COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

JUNE 21, 2017

MEDICAID MANAGED CARE

MEMBER HANDBOOK

Plan's Logo/ Slogan *must remain in the page position of this text box.*

Plan Specific areas noted in gold - *use same font and colors as surrounding text where appropriate*

Footer must remain a single line of text with the

The (m3.0) Program Member Handbook Template is to be used as the base handbook by all Plans. Plans must fill in areas that reference plan-specific information such as plan contact information, referral and service authorization requirements, enhanced benefits, and plan specific instructions to empower Members to access their care and services. Information added by plans

should be person-centered. Plans must contact DMAS to discuss any changes outside of the instructions listed below with respect to customization or improvements, including such as content that is believed to be missing, ambiguous, or incorrect.

Plans may customize the base handbook with plan specific information as described in the handbook and below. Plans have the option to do all of the following:

- ✓ Use plan-specific branded templates.
- ✓ Add the plan logo and resize / position the logo. The aspect of the logo should not be changed/distorted. (Resize from the corner).
- ✓ Add pictures, text boxes or bubbles that highlight important content.
- ✓ Revise the front cover.
- ✓ Relocate or otherwise include important phone numbers inside front or back cover for easy reference.
- ✓ Move the Help in Other Languages information to the inside of the front cover.
- ✓ Revise the layout as long as the base content remains unchanged, and the font remains at least 14 point. At least 18 point font must be used for sections related to getting materials or help in alternate formats.
- ✓ Change the content of the footer to reflect the hours of operation for Member Services, for example if the plan's Member Services Department is available 24/7/365.
- ✓ Customize in the appropriate sections where the plan provides enhanced services.
- ✓ Add additional specific details as noted in the plan instructions throughout the handbook.
- ✓ Revise the format for phone numbers; plans are not required to use the table format seen on page 30 as long as the required content is included.
- ✓ Flesch readability score should be at the 6th grade level.

About the fonts used in this document: If you plan to update using the existing font/format, the body of the document is in "Style 2" or 14 Font Segoe UI Light, multiple spacing @ 1.15; 6 spacing (before and after). The Table of Contents is built from the headers. Section headings used is "1 Heading"; subsection headings used are "2 Heading."

Plans should delete all "plan instruction" references from their final handbooks.

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Contents

Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including on-line, large print, braille or audio CD. To request this handbook in an alternate format and/or language [Plan inserts instructions in 18 font] will be provided within 5 business days.

If you are having difficulty understanding this information, please

contact our Member Services staff at <insert> (TTY insert)> 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 [plan name's] Member Services staff. Voice and TRS users can make a 711 call from any telephone anywhere in the United States free of charge.

If you do not speak English, call us at <insert number (TTY: insert)>. 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 <insert number (TTY: insert)>.
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<insert number (TTY: insert)>. 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 <insert number (TTY: insert)>. 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<insert number (TTY: insert)>。 **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: **إذا كنت لا تتكلم الإنجليزية، اتصل بنا على < 1-الثلاثون-الثلاثون>**<insert number (TTY: insert)>**للحصول على العثور مساعدتك أيضا يمكننا .بك الخاصة باللغة أسئلتك على الإجابة في تساعد أن ويمكن ،شفوي مترجم خدمات على بك الخاصة باللغة معك التواصل يمكن الذين الصحية الرعاية موفر.**

Tagalog:

kung ikaw ay hindi nagsasalita ng ingles , mo sa amin & lt ; 1 xxx xxx xxxx (tty : 1 xxx xxx xxxx) & gt ; . 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 <1-xxx-xxx-xxxx (tty: 1-xxx-xxx-xxxx)=""><. 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 መናገር የማይችሉ ከሆነ, <1-XXX-XXX-XXXX (: 1-XXX-XXX-XXXX TTY)> ይደውሉልን. እኛ የአስተርጓሚ አገልግሎቶች መዳረሻ ያላቸው እና ከክፍያ ነጻ በራስዎ ቋንቋ ውስጥ የእርስዎን ጥያቄዎች መልስ ለማግኘት ይችላሉ. እኛ ደግሞ እንደ እናንተ የእርስዎን ቋንቋ ከእንተ ጋር መገናኘት የሚችል የጤና እንክብካቤ አቅራቢ እንዲያገኙ ሊረዱዎት ይችላሉ.

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

French: Si vous ne parlez pas anglais, appelez-nous à <1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)>. 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-XXX-XXX-XXXX (TTY: 1-xxx-XXX-XXXX)>. 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 नहीं बोलते हैं, तो <1-XXX-XXX-XXXX (: 1-XXX-XXX-XXXX TTY)> पर कॉल करें। हम दुभाषिया सेवाओं के लिए उपयोग किया है और नि: शुल्क अपनी भाषा में आपके सवालों के जवाब कर सकते हैं। हम यह भी मदद कर सकता है आप एक स्वास्थ्य देखभाल प्रदाता जो आपकी भाषा में आप के साथ संवाद कर सकते हैं।**

German: Wenn Sie kein Englisch sprechen, rufen Sie uns unter <1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)> 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 ইংরেজি বলতে পারি না, তাহলে <1-**রচনা**-XXX-XXXX (: 1-**রচনা**-XXX-XXXX TTY)> আমাদের সঙ্গে যোগাযোগ করুন. আমরা দোভাষীর পরিষেবাগুলিতে অ্যাক্সেস আছে এবং নিখরচা আপনার ভাষায় আপনার প্রশ্নের উত্তর সাহায্য করতে পারেন. আমরা সাহায্য করতে পারেন একটি স্বাস্থ্যের যত্ন প্রদানকারী যারা আপনার ভাষায় আপনার সাথে যোগাযোগ করতে পারেন.

Portuguese: Se você não fala inglês, ligue para <1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)>. 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 [Plan Name]

Thank you for choosing [Plan] as your preferred Medicaid Managed Care plan. If you are a new member, we will 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 <Plan Name> Member Services at<Member Services Contact Number>, visit our website at <Plan web address>, or call Virginia Medicaid Managed Care Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) Monday – Friday, 8:30 a.m. – 6:00 p.m. for help. This handbook is also available on the [Plan's] website located at [Plan web address].

[Plan may include additional language about itself here so long as it does not duplicate information provided elsewhere in the guide.]

How to Use This Handbook

This handbook will help you understand your benefits and how you can get help from <Plan Name>. This handbook is a health care and <Plan Name> 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 <Plan Name> Member Services <Member Services Contact Number>, visit our website at <Plan web address>, or call Virginia Medicaid Managed Care Helpline free of charge at 1-800-643-2273 (TTY: 1-800-817-6608) Monday – Friday, 8:30 a.m. – 6:00 p.m.

Your Welcome Packet

Member ID Card

You should have received a welcome packet that included your [Plan] Member ID Card. Your [Plan] 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:

[Insert picture of front and back of Member ID Card. Mark it as a sample card (for example, by superimposing the word "sample" on the image of the card).]

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 will 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 Services Covered through Medicaid Fee-For-Service, in Section 10 of this handbook.

Provider and Pharmacy Directories

You should have received information about [Plan] Provider and Pharmacy Directories. These directories list the providers and pharmacies that participate in [Plan] network. While you are a member of our plan, and in most cases, 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 <web address>.

[Plans must add information describing the information available in the directory.] [Plan should insert information about how to access all of these references.]

What Is <Plan's > Service Area?

[Insert plan service area here or within an appendix. Example: Our service area includes these cities and counties.]

Only people who live in our service area can enroll with [Plan]. If you move outside of our service area, you cannot 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.

[Insert any enhanced benefits offered for Members that select your plan]

List of Covered Drugs

You can access or download the Provider and Pharmacy Directory at <insert web address> or receive a printed copy by calling <insert telephone number>.

[Plans must add information describing the information available in the directory.]

[Plan should insert information about how to access all of these references.]

List of Covered and Non-Covered Services

See section 8 of this handbook or you can access or download <Plan's> Covered Services at <insert web address> or receive a printed copy by calling <telephone number>.

[Plans must add information describing the information available in the directory.] [Plan should insert information about how to access all of these references.] See Continuity of Care Period in Section 2 of this handbook.

Your Cost Sharing Responsibilities

[Plans should indicate what the member's cost sharing responsibilities are or indicate that there are no member cost sharing responsibilities for in network covered services]

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 [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

<Plan's> Member Services

Our Member Services Staff are available to help you if you have any questions about your benefits, services, or procedures or have a concern about [Plan].

How To Contact <Plan> Member Services

CALL	<Phone number(s)> This call is free. <insert time> [Include information on the use of alternative technologies.] We have free interpreter services for people who do not speak English.
TTY	<TTY/TDD phone number> This call is free. [Insert if [Plan] uses a direct TTY number: This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.] <Days and hours of operation>
FAX	<Fax number>
WRITE	<Mailing address>
EMAIL	<Email address>
WEBSITE	<Web address >

How <Plan's> Member Services Representatives Can Help You:

- Answer questions about the [Plan]
- Answer questions about claims, billing or Member ID Cards
- Assistance finding or checking to see if a doctor is in [Plan] network
- Assistance with changing your Primary Care Provider (PCP)
- Help you understand your benefits and covered services including the amount that we will pay so that you can make the best decisions about your health care.
- 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.
- 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.

How To Contact <Plan> Care Manager/Coordinator (if the plan has a dedicated team or if the individual has been assigned a care coordinator due to special circumstances)

[Plans should include information explaining what a Care Manager/Coordinator is, how Members can get a Care Coordinator, how they can contact the Care Coordinator, and how they can change their Care Coordinator.]

CALL	<Phone number(s)> This call is free. <Days and hours of operation> [Include information on the use of alternative technologies.] We have free interpreter services for people who do not speak English.
TTY	<TTY/TDD phone number> This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.] <Days and hours of operation>
FAX	[Fax number.]
WRITE	<Mailing address>

EMAIL	[Email address.]
WEBSITE	[Web address.]

Medical Advice Line Available 24 Hours A Day, 7 Days A Week

You can reach a nurse or behavioral health professional 24 hours a day, 7 days a week to answer your questions toll-free at: 1-8XX-XXX-XXXX. [Plans should include information about what the Medical Advice Call Line is.]

CALL	<Phone number(s)> This call is free. Available 24 hours a day, 7 days a week [Include information on the use of alternative technologies.] We have free interpreter services for people who do not speak English.
TTY	<TTY/TDD phone number> This call is free. [Insert if [Plan] uses a direct TTY number: This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Behavioral Health Crisis Line

[Plans should describe the Behavioral Health Crisis Line.]

Contact<Plan name> if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call 1-8XX-XXX-XXXX. 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	<Phone number(s)> This call is free. Available 24 hours a day, 7 days a week [Include information on the use of alternative technologies.] We have free interpreter services for people who do not speak English.

TTY	<TTY/TDD phone number> This call is free. [Insert if [Plan] uses a direct TTY number: This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

[PLANS SHOULD ADD OTHER IMPORTANT CONTACT NUMBERS THAT MEMBERS MAY NEED/REQUIRE FOR A QUICK REFERENCE: MUST INCLUDE ITEMS BELOW]

[Plan] Adult Dental (if offered)	
Smiles for Children through DentaQuest, DMAS Dental Benefits Administrator	For questions or to find a dentist in your area, call Smiles For Children at 1-888-912-3456. Information is also available on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/dnt-home.aspx or the DentaQuest website at: http://www.dentaquestgov.com/
Transportation	[Insert Vendor Information]
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 www.hhs.gov/ocr
Maximus	1-800-643-2273

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. [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 Assistance Program page for eligibility details and/or VDSS Medicaid Forms and Applications page for application and other Medicaid form details.

You are eligible for when you have full Medicaid benefits, and 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 UNQUALIFIED TO BE A MANAGED CARE 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 see appendix A.
- 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
- Third Party Liability

Enrollment

Enrollment in the program is required for eligible individuals. DMAS and the Managed Care Helpline manage the enrollment for the program. To participate in, 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 previously through Medicaid and we were your managed care organization. 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 am to 6 pm. 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 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 [Plan]. You will be sent a re-enrollment letter from the Department of Medical Assistance Services.

ENROLLMENT FOR NEWBORNS

If you have a baby, you will need to report the birth of your child as quickly as possible to enroll you 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
- The infant's mother's name and Medicaid ID number

<Plan> will provide coverage for your newborn for the entire birth month plus two additional consecutive month period regardless of whether the newborn receives a Medicaid ID number. If you change the newborn's enrollment during the "birth month plus two" period, then the new MCO will provide coverage for your newborn. In such cases, the former MCO is not responsible once the newborn is enrolled into another MCO.

Coverage for your newborn for the "birth month plus two" period is not contingent on the mother's continued enrollment with <Plan>. <Plan> will covapper the newborn even if the mother does not remain enrolled after the MCO Newborn's date of birth.

Babies born to a Medicaid-enrolled mom at the time of birth are eligible for Medicaid for their first year of life. (Must apply before their first birthday for continued Medicaid coverage.)

What Are the Advantages of Choosing [Plan]?

Some of the advantages of include:

- You will have access to <Plan's> Care Managers. <Plan's> Care 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 <Plan's> care team and Care Managers.
- The care team and Care 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, 7 days per week to answer your questions. We are here to help you. You can reach us by calling <insert> at any time.

[Plan can include language about [Plan] and any enhanced benefits and services.]

What is a Health Risk Assessment?

Within the first few weeks after you enroll with [Plan], a Care Manager will reach out to you to ask 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 Manager **within the first 30 to 60 days** of your enrollment with <Plan name> depending upon the type of services that you require. This health risk assessment will enable your Care Manager to help you get the care that you need.

Continuity of Care Period

If [Plan] is new for you, you can keep previously authorized and/or scheduled doctor's appointments and prescriptions for the **first 30 days**. If your provider is not currently in <Plan's> network, then you may be asked to select a new provider that is in <Plan's> provider network. If your doctor leaves <Plan's> network, we will 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 other insurance such as Tricare, Medicare, or private insurance, that insurance will have 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. <Plan's> Care

Managers will also work with you and your other health plan to coordinate your services. <Revise as necessary>

3. How To Get Regular Care and Services

"Regular care" means routine care such as exams, well care check-ups, shots or other treatments to keep you well, getting medical advice when you need it, and refer you to the hospital or specialists when needed. Be sure to call your PCP whenever you have a medical question or concern. If you call after hours on weekends, leave a message and 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 who work with [plan name]. We will also provide you with a paper copy of the provider directory upon request. You can also call [Plan] Member Services 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 IN YOUR COMMUNITY. FOR HELP LOCATING A PROVIDER YOU CAN USE OUR ON-LINE PROVIDER DIRECTORY AT: [PLAN WEBSITE].

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 include 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, <Plan> will auto-enroll you with a PCP. <Plan> will 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.

[Plan can revise to describe how Member should request a PCP or obtain assistance in finding a PCP.]

IF YOUR CURRENT PCP IS NOT IN [PLAN NAME'S] NETWORK

You can continue to see your current PCP for up to 90 days even if they are not in the [plan name's] network. During the first 90 days of your enrollment with [Plan] your Care Coordinator can help you find a PCP in [plan name's] network. At the end of the 90 day period, if you do not choose a PCP in the [Plan] network, [Plan] will assign a PCP to you.

CHANGING YOUR PCP

You may call or visit [Plan's] Member Services to change your PCP at any time to another PCP in our network. Please understand that it is possible your PCP will leave [Plan] network. We will tell you within 30 days of the provider's intent to leave our network. We are happy help you find a new PCP.

The web address for our Member Services program is [insert].

[Plans should describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]

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.

HOW TO GET CARE FROM OTHER NETWORK PROVIDERS

Our provider network includes access to care 24 hours a day 7 days per week and includes hospitals, doctors, specialists, urgent care facilities, home and community based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health, durable medical equipment providers, and other types of providers. [Plan] provides 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.

TRAVEL TIME AND DISTANCE STANDARDS

[Plan] will 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 45 minutes to receive services. If you live in a rural area you should not have to travel more than 60 miles or 75 minutes to receive services.

Member Travel Time & Distance Standards		
Standard	Distance	Time
Urban		
• PCP	15 Miles	30 Minutes
• Specialists	30 Miles	NA
• Obstetrician	NA	45 Minutes
Rural		
• PCP,	30 Miles	60 Minutes
• Specialists	60 Miles	NA
• Obstetrician	NA	45 Minutes

ACCESSIBILITY

[Plan] wants 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 <PLAN'S> 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 are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.

- We will 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 will 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 a complaint.
- 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?

[Plan name's] 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
  - [Note: please include in this section any restrictions your plan places on freedom of choice among network providers, such as geographic restrictions, i.e. members in Norfolk cannot go to a network provider in Arlington]

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.

Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them. Call Member Services at the number at the bottom of the page for more information. Both

Member Services and [Plan]'s website can give you the most up-to-date information about changes in our network pharmacies and providers

SERVICES YOU CAN GET WITHOUT A REFERRAL OR PRIOR AUTHORIZATION

[Note: Insert this Section only if plans require referrals to network providers.]

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 below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers.
- Urgent 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.

[Plans should add additional bullets as appropriate.]

4. How to Get Specialty Care and Services

WHAT ARE SPECIALISTS?

If you need care that your PCP cannot provide, your PCP may refer you to a specialist. Most of the specialists are in [Plan's] 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 will not need a new referral each time you need care. If you have a disabling condition or chronic illnesses you can ask us if your specialist can be your PCP.

How Do I Access A Network Specialist?

[Plans should describe how Members access specialists and other network providers, including:

What is the role (if any) of the PCP in referring Members to specialists and other providers?

What is the process for getting authorization? Explain that authorization means that the Member must get approval from [Plan] before getting a specific service or drug. Include information about who makes the authorization decision (e.g., [Plan], the PCP, or another entity) and who is responsible for getting the authorization (e.g., the PCP, the Member). Refer Members to the Benefits Section [plans may insert reference, as applicable] for information about which services require authorization.

How to Get Care From Out-Of-Network Providers

[Plans should tell Members under what circumstances they may obtain services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.]

If we do not have a specialist in the [Plan] network to provide the care you need, we will get you the care you need from a specialist outside of the [Plan] network. We will also get you care outside of the [Plan] network in any of the following circumstances:

- When [Plan] has approved a doctor out of its 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 <plan's> network;
- When [Plan] cannot 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 [plan's] network does not, because of moral or religious objections, furnish the service you need ([Plan] does not have moral or religious restrictions on coverage for counseling or referral services, but certain in-network providers may have restrictions);
- Within the first ninety (90) calendar days of your enrollment, where your provider is not part of [plan's] network but he has treated you in the past; and,
- If you are in a nursing home when you enroll with [Plan], and the nursing home is not in [plan's] network.

If your PCP or [Plan] refer you to a provider outside of our network, you are not responsible for any of the costs. 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

[Plan] is 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 < plan> 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 a < plan> Member. Ask them to call < plan> at the number on the back of your Insurance 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.
  - 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 are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. If you are not sure, call your PCP or the [Plan's] 24/7 medical advice line at: [ ].

If You Have an Emergency When You are 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 < Plan> card. Tell them you are in [plan's] 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 will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is complete.

Notifying [Plan] About Your Emergency

Notify your doctor and [Plan] as soon as possible about the emergency within 48 hours if you can. However, you will not 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 [Plan inserts instructions with contact information]. This number is also listed on the back of [plan's] Member card.

After An Emergency

[Plan] will 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 will 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 < Plan> as soon as possible. By keeping < Plan> 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 will cover your care.

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

- you go to a network provider, or
- the additional care you get is considered "urgent care" and you follow the rules for getting urgently needed care this 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 will cover urgently needed care only if you get this care from a network provider. [Plan can keep or delete. However, if you can't get to a network provider, we will 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 [insert].

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 [Plan]'s Outpatient Drug Coverage

[Plan] will 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 generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on [Plan]'s List of Covered Drugs. If it is not on the Drug List, we may be able to cover it by giving you an authorization. [Plan includes instructions].
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.

[Plan adds additional information as applicable]

Getting Your Prescriptions Filled

In most cases, [Plan] will pay for prescriptions only if they are filled at [plan's] 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 [Plan] 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 [Plan] to get the necessary information.

If you need help getting a prescription filled, you can contact Member Services at the number at the bottom of the page.

List of Covered Drugs

[Plan] has a List of Covered Drugs that are selected by [Plan] with the help of a team of doctors and pharmacists. The [Plan] 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 [plan inserts plan website]. The List of Covered Drugs tells you which drugs are covered by [Plan] and 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 [website] or we can mail you a paper copy of the List of Covered Drugs. The List of Covered Drugs may change during the year. To get the most up-to-date List of Covered Drugs, visit [enter plan website information] or call [plan contact information including hours, etc.].

Plan provides instructions on how the member can access the list of covered drugs electronically and via paper upon request. Plan adds additional information as applicable including how individuals are notified of changes to the Drug list, especially if a medication they have been taking comes off the Plan's Drug list.

We will generally cover a drug on [Plan's] 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 Continuity of Care in Section 11 of this Handbook.

If [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 Continuity 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. Your Care Coordinator will 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 [Plan] before you fill your prescription. If you don't get approval, [Plan] may not cover the drug.

TRYING A DIFFERENT DRUG FIRST

We may require that you first try one (usually less-expensive) drug before we will 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 will 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 [Plan website].

EMERGENCY SUPPLY

There may be an instance where your medication requires a service authorization, and your prescribing physician cannot 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®, Cialis®, Levitra®, and Caverject®, 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 Member Services at the number at the bottom of the page or your Care Coordinator.

If the pharmacy you use leaves [plan's] 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 Member Services at the number at the bottom of the page 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. [Plan's add language regarding specialized pharmacies]

Can You Use Mail-Order Services To Get Your Prescriptions?

Plan Fills in specifics as applicable

Can You Get a Long-Term Supply of Drugs?

Plan Fills in as applicable

Can You Use a Pharmacy that is not in [Plan]'s Network?

Plan Fills in as applicable

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 will 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 [Plan] 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 [Plan] if placed in the PUMS program;
- information regarding how request a State Fair Hearing after first exhausting the [plan's] 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 [Plan]. In most cases, [Plan] will not pay for care you get from an out- of-network provider unless the service is authorized by [Plan]. 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 [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 Continuity of Care Period in Section 11.

Benefits Covered Through [Plan]

[Plan] covers 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/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.
- 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 for children from birth to age 3. 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 [plan's] network. [Plan] does not 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).
- Scheduled immunizations
- Second opinion services from a qualified health care provider within the network or we will 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 [plan.]
- Telemedicine services.
- Temporary detention orders (TDO).
- Tobacco Cessation Services.
- TracPhone
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus,

  volunteer/ registered drivers, taxi cabs. [Plan] will also provide transportation to/from most carved-out services. Additional information about transportation services is provided later in this Section of the handbook.
- Vision services.
- Well Visits (Plans include specifics).
- Abortion services- coverage is only available in cases where there would be a substantial danger to life of the mother.

Extra Benefits Included in [Plan]

As a member of [Plan] 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: Plan provides information on enhanced benefits.

* If you have any questions about these benefits, please call our Member Services Department at the number on the bottom of this page.

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

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a federally mandated Medicaid benefit that provides comprehensive and preventive health care services for children under age 21. If you have a child that is under age 21, EPSDT provides appropriate preventive, dental, behavioral health, developmental, and specialty services. It includes coverage for immunizations, well child visits, lead investigations, private duty nursing, personal care, and other services and therapies that treat or make a condition better. It will also cover services that keep your child's condition from getting worse. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid.

HOW TO ACCESS EPSDT SERVICE COVERAGE

[Plan] provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by [Plan]. For any services not covered by [Plan], you can get these through the Medicaid fee-for-service program. Additional information is provided in Section 11 of this handbook. [Plans should provide applicable information about getting EPSDT services, including service authorization requirements.]

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 includes services such as speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to help families support their child's learning and development during everyday activities and routines. Services are generally provided in your home.

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 [Plan] we provide coverage for early intervention services. 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.

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). [Plan's] Member Services can help coordinate the services you need, including those that are provided through the BHSA.

[Plans should provide applicable information about getting behavioral health services, including service authorization requirements. Plans must follow Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.]

[Plans should provide applicable information about getting behavioral health services, including service authorization requirements.]

How To Access Addiction and Recovery Treatment Services (ARTS)

[Plan] offers 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 and in recovery), as well as case management services. Talk to your PCP or call your Care Coordinator 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 Care Coordinator, or contact Member Services at one of the numbers below.

[Plans should provide applicable information about getting ARTS services, including service authorization requirements. Plans must follow Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.]

How To Access Non-Emergency Transportation Services

TRANSPORTATION SERVICES COVERED BY [PLAN]

Non-Emergency transportation services are covered by [Plan] for covered services, carved out services, and enhanced benefits.

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 non-emergency medical appointments, call the reservation line at <inset>. If you are having problems getting transportation to your appointments, call [Plan Transportation Contractor] at [insert phone number] 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.

[Plans should provide applicable information about getting transportation services including advance notice for routine reservations and contact information.]

9. Services Not Covered

The following services are not covered by Medicaid or [Plan].If you receive any of the following non-covered services you will be responsible for the cost of these services. (Plans revise if any of these are covered as enhanced benefits through your plan)

- 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 [Plan])
- Medical care other than emergency services, urgent services, [plan keeps or deletes urgent care services], or family planning services, received from

  providers outside of the network unless authorized by [Plan]
- Routine dental care if you are age 21 or older
- Services rendered while incarcerated
- Weight loss clinic programs unless authorized

- Care outside of the United States

  <Plan should revise/add if any of these services are covered as enhanced benefits or when authorized through [Plan]>

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 [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 will 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 will not pay for your services, you have the right to appeal our decision. Section 12 provides instructions for how to appeal [Plan]'s coverage decisions. You may also call Member Services to learn more about your appeal rights or to

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 [Plan] when receiving these services. Your provider bills fee-for-service Medicaid (or its Contractor) for these services.

Carved Out services

- Community Mental Health Rehabilitation Services (CMHRS) are provided through Magellan, the DMAS Behavioral Health Services Administrator. CMHRS are listed below. Detailed information about CMHRS is available on the Magellan website at: http://www.magellanofvirginia.com or by calling: 1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711.
  - Mental Health Case Management
  - Therapeutic Day Treatment (TDT) for Children Under Age 21
  - Crisis Intervention and Stabilization
  - Intensive Community Treatment
  - Mental Health Skill-building Services (MHSS)
  - Intensive In-Home
  - Psychosocial Rehab
  - Level A and B Group Home for Children Under Age 21

- Treatment Foster Care Case Management
- Behavioral Therapy
- Mental Health Peer Supports

➢ 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 not covered for adults other than as described above for pregnant women.

  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, 8:00 AM - 6:00 PM EST. 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.

  [Plan] provides coverage for non-emergency transportation for any dental services covered through Smiles for Children, as described above. Contact [Plan] 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 [Plan] will close and you will be served by the Medicaid Fee-For-Service program so long as you remain eligible for Medicaid.

- You are receiving care in an Intermediate Care Facility for Individuals with Intellectual Disabilities.
- You are receiving care in a Psychiatric Residential Treatment Level C Facility (children under 21).
- You are receiving care in a Nursing Facility.
- You are receiving care in a long-term care facility.

[Plans add details as desired]

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.

If the services you require are covered through Medicare then a service authorization from [Plan] is not required. If you have questions regarding what services are covered under Medicare, please contact your Medicare health plan. You can also contact your [Plan] Care Coordinator.

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

[Plan] does not 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:

[Plan enters all services that require service authorization, including those that require an authorization beyond a certain limit].

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.

Service Authorizations and Continuity of Care

If you are new to [Plan] we will 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

[Plan enters other instructions for how to obtain a service authorization]

What Happens After Submitting A Service Authorization Request?

[Plan] has 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 will 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 will tell you and your case will be handled under the standard review process.

Timeframes for Service Authorization Review

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

Physical Health Services	Service Authorization Review Timeframes
Inpatient Hospital Services (Standard or Expedited Review Process)	Within 1 business day if we have all the information we need, or up to 3 business days if we need additional information, or as quickly as your condition requires.
Outpatient Services (Standard Review Process)	Within 3 business days if we have all the information we need, or up to 5 business days if we need additional information.

Physical Health Services	Service Authorization Review Timeframes
Outpatient Services (Expedited Review Process)	Within 72 hours from receipt of your request; or, as quickly as your condition requires.

Behavioral Health Services	Service Authorization Review Timeframes
Outpatient (Standard Review Process)	Within 3 business days if we have all of the information we need, or up to 5 business days if we need additional information, or as quickly as your condition requires.
Inpatient (Standard Review)	Within 1 business day if we have all of the information we need, or up to 3 business days if we need additional information, or as quickly as your condition requires.
Inpatient (Expedited Review)	Within 3 hours.
Other Urgent Services	Within 24 hours 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 cannot 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 will:

- Write and tell you and your provider what information is needed. If your request is in an expedited review, we will 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 [Plan] to help decide your case. This can be done by calling [plan enters phone number(s) and address].

You or someone you trust can file a complaint with [Plan] 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 [Plan] 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 will 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 will 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 will 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 will 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.

Care Notification

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 will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by [Plan] 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 [Plan] that you disagree with that relates to coverage or payment of services.

For example, you can appeal if [Plan] denies:

- A request for a health care service, supply, item or drug that you think you should be able to get, or
- A request for payment of a health care service, supply, item, or drug that [Plan] denied.

You can also appeal if [Plan] stops providing or paying for all or a part of a service or drug you receive through 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 [Plan] 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 will provide you with a form that you can fill out and sign stating who your representative will be.

Please note: A written consent from the member is required to file an appeal on the member's behalf

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 will 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 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 will tell you and your appeal will be reviewed under the standard process.

Send your Appeal request to: [plan address, FAX, phone]. 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
- 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 [plan provides timeframe for acknowledging appeal] days, we will 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 did not 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. [Plan provides where the Member can call or send information].

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 will tell you our decision within 30 days of when we receive your appeal request. We will tell you within 2 calendar days after receiving your appeal if we need more information. A written notice of our decision will be sent within [Plan enters timeframe] 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 3 business days** receipt of your appeal. We will tell you our decision by phone and send a written notice within 14 calendar days from when we make the decision.

If We Need More Information

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

- Write you and tell you what information is needed. If your request is in an expedited review, we will 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 [Plan] to help decide your case. This can be done by calling or writing to: [plan enters appropriate contact information and any additional instructions].

You or someone you trust can file a complaint with [Plan] 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 [Plan] handled your appeal to the State through the Help Line at 1-800-643-2273.

WRITTEN NOTICE OF APPEAL DECISION

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 will tell you and your provider in writing if your request is denied or approved in an amount less than requested. We will 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 will 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) [Plan] 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 [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. 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, or 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: (804) 452-5454
Standard and Expedited Appeals may also be made by calling (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 [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 [Plan] for any services you receive during the continued coverage period if [Plan's] 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

If services were not continued while the State Fair Hearing was pending

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

If 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, [Plan] 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.

Your Right to File a Complaint

[Plan] will try its 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 the [Plan's] complaint process.

Complaints about quality

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

Complaints about privacy

- You think that someone did not respect your right to privacy or shared information about you that is confidential or private.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- [Plan] staff treated you poorly.
- [Plan] is not responding to your questions.
- You are not happy with the assistance you are getting from your Care Coordinator.

Complaints about accessibility

- You cannot 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.

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.

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 [Plan] staff.

Complaints about cleanliness

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

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 did not receive it.

THERE ARE DIFFERENT TYPES OF COMPLAINTS

You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by [Plan]. An external complaint is filed with and reviewed by an organization that is not affiliated with [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 will respond to your complaint in writing. You can file a complaint in writing, by mailing or faxing it to us at [Plan Name, FAX, address, etc.]

So that we can best help you, include details on who or what the complaint is about and any information about your complaint. [Plan] will 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 will 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 will 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 [plan] to the Managed Care Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) Monday – Friday, 8:30 a.m. – 6:00 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: 215-861-4431 TDD: 1-800-537-7697

13. Member Rights

Your Rights

It is the policy of [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 [Plan] network providers and your right to refuse treatment;
- Confidentiality and privacy about your medical records and when you get treatment;
- Receive information and to discuss available treatment options and alternatives presented in a manner and language you understand;
- 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 a s 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 [Plan], including how you can receive benefits from out-of-network providers if the services are not available in [Plan name's] network.
- Complain about [Plan] 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 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 [Plan] 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.)

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

[Plan] will 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.

[Plan] staff will ask questions to confirm your identity before we discuss or provide any information regarding your health information.

Plan inserts information on confidentiality consistent with confidentiality requirements, including special rules related to substance use disorder and addiction, recovery, and treatment services.

Your Right to Privacy

Plan inserts information on privacy practices as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

How to Join the Member Advisory Committee

[Plan] 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 [Plan] Member Services using one of the numbers below.

We Follow Non-Discrimination Policies

You cannot 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.

[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 [Plan] Membership card whenever you seek medical care.
- Provide complete and accurate information to the best of your ability on your health and medical history.
- 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.
    - Keep your appointments. If you must cancel, call as soon as you can.
    - Receive all of your covered services from [Plan's] network.
    - Obtain authorization from [Plan] prior to receiving services that require a service authorization review (see Section 14).
    - Call [Plan] whenever you have a question regarding your Membership or if you need assistance toll-free at one of the numbers below.
    - Tell [Plan] when you plan to be out of town so we can help you arrange your services.
- Use the emergency room only for real 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.
    - Call your PCP when you need medical care, even if it is after hours.
    - Tell [Plan] 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.
        - If you have any liability claims, such as claims from an automobile accident.

- If you are admitted to a nursing facility or hospital.
- 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. Organizations that give people information about Medicaid [plans should insert examples of those organizations] may also have advance directive forms. [Insert if applicable: 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 did not 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: 804-367-4691
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
FAX	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: 804-367-2106
WRITE	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1463
FAX	804-527-4503
EMAIL	OLC-Complaints@vdh.virginia.gov
WEBSITE	http://www.vdh.state.va.us/olc/complaint/

15. Fraud, Waste, and Abuse

Plan includes relevant information and instructions including but not limited to the subsections below.

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 fail 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

Plan Instructions

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 (804) 786-1066

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

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

Email: MFCU_mail@oag.state.va.us

Fax: 804-786-3509

Mail: Office of the Attorney General

Medicaid Fraud Control Unit

202 North Ninth Street

Richmond, VA 23219

Virginia Office of the State Inspector General

Fraud, Waste, and Abuse Hotline

Phone: 1-800-723-1615

Fax: 804-371-0165

Email: covhotline@osig.virginia.gov

Mail: State FWA Hotline

101 N. 14th Street

The James Monroe Building 7th Floor

Richmond, VA 23219

16. Other Important Resources

[Plan may insert this Section to provide additional information resources, such as maternal and child resource centers, choice counselors, Helpline or area agencies on maternal and child health.]

17. 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 [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 [Plan]'s 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 [Plan] who works with you and with your care providers to make sure you get the care you need.
- 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.
- 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.
- "Carved-Out Service(s)" The subset of Medicaid covered services for which the Plan will not be responsible. These services may be covered under the Fee-for-Service benefit.
- 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 will pay for your health services.

- Cost Sharing – member pays a portion of the co-pay and/or medical bill. The Medallion managed Care Program does not have cost sharing.
- Covered drugs: The term we use to mean all of the prescription drugs covered by [Plan].
- Covered services: The general term we use to mean all of the health care, services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by [Plan].
- Durable medical equipment: Certain items your doctor orders 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. Hospice Services: A full set of services coordinated by a variety of health care professionals to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as described in a specific patient plan of care.
- 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 [Plan]. [Plan] chooses 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."
- 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.
- Member Services: A department within [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, and medical equipment. 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 [Plan] and accept our payment and not charge our Members an extra amount. While you are a Member of [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 [Plan] Members. We call them "network pharmacies" because they have agreed to work with [Plan]. 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 by [Plan] and is not under contract to provide covered services to Members of [Plan].
- Nursing facility: A medical care facility that provides care for people who cannot 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 [Plan] and is not under contract to provide covered services to Members of [Plan].
- Participating provider: Providers, hospitals, clinics, and other places that provide your health care services, medical equipment, and services that are contracted with [Plan]. 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.
- Health Plan: An organization made up of doctors, hospitals, pharmacies, 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.
- 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.

- Prior 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 [Plan].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 [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 [Plan]'s 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 a [Plan] is allowed to operate. It is also generally the area where you can get routine (non-emergency) 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 [Plan].
- Skilled Nursing Care: Services from licensed nurses or other health care professionals, such as physical therapists who provide services in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing homeSpecialist: 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 cannot get to them.

[Plans may add a back cover for the Member Handbook that contains contact information for Member Services. Below is an example plans may use. Plans also may add a logo and/or photographs, as long as these elements do not make it difficult for Members to find and read the contact information.]

[Plan]

Member Services

CALL	[Insert phone number(s).] Calls to this number are free. [Insert days and hours of operation, including information on the use of alternative technologies.] Member Services also has free language interpreter services available for non-English speakers.
TTY	[Insert number.] [Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] Calls to this number are free. [Insert days and hours of operation.]
FAX	[Optional: Insert fax number.]
WRITE	[Insert address.] [Note: Plans may add email addresses here.]
WEB SITE	[Insert URL.]

Appendix A.

The following individuals shall be excluded (as defined in 12VAC30-120-360) from participating in mandatory managed care as defined in the § 1915(b) managed care waiver. Individuals excluded from mandatory managed care shall include the following:

1. Individuals who are inpatients in state mental hospitals;

2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities;

3. Individuals who are placed on spend-down;

4. Individuals who are participating in the family planning waiver, or in federal waiver programs for home-based and community-based Medicaid coverage prior to managed care enrollment (except eligible EDCD members);

5. Individuals under age 21 who are approved for DMAS residential facility Level C programs as defined in 12VAC30-130-860;

6. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (i.e., physician, hospital, or midwife) does not participate with the member's assigned MCO. Exclusion requests made during the third trimester may be made by the member, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;

7. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;

8. Individuals who receive hospice services in accordance with DMAS criteria;

9. Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);

10. Individuals requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time of MCO enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion reason shall not apply to members admitted to the hospital while already enrolled in a department-contracted MCO;

11. Individuals who request exclusion during assignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The individual's physician must certify the life expectancy;

12. Certain individuals between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory managed care enrollment;

13. Individuals who have an eligibility period that is less than three months;

14. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program;

15. Individuals who have an eligibility period that is only retroactive; and

16. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.