you must get your care from a network provider. A network provider is a provider who works with us. In most cases, we won't pay for care you get from an out-of-network provider unless the service is authorized by us. **Section 3** has information about services you can get without first getting approval from your PCP. **Section 4** has more information about using network and out-of-network providers.

3. Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called service authorization. **Section 11** includes more information about service authorizations

4. If the Anthem HealthKeepers Plus plan is new for you, you can keep seeing the doctors you go to now for the first **30 days**. You can also keep getting your authorized services for the duration of the authorization or for 30 days after you first enroll, whichever is sooner. Also see "Transition of care period" in **section 11**.

### Benefits covered through the Anthem HealthKeepers Plus plan

We cover all of the following services for you when they are medically necessary.

Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. See section 3 of this handbook for more information about PCP services.

Preventive care, including regular check-ups, well-baby/well-child care. See section 3 of this handbook for more information about PCP services.

Addiction, recovery, and treatment services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services and case management. Services may require authorization. Additional information about ARTS services is provided later in this section of the handbook.

➢ Behavioral health services, including inpatient and outpatient psychotherapy individual, family, and group are covered. (Except community mental health rehabilitation services are covered through Magellan, the DMAS Behavioral Health Services Administrator; see section 8 of this handbook.)

Clinic services

Colorectal cancer screening

Community Mental Health and Rehabilitative Services (Beginning August 1, 2018)

- Court ordered services
- > Durable medical equipment and supplies (DME)

➤ Early and periodic screening diagnostic and treatment services (EPSDT) for children under age 21. Additional information about EPSDT services is provided later in this section of the handbook.

➤ Early intervention services designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third birthday. Additional information about early intervention services is provided later in this section of the handbook.

- Electroconvulsive therapy (ECT)
- Emergency custody orders (ECO)

> Emergency services including emergency transportation services (ambulance, etc.)

Emergency and post stabilization services. Additional information about emergency and post stabilization services is provided in **section 5 and 6** of this handbook.

End stage renal disease services

➢ Eye examinations

➤ Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of our network. We don't require you to obtain service authorization or PCP referrals on family planning services.

- Glucose test strips
- Hearing (audiology) services
- ➢ Home health services
- ➢ Hospice services
- Hospital care inpatient/outpatient
- > Human Immunodeficiency Virus (HIV) testing and treatment counseling
- ➤ Immunizations
- > Inpatient psychiatric hospital services
- Laboratory, Radiology and Anesthesia Services

Lead investigations

➤ Mammograms

Maternity care — includes pregnancy care, doctors/certified nurse-midwife services. Additional information about maternity care is provided in section 6 of this handbook.

> Nurse Midwife Services through a Certified Nurse Midwife provider

➢ Organ transplants

> Orthotics, including braces, splints and supports — for children under 21, or adults through an intensive rehabilitation program

- Outpatient hospital services
- ➢ Pap smears
- > Physician's services or provider services, including doctor's office visits
- > Physical, occupational, and speech therapies
- Podiatry services (foot care)
- ➢ Prenatal and maternal services

Prescription drugs. See section 7 of this handbook for more information on pharmacy services.

- Private duty nursing services (through EPSDT) Under Age 21
- > Prostate specific antigen (PSA) and digital rectal exams
- Prosthetic devices including arms, legs and their supportive attachments, breasts and eye prostheses
- Psychiatric or psychological services

Radiology services

- Reconstructive breast surgery
- Renal (kidney) dialysis services

Rehabilitation services — inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services)

➤ Second opinion services from a qualified health care provider within the network or we'll arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs

Surgery services when medically necessary and approved by us

> Telemedicine service

Temporary detention orders (TDO)

Tobacco Cessation Service

> Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). We'll also provide transportation to/from most carved-out services. Additional information about transportation services is provided later in this section of the handbook.

➤ Vision service

➢ Well visits and checkups

Abortion services — coverage is only available in cases where there would be a substantial danger to life of the mother.

### Extra benefits included in the Anthem HealthKeepers Plus plan

As our member, you have access to services that are not generally covered through Medicaid fee-for-service. These are known as "enhanced benefits." We provide the following enhanced benefits:

> Adult dental care—one cleaning, one exam, and a set of bitewing X-rays per year

Smartphone with 350 monthly minutes, data, and unlimited texts. You also get unlimited calls to Member Services.

➢ Rides to the grocery store — find out more at the end of this section under "Transportation services covered by the Anthem HealthKeepers Plus plan."

> Meals delivered to your home after you leave the hospital of nursing facility

➤ GED assistance (testing voucher up to \$120 in value)

Sports physicals for kids

Boys & Girls Club memberships for kids (where available)

➢ Books for Babies Program — get up to three no-cost children's books delivered right to your home if your newborn is under 24 months old.

➢ WeightWatchers<sup>®</sup> vouchers worth \$120, or 13 weeks of membership fees and 14 weeks of E-tools vouchers\*

Coupon booklet with over \$1,000 in savings at local stores

> \$20 Walmart gift card for completing your health assessment or screener

> \$25 gift card to Walmart or Kohl's for high school and college students who earn A's and B's

➢ Fitness Coach Program — access to online information, fitness, and exercise classes.
For more information, please go to www.choosehealthy.com/fitnesscoachanthem.

➤ Mobile app — easily find health plan details on the go, search for nearby plan doctors, call the 24/7 NurseLine, and more right from the app. You can even view your ID card.

Community Resource Link —find community events, jobs and more with this useful online tool.

➢ Baby Essentials Catalog — choose up to two essential baby items, such as diapers, umbrella stroller, or highchair, from a custom catalog for completing a prenatal or postpartum visit.

➤ Asthma and COPD Relief Catalog — choose up to \$100 worth of asthma and allergy relief products from a catalog of options each year. Options include air filters, hypoallergenic bedding, and more.

\* WeightWatchers<sup>®</sup> vouchers are for a free 13-week program with WeightWatchers. A WeightWatchers account must be created to use the voucher. Unless the account is cancelled before the end of the 13 weeks, WeightWatchers may bill for monthly membership fees after the 13-week course is complete.

If you have any questions about these benefits, please call our Member Services Department at the number on the bottom of this page. We're here to help Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

### **Our Healthy Rewards program**

Our Healthy Rewards program rewards you for doing things that are good for your health. You can earn up to \$25 for completing activities like wellness check-ups, diabetic screenings, mammograms or refilling your medication.

You can spend these Healthy Rewards dollars at stores near you on a variety of approved items you need to stay healthy. Check the list below and see which healthy activities you may qualify for:

Healthy activities	Who's eligible	Reward	Limit
Breast cancer screening	Members ages 50-74	\$25	Once every 24 months
Cervical cancer screening	Members ages 21-64	\$10	Once every 36 months
Chlamydia screening	Members ages 16-24	\$10	Once every 12 months

Childhood immunizations combo 3	Members ages 0-2	\$15	Once every 12 months
Adolescent immunizations	Members ages 10-13	\$10	Once every 12 months
Lead screening	Members ages 0-2	\$10	Once every 12 months
Adolescent well-visit	Members ages 12-21	\$10	Once every 12 months
Human papillomavirus (HPV) vaccine	Members ages 9-13	\$10	Once Every 12 months
Well-child visit	Members ages 15 months-11 years	\$10	Once every 12 months
High blood pressure medication refill	Members ages 18-85	\$10	Three times per every 12 months
Diabetic A1c testing	Members ages 18-75	\$10	Once every 12 months
Diabetic eye exam	Members ages 18-75	\$25	Once every 12 months
Diabetic nephropathy exam	Members ages 18-75	\$10	Once every 12 months
Adult well-visit	Members ages 18-74	\$10	Twice every 12 months
Flu vaccine	Members ages 18-64	\$10	Once every 12 months

To find out more about the Healthy Rewards program and to enroll, call 1-877-868-2004 (TTY 711) or visit us online at **mss.anthem.com/healthyrewards**. You must enroll in the program before completing the healthy activities to earn rewards.

# What is Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for

individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly.

EPSDT promotes the early and universal assessment of children's health care needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. EPSDT screenings are conducted by physicians or certified nurse practitioners and can occur during the following:

- Screening/well child check-ups (EPSDT/Periodic screenings) Checkup that occurs at regular intervals.
- Sick visits (EPSDT/Inter-periodic Screenings) Unscheduled check-up or problem focused assessment that can happen at any time because of child's illness or a change in condition.

We also cover any and all services identified as necessary to correct, or ameliorate any identified defects or conditions. Coverage is available under EPSDT for services even if the service is not available under the State's Medicaid Plan to the rest of the Medicaid population. All treatment services require service authorization (before the service is rendered by the provider).

### How to access EPSDT service coverage

The Anthem HealthKeepers Plus plan provides most of the Medicaid EPSDT covered services. These services require a prior authorization from your doctor. However, some EPSDT services, like pediatric dental care, are not covered by us. For any services not covered by us, you can get these through the Medicaid fee-for-service program. Additional information is provided in **section 11** of this handbook.

### How to access Early Intervention service coverage

If you have a baby under the age of three, and you believe that he or she is not learning or developing like other babies and toddlers, your child may qualify for early intervention services. Early intervention services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional or adaptive development. The services include speech therapy, physical therapy and occupational therapy. The first step is meeting with the local Infant and Toddler Connection program in your community to see if your child is eligible. Children from birth to age three are eligible if he or she has (i) a 25% developmental delay in one or more areas of development, (ii) atypical development or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

For more information, call your care coordinator. Your care coordinator can help. If your child is enrolled in the Anthem HealthKeepers Plus plan, we provide coverage for early intervention services. If the family requests assistance with transportation and scheduling to receive Early Intervention services, we provide this assistance.

Your care coordinator will work closely with you and the Infant and Toddler Connection program to help you access these services and any other services that your child may need. Information is also available at **www.infantva.org** or by calling 1-800-234-1448.

### Foster Care and Adoption Assistance

We can provide individuals who are in foster care or are receiving adoption assistance with assistance in referrals to providers, transition planning (for youth about to leave the foster care system) and care coordination. In fact, we have a case management team that specializes in these services and in working with local Departments of Social Services to help navigate medical and/or behavioral health care and other resources.

For more information about these resources, please call our Foster Care Case Management Team at 1-844-533-1994, ext. 106-125-5019.

### How to access Maternal and Child Health Services

With your Medicaid or FAMIS MOMS health care coverage, you can get free services to help you have a healthy pregnancy and a healthy baby. Medicaid and FAMIS MOMS pay for your prenatal care and the delivery of your baby. Getting medical care early in your pregnancy is very important.

We have programs for pregnant women that include:

- > Pregnancy-related and postpartum services.
- > Prenatal and infant programs.
- Services to treat any medical condition that may complicate pregnancy.
- Lactation consultation and breast pumps.
- ➤ Smoking cessation.
- Postpartum depression screening.

### The Anthem HealthKeepers Plus New Baby, New Life<sup>™</sup> Program

New Baby, New Life<sup>SM</sup> is a program for pregnant members. It is very important to see your primary care provider (PCP) or obstetrician or gynecologist (OB/GYN) for care when you are pregnant. This kind of care is called prenatal care. It can help you to have a healthy baby. Prenatal care is always important even if you have already had a baby. Our program helps pregnant members with complicated health care needs. A nurse care coordinator works closely with pregnant members to provide:

- ≻ Education.
- ➢ Emotional support.
- > Help in following their doctor's care plan.
- Information on services and resources in your community, such as transportation, the Women, Infants, and Children program (WIC), breastfeeding and counseling.

Your case manager will also work with your doctors and help with other services you may need. The goal is to promote better health for members and delivery of healthy babies.

### When you become pregnant

If you think you are pregnant:

- Call your PCP or OB/GYN right away. You do not need a referral from your PCP to see an OB/GYN.
- Call Member Services if you need help finding an OB/GYN in the Anthem HealthKeepers Plus network.

When you find out you are pregnant, you must also call Member Services.

### Your pregnancy education package

We will send you a pregnancy education package. It will include:

- ➢ A congratulations letter.
- A self-care book with information about your pregnancy; you can also use this book to write down things that happen during your pregnancy.
- Having a Healthy Baby brochure with helpful resources.

### Get to know My Advocate<sup>TM</sup>

We want to give you the very best care during your pregnancy. That's why you will also be part of My Advocate<sup>TM</sup>, which is part of our New Baby, New Life<sup>SM</sup> program. My Advocate<sup>TM</sup> gives you the information and support you need to stay healthy during your pregnancy.

My Advocate<sup>TM</sup> delivers maternal health education by phone, text messaging and smartphone app that is helpful and fun. You will get to know Mary Beth, the My Advocate<sup>TM</sup> automated personality. Mary Beth will respond to your changing needs as your baby grows and develops. You can count on:

- Education you can use.
- ➤ Communication with your case manager based on My Advocate<sup>TM</sup> messaging should questions or issues arise.
- An easy communication schedule.

➢ No cost to you.

With My Advocate<sup>TM</sup>, your information is kept secure and private. Each time Mary Beth calls, she'll ask you for your year of birth. Please don't hesitate to tell her. She needs the information to be sure she's talking to the right person.

My Advocate<sup>™</sup> calls give you answers to your questions, plus medical support if you need it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn and answer a question or two over the phone.\* If you tell us you have a problem, you'll get a call back from a case manager.

My Advocate<sup>™</sup> topics include:

- Pregnancy and postpartum care.
- Well-child care.
- ➢ Dental care.
- Immunizations.
- Healthy living tips.

\*Phone or text rates may apply.

### **During your pregnancy**

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from WIC. Member Services can give you the phone number for the WIC program close to you.

When you are pregnant, you must go to your PCP or OB/GYN at least:

- > Every four weeks for the first six months.
- Every two weeks for the seventh and eighth months.
- Every week during the last month.

Your PCP or OB/GYN may want you to visit more than this based on your health needs.

### When you have a new baby

When you deliver your baby, you and your baby may stay in the hospital at least:

- ▶ 48 hours after a vaginal delivery.
- ➢ 72 hours after a Cesarean section (C-section).

You may stay in the hospital less time if your PCP or OB/GYN and the baby's provider sees that you and your baby are doing well. If you and your baby leave the hospital early, your PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.

### After you have your baby

After you have your baby, you must:

- Call Member Services as soon as you can to let your case manager know you had your baby. We will need details about your baby.
- Call and apply for Medicaid for your baby.

We'll send you a postpartum education package after you have your baby. It will include:

- ► A congratulations letter.
- A self-care book with information on caring for your newborn.
- Postpartum depression brochure.
- Making a Family Life Plan brochure.

If you were enrolled in My Advocate<sup>TM</sup> and received educational calls during your pregnancy, you will now get calls on postpartum and well-child education up to 12 weeks after your delivery.

It's important to set up a visit with your PCP or OB/GYN after you have your baby for a postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.

> The visit should be done between 21 and 56 days after you deliver.

If you delivered by C-section, your PCP or OB/GYN may ask you to come back for a one or two week post-surgery checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within 21 to 56 days after your delivery for your postpartum checkup.

> You may also get a call from our postpartum outreach team to see how you're doing. The team can help you schedule your postpartum visit 21 to 56 days after you have your baby. The team may also call with reminders.

### **Enrollment for newborns**

Once you have your baby, you will need to report the birth of your child as quickly as possible to enroll your baby for Medicaid. You can do this by:

Calling the Cover Virginia Call Center at 1-855-242-8282 to report the birth of your child over the phone, or

Contacting your local Department of Social Services to report the birth of your child. You will be asked to provide your information and your infant's:

- ≻ Name
- ➢ Date of birth
- ➢ Race

- ≻ Sex
- Mother's name and Medicaid ID number

### How to access Family Planning services

Family planning services include services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of our network.

### How to access Behavioral Health services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety or other mental health issues as well as using substances at some time in their lives.

These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in your home or in the community, for a short or long timeframe, and all are performed by qualified individuals and organizations.

Some Behavioral Health services are covered for you through Magellan, the DMAS Behavioral Health Services Administrator (BHSA). Our Member Services team can help coordinate the services you need, including those that are provided through the BHSA.

If you need Behavioral Health services, call our Member Services team at the number at the bottom of the page. We're here to help you get the services and providers you need.

### Some services may require a prior authorization (preapproval), including:

- Inpatient Behavioral Health services.
- > Any psychological testing that takes more than four hours.
- > All neuropsychopathic testing.

### How to access Addiction and Recovery Treatment Services (ARTS)

We offer a variety of services that help individuals who are struggling with using substances, including drugs and alcohol. Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment no matter how bad the problem may seem.

If you need treatment for addiction, we provide coverage for services that can help you.

These services include settings in inpatient, outpatient, residential and community-based treatment. Medication assisted treatment options are also available if you are dealing with using prescription or non-prescription drugs.

Other options that are helpful include peer services (someone who has experienced similar issues), as well as case management services. Talk to your PCP or call your case manager to determine the best option for you and how to get help in addiction and recovery treatment services. To find an ARTS provider, you can look in the Provider and Pharmacy Directory, visit our website, call your case manager or contact Member Services at one of the numbers below.

To get ARTS services, talk with your provider directly, or give us a call at the Member Services number at the bottom of this page. Certain ARTS program services require a preapproval, including:

- Substance abuse Intensive Outpatient Programs (IOPs).
- Substance abuse peer support services.
- Substance abuse inpatient detox services.
- Suboxone and other substance abuse pharmacy-related services.

### Transportation services covered by the Anthem HealthKeepers Plus plan

We cover non-emergency transportation services for covered services, carved out services, and enhanced benefits. We contract with **Access2Care** to help you get where you need to go. Transportation may be provided if you have no other means of transportation and need to go to a physician or a health care facility for a covered service.

For urgent or nonemergency medical appointments, call **1-877-892-3988 (TTY 711)** to reserve a ride. If you are having problems getting transportation to your appointments, call **Access2Care** at **1-877-892-3988 (TTY 711)** or Member Services at the number below.

In case of a life-threatening emergency, **call 911**. Refer to "How to get care for emergencies" in **section 5** of this handbook.

We offer unlimited rides to doctor appointments and the pharmacy to pick up medication for Medallion Medicaid members, but nonemergency rides are **NOT** a benefit for FAMIS members at this time.

### How to set up your ride

To set up your ride, just follow these steps:

- Call Access2Care <u>two business days in advance</u> of when you need your ride at 1-877-892-3988 (TTY 711). Please have your member ID number, address and date and time of your appointment ready when you call. Remember to write down your confirmation number in case you need to refer to it later.
- 2. Let them know if you have any special transportation needs.
- 3. Go ahead and schedule a return trip if you know when your appointment will be over. They'll pick you up within up to an hour. If you don't know how long you'll be, just call Access2Care when your appointment is over.

If you can't coordinate a ride or have a complaint, call our Member Services team at 1-800-901-0020 (TTY 711).

# We offer nonmedical rides to grocery stores and farmers markets as an extra benefit for our Medallion Medicaid and FAMIS members.\*

\*Members under the age of 17 must be accompanied by a parent or guardian.

These rides are available seven days a week from 8 a.m. to 5 p.m. We'll cover up to

12 round trips\* annually, or three every three months. A round trip is classified as one pickup and one drop-off not exceeding more than 30 miles round trip for urban locations and 60 miles for rural areas.

### Mileage reimbursement

We'll reimburse you or your caregiver if a personal car is used for medical or nonmedical rides. To receive mileage reimbursement, call Access2Care two business days in advance of your appointment. You'll receive the reimbursement form by mail or fax, and your provider must sign the form to verify the appointment.

### For recurring transportation needs

If you need recurring rides to critical dialysis services, substance abuse treatment and adult day care, your providers need to contact Access2Care and have them complete a form that will be approved for three-months at a time.

\*A round trip is comprised of two trips (one pickup and one drop-off per trip). You'll be picked up, transported to the destination and returned to the starting location. In urban locations, a round trip cannot exceed 30 miles. In rural locations, a round trip cannot exceed 60 miles.

For more information, visit www.anthem.com/vamedicaid.

## 9. Services not covered

The following services are not covered by Medicaid or the Anthem HealthKeepers Plus plan. If you receive any of the following non-covered services you will be responsible for the cost of these services.

- ➤ Acupuncture
- Administrative expenses, such as completion of forms and copying records
- > Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Assisted suicide
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Christian Science nurses
- Cosmetic treatment or surgery
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers)
- Dentures for members age 21 and over
- Drugs prescribed to treat hair loss or to bleach skin
- Elective Abortions
- Erectile Dysfunction Drugs
- > Experimental or Investigational Procedures
- > Eyeglasses or their repair for members age 21 or older

> Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by us)

> Medical care other than emergency services, urgent services or family planning services, received from providers outside of the network unless authorized by us

- Services rendered while incarcerated
- ➤ Weight loss clinic programs unless authorized
- Care outside of the United States

### If you receive non-covered services

We cover your services when you are enrolled with our plan and:

➤ Services are medically necessary, and

Services are listed as "Benefits covered through the Anthem HealthKeepers Plus plan" in section 8 of this handbook, and

> You receive services by following plan rules.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we'll pay for any medical service or care, you have the right to ask us. You can call Member Services or your care coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we'll not pay for your services, you have the right to appeal our decision. **Section 12** provides instructions for how to appeal our coverage decisions. You may also call Member Services to learn more about your appeal rights or to obtain assistance in filing an appeal.

## 10. Services covered through Medicaid Fee-For-Service

DMAS will provide you with coverage for any of the services listed below. These services are known as "carved-out services." You stay in the Anthem HealthKeepers Plus plan when receiving these services. Your provider bills fee-for-service Medicaid (or its Contractor) for these services.

### **Carved out services**

> Dental Services provided through the Smiles For Children program

The state has contracted with DentaQuest to coordinate the delivery of all Medicaid dental services. The name of the program is Smiles For Children. Smiles For Children provides coverage for the following populations and services:

- For children under age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services
- For pregnant women: X-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, bridges, partials, and dentures, tooth extractions and other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. The dental coverage ends 60 days after the baby is born.
- For adults age 21 and over, coverage is only available for limited medically necessary oral surgery services. Routine dental services are covered for adults ages 21-64 as an extra benefit with the Anthem HealthKeepers Plus plan.

If you have any questions about your dental coverage through Smiles For Children, you can reach DentaQuest Member Services at 1-888-912-3456, Monday through Friday, 8 a.m.-6 p.m. Eastern time. The TTY/TDD number is 1-800-466-7566. Additional Smiles For Children program information is provided at https://www.coverva.org/programs\_smiles.cfm.

We provide coverage for non-emergency transportation for any dental services covered through Smiles for Children, as described above. Contact Anthem HealthKeepers Plus Member Services at the number below if you need assistance. School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.

### Services that will end your enrollment

If you receive any of the services below, your enrollment with the Anthem HealthKeepers Plus plan will close and you will be served by the Medicaid Fee-For-Service program so long as you remain eligible for Medicaid.

- > You get care in certain facilities, including:
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities.
  - Psychiatric Residential Treatment Level C Facilities (children under 21).
  - Nursing facilities.
  - Long-term care facilities.
  - Long-stay hospitals.
  - Piedmont, Catawba or Hancock State facility operated by DBHDS.
  - Nursing facilities operated by the Veterans Administration.
- > You get care through certain programs, including:
  - Spend down.
  - Federal Waiver programs for home-based and community based Medicaid coverage.
  - Commonwealth Coordinated Care (CCC) Plus program.
  - Birth Injury Fund.
  - Plan First benefit.
  - Governor's Access Plan (GAP).
  - FAMIS Select.
  - Program for All-Inclusive Care for the Elderly (PACE) benefit.
- > You're receiving certain services like hospice care.
- Your status changes, because:
  - You're dual eligible and are enrolled in both Medicaid and Medicare.
  - You're not a student and permanently live outside our service area for more than sixty (60) consecutive days (unless you are placed there for medically necessary services).

- You're an inpatient in a hospital, at the scheduled time of enrollment or are scheduled for inpatient hospital stay or surgery within thirty (30) calendar days of enrollment. You'll remain excluded until the first day of the month following discharge. (This does not apply to newborns unless there is a break in coverage.)
- Your eligibility period is less than three (3) months or is only retroactive.
- Your request exclusion, because:
  - You've been assigned to us, but your doctor gave you a life expectancy of six (6) months or less.
  - You're in your third trimester of pregnancy, ask for exclusion by the 15th of the month in which you're enrolled with us and your obstetrical provider doesn't participate with any of the state-contracted MCOs.

# 11. Service authorization procedure

### Service authorizations explained

There are some treatments, services and drugs that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called a service authorization. Your doctor makes requests for service authorizations.

A service authorization helps to determine if certain services or procedures are medically needed and covered by the plan. Decisions are based on what is right for each member and on the type of care and services that are needed.

### We look at standards of care based on:

- ➢ Medical policies.
- National clinical guidelines.
- Medicaid guidelines.
- > Your health benefits.

### We don't reward employees, consultants or other providers to:

- Deny care or services that you need.
- Support decisions that approve less than what you need.
- Say you don't have coverage.

Service authorizations are not required for early intervention services, emergency care, family planning services (including long acting reversible contraceptives), preventive services and basic prenatal care.

### The following treatments and services must be authorized before you get them:

- Outpatient services
- Behavioral Health services
- > Transplants
- Out-of-network services
- Inpatient services

To find out more about how to request approval for these treatments or services you can contact Member Services at the number below or call your care coordinator. If you're unsure about whether or not a service you need requires authorization, ask your doctor or provider to check for you.

### Service authorizations and transition of care

If you are new to the Anthem HealthKeepers Plus plan we'll honor any service authorization approvals made by the Department of Medical Assistance Services or issued by another plan for up to 30 days (or until the authorization ends if that is sooner than 30 days).

### How to submit a service authorization request

Usually, your provider will submit a service authorization request, but if you wish to submit a service authorization request yourself, just call Member Services at the number at the bottom of this page.

### What happens after submitting a service authorization request?

We have a review team to be sure you receive medically necessary services. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards. The standards we use to determine what is medically necessary are not allowed to be more restrictive than those that are used by DMAS.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination (decision). These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a medical or behavioral health professional, who may be a doctor or other health care professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

After we get your request, we'll review it under a standard or expedited (fast) review process. You or your doctor can ask for an expedited review if you believe that a delay will cause serious harm to your health. If your request for an expedited review is denied, we'll tell you and your case will be handled under the standard review process.

### Timeframes for service authorization review

In all cases, we'll review your request as quickly as your medical condition requires us to do so but no later than mentioned next.

Physical Health Services	Service Authorization Review Timeframes
Inpatient Hospital Services	Within 1 business day if we have all the
(Standard or Expedited Review	information we need, or up to 3 more
Process)	business days if we need additional
	information, or as quickly as your condition
	requires.
Outpatient Services	Within 14 business days if we have all the
(Standard Review Process)	information we need, or up to 14 more
	business days if we need additional
	information.
Outpatient Services	Within 72 hours from receipt of your
(Expedited Review Process)	request; or, as quickly as your condition
	requires.

Behavioral Health Services	Service Authorization Review Timeframes
Inpatient	Within 1 business days if we have all of the
(Standard Review)	information we need, or up to 3 more
	business days if we need additional
	information, or as quickly as your condition
	requires.
Outpatient	Within 14 business days if we have all of the
(Standard Review)	information we need, or up to 14 more
	business days if we need additional
	information, or as quickly as your condition
	requires.

Pharmacy Services	Service Authorization Review Timeframes
Pharmacy services	We must provide decisions by telephone or
	other telecommunication device within
	24 hours.

There may be an instance where your medication requires a service authorization, and your prescribing physician can't readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit an authorization request for the prescribed medication.

# If we need more information to make either a standard or expedited decision about your service request, we'll:

- ➤ Write and tell you and your provider what information is needed. If your request is in an expedited review, we'll call you or your provider right away and send a written notice later.
- > Tell you why the delay is in your best interest.

➤ Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give us to help decide your case. This can be done by calling our Member Services team at the number listed on the bottom of this page. We're here to help Monday through Friday from 8 a.m. to 8 p.m. Eastern time. You can also fax in your information to 1-800-964-3627.

You or someone you trust can file a complaint with us if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the way we handled your service authorization request to the State through the Managed Care Helpline at 1-800-643-2273. Also see "Your Right to File a Complaint," in section 12 of this handbook.

### **Benefit determination**

We'll notify you with our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you disagree with our decision, you have the right to file an appeal with us. Also see "Your Right to Appeal," in section 12 in this handbook.

We'll tell you and your provider in writing if your request is denied. A denial includes when the request is approved for an amount that is less than the amount requested. We'll also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We'll explain what options for appeals you have if you do not agree with our decision. Also see "Your Right to Appeal," in section 12 of this handbook.

### **Continuation of care**

In most cases, if we make a benefit determination to reduce, suspend, or end a service we have already approved and that you are now getting, we must tell you at least 10 days before we make any changes to the service.

### Post payment review

If we are checking on care or services that you received in the past, we perform a provider post payment review. If we deny payment to a provider for a service, we'll send a notice to you and your provider the day the payment is denied. You won't have to pay for any care you received that was covered by us even if we later deny payment to the provider.

# 12. Appeals, State Fair Hearings, and Complaints (Grievances)

### Your right to appeal

You have the right to appeal any adverse benefit determination (decision) by us that you disagree with that relates to coverage or payment of services. For example, you can appeal if the Anthem HealthKeepers Plus plan denies:

> A request for a health care service, supply, item or drug that you think you should be able to get, or

 $\triangleright$  A request for payment of a health care service, supply, item, or drug that we denied.

You can also appeal if we stop providing or paying for all or a part of a service or drug you receive that you think you still need.

### Authorized representative

You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform us of the name of your authorized representative. You can do this by calling our Member Services department at one of the phone numbers below. We'll provide you with a form that you can fill out and sign stating who your representative will be.

### Adverse Benefit Determination

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision we make to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. Refer to "Service authorization" and "Benefit determinations" in **section 11** of this handbook.

### How to submit your appeal

If you are not satisfied with a decision we made about your service authorization request, you have 60 calendar days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at one of the numbers below if you need help filing an appeal or if you need assistance in another language or require an alternate format. We'll not treat you unfairly because you file an appeal.

You can file your appeal by phone or in writing. You can send the appeal as a standard appeal or an expedited (fast) appeal request.

You can file your appeal by phone or in writing. You can send the appeal as a standard appeal or an expedited (fast) appeal request.

You or your doctor can ask to have your appeal reviewed under the expedited process if you believe your health condition or your need for the service requires an expedited review. Your doctor will have to explain how a delay will cause harm to your physical or behavioral health. If your request for an expedited appeal is denied we'll tell you and your appeal will be reviewed under the standard process.

### Send your appeal request to:

Grievance and Appeals Department HealthKeepers, Inc. P.O. Box 62429 Virginia Beach, VA 23466

You can also call Member Services at 1-800-901-0020 (TTY 711).

# If you send your standard appeal by phone, it must be followed up in writing.

Expedited process appeals submitted by phone do not require you to submit a written request.

### **Continuation of benefits**

In some cases you may be able to continue receiving services that were denied by us while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- ➢ Within ten days from being told that your request is denied or care is changing; or
- $\triangleright$  By the date the change in services is scheduled to occur.

If your appeal results in another denial you may have to pay for the cost of any continued benefits that you received if the services were provided solely because of the requirements described in this section.

### What happens after we get your appeal

Within **five** days, we'll send you a letter to let you know we have received and are working on your appeal.

Appeals of clinical matters will be decided by qualified health care professionals who didn't make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to make a decision on your case. This information is available at no cost to you.

You can also provide information that you want to be used in making the appeal decision in person or in writing. Just send your information to:

Grievance and Appeals Department HealthKeepers, Inc. P.O. Box 62429 Virginia Beach, VA 23466

You can also call Member Services at one of the numbers below if you are not sure what information to give us.

### Timeframes for appeals

### Standard appeals

If we have all the information we need we'll tell you our decision within 30 days of when we receive your appeal request. We'll tell you within two calendar days after receiving your appeal if we need more information. A written notice of our decision will be sent within **two** calendar days from when we make the decision.

### **Expedited** appeals

If we have all the information we need, expedited appeal decisions will be made within 72 hours of receipt of your appeal, and we will send a written notice and attempt to provide oral notice within this timeframe. If there is a need for additional documentation or if a delay in rendering a decision is in your interest, the timeframe may be increased up to an additional 14 days.

### If we need more information

If we can't make the decision within the needed timeframes because we need more information, we'll:

- Write you and tell you what information is needed. If your request is in an expedited review, we'll call you right away and send a written notice later;
- > Tell you why the delay is in your best interest; and
- Make a decision no later than 14 additional days from the timeframes described above.

You, your provider or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give us to help decide your case. This can be done by writing to:

Grievance and Appeals Department HealthKeepers, Inc.

P.O. Box 62429 Virginia Beach, VA 23466

You can also give us a call. Just call the Member Services number listed at the bottom of this page. We're here to help Monday through Friday from 8 a.m. to 8 p.m.

You or someone you trust can file a complaint with us if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a complaint about the way we handled your appeal to the State through the Help Line at 1-800-643-2273.

### Written notice of appeal decision

If we do not tell you our decision about your appeal on time, you have the right to appeal to the State through the State Fair Hearing process. An untimely response by us is considered a valid reason for you to appeal further through the State Fair Hearing process.

We'll tell you and your provider in writing if your request is denied or approved in an amount less than requested. We'll also tell you the reason for the decision and the contact name, address and telephone number of the person responsible for making the adverse determination. We'll explain your right to appeal through the State Fair Hearing Process if you do not agree with our decision.

### Your right to a State Fair Hearing

If you disagree with our decision on your appeal request, you can appeal directly to DMAS. This process is known as a State Fair Hearing. You may also submit a request for a State Fair Hearing if we deny payment for covered services or if we do not respond to an appeal request for services within the times described in this handbook. The State requires that you first exhaust (complete) our appeals process before you can file an appeal request through the State Fair Hearing process. If we do not respond to your appeal request timely DMAS will count this as an exhausted appeal.

### Standard or expedited review requests

For, appeals that will be heard by DMAS you will have an answer generally **within 90 days** from the date you filed your appeal with us. The 90 day timeframe does not include the number of days between our decision on your appeal and the date you sent your State fair hearing request to DMAS. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited
appeal within 72 hours of receiving the letter from your doctor.

## Authorized representative

You can give someone like your PCP, provider, friend, or family member written permission to help you with your State Fair Hearing request. This person is known as your authorized representative.

#### Where to send the State Fair Hearing request

You or your representative must send your standard or expedited appeal request to DMAS by internet, mail, fax, email, telephone, in person, or through other commonly available electronic means. Send State Fair Hearing requests to DMAS within no more than 120 calendar days from the date of our final decision. You may be able to appeal after the 120 day deadline in special circumstances with permission from DMAS.

You may write a letter or complete a Virginia Medicaid Appeal Request Form. The form is available at your local Department of Social Services or on the internet at **http://www.dmas.virginia.gov/Content\_atchs/forms/dmas-200.pdf**. You should also send DMAS a copy of the letter we sent to you in response to your Appeal.

You must sign the appeal request and send it to:

Appeals Division Department of Medical Assistance Services 600 E. Broad Street Richmond, Virginia 23219 Fax: 1-804-452-5454 Standard and Expedited Appeals may also be made by calling 1-804-371-8488

## After you file your State Fair Hearing appeal

DMAS will notify you of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

## **State Fair Hearing timeframes**

## **Expedited** appeal

If you qualify for an expedited appeal, DMAS will give you an answer to your appeal within 72 hours of receiving the letter from your doctor. If DMAS decides right away that you win your appeal, they will send you their decision within 72 hours of receiving the letter from your doctor.

If DMAS does not decide right away, you will have an opportunity to participate in a hearing to present your position. Hearings for expedited decisions are usually held within one or two days of DMAS receiving the letter from your doctor. DMAS still has to give you an answer within 72 hours of receiving your doctor's letter.

# Standard appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will give you an answer within 90 days from the date you filed your appeal with the Anthem HealthKeepers Plus plan. The 90 day timeframe does not include the number of days between our decision on your appeal and the date you sent your State fair hearing request to DMAS. You will have an opportunity to participate in a hearing to present your position before a decision is made.

# **Continuation of benefits**

In some cases you may be able to continue receiving services that were denied by us while you wait for your State Fair Hearing appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- > Within ten days from being told that your request is denied or care is changing;
- > By the date the change in services is scheduled to occur.

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. You may, however, have to repay us for any services you receive during the continued coverage period if our adverse benefit determination is upheld and the services were provided solely because of the requirements described in this section.

## If the State Fair Hearing reverses the denial, and services were not continued while the State Fair Hearing was pending

If the State Fair Hearing decision is to reverse the denial, we must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date we receive notice from the State reversing the denial.

# If the State Fair Hearing reverses the denial, and services were provided while the State Fair Hearing was pending

If the State Fair hearing decision is to reverse the denial and services were provided while the appeal is pending, we must pay for those services, in accordance with State policy and regulations.

## If you disagree with the State Fair Hearing decision

The State Fair Hearing decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision you may appeal it to your local circuit court.

## **External appeals for FAMIS members**

If you have a problem with what we decide after completing our appeal process, you can ask for an external review. This process is different for FAMIS members than it is for Medallion Medicaid members.

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 Road, Suite 305

Henrico, VA 23294

Find out more online at **www.dmas.kepro.com.** This right is only available to you when you have completed our appeal process.

# Your right to file a complaint

We'll try our best to deal with your concerns as quickly as possible to your satisfaction. Depending on what type of concern you have, it will be handled as a complaint or as an appeal.

# What kinds of problems should be complaints?

The complaint process is used for concerns related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by our complaint process.

# 1. Complaints about quality

> You are unhappy with the quality of care, such as the care you got in the hospital.

# 2. Complaints about privacy

> You think that someone didn't respect your right to privacy or shared information about you that is confidential or private.

## 3. Complaints about poor customer service

> A health care provider or staff was rude or disrespectful to you.

- > Anthem HealthKeepers Plus staff treated you poorly.
- > We're not responding to your questions.

➢ You are not happy with the assistance you are getting from your care coordinator.

# 4. Complaints about accessibility

> You can't physically access the health care services and facilities in a doctor or provider's office.

> You were not provided requested reasonable accommodations that you needed in order to participate meaningfully in your care.

## 5. Complaints about communication access

> Your doctor or provider does not provide you with a qualified interpreter for the deaf or hard of hearing or an interpreter for another language during your appointment.

## 6. Complaints about waiting times

> You are having trouble getting an appointment, or waiting too long to get it.

➢ You have been kept waiting too long by doctors, pharmacists or other health professionals or by Member Services or other Anthem HealthKeepers Plus staff.

# 7. Complaints about cleanliness

> You think the clinic, hospital or doctor's office is not clean.

# 8. Complaints about communications from us

- > You think we failed to give you a notice or letter that you should have received.
- > You think the written information we sent you is too difficult to understand.
- > You asked for help in understanding information and didn't receive it.

## **Different types of complaints**

You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by us. An external complaint is filed with and reviewed by an organization that is not affiliated with the Anthem HealthKeepers Plus plan.

## **Internal complaints**

To make an internal complaint, call Member Services at the number below. You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.

You can file a complaint in writing, by mailing it to us at:

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

You can also fax us at 1-800-964-3627 or call Member Services if you have any questions.

So that we can best help you, include details on who or what the complaint is about and any information about your complaint. We'll review your complaint and request any additional information. You can call Member Services at the number below if you need help filing a complaint or if you need assistance in another language or format.

We'll notify you of the outcome of your complaint within a reasonable time, but no later than 30 calendar days after we receive your complaint.

If your complaint is related to your request for an expedited appeal, we'll respond **within 24 hours** after the receipt of the complaint.

#### **External complaints**

## You can file a complaint with the Managed Care Helpline

You can make a complaint about the Anthem HealthKeepers Plus plan to the Managed Care Helpline at 1-800-643-2273 (TTY 1-800-817-6608) Monday–Friday, 8:30 a.m.–6 p.m.

## You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance.

You can also visit http://www.hhs.gov/ocr for more information.

Office of Civil Rights- Region III Department of Health and Human Services 150 S. Independence Mall West, Suite 372 Public Ledger Building Philadelphia, PA 19106 1-800-368-1019 Fax: 1-215-861-4431 TDD: 1-800-537-7697

# 13. Member rights

# Your rights

It is the policy of the Anthem HealthKeepers Plus plan to treat you with respect. We also care about keeping a high level of confidentiality with respect for your dignity and privacy. As a member, you have certain rights. You have the right to:

Receive timely access to care and services.

> Take part in decisions about your health care, including your right to choose your providers from our network providers and your right to refuse treatment.

Choose to receive long term services and supports in your home or community or in a nursing facility.

➢ Confidentiality and privacy about your medical records and when you get treatment.

➢ Receive information and to discuss all available treatment options and alternatives presented in a manner and language you understand and regardless of cost or benefit coverage.

➢ Get information in a language you understand — you can get oral translation services free of charge.

➢ Receive reasonable accommodations to ensure you can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling and physically accessible buildings and services.

Receive information necessary for you to give informed consent before the start of treatment.

Be treated with respect and dignity.

➢ Get a copy of your medical records and ask that the records be amended or corrected.

➢ Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to you or others or when there is a specific medical necessity. Seclusion and restraint will never be used as a means of coercion, discipline, retaliation, or convenience.

➢ Get care without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status or religion.

➤ Be informed of where, when and how to obtain the services you need from us, including how you can receive benefits from out-of-network providers if the services are not available in our network.

➤ Complain about us to the State. You can call the Helpline at 1-800-643-2273 to make a complaint about us.

Appoint someone to speak for you about your care and treatment and to represent you in an Appeal.

➤ Make advance directives and plans about your care in the instance that you are not able to make your own health care decisions. See section 14 of this handbook for information about Advance Directives.

Change your health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference section 2 of this handbook or you can download and use the Virginia Managed Care mobile app, call the Managed Care Helpline at 1-800-643-2273

(TTY 1-800-817-6608) or visit the website at **virginiamanagedcare.com** for more information.

> Appeal any adverse benefit determination (decision) by us that you disagree with that relates to coverage or payment of services. See "Your Right to Appeal" in this section 15 of the handbook.

➢ File a complaint about any concerns you have with our customer service, the services you have received, or the care and treatment you have received from one of our network providers. See "Your Right to File a Complaint" in section 15 of this handbook.

> To receive information from us about our plan, your covered services, providers in our network, and about your rights and responsibilities.

➤ To make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this section of the handbook.)

➢ Have your or your child's doctor tell you about any treatment choices you may have, no matter what the cost or benefit coverage.

## Your right to be safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If you, or someone you know, is being abused, physically, is being neglected, or is being taken advantage of financially by a family member or someone else, you should call your local department of social services or the Virginia Department of Social Services' 24-hour, toll-free hotline at 1-888-832-3858.

You can make this call anonymously; you do not have to provide your name. The call is free.

They can also provide a trained local worker who can assist you and help you get the types of services you need to assure that you are safe.

# Your right to confidentiality

We'll only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse.

Anthem HealthKeepers Plus staff will ask questions to confirm your identity before we discuss or provide any information regarding your health information.

We will request your written authorization to coordinate treatment related to substance use disorder and addiction, recovery and treatment services.

# Your right to privacy

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

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

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

> On paper (called physical), we:

- $\circ\,$  Lock our offices and files.
- $\circ\,$  Destroy paper with health information so others can't get it.

Saved on a computer (called technical), we:

- $\circ\,$  Use passwords so only the right people can get in.
- Use special programs to watch our systems.
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures).
  - $\circ\,$  Teach people who work for us to follow the rules.

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

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

# ➢ For your medical care

 $\circ\,$  To help doctors, hospitals and others get you the care you need.

## > For payment, health care operations and treatment

 $\circ \text{To}$  share information with the doctors, clinics and others who bill us for your care.

•When we say we'll pay for health care or services before you get them •To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't want this, please visit

www.anthem.com/vamedicaid for more information.

# > For health care business reasons

 $\circ \textsc{To}$  help with audits, fraud and abuse prevention programs, planning, and everyday work.

•To find ways to make our programs better.

# For public health reasons

•To help public health officials keep people from getting sick or hurt.

# > With others who help with or pay for your care

 $\circ$ With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK.

 $\circ$ With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you.

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

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

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

> To help the police and other people who make sure others follow laws.

- ➤ To report abuse and neglect.
- $\blacktriangleright$  To help the court when we're asked.

To answer legal documents.

> To give information to health oversight agencies for things like audits or exams.

> To help coroners, medical examiners or funeral directors find out your name and cause of death.

> To help when you've asked to give your body parts to science.

≻ For research.

> To keep you or others from getting sick or badly hurt.

> To help people who work for the government with certain jobs.

> To give information to workers' compensation if you get sick or hurt at work.

# What are your rights?

> You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. If you want a copy of your whole medical record, ask your doctor or health clinic.

➤ You can ask us to change the medical record we have for you if you think something is wrong or missing.

Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.

> You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.

➤ You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.

 $\blacktriangleright$  You can ask for a paper copy of this notice at any time, even if you asked for this one by email.

> If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

# What do we have to do?

> The law says we must keep your PHI private except as we've said in this notice.

> We must tell you what the law says we have to do about privacy.

> We must do what we say we'll do in this notice.

We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.

> We must tell you if we have to share your PHI after you've asked us not to.

➤ If state laws say we have to do more than what we've said here, we'll follow those laws.

> We have to let you know if we think your PHI has been breached.

#### We may contact you

You agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless phone number, using an automatic telephone dialing system and/or a pre-recorded message. Without limit, these calls or texts may be about treatment options, other health-related benefits and services, enrollment, payment or billing.

## What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call our Member Services team at 1-800-901-0020 (TTY 711).

#### What if you have a complaint?

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

#### Write to or call the Department of Health and Human Services:

Office for Civil Rights U.S. Department of Health and Human Services 150 S. Independence Mall West Suite 372, Public Ledger Building Philadelphia, PA 19106-9111 Phone: 1-800-368-1019 TDD: 1-800-537-7697 Fax: 1-215-861-4431

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the web at **www.anthem.com/vamedicaid**.

#### Race, ethnicity and language

We receive race, ethnicity and language information about you from the state Medicaid agency and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:

- ➤ Make sure you get the care you need.
- Create programs to improve health outcomes.
- > Develop and send health education information.

- Let doctors know about your language needs.
- Provide translator services.

We do **<u>not</u>** use this information to:

- ► Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Disclose to unapproved users.

#### Your personal information

We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

> We may use your PI to make decisions about your health, habits and hobbies.

> We may get PI about you from other people or groups like:

- o Doctors.
- $\circ$  Hospitals.
- Other insurance companies

➤ We may share PI with people or groups outside of our company without your OK in some cases.

➤ We'll let you know before we do anything where we have to give you a chance to say no.

- > We'll tell you how to let us know if you don't want us to use or share your PI.
- > You have the right to see and change your PI.
- ➢ We make sure your PI is kept safe.

## How to join the Member Advisory Committee

We would like you to help us improve our health plan. We invite you to join our Member Advisory Committee. On the committee, you can let us know how we can better serve you. Going to these meetings will give you and your caregiver or family member the chance to help plan meetings and meet other members in the community. These educational meetings are held once every three months. If you would like to attend or would like more information, please contact Anthem HealthKeepers Plus Member Services using the number at the bottom of this page.

## We follow non-discrimination policies

You can't be treated differently because of your race, color, national origin, disability, age, religion, gender, marital status, pregnancy, childbirth, sexual orientation or medical conditions.

If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit **http://www.hhs.gov/ocr** for more information.

The Anthem HealthKeepers Plus plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

# 14. Member responsibilities

# Your responsibilities

As a member, you also have some responsibilities. These include:

Present your Anthem HealthKeepers Plus membership card whenever you seek medical care.

Provide complete and accurate information to the best of your ability on your health and medical history.

 $\triangleright$  Participate in your care team meetings, develop an understanding of your health condition, and provide input in developing mutually agreed upon treatment goals to the best of your ability.

> Follow your treatment plans and instructions for care, to the best of your ability.

➤ Keep your appointments. If you must cancel, call as soon as you can.

Receive all of your covered services from within our network.

➢ Obtain authorization from us prior to receiving services that require a service authorization review (see section 14).

Call us whenever you have a question regarding your membership or if you need assistance toll-free at one of the numbers below.

> Tell us when you plan to be out of town so we can help you arrange your services.

> Use the emergency room only for real emergencies.

> Call your PCP when you need medical care, even if it is after hours.

> Tell us when you believe there is a need to change your plan of care.

➤ Tell us if you have problems with any health care staff. Call Member Services at one of the numbers below.

➤ Call Member Services at one of the phone numbers below about any of the following:

If you have any changes to your name, your address or your phone number.
Report these also to your case worker at your local Department of Social Services.
If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer or workers' compensation.

o If you have any liability claims, such as claims from an automobile accident.

 $_{\odot}$  If you are admitted to a nursing facility or hospital.

o If you get care in an out-of-area or out-of-network hospital or emergency room.

• If your caregiver or anyone responsible for you changes.

• If you are part of a clinical research study.

# **Advance Directives**

You have the right to say what you want to happen if you are unable to make health care decisions for yourself. There may be a time when you are unable to make health care decisions for yourself. Before that happens to you, you can:

➢ Fill out a written form to give someone the right to make health care decisions for you if you become unable to make decisions for yourself.

➢ Give your doctors written instructions about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. An advance directive goes into effect only if you are unable to make health care decisions for yourself. Any person age 18 or over can complete an advance directive. There are different types of advance directives and different names for them. Examples are a living will, a durable power of attorney for health care, and advance care directive for health care decisions.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

#### Where to get the Advance Directives form

# You can get the Virginia Advance Directives form at: http://www.vdh.virginia.gov/OLC/documents/2011/pdfs/2011-VA-AMD-Simple.pdf.

You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. You can also contact Member Services to ask for the forms.

## **Completing the Advance Directives form**

Fill it out and sign the form. The form is a legal document. You may want to consider having a lawyer help you prepare it. There may be free legal resources available to assist you.

#### Share the information with people you want to know about it

Give copies to people who need to know about it. You should give a copy of the Living Will, Advance Care Directive or Power of Attorney form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, take a copy of it to the hospital. The hospital will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

# We can help you get or understand Advance Directives documents

Your care coordinator can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself. Remember, it is your choice to fill out an advance directive or not. You can revoke or change your advance care directive or power of attorney if your wishes about your health care decisions or authorized representative change.

#### **Other resources**

You may also find information about advance directives in Virginia at **www.virginiaadvancedirectives.org**.

You can store your advance directive at the Virginia Department of Health Advance Healthcare Directive Registry: **www.virginiaregistry.org**.

## If your Advance Directives are not followed

If you have signed an advance directive, and you believe that a doctor or hospital didn't follow the instructions in it, you may file a complaint with the following organizations. For complaints about doctors and other providers, contact the Enforcement Division at the Virginia Department of Health Professions:

CALL	Virginia Department of Health Professions: Toll-Free Phone: 1-800-533-1560 Local Phone: 1-804-367-4691				
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463				
FAX	1-804-527-4424				
EMAIL	enfcomplaints@dhp.virginia.gov				
WEBSITE	http://www.dhp.virginia.gov/Enforcement/complaints.htm				

For complaints about nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories and health plans (also known as managed care organizations), contact the Office of Licensure and Certification at the Virginia Department of Health:

CALL	Toll-Free Phone: 1-800-955-1819 Local Phone: 1-804-367-2106			
WRITE	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1463			
FAX	1-804-527-4503			
EMAIL	OLC-Complaints@vdh.virginia.gov			
WEBSITE	http://www.vdh.state.va.us/olc/complaint			

# 15. Fraud, waste and abuse

#### What is fraud, waste and abuse?

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste includes overutilization, underutilization or misuse of resources. Waste typically is not an intentional act, but does result in spending that should not have occurred. As a result, waste should be reported so that improper payments can be identified and corrected

Abuse includes practices that are inconsistent with sound fiscal, business or medical practice, and result in unnecessary cost to the Medicaid program, payment for services that are not medically necessary, or failure to meet professionally recognized health care standards.

Common types of health care fraud, waste and abuse include:

≻ Medical identity theft.

Billing for unnecessary items or services.

▶ Billing for items or services not provided.

➢ Billing a code for a more expensive service or procedure than was performed (known as up-coding).

➤ Charging for services separately that are generally grouped into one rate (Unbundling).

Items or services not covered.

➤ When one doctor receives a form of payment in return for referring a patient to another doctor. These payments are called "kickbacks."

## How do I report fraud, waste or abuse

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

Examples of client waste, abuse or fraud include. but are not limited to:

Loaning insurance ID cards.

▶ Using more than one provider to obtain similar treatments and/or medications.

> Frequent emergency room visits for nonemergency conditions.

Examples of provider waste, abuse or fraud include, but are not limited to:

- Billing for services not provided.
- Billing professional services performed by untrained personnel.
- Altering medical records.

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

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

When reporting a person who receives benefits, provide this information:

- ➤ The person's name
- > The person's date of birth, Social Security number or case number, if possible
- > The city where the person resides
- Specific details about the waste, abuse or fraud

When reporting a provider (doctor, dentist or counselor), provide this information:

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

If you would prefer to refer your fraud, waste or abuse concerns directly to the State, you can report to the contacts listed below.

# **Department of Medical Assistance Services Fraud Hotline**

Recipient Fraud: 1-800-371-0824 or 1-804-786-1066

Provider Fraud: 1-800-371-0824 or 1-804-786-2071

# Virginia Medicaid Fraud Control Unit (Office of the Attorney General)

# Email: MFCU\_mail@oag.state.va.us

Fax: 1-804-786-3509

Mail:

Office of the Attorney General Medicaid Fraud Control Unit 202 N. Ninth St. Richmond, VA 23219 Virginia Office of the State Inspector General

## Fraud, Waste and Abuse Hotline

Phone: 1-800-723-1615

Fax: 1-804-371-0165

## Email: covhotline@osig.virginia.gov

Mail:

State FWA Hotline 101 N. 14th St. The James Monroe Building 7<sup>th</sup> Floor Richmond, VA 23219

# 16. Information for Medicaid expansion members

# What makes you eligible to be a Medicaid expansion member?

You're eligible for Medicaid expansion if you are 19 years of age to 64 years of age and you meet <u>all</u> of the following categories:

- You are not already eligible for Medicare coverage.
- You are not already eligible for Medicaid coverage through a mandatory coverage group (you are pregnant or disabled, for example).
- > Your income does not exceed 138% of the Federal Poverty Limit (FPL).
- > You indicated in your application that you have complex medical needs.

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at 1-855-242-8282 (TDD 1-888-221-1590) about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at **www.coverva.org**.

# Enrollment for a Medicaid expansion member

You can change your health plan during the first 90 days of your Medallion program enrollment for any reason. You can also change your health plan during your annual open enrollment period for any reason.

You may contact the Managed Care Helpline at 1-800-643-2273

(TTY 1-800-817-6608) or visit **www.virginiamanagedcare.com** to find out the open enrollment period for your region. You will get a letter from DMAS during the open enrollment period with more information.

# Medicaid expansion benefits and services

As a Medicaid expansion member, you have a variety of health care benefits and services available to you. You will receive most of your services through us.

If you're an eligible Medicaid expansion member, in addition to the standard Medicaid services, you'll receive:

- Annual adult wellness exams.
- Individual and group smoking cessation counseling.

➢ Nutritional counseling if you are diagnosed with obesity or chronic medical diseases.

Recommended adult vaccines or immunizations.

We'll also encourage you to take an active role in your health. This may mean taking part in disease management programs, getting a flu shot, quitting smoking or using tobacco/nicotine products, or accessing services not typically covered by traditional medical practices like gym memberships or vision services. Be sure to check out our Healthy Rewards program in section 8 of this handbook.

If you frequently visit the emergency room, we'll reach out to you to help you address your needs. There may be opportunities to address your needs outside of the emergency room, like in doctor's offices and clinics.

We may also discuss several opportunities with you to help you take advantage of job training, education and job placement assistance to help you find the work situation that is right for you.

# What is a health screening?

Within four months after you enroll with the Anthem HealthKeepers Plus plan, we'll contact you or your authorized representative via telephone or in person to ask some questions about your health needs and social circumstances. These questions will make up what is called the "health screening." The representative will ask about any medical conditions you currently have or have had in the past, your ability to do everyday things and your living conditions.

Your answers will help us understand your needs and identify whether or not you have medically complex needs.

If you meet the medically complex criteria, you'll transfer from the Medallion 4.0 program to the CCC Plus program. If it's determined you don't have medically complex needs, or if we're unable to contact you, or you refuse to participate in the entire health screening you'll remain in the Medallion 4.0 program. Please contact us if you need accommodations to participate in the health screening.

You'll stay with us no matter which program you're in. If you prefer to change health plans, you can change within the first 90 days of enrolling into the Medallion 4.0 program.

If you don't meet medically complex criteria and don't agree, you have a right to submit a complaint or grievance. See section 12 for details.

# **17. FAMIS Covered Services**

If you have a child who is a FAMIS member, their covered services differ from covered services for Medallion members. There is no cost sharing for members who are American Indians or Alaskan Natives. Here is a list of FAMIS covered services:

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4							
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS 150% 150%		NOTES AND DAY LIMITATIONS				
Inpatient Hospital Services	Yes	\$15 per stay	\$25 per stay	We'll cover inpatient stays in general acute care and rehabilitation hospitals for all members up to 365 days per stay in a semi-private room or intensive care unit for the care of illness, injury or pregnancy (includes medically necessary ancillary services). We'll cover alternative treatment plans for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. We must approve the alternative treatment plan in advance.				
Outpatient Hospital Services	Yes	\$2 per visit (waived if admitted)	\$5 per visit (waived if admitted)	We'll cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed				

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4							
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS 150% 150%		NOTES AND DAY LIMITATIONS				
				or formally approved as a hospital by an officially designated authority for State standard-setting. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. Outpatient services include emergency services, surgical services, diagnostic and professional provider services. Facility charges are also covered.				
Chiropractic Services	Yes	\$2 (limited to \$500 per calendar year)	\$5 (limited to \$500 per calendar year)	We'll provide \$500 per calendar year coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.				

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4							
SERVICE	FAMIS	NETWORK COST SHARING & Benefit Limits		NOTES AND DAY LIMITATIONS				
	COVERED	150%	150%					
Clinic Services	Yes	\$2	\$5	We'll cover clinic services that are defined as				
				preventive, diagnostic, therapeutic, rehabilitative or				
Outpatient		\$0	\$0	palliative services that are provided to outpatients				
physician visit in				and are provided by a facility that is not part of a				
the office or				hospital but is organized and operated to provide				
hospital				medical care to outpatients. With the exception of				
Primary care				nurse-midwife services, clinic services are				
Specialty care				furnished under the direction of a physician or a				
Maternity				dentist. Renal dialysis clinic visits are also covered.				
Services				There are no copayments for maternity services.				
Court Ordered	No			We won't cover this service unless the service is				
Services				both medically necessary and is a FAMIS covered				
				service.				

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4								
SERVICE	SERVICE FAMIS	NETWORK COST SHARING & Benefit Limits		NOTES AND DAY LIMITATIONS					
	COVERED	150%	150%						
Dental Services	No except in certain circumstances			We'll cover CPT codes billed by an MD as a result of an accident. The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care. Pediatric dental services (for eligible children up to age 21) are covered through the Smiles for Children Program through the Department's Dental Benefit Administrator (DBA). For more information regarding SFC benefits, call 1-888-912-3456.					

SUMMARY OF F	AMIS COVER			
SERVICE	FAMIS Covered	& BENEF	OST SHARING <u>TT Limits</u> 150%	NOTES AND DAY LIMITATIONS
Early Intervention	Yes			We'll provide coverage for Early Intervention
Services				services as defined by 12 VAC 30-50-131. EI services for children who are enrolled in a contracted Contractor are covered by the Department within the Department's coverage criteria and guidelines. Early intervention billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManu als/Default.aspx. We'll cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.
Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)	No			We won't cover this service, but we'll cover well- baby and well child care services.

SUMMARY OF FAMIS COVERED SERVICES – PART 4							
FAMIS	NETWORK COST SHARING						
			NOTES AND DAY LIMITATIONS				
	150%	150%					
Yes			We'll provide for the reasonable reimbursement of				
			services needed to ascertain whether an emergency				
			exists in instances in which the clinical				
	<b>**</b> • • •	<b>* -</b> • •	circumstances that existed at the time of the				
	\$2 per visit	\$5 per visit	beneficiary's presentation to the emergency room				
		<b>* - • • •</b>	indicate that an emergency may exist. We'll ensure				
	-		that all covered emergency services are available				
			twenty-four (24) hours a day and seven (7) days a				
	-		week.				
	emergency	emergency	We'll cover all emergency services provided by				
	¢10 · ·	фо <i>с</i> · · ·	out-of-network providers. We don't require prior				
	\$10 per visit	\$25 per visit	authorization for emergency services. This applies				
			to out-of-network as well as to in-network services				
			that a member seeks in an emergency.				
			Members who present to the emergency room shall				
			pay the emergency room co-payment. If it is				
			determined that the visit was a nonemergency, the				
			hospital may bill the member only for the				
			difference between the emergency room and				
			nonemergency co-payments, i.e. \$8 for 150% and				
			\$20 for 150%. The hospital may not bill for				
			additional charges.				
	AMIS COVER FAMIS COVERED Yes	FAMIS COVERED NETWORK Co & BENEFI 150%	FAMIS COVEREDNETWORK COST SHARING & BENEFIT LIMITSYes150% 150%Yes\$2 per visit\$2 per visit\$5 per visit\$2 per visit\$5 per visitwaived if part of ER visit for true emergency\$5 per visit visit for true emergency				

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4							
SERVICE	FAMIS	NETWORK COST SHARING & Benefit Limits		NOTES AND DAY LIMITATIONS				
	COVERED	150%	150%					
Post Stabilization Care Following Emergency Services	Yes			We'll cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized. We'll cover the following services without requiring authorization, and regardless of whether the member obtains the services within or outside of our network.				
Experimental and Investigational Procedures	No			We won't cover this service.				

SUMMARY OF F	FAMIS COVER	ED SERVICE	S – PART 4	
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS 150% 150%		NOTES AND DAY LIMITATIONS
Family Planning Services	Yes	\$2 per visit	\$5 per visit	We'll cover all family planning services, which includes services and drugs and devices for individuals of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. FAMIS covered services include drugs, and devices provided under the supervision of a physician. We won't restrict your choice of provider for family planning services or drugs and devices, and the We'll cover all family planning services and supplies provided to its members by network providers. <i>Code of Virginia</i> § 54.1-2969 (D), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization.
Hearing Aids	Yes	\$2	\$5	We'll cover hearing aids as outlined under Durable Medical Equipment. Hearing aids shall be covered twice every five years.

SUMMARY OF F	<b>CAMIS COVER</b>	ED SERVICE	S – PART 4	
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS 150% 150%		NOTES AND DAY LIMITATIONS
Home Health Services	Yes	\$2 per visit	\$5 per visit	We'll cover home health services, including nursing and agency-directed or consumer-directed personal care services, home health aide services, PT, OT, speech, hearing and inhalation therapy up to 90 visits per calendar year. Personal care means assistance with walking, taking a bath, dressing, giving medicine, teaching self-help skills, and performing a few essential housekeeping tasks. We won't cover the following home health services: medical social services, services that would not be paid for by FAMIS if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery. Refer to Sections 8.2.S and 8.2.S.a.

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4								
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS 150% 150%		NOTES AND DAY LIMITATIONS					
Hospice Services	Yes	\$0	\$0	We'll cover hospice care services to include a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a Provider licensed to do so, furnished and billed by a licensed hospice, and medically necessary. Hospice care services are available if the member is diagnosed with a terminal illness with a life expectancy of six months or fewer. Hospice care is available concurrently with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made.					

SUMMARY OF FAMIS COVERED SERVICES – PART 4							
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS 150% 150%		NOTES AND DAY LIMITATIONS			
Immunizations	Yes	\$0	\$0	We'll cover immunizations. We'll ensure that providers render immunizations, in accordance with the most current Advisory Committee on Immunization Practices (ACIP). We'll work with the Department to achieve its goal related to increased immunization rates. The Contractor is responsible for educating providers, parents and guardians of members about immunization services and coordinating information regarding member immunizations. FAMIS eligible members shall not qualify for the Free Vaccines for Children Program.			

SUMMARY OF FAMIS COVERED SERVICES – PART 4								
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS 150% 150%		NOTES AND DAY LIMITATIONS				
Inpatient Mental Health Services	Yes	\$15 per stay	\$25 per stay	Inpatient mental health services are covered for 365 days per stay, including partial day treatment services. Inpatient hospital services may include room, meals, general-nursing services, prescribed drugs and emergency room services leading directly to admission. We won't cover any services rendered in free-standing psychiatric hospitals to members up to nineteen (19) years of age. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS members. All inpatient mental health admission for individuals of any age to general acute care hospitals shall be approved by us using our own prior authorization criteria. We <u>may</u> cover services rendered in free-standing psychiatric hospitals as an enhanced benefit. Psychiatric residential treatment (level C) is not a covered service under FAMIS.				
Inpatient Rehabilitation Hospitals	Yes	\$15 per stay	\$25 per stay	We'll cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and which have been certified by the Department of Health.				

SUMMARY OF FAMIS COVERED SERVICES – PART 4							
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS		NOTES AND DAY LIMITATIONS			
			150%				
Inpatient	Yes	\$15 per stay	\$25 per stay	The Mental Health Parity and Addiction Act of			
Substance Abuse				2008 mandate coverage for mental health and			
Services				substance abuse treatment services. Inpatient			
				substance abuse services in a substance abuse			
				treatment facility are covered.			
Laboratory and	Yes	\$2 per visit	\$5 per visit	We'll cover all laboratory and x-ray services			
X-ray Services				ordered, prescribed and directed or performed			
				within the scope of the license of a practitioner in			
				appropriate settings, including physician office,			
				hospital, independent and clinical reference labs.			
				No co-pay shall be charged for laboratory or x-ray			
				services that are performed as part of an encounter			
				with a physician.			
Lead Testing	Yes	\$0	\$0	We'll cover blood lead testing as part of well-baby,			
				well-child care.			
SUMMARY OF I	FAMIS COVER	ED SERVIC	CES – PART 4				
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SERVICE	FAMIS Covered		Cost Sharing efit Limits 150%	NOTES AND DAY LIMITATIONS			
Lead Investigations	Yes	\$0	\$0	We'll provide coverage for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels. Environmental investigations are coordinated by local health departments. Coverage includes costs that are eligible for Federal funding participation in accordance with current Federal regulations and does not include the testing of environmental substances such as water, paint or soil which are sent to a laboratory for analysis. Contact the member's local health department to see if a member qualifies for a risk assessment. More information is available at: http://www.vdh.virginia.gov/environmental- epidemiology/fact-sheets-for-publichealth/ elevated-blood-lead-levels-in-children Payments for environmental investigations shall be limited to no more than two visits per residence.			
Mammograms	Yes	\$0	\$0	We'll cover low-dose screening mammograms for determining presence of occult breast cancer.			

SUMMARY OF FAMIS COVERED SERVICES – PART 4				
SERVICE	FAMIS Covered	NETWORK COST SHARING & Benefit Limits		NOTES AND DAY LIMITATIONS
	COVERED	150%	150%	
Medical Supplies	Yes	\$0 for	\$0 for	We'll cover durable medical equipment and other
		supplies	supplies	medically related or remedial devices (such as
Medical				prosthetic devices, implants, eyeglasses, hearing
Equipment		\$2 per item	\$5 per item	aids, dental devices and adaptive devices). Durable
		for	for	medical equipment and prosthetic devices and
		equipment	equipment	eyeglasses are covered when medically necessary.
				We'll cover supplies and equipment necessary to
				administer enteral nutrition. We'll pay for any
				specially manufactured DME equipment that we
				prior authorized.

SUMMARY OF F	AMIS COVER			
SERVICE	FAMIS Covered		COST SHARING FIT LIMITS 150%	NOTES AND DAY LIMITATIONS
Medical Transportation	Yes	\$2	\$5	Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary, if prearranged by the primary care physician and authorized by us if, because of the member's medical condition, the member cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the member's condition suddenly becomes worse and must go to a local hospital's emergency room. For coverage of ambulance services, the trip to the facility or office must be to the nearest one recognized by us as having services adequate to treat the member's condition, the services received in that facility or provider's office must be covered services and if we or the Department requests it, the attending provider must explain why the member could not have been transported in a private car or by any other less expensive means. <b>Transportation</b> <b>services are not provided for routine access to and from providers of covered medical services</b> .

SUMMARY OF F.	AMIS COVER	ED SERVICE		
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS		NOTES AND DAY LIMITATIONS
	COVERED	150%	150%	
Organ	Yes	\$15 per stay	\$25 per stay	We'll cover organ transplantation services as
Transplantation		and	and	medically necessary and per industry treatment
		\$2 per	\$5 per	standards for all eligible individuals, including but
		outpatient	outpatient	not limited to transplants of tissues, autologous,
		visit	visit	allogeneic or synegenic bone marrow transplants or
		(Services to	(Services to	other forms of stem cell rescue for children with
		identify	identify	lymphoma and myeloma. We'll cover kidney
		donor	donor	transplants for patients with dialysis dependent
		limited to	limited to	kidney failure, heart, liver, pancreas and single
		\$25,000 per	\$25,000 per	lung transplants. We'll cover necessary
		member)	member)	procurement/donor related services. We won't
				cover transplant procedures determined to be
				experimental or investigational.

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4					
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS		NOTES AND DAY LIMITATIONS		
Outpatient Mental Health and Substance Abuse Services	Yes	150% \$2 per visit	<b>150%</b> \$5 per visit	The Mental Health Parity and Addiction Act of 2008 mandates coverage for mental health and substance abuse treatment services. Accordingly, the Contractor is responsible for covering medically necessary outpatient individual, family, and group mental health and substance abuse treatment services. We'll provide coverage to members, for mental health and substance abuse treatment services. Emergency counseling services, intensive outpatient services, day treatment, and substance abuse case management services are carved-out of this contact and shall be covered by the Department.		

Community	Yes	No later than December 1, 2018, the following
Mental Health		behavioral health services known as Community
Rehabilitative		Mental Health Rehabilitation Services (CMHRS),
Services		shall be covered under the MEDALLION 4.0
(CMHRS)		Program for FAMIS and FAMIS MOMS
(CIVITING)		Medallion 4.0 enrollees:
		Intensive In-Home Services for Children and     Adalagements
		Adolescents
		Therapeutic Day Treatment for Children and Adolescents
		Mental Health Crisis Intervention
		Mental Health Case Management for
		Children at Risk of Serious Emotional
		Disturbance, Children with Serious
		Emotional Disturbance in accordance with
		the DMAS Community Mental Health
		Rehabilitative Services Manual, Chapter IV
		and Virginia State Regulation
		The Department's BHSA will continue to provide
		these services for Medallion 4.0/FAMIS members
		through the fee-for-service program until the
		services transition to Medallion 4.0.We'll provide
		coverage for CMHRS within the Department's
		coverage criteria and guidelines and consistent with
		Federal Mental Health Parity law. (See the CMS
		redefat Mental featur ranty law. (See the CMS

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4					
SERVICE	FAMIS	NETWORK COST SHARING & BENEFIT LIMITS		NOTES AND DAY LIMITATIONS		
	COVERED	150%	150%			
				State Official Letter, dated January 16, 2013; SHO # 13-001).		
				CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications and service		
				limitations.		
Pap Smears	Yes	\$0	\$0	We'll cover annual pap smears.		
Physical Therapy, Occupational Therapy, Speech Pathology and	Yes	\$2 per visit	\$5 per visit	We'll cover therapy services that are medically necessary to treat or promote recovery from an illness or injury, to include physical therapy, speech therapy, occupational therapy, inhalation		
Audiology Services				therapy and intravenous therapy. We'll not be required to cover those services rendered by a school health clinic when included in the IEP.		

SUMMARY OF I	SUMMARY OF FAMIS COVERED SERVICES – PART 4					
SERVICE	FAMIS Covered		Cost Sharing Fit Limits 150%	NOTES AND DAY LIMITATIONS		
Physician Services	Yes	\$0	\$0	We'll cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses. Cosmetic services are not covered		
Inpatient physician care Outpatient physician visit in the office or				unless performed for medically necessary physiological reasons. Physician services include services while admitted in the hospital, outpatient hospital departments, in a clinic setting or in a physician's office.		
hospital Primary Care		<ul><li>\$2 per visit</li><li>\$2 per visit</li><li>\$0 per visit</li></ul>	<ul><li>\$5 per visit</li><li>\$5 per visit</li><li>\$0 per visit</li></ul>			
Specialty care Maternity services		φυ per visit	\$0 per visit			
Pregnancy- Related Services	Yes	\$0	\$0	We'll cover services to pregnant women, including prenatal services for FAMIS and FAMIS MOMS. There is no co-pay for pregnancy related services. <b>No cost sharing at all will be charged to</b> <b>members enrolled in FAMIS MOMS.</b>		

SUMMARY OF F	AMIS COVER	ED SERVICE		
SERVICE	FAMIS Covered	& BENEF	OST SHARING IT LIMITS	NOTES AND DAY LIMITATIONS
Prescription	Yes	15070	150%	We'll cover all medically necessary drugs for its
Drugs	1.00			members that by Federal or State law requires a
8-		\$2 per	\$5 per	prescription. We'll cover all FAMIS covered
Retail up to 34-		prescription	prescription	prescription drugs prescribed by providers licensed
day supply				and/or certified as having authority to prescribe the
		\$4 per	\$10 per	drug. We'll cover prescription drugs prescribed by
Retail 35-90-day		prescription	prescription	the outpatient mental health provider. We won't
supply		<b>.</b>	<b>\$10</b>	cover Drug Efficacy Study Implementation (DESI)
		\$4 per	\$10 per	drugs or over the counter prescriptions. If a generic
		prescription	prescription	is available, member pays the copayment <b>plus</b>
Mail service up to				100% of the difference between the allowable
90-day supply Private Duty	Yes	\$2 non visit	\$5 por visit	charge of the generic drug and the brand drug. We'll cover private duty nursing services for
Nursing Services	1 65	\$2 per visit	\$5 per visit	children up to age 19 only if the services are
Nursing Services				provided by a Registered Nurse (RN) or a Licensed
				Practical Nurse (LPN), must be medically
				necessary, the nurse may not be a relative or
				member of the member's family, the member's
				provider must explain why the services are required
				and the member's provider must describe the
				medically skilled service provided. Private duty
				nursing services must be pre-authorized.

SUMMARY OF	FAMIS COVER	ED SERVICE		
SERVICE	FAMIS Covered		Cost Sharing <u>fit Limits</u> 150%	NOTES AND DAY LIMITATIONS
Prosthetics/ Orthotics	Yes	\$2 per item	\$5 per item	We'll cover prosthetic services and devices (at minimum, artificial arms, legs and their necessary supportive attachments) for all members. At a minimum, we'll cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc. add items listed in handbook) for members. We'll cover medically necessary orthotics for members when recommended as part of an approved intensive rehabilitation program.
Psychiatric Residential Treatment Services	No			This service is non-covered under FAMIS.
School Health Services	Yes*			*We won't cover school-based services provided by a local education agency or public school system. We'll not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies at school. School health services that meet the Department's criteria will continue to be covered as a carve-out service. We'll not be required to cover these services rendered by a school health clinic when included in the IEP.

SUMMARY OF F	SUMMARY OF FAMIS COVERED SERVICES – PART 4					
SERVICE	FAMIS Covered	FAMIS NETWORK COST S		NOTES AND DAY LIMITATIONS		
	COVERED	150%	150%			
Second Opinions	Yes	\$2 per visit	\$5 per visit	We'll provide coverage for second opinions when requested by the member for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. We'll provide for second opinions from a qualified health care professional within the network or arrange for the member to obtain one outside the network, at no cost to the member. We may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.		
Skilled Nursing Facility Care	Yes	\$15 per stay	\$25 per stay	We'll cover medically necessary services that are provided in a skilled nursing facility for up to 180 days per stay.		

SUMMARY OF F				
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS 150% 150%		NOTES AND DAY LIMITATIONS
Telemedicine Services	Yes			We'll provide coverage for medically necessary telemedicine services. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. Currently the Department recognizes only physicians and nurse practitioners for medical telemedicine services and requires one of these types of providers at the main (hub) satellite (spoke) sites for a telemedicine service to be reimbursed. Additionally, the Department currently recognizes three telemedicine projects.
Temporary Detention Orders	No			We won't cover this service. Coverage may be available through the State TDO program.
Therapy Services	Yes	<ul><li>\$15 per stay if inpatient</li><li>\$2 per visit outpatient</li></ul>	<ul><li>\$25 per stay if inpatient</li><li>\$5 per visit outpatient</li></ul>	We'll cover the costs of renal dialysis, chemotherapy and radiation therapy and intravenous and inhalation therapy.

SUMMARY OF FAMIS COVERED SERVICES – PART 4				
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS		NOTES AND DAY LIMITATIONS
		150%	150%	
Tobacco	Yes			We'll provide coverage for tobacco dependence
Dependence				treatment for pregnant women without cost sharing.
Treatment (i.e.,				Treatment includes counseling and
Tobacco or				pharmacotherapy.
Smoking				
Cessation) for				
Pregnant Women				
Transportation	No			Transportation services are not provided for routine access to and from providers of covered medical services.

SUMMARY OF FAMIS COVERED SERVICES – PART 4				
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS		NOTES AND DAY LIMITATIONS
Well-Baby and Well-Child Care	Yes	<b>150%</b> \$0	150% \$0	We'll cover all routine well baby and well childcare recommended by the American Academy of Pediatrics Advisory Committee, including routine office visits with health assessments and physical exams, as well as routine lab work and age appropriate immunizations. The following services rendered for the routine care of a well child: Laboratory services, blood lead testing, HGB, HCT or FEP (maximum of 2, any combination), Tuberculin test (maximum of 3 covered); Urinalysis (maximum of 2 covered), Pure tone audiogram for ages 3-5 (maximum of 1), Machine vision test (maximum of 1 covered).Well- child visits rendered at home, office and other outpatient provider locations are covered at birth and months, according to the American Academy of Pediatrics recommended periodicity schedule. Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth.

SUMMARY OF FAMIS COVERED SERVICES – PART 4				
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS		NOTES AND DAY LIMITATIONS
		150%	150%	
Vision Services	Yes			We'll cover vision services that are defined as
Once every two				diagnostic examination and optometric treatment
<i>(2) years:</i>				procedures and services by ophthalmologists,
Routine eye exam		\$2 Member Payment	\$5 Member Payment	optometrists and opticians. Routine comprehensive eye examinations, for all members, shall be allowed at least once every two (2) years. We'll
Eyeglass frames (one pair)				cover eyeglasses (one pair of frames and one pair of lenses) or contact lenses prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist for members.
Eyeglass lenses (one pair)				eye of ey an optometrist for memoers.
single vision				
bifocal				
trifocal				
contacts				

SUMMARY OF FAMIS COVERED SERVICES – PART 4				
SERVICE	FAMIS Covered	NETWORK COST SHARING & BENEFIT LIMITS		NOTES AND DAY LIMITATIONS
		150%	150%	
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	No			We won't cover this service. However, we may cover services rendered in free-standing psychiatric hospitals to members up to nineteen (19) years of age as an enhanced benefit offered by the Contractor. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS members.
Abortions	No			We won't cover services for abortions.
Cost Sharing: Annual Co- Payment Limit		Calendar year limit: \$180 per family	Calendar year limit: \$350 per family	Plan pays 100% of allowable charge once limit is met for covered services. No cost sharing will be charged to American Indians and Alaska Natives.
FAMIS MOMS				Benefits are the same as those available under Medallion 4.0.

## 18. Key words and definitions used in this handbook

- Adverse benefit determination: Any decision to deny a service authorization request or to approve it for an amount that is less than requested.
- Appeal: A way for you to challenge an adverse benefit determination (such as a denial or reduction of benefits) made by the Anthem HealthKeepers Plus plan if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.
- Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing or brushing the teeth.
- Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than our cost-sharing amount for services. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.
- Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.
- Care coordinator: One main person from the Anthem HealthKeepers Plus plan who works with you and with your care providers to make sure you get the care you need. May also be called a case manager.
- Care coordination: A person-centered individualized process that assists you in gaining access to needed services. The care coordinator will work with you, your family members, if appropriate, your providers and anyone else involved in your care to help you get the services and supports that you need. May also be called case management.
- Care plan: A plan for what health and support services you will get and how you will get them.
- Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.
- Helpline: An Enrollment Broker that DMAS contracts with to perform choice counseling and enrollment activities.
- Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid programs.

- Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."
- Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we'll pay for your health services.
- Covered drugs: The term we use to mean all of the prescription drugs covered by the Anthem HealthKeepers Plus plan.
- Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by the Anthem HealthKeepers Plus plan.
- Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs or hospital beds.
- Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.
- Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.
- Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.
- > Excluded services: Services that are not covered under the Medicaid benefit.
- Fair hearing: See State Fair Hearing. The process where you appeal to the State on a decision made by us that you believe is wrong.
- Fee-for-service: The general term used to describe Medicaid services covered by the Department of Medical Assistance Services (DMAS).
- Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.
- Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.
- Habilitation services and devices: Services and devices that help you keep, learn or improve skills and functioning for daily living.

- Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.
- Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.
- Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.
- Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.
- Home health care: Health care services a person receives in the home including nursing care, home health aide services and other services.
- > Hospitalization: The act of placing a person in a hospital as a patient.
- Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.
- List of covered drugs (Drug List): A list of prescription drugs covered by the Anthem HealthKeepers Plus plan. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."
- Long-term services and supports (LTSS): A variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and maintain maximum independence. Examples include assistance with bathing, dressing, toileting, eating, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital.
- Medically necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

- Medicaid (or Medical Assistance): A program run by the federal and the state government that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Most health care costs are covered if you qualify for both Medicare and Medicaid.
- Member Services: A department within the Anthem HealthKeepers Plus plan responsible for answering your questions about your membership, benefits, grievances and appeals.
- Model of care: A way of providing high-quality care. The model of care includes care coordination and a team of qualified providers working together with you to improve your health and quality of life.
- Network: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them "network providers" when they agree to work with the Anthem HealthKeepers Plus plan and accept our payment and not charge our members an extra amount. While you are a member of the Anthem HealthKeepers Plus plan, you must use network providers to get covered services. Network providers are also called "plan providers."
- Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our members. We call them "network pharmacies" because they have agreed to work with us. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- Non-participating provider: A provider or facility that is not employed, owned, or operated us and is not under contract to provide covered services to our members.
- Nursing facility: A medical care facility that provides care for people who can't get their care at home but who do not need to be in the hospital. Specific criteria must be met to live in a nursing facility.
- Out-of-network provider or out-of-network facility: A provider or facility that is not employed, owned, or operated by the Anthem HealthKeepers Plus plan and is not under contract to provide covered services to members of the Anthem HealthKeepers Plus plan.
- Participating provider: Providers, hospitals, home health agencies, clinics and other places that provide your health care services, medical equipment, and long-term services and supports that are contracted with us. Participating providers are also "in-network providers" or "plan providers."

- Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery or behavioral health.
- Prescription drug coverage: Prescription drugs or medications covered (paid) by your plan. Some over-the-counter medications are covered.
- Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.
- Primary care physician (PCP): Your primary care physician is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.
- Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces, artificial limbs, artificial eyes and devices needed to replace an internal body part or function.
- Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with the Anthem HealthKeepers Plus plan, including doctors, nurses, behavioral health providers and specialists.
- Referral: In most cases you PCP must give you approval before you can use other providers in our network. This is called a referral.
- Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, injury or major operation.
- Service area: A geographic area where we're allowed to operate. It is also generally the area where you can get routine (nonemergency) services.
- Service authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from us.
- Specialist: A doctor who provides health care for a specific disease, disability or part of the body.
- Urgently needed care: Care you get for a non-life threatening sudden illness, injury or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you can't get to them.

## Anthem HealthKeepers Plus Member Services

	1-800-901-0020		
CALL	Calls to this number are free. Monday-Friday from 8 a.m. to 8 p.m. Eastern time. Member Services also has free language interpreter services available for non-English speakers.		
ТТҮ	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free Monday-Friday from 8 a.m. to 8 p.m. Eastern time.		
FAX	1-800-964-3627		
WRITE	Member Services HealthKeepers, Inc. P.O. Box 27401 Mail Drop VA2002-N500 Richmond, VA 23279		
WEB SITE	www.anthem.com/vamedicaid		



Anthem HealthKeepers Plus Member Services 1-800-901-0020 (TTY 711)



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