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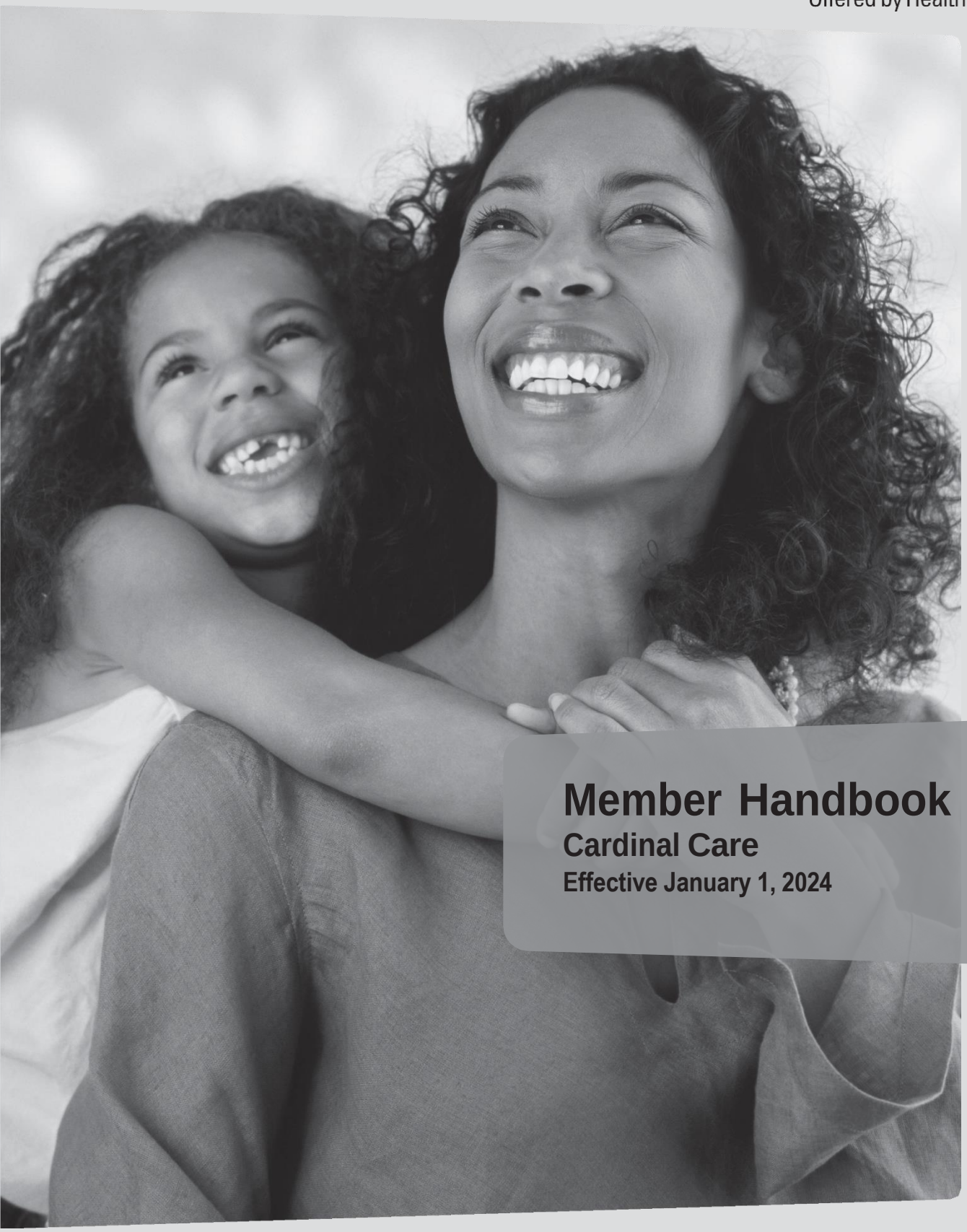

Member Handbook

Cardinal Care

Effective January 1, 2024

1045611VAMENAHP 12/23

anthem.com/vamedicaid

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

Cardinal Care Model Member Handbook

January 1, 2024

CardinalCare
Virginia's Medicaid Program

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

1045611VAMENAHP 12/23

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1. Let's Get Started

Welcome to Cardinal Care

Medicaid and Family Access to Medical Insurance Security (FAMIS) Plan are health insurance programs funded by the state and the federal government. They are run by the Virginia Department of Medical Assistance Services (DMAS or "the Department"). For more information, visit dmas.virginia.gov and dmas.virginia.gov/for-members/cardinal-care. Monthly income limits for eligibility vary by program. For more information on eligibility, visit coverva.org. Both programs have full benefits as described below.

This Member Handbook explains benefits and how to access services for Cardinal Care, Virginia's Medicaid/FAMIS program. For questions, call Anthem HealthKeepers Plus Member Services at **800-901-0020 (TTY: 711)** Monday through Friday from 8 a.m. to 8 p.m. Eastern time, visit our website at **anthem.com/vamedicaid**, or call your care manager.

Other Languages and Formats

If you need this handbook in large print, in other formats or languages, read aloud, or if you need a paper copy, call Anthem HealthKeepers Plus Member Services at **800-901-0020 (TTY: 711)**. You can get what you need for free. Members with alternative hearing or speech communication needs can dial **711** to reach a Telecommunications Relay Services (TRS) operator who can help you. Auxiliary aids and services are available upon request at no cost. Visit us online anytime at **anthem.com/vamedicaid** or dmas.virginia.gov.

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 800-901-0020 (TTY: 711).

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

Spanish
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-901-0020 (TTY 711).

El plan Anthem HealthKeepers Plus cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-901-0020 (TTY 711)번으로 전화해 주십시오.

Anthem HealthKeepers Plus 플랜 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-901-0020 (TTY 711).

Chương trình Anthem HealthKeepers Plus tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-901-0020 (TTY 711)

Anthem HealthKeepers Plus 計劃遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。

Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات الغوية المساعدة تتوافر لك بالمجان. اتصل برقم 800-901-0020 (هـ الصم والبكم: 711).

تلتزم خطة Anthem HealthKeepers Plus بقوانين الحقوق المدنية الفدرالية المعمول بها ولا تميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس .

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-901-0020 (TTY 711).

Sumusunod ang planong Anthem HealthKeepers Plus sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد با شماره 800-901-0020 بگیرید. تماس بگیرید (TTY 711).

طرح Anthem HealthKeepers Plus از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-901-0020 (መስማት ለተሳናቸው: 711).

የAnthem HealthKeepers Plus እቅድ የሚመለከቱ የፌደራል ሲቪል መብቶች ሀጎችን የሚያከብር ሲሆን ሰዎችን በዘር፣ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት፣ ወይም በጾታ ማንኛውንም ሰው አያገልም።

Urdu

توجہ: اگرآپ اردو بولتے ہیں، آپ کے لیے زبان کی مدد،مفت دستیاب ہے۔ کال800-901-0020 (TTY: 711)

Anthem HealthKeepers Plus ہے پلان کرتا تعمیل کی قوانین کے حقوق شہری وفاقی اطلاق قابل
کرتا نہیں امتیاز پر بنیاد کی جنس یا معذوری عمر، قومیت، رنگ نسل، کہ یہ اور ۔

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont 7roposes gratuitement. Appelez le 800-901-0020 (ATS : 711).

Le régime Anthem HealthKeepers Plus respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-901-0020 (телетайп: 711).

План Anthem HealthKeepers Plus соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Hindi
ान द: यद आप हदी बोलते ह तो आपके ि लए मु म भाषा सहायता सेवाएं उपल ह। 800-901-0020 (TTY 711) पर कॉल कर।

Anthem HealthKeepers Plus योजना लागू संघीय नाग रक अिधकार कानूनों का अनुपालन करती है और जाि त, रंग, रा ीय मूल, आयु, िवकलांगता, या िलंग केआधार पर भेदभाव नही करती है।

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-901-0020 (TTY: 711).

Die Anthem HealthKeepers Plus-Krankenversicherung erfüllt geltende bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Bengali

লয্ করনঃ িযদ আিযন বাংলা, কথা বললত িাল রন, তাে লল য নঃখরচায় ভাষা ে সায়তা িযলরষবা
িউল আআছ্। আ ফান করন ১-800-901-0020 (TTY: ১-711)।

Anthem HealthKeepers Plus ান ে যাজ ে ফডা রল নাগিরক অিধকার আইন ে মেন চেল জাি ত, রঙ, জাতীয় উৎপি , বয়স, অ মতা, বা িলে র িভি ে ত ৈবষম কের না।

Bassa

Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ ɔ̀ -wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ ìn m̀ gbo kpáa. Đá 800-901-0020 (TTY:711)

Anthem HealthKeepers Plus dyí-sɔ́-ɖɛ̀ Nyɔ ɓɛ̌è kpɔ̃ nyɔŭn-dyù gbo-gmɔ̀ -gmà ɓɛ̌ɔ̀ dyi ké wa ní ge nyɔŭn-dyù mú dyììn ɖé ɓóɖó-dù nyɔɔ̀ sɔ̀ kɔ̃ ɛ mú, mɔɔ kà nyɔɔ̀ dyɔɔ̀ -kù nyu nìɛ̀ kɛ mú, mɔɔ ɓóɖó ɓɛ́ nyɔɔ̀ sɔ̀ kɔ̃ ɛ mú, mɔɔ zɔj̃ ǐ kà nyɔɔ̀ ɖă nyuɛ mú, mɔɔ nyɔɔ̀ mɛ kɔ́ dyíɛ mú, mɔɔ nyɔɔ̀ mɛ mɔ̀ gàa, mɔɔ nyɔɔ̀ mɛ mɔ̀ màa kɛɛ mú.

Notice of Nondiscrimination

The Anthem HealthKeepers Plus does not discriminate (or treat you differently) based on race, color, national origin, age, disability, or sex. The Anthem HealthKeepers Plus plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Anthem HealthKeepers Plus plan provides:

- Free aids and services to people with disabilities to communicate effectively, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Anthem HealthKeepers Plus Member Services at **800-901-0020 (TTY: 711)**. This call is free.

If you think the Anthem HealthKeepers Plus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: HealthKeepers, Inc. for Anthem HealthKeepers Plus, Attention: Civil Rights Coordinator for Discrimination Complaints, P.O. Box 62509, Virginia Beach, VA 23466-2509, Telephone: **800-901-0020 (TTY: 711)**.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; **800-368-1019 (TTY 800-537-7697)**. Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Important Contact Information

Below is a list of important phone numbers you may need. If you are not sure who to call, contact Anthem HealthKeepers Plus Member Services for help. This call is free. Free interpreter services are available in all languages for people who do not speak English.

Entity Name	Contact Information
Anthem HealthKeepers Plus Member Services	**800-901-0020** **TTY: 711** Monday through Friday, 8 a.m. to 8 p.m. Eastern time **anthem.com/vamedicaid** Anthem Medicaid mobile app

Entity Name	Contact Information
Anthem HealthKeepers Plus Care Management	**800-901-0020 option 6** **TTY: 711** Monday through Friday, 8 a.m. to 6 p.m. Eastern time
Anthem HealthKeepers Plus Medical Advice Line	**800-901-0020** **TTY: 711** 24 hours a day, seven days a week
Anthem HealthKeepers Plus Behavioral Health Crisis Line	**844-429-9620** **TTY: 711** 24 hours a day, seven days a week
Addiction and Recovery Treatment Services (ARTS) Medical Advice Line	**800-901-0020** **TTY: 711** 24 hours a day, seven days a week
Department of Behavioral Health and Developmental Services (DBHDS) for DD Waiver Services	My Life, My Community Helpline **844-603-9248** **TDD: 804-371-8977** Monday through Friday, 9 a.m. to 4:30 p.m. mylifemycommunityvirginia.org
Cardinal Care Dental Benefits Administrator	**888-912-3456** **TTY: 800-466-7566** https://dentaquest.com/state-plans/regions/virginia/ Monday through Friday, 8 a.m. to 6 p.m.
Anthem HealthKeepers Plus Vision Services	**800-901-0020** **TTY: 711** Monday through Friday, 8 a.m. to 8 p.m. Eastern time
Anthem HealthKeepers Plus Transportation Services	**877-892-3988** **TTY: 711** Monday through Friday, 8 a.m. to 8 p.m. Eastern time
Cardinal Care Transportation for Developmental Disability Waiver Services	**866-386-8331** **TTY: 866-288-3133** Dial **711** to reach a TRS operator 24 hours a day, seven days a week

Entity Name	Contact Information
Cardinal Care Managed Care Enrollment Helpline	**800-643-2273** **TTY: 800-817-6608** Monday through Friday, 8:30 a.m. to 6 p.m.
Department of Health and Human Services' Office for Civil Rights	**800-368-1019** **TTY: 800-537-7697** hhs.gov/ocr
Office of the State Long-Term Care Ombudsman	**800-552-5019** **TTY: 800-464-9950** elderrightsva.org

Staying Connected

Have you moved, changed phone numbers, or gotten a new email address? It is important to let us know so that you keep getting high-quality health insurance. The Department and the Anthem HealthKeepers Plus plan need your current mailing address, phone number, and email address so that you do not miss any important updates and you receive information about changes to your health insurance.

You can update your contact information today:

- ✓ By calling Cover Virginia at **833-5CALLVA**.
- ✓ Online at commonhelp.virginia.gov.
- ✓ By calling Anthem HealthKeepers Plus Member Services.
- ✓ By calling your local Department of Social Services (DSS).

2. Cardinal Care Managed Care Overview

Health Plan Enrollment

You are successfully enrolled in the Anthem HealthKeepers Plus plan. The Anthem HealthKeepers Plus plan, a Cardinal Care Medicaid/FAMIS managed care plan (a "health plan"), covers your healthcare and provides care management. A health plan is an organization that contracts with doctors, hospitals, and other providers to work together to get you the healthcare you (the member) need. In Virginia, there are six Cardinal Care health plans that operate statewide.

If you move out-of-state you will no longer be eligible for Cardinal Care in Virginia, but you may be eligible for the Medicaid program in the state where you live. If you have questions about your eligibility for Cardinal Care, contact your local DSS or call Cover Virginia at **833-5CALLVA (TTY: 888-221-1590)**. This call is free.

Three steps new members should take

1. Look for your member ID card in the mail. Schedule a visit with the primary care provider (PCP) listed on your ID card within 60 days.
2. Go online to **anthem.com/vamedicaid** to register for your secure online account and view your quick start guide, member handbook, Provider Directory and Formulary. You can use the Provider Directory or online *Find a Doctor* tool to choose or switch PCPs.
3. Complete your health screener within your first 120 days. It's a short questionnaire that helps us determine how we can best get you the care you need.

Anthem HealthKeepers Plus Member Services is available to help if you have any questions or concerns. Call **800-901-0020 (TTY: 711)**, Monday through Friday from 8 a.m. to 8 p.m. Eastern time or visit us at **anthem.com/vamedicaid**.

You can change your health plan:

- For any reason during the first 90 calendar days of enrollment.
- For any reason once a year during your open enrollment period.
- For "good cause" reasons determined by the Department. Examples include poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care. This includes OB care. If you are pregnant and your OB provider does not participate with the Anthem HealthKeepers Plus plan and does participate with Medicaid fee-for-service (FFS), you can ask to get coverage through Medicaid FFS until after the delivery of your baby.

Call the Cardinal Care Managed Care Enrollment Helpline at **800-643-2273 (TTY: 800-817-6608)** Monday through Friday, 8:30 a.m. to 6:00 p.m., for information about your open enrollment period, or "good cause," or to help you choose or change your health plan. Cardinal Care Managed Care Enrollment Helpline services are free. FAMIS members can call Cover Virginia at **833-5CALLVA** to change health plans.

Welcome Packet

You should have received a welcome packet that includes your member ID card, information on the Anthem HealthKeepers Plus plan Provider Directory, and the Preferred Drug List. If you did not receive your welcome packet, call the Anthem HealthKeepers Plus plan's Member Services. You can also visit our website at **anthem.com/vamedicaid** to find providers in your plan and view our Preferred Drug List. To access your member ID card, log in to your secure account at **anthem.com/vamedicaid**.

Anthem HealthKeepers Plus Member ID Card

You must show your Anthem HealthKeepers Plus member ID card to get services or prescription drugs covered by the Anthem HealthKeepers Plus plan (see sample member ID card below) when you go to your provider or pharmacy. If you have not received your card, or if your card is damaged, lost, or stolen, call Anthem HealthKeepers Plus Member Services right away to get a new one.

All members will be sent new ID cards with the Cardinal Care logo between January 1, 2023 and March 31, 2023. Providers will continue to accept your current Anthem HealthKeepers Plus plan ID cards.

You may have more than one health insurance card. In addition to your Anthem HealthKeepers Plus member ID card, you should also have your Commonwealth of Virginia Medicaid/FAMIS ID card. Keep this card to access services that are covered by the Department under Medicaid. If you have Medicare and Medicaid, show your Medicare card and Anthem HealthKeepers Plus member ID card when you receive services. If you have coverage with a private (non-

Medicaid) insurance company, show your private insurance ID card and your Anthem HealthKeepers Plus member ID card when you receive services.

The Anthem HealthKeepers Plus Provider Directory
The Provider Directory lists providers and pharmacies that participate in the Anthem HealthKeepers Plus plan's network of contracted providers. It also includes information on the accommodations each provider has for members with disabilities or who do not speak English. You can use the *Find a Doctor* tool at mss.anthem.com/va/care/find-a-doctor.html or you can call Anthem HealthKeepers Plus Member Services at **800-901-0020 (TTY: 711)** and ask us to mail you a paper copy of the Provider Directory for your region.

In both the *Find a Doctor* tool and in the paper copy of the Provider Directory, you will find the names, addresses, and telephone numbers of providers in our network. You will also see information about the provider's license, including specialty and board certification, whether the provider is accepting new patients, languages spoken in the provider's office, and whether the provider's office is accessible for purposes of the Americans with Disabilities Act.

To find out even more about a PCP or a specialist, like the medical school or residency training, visit these websites:

- American Medical Association (AMA) at apps.ama-assn.org/doctorfinder/home.jsp.* This will take you to the Doctor Finder tool.
- Certification Matters at certificationmatters.org.***** Select *Is My Doctor Board Certified?* This will let you search for a provider.

* These links lead to third-party websites. Those organizations are solely responsible for the privacy policies and contents of their sites.

Preferred Drug List
This list tells you which prescription drugs are covered by the Anthem HealthKeepers Plus plan and the Department. It also tells you if there are any rules or restrictions on the drugs, like a limit on the amount you can get (see *Section 6, Your Prescription Drugs*). Call Anthem HealthKeepers Plus Member Services to find out if your drugs are on the list or check online at **anthem.com/vamedicaid**. The Anthem HealthKeepers Plus plan can also mail you a paper copy at your request.

Other Insurance

If you have more than one health insurance plan, then Medicaid pays for services after your other insurance plans have paid your provider. This means that if you have other insurance, are in a car accident, or if you are injured at work, then your other insurance or workers compensation must pay for your services first. Let Anthem HealthKeepers Plus Member Services know if you have other insurance so that the Anthem HealthKeepers Plus plan can

coordinate your benefits. The Virginia Insurance Counseling and Assistance Program (VICAP) can also help. Call **800-552-3402 (TTY: 711)** for health insurance counseling available to people with Medicare. This call is free.

3. Providers and Getting Care

The Anthem HealthKeepers Plus Plan's Provider Network

It is important that the providers you choose accept Cardinal Care members and participate in the Anthem HealthKeepers Plus plan's network. The Anthem HealthKeepers Plus plan's network includes access to care 24 hours a day, seven days a week.

The Anthem HealthKeepers Plus plan provides you with a choice of providers that are located near you. 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 and distance standards		
Standard	**Distance**	**Time**
Urban • PCP • Specialists and other providers	 15 miles 30 miles	 30 minutes 45 minutes
Rural • PCP • Specialists and other providers	 30 miles 60 miles	 45 minutes 75 minutes
Roanoke/Alleghany and Southwest Regions		
Urban and Rural • PCP • Specialists and other providers	 30 miles 60 miles	 45 minutes 75 minutes

To find providers, such as primary care providers (PCPs), specialists, and hospitals, you can:

- Search for providers in the Provider Directory (see *Section 2, Cardinal Care Managed Care Overview*).
- Call Anthem HealthKeepers Plus Member Services at **800-901-0020 (TTY: 711)**, or visit us at **anthem.com/vamedicaid**.

Our provider network includes access to care 24 hours a day, seven days per week and includes hospitals, doctors, specialists, urgent care facilities, nursing facilities, home and community-based service providers, early intervention providers, rehabilitative therapy providers,

mental health providers, addiction and recovery treatment services providers, home health and hospice providers, durable medical equipment providers and other types of providers.

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

You do not need a referral or service authorization to get:

- Care from your primary care provider (PCP).
- Family planning services and supplies.
- Routine women's healthcare services like breast exams, screening mammograms, pap tests, and pelvic exams, as long as you get them from a network provider.
- Emergency or urgently needed services.
- Routine dental services.
- Services from Indian health providers if you are eligible.
- Other services for members with special healthcare needs as determined by the Anthem HealthKeepers Plus plan.

See below for more information about when a provider leaves the network and times when you can get care from out-of-network providers.

Primary Care Providers (PCPs)

Your PCP is a doctor or nurse practitioner who helps you get and stay healthy. Your PCP will provide and coordinate your healthcare services. You should see your PCP:

- For physical exams and routine checkups.
- For preventive care services.
- When you have questions or concerns about your health.
- When you are not feeling well and need medical help.

To help your PCP get to know you and your medical history, you should have your past medical records sent to your PCP's office. Anthem HealthKeepers Plus Member Services or your care manager can help.

Choosing Your PCP

You have the right to choose a PCP that is in the Anthem HealthKeepers Plus plan's network. Review your Provider Directory to find a PCP in your community who can best meet your healthcare needs. You can also call Anthem HealthKeepers Plus Member Services or your care manager for help. If you do not choose a PCP by the 25th day of the month before your health coverage begins, the Anthem HealthKeepers Plus plan will assign you a PCP. The Anthem HealthKeepers Plus plan will notify you in writing of your assigned PCP.

You can choose between many types of network providers for your PCP. Some types of PCPs include:

- Family doctor (also called a general practitioner) – cares for children and adults
- Gynecologist (GYN) – cares for women
- Internal medicine doctor (also called an internist) – cares for adults
- Nurse Practitioner (NP) – cares for children and adults
- Obstetrician (OB) – cares for pregnant women
- Pediatrician – cares for children

If you already have a PCP who is not in the Anthem HealthKeepers Plus plan's network, you can continue seeing them for up to 30 days after enrolling in the Anthem HealthKeepers Plus plan. For individuals who are pregnant or have significant health or social needs, you can continue seeing your PCP for up to 60 days after enrolling. If you do not choose a PCP in the Anthem HealthKeepers Plus plan's network after the 30-day or 60-day period, the Anthem HealthKeepers Plus plan will assign you a PCP. If you have a Medicare assigned PCP, you do not have to choose a PCP in the Anthem HealthKeepers Plus plan's network. Call the Anthem HealthKeepers Plus plan's Member Services or your care manager for help with selecting your PCP and coordinating your care.

Changing Your PCP

You can change your PCP at any time. Call Anthem HealthKeepers Plus Member Services to choose another PCP in the Anthem HealthKeepers Plus plan's network. Please understand that it is possible your PCP will leave our network. We'll tell you within 30 days of the provider's intent to leave our network. We are happy to help you find a new PCP.

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

- Go to **anthem.com/vamedicaid** and log in to your secure account. Haven't set up an account yet? Follow the instructions on the login page — all you need is your Anthem HealthKeepers Plus member ID number.
- Use our *Find a Doctor* tool to search for a PCP.
- Follow the instructions to change your PCP right from your secure account.

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

Specialists

If you need care that your PCP cannot provide, the Anthem HealthKeepers Plus plan or your PCP may refer you to a specialist. A specialist is a provider who has additional training on

services in a specific area of medicine, like a surgeon. The care you receive from a specialist is called specialty care. If you need ongoing specialty care, your PCP may be able to refer you for a specified number of visits or length of time (a "standing referral").

Hospital Services
Your PCP can send you to any hospital in your plan. Look in your Provider Directory to find a list of hospitals in your plan. You can find the Provider Directory on our website at **mss.anthem.com/va/care/find-a-doctor.html**. You can also request a printed Provider Directory at no cost by calling Anthem HealthKeepers Plus Member Services at **800-901-0020 (TTY: 711)**. **Go to the nearest hospital in an emergency**.

Out-of-State Providers

The care you can get from out-of-state providers is limited to:

- Necessary emergency, crisis, or post-stabilization services.
- Special cases in which it is common practice for those living in your locality to use medical resources in another state.
- Medically necessary and required services that are not available in-network and within the state of Virginia.
- Periods of transition (until you can get timely services from a network provider in the state).
- Out-of-state ambulances for facility-to-facility transfers.

The Anthem HealthKeepers Plus plan may need to give you authorization to see a provider who is out-of-state. The Anthem HealthKeepers Plus plan does not cover any healthcare services outside of the U.S.

When a Provider Leaves the Network

If your PCP leaves the Anthem HealthKeepers Plus plan's network, the Anthem HealthKeepers Plus plan will let you know and help you find a new PCP. If one of your other providers is leaving the Anthem HealthKeepers Plus plan's network, contact Anthem HealthKeepers Plus Member Services or your care manager for help finding a new provider and managing your care. You have the right to:

- Ask that medically necessary treatment you get is not interrupted and the Anthem HealthKeepers Plus plan will work with you to ensure that it continues.
- Get help selecting a new qualified provider.
- File a complaint (see *Section 8, Appeals and Complaints*) or request a new provider if you feel the Anthem HealthKeepers Plus plan has not replaced your previous provider with a qualified provider or that your care is not being appropriately managed.

Getting Care Outside of the Anthem HealthKeepers Plus Plan's Network

You can get the care you need from a provider outside of the Anthem HealthKeepers Plus plan's network in any of the following circumstances:

- If the Anthem HealthKeepers Plus plan does not have a network provider to give you the care you need.
- If a specialist you need is not located close enough to you (within 30 miles in urban areas or 60 miles in rural areas).
- If a provider does not provide the care you need because of moral or religious objections.
- If the Anthem HealthKeepers Plus plan approves an out-of-network provider.
- If you are in a nursing facility when you enroll with the Anthem HealthKeepers Plus plan, and the nursing facility is out-of-network.
- If you get emergency care or family planning services from a provider or facility that is out-of-network. You can receive emergency treatment and family planning services from any provider, even if the provider is not in the Anthem HealthKeepers Plus plan's network. This care is free.

If your PCP or the Anthem HealthKeepers Plus plan refers you to a provider outside of our network, you are not responsible for any of the costs, except for your patient pay toward long-term services and supports.

You also have the right to see your old providers and access prescription drugs or other needed medical supplies for up to 30 days (or 60 days, if you are pregnant or have significant health or social needs) if you were previously enrolled in Virginia's Medicaid program but are new to the Anthem HealthKeepers Plus plan. After 30 days (or 60 days), you will need to see providers in the Anthem HealthKeepers Plus plan's network unless the Anthem HealthKeepers Plus plan extends this timeframe for you. You can call the Anthem HealthKeepers Plus plan's Member Services or your care manager, if you have one, for help finding a network provider (see *Section 4, Care Coordination and Care Management,* for more information about your care manager).

Choices for Nursing Facility Members

If you are in a nursing facility at the time you enroll in the Anthem HealthKeepers Plus plan, you may choose to:

- Remain in the facility as long as you remain eligible for nursing facility care.
- Move to a different nursing facility.
- Receive services in your home or other community-based settings.

Making Appointments with Providers

Call your provider's office to make an appointment. For help with making an appointment, call the Anthem HealthKeepers Plus plan's Member Services. If you need a ride to your

appointment, call **877-892-3988 (TTY 711)**. If you call after hours, leave a message explaining how to reach you. Your PCP or other provider will call you back as quickly as possible. If you have difficulty getting an appointment with a provider, contact the Anthem HealthKeepers Plus plan's Member Services. Remember to tell the Anthem HealthKeepers Plus plan when you plan to be out of town so the Anthem HealthKeepers Plus plan can help you arrange your services.

Telehealth

Telehealth lets you get care from your provider without an in-person office visit. Telehealth is usually done online with internet access on your computer, tablet, or smartphone. Sometimes it can be done over the phone. While telehealth is not appropriate for every condition or situation, you can often use telehealth to:

- Talk to your provider over the phone or through video chat.
- Send and receive electronic messages with your provider.
- Participate in remote monitoring so that your provider can track how you are doing at home.
- Get medically necessary medical and behavioral healthcare.

To make a telehealth appointment, contact your provider to see what services they provide through telehealth.

Getting Care from the Right Place When You Need It Quickly

It is important to choose the right place to get care based on your health needs, especially when you need care quickly or unexpectedly. Below is a guide to help you decide whether your usual care team, like your PCP, can help you or whether you should go to an urgent care center or the emergency room. If you are not sure of what type of care you need, call your PCP or the Anthem HealthKeepers Plus plan's Medical Advice Line at **800-901-0020 (TTY: 711)** 24 hours a day, seven days a week. This call is free.

Type of Care	How to Get Care	Examples of When to Get This Type of Care	Need a Referral?
PCPs can provide care for when you get sick or injured and preventive care that keeps you healthy	Contact your PCP's office or the Anthem HealthKeepers Plus plan to schedule an appointment	• Minor illness/injury • Flu/fever • Vomiting/diarrhea • Sore throat, earache, or eye infection • Sprains/strains • Possible broken bones	No

Type of Care	How to Get Care	Examples of When to Get This Type of Care	Need a Referral?
Urgent care is care you get for a sickness or an injury that needs medical care quickly and could turn into an emergency	Check the Provider Directory at **anthem.com/vamedicaid** to find an urgent care clinic	Urgent care can manage similar things as your PCP, but is available when other offices are unavailable	No; but make sure to go to an urgent care clinic that is in the Anthem HealthKeepers Plus plan's network if you can.
Emergency care (or care for an emergency medical condition) is care you get when an illness or injury is so serious that your (or, as applicable, your unborn baby's) health, bodily functions, body organs or body parts may be in danger if you do not get medical care right away	Call 911 and go to the nearest hospital. You have the right to get emergency care 24 hours a day, seven days a week from any hospital or other setting, even if you are in another city or state. The Anthem HealthKeepers Plus plan will provide follow-up care after the emergency.	• Unconsciousness • Difficulty breathing • Serious head, neck, or back injury • Chest pain/pressure • Severe bleeding • Severe burns • Convulsions/seizures • Broken bones • Fear you might hurt yourself or someone else ("behavioral health emergency") • Sexual assault	No. You can get emergency care from network providers or out-of-network providers. You do not need a referral or service authorization.

Getting Care After Hours

If you need non-emergency care after normal business hours, call 24/7 NurseLine at **800-901-0020 (TTY: 711)**.

A nurse or behavioral health professional can:

- Answer medical questions and give you advice for free.
- Help you decide if you should see a provider right away.
- Help with medical conditions.
- Provide self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments.
- Discuss health issues specific to teenage members.

- Offer information on more than 300 healthcare topics through 24/7 NurseLine audio health library.

You may also visit a doctor online via a computer or a mobile device anytime, anywhere by signing up on **livehealthonline.com**. This is at no cost to you. It's an ideal care option for issues like a cold, the flu, allergies, pink eye, coughs, fever, and headaches.

Transportation to Care

Non-Emergency Medical Transportation

If you need transportation to receive covered benefits such as medical, behavioral, dental, vision and pharmacy services, call the Anthem HealthKeepers Plus plan's Transportation Reservation line at **877-892-3988 (TTY: 711)**. The Anthem HealthKeepers Plus plan covers non-emergency transportation for covered services. If you have trouble getting an appointment, call the Anthem HealthKeepers Plus plan's Transportation Where's My Ride/Ride Assist, Member Services or your care manager. If you have your own ride to your appointment, your driver may be paid back at a set rate per mile (limits apply). Members, family, friends, and caregivers are eligible for mileage reimbursement through the Anthem HealthKeepers Plus plan. You must call Access2Care at 877-892-3988 (TTY 711) before your appointment to be eligible for reimbursement. For gas mileage reimbursement, the driver's name, date of birth, and correct mailing address are required. FAMIS children are not eligible for Non-Emergency Medical Transportation.

If you need transportation to developmental disability waiver services, contact the Cardinal Care Transportation for Developmental Disability Waiver Services Contractor at **866-386-8331 (TTY: 866-288-3133)** or visit transportation.dmas.virginia.gov/. If you have problems getting transportation to your developmental disability waiver services, call Where's My Ride at **866-246-9979** or your developmental disability waiver Case Manager.

Emergency Medical Transportation

If you are experiencing an emergency medical condition and need transportation to the hospital, call 911 for an ambulance. The Anthem HealthKeepers Plus plan will cover an ambulance if you need it.

4. Care Coordination and Care Management

Care Coordination

All members can get help finding the right healthcare or community resources by calling the Anthem HealthKeepers Plus plan's Member Services. Care Coordination services are available to all Anthem HealthKeepers Plus members. Member can reach our highly trained and experienced team of case managers/care coordinators by calling **800-901-0020 option 6**. You can also call **800-901-0020 (TTY: 711)**, 24 hours a day, seven days a week to talk to an on-call nurse or other licensed health professional.

What is Care Management?

If you have significant healthcare needs, you will receive care management. Care management helps to improve the coordination between your different providers and the services you receive. If you get care management, the Anthem HealthKeepers Plus plan will assign you a care manager. Your care manager is someone from the Anthem HealthKeepers Plus plan with special healthcare expertise who works closely with you, your PCP and treating providers, family members, and other people in your life to understand and support your needs and goals.

How to Get a Care Manager

During the first three months after you enroll, the Anthem HealthKeepers Plus plan will contact you or someone you trust (your "authorized representative") to conduct a Health Screening. During the Health Screening, you will be asked to answer some questions about your health needs (such as medical care) and social needs (such as housing, food, and transportation). The Health Screening includes questions about your health conditions, your ability to do everyday things, and your living conditions. Your answers will help the Anthem HealthKeepers Plus plan understand your needs and decide whether to assign you to a care manager. If you are not assigned a care manager, you can ask the Anthem HealthKeepers Plus plan to consider giving you one if you need help getting care now or in the future.

If you have questions or need help with the Health Screening, contact Member Services at **800-901-0020 (TTY: 711)**. This call is free.

How Your Care Manager Can Help You

Your care manager is someone from the Anthem HealthKeepers Plus plan with special healthcare expertise who can help you manage your health and social needs. Your care manager can:

- Assess your health and social needs.
- Answer questions about your benefits, like physical health services, behavioral health services, and long-term services and supports (LTSS) (see *Section 5, Your Benefits*).

- Help connect you to community resources (for example, programs that can support your housing and food needs).
- Support you in making informed decisions about your care and what you prefer.
- Assist you with scheduling appointments when needed and find available providers in the Anthem HealthKeepers Plus plan's network, and make referrals to other providers, as needed.
- Help you get transportation to your appointments (see *Section 3, Providers and Getting Care*).
- Make sure you get your prescription drugs and help if you feel side effects.
- Share your test results and other healthcare information with your providers so your care team knows your health status.
- Help with moving between healthcare settings (like from a hospital or nursing facility to home or another facility).
- Make sure your needs are met once you leave a hospital or nursing facility and on an ongoing basis.

How to Contact Your Care Manager
If you need to change your care manager, call Member Services and ask to speak to your care manager's regional manager. They can help you with next steps.

Free interpreter services are available in all languages for people who do not speak English.

Contact Method	Contact Information
Call	**800-901-0020** **TTY: 711** 8 a.m. to 6 p.m.
Fax	866-920-4097
Write	P.O. Box 27401, Richmond, VA 23286-8708
Website	**anthem.com/vamedicaid**

Your care manager will regularly check in with you and can help with any questions or concerns you may have. You have the right at any time to ask your care manager to contact you more or less often. You decide how you want your care manager to contact you (by phone, videoconference, or visit you in-person). If you meet your care manager in-person, you can suggest the time and place. You are encouraged to work with your care manager and to have open communication with them.

Health Risk Assessment

After the Anthem HealthKeepers Plus plan assigns you a care manager, an Anthem HealthKeepers Plus representative will contact you or your authorized representative via telephone, mail, or in person to ask you some questions about your health and social needs to conduct the Health Screening. Your care manager will then contact you to conduct a more in-depth Health Risk Assessment. During the Health Risk Assessment, your care manager or another healthcare professional will ask you more questions about your physical health, behavioral health, social needs, and your goals and preferences. The Health Risk Assessment helps your care manager to understand your needs and get you the right care. You can choose to do the Health Risk Assessment in-person, over the phone, or by videoconference. Over time, your care manager will check in with you to repeat the Health Risk Assessment questions to find out if your needs are changing.

Your Care Plan

Based on your Health Risk Assessment, your care manager will work with you to develop your personalized Care Plan. Your Care Plan will include the healthcare, social services, and other supports that you will get and explains how you will get them, how often, and by what provider. Your care manager will update your Care Plan once a year. Your care manager may make changes more often than once a year if your needs change. It is important to keep your Care Plan updated.

Your Care Team

Your care team includes your providers, nurses, counselors, or other health professionals. You and your family members or caregivers are important members of your care team. Your care manager may organize a meeting with your care team depending on your needs, or you can ask to meet with your care team. You have the choice of whether to participate in care team meetings. Communication among your care team members helps ensure your needs are met.

Coordination with Medicare or Other Health Plans

If you have Medicaid and Medicare, the Anthem HealthKeepers Plus plan is responsible for coordinating your Cardinal Care benefits with your Medicare health plan and any other health plan(s) you have. Call the Anthem HealthKeepers Plus plan's Member Services or your care manager if you have questions about how your different health plans work together and make sure your services are paid for correctly.

Additional Care Management Services

You may be able to get additional care management services if you:

- Are in foster care or were in foster care.
- Are pregnant and are at higher risk for complications during and after pregnancy.

- Receive services in your home or the community, such as a home health, personal care, or respite services.
- Have a substance use disorder.
- Use a ventilator.
- Are homeless.

If you need a care manager, call Anthem HealthKeepers Plus Member Services for assistance.

5. Your Benefits

Overview of Covered Benefits

Covered benefits are services provided by the Anthem HealthKeepers Plus plan, the Department, or its contractor. In order to get covered benefits, the service must be medically necessary. A medically necessary service is a service you need to prevent, diagnose, or treat a medical condition or its symptoms.

You can also access the full list of covered benefits at: anthem.com/vamedicaid. Call the Anthem HealthKeepers Plus plan's Member Services at 800-901-0020 (TTY: 711) or your care manager, if you have one, for more information about your services and how to get them.

Generally, you must get services from a provider that participates in the Anthem HealthKeepers Plus plan's network. In some cases, you may need to get approval (a "service authorization") from the Anthem HealthKeepers Plus plan or your PCP before getting a service. The services marked in this section with an asterisk (*) require service authorization. See *Section 3, Providers and Getting Care,* for more information on what to do if you need services from an out-of-network provider. See *Section 7, Getting Approval for Your Services, Treatments, and Drugs,* for more information if a service you need requires approval.

Benefits for All Members

Physical Health Services

The Anthem HealthKeepers Plus plan and the Department cover physical health services (including dental and vision) for Cardinal Care members:

- Adult Day Healthcare*
- Cancer screenings and services (colorectal cancer screening, mammograms, pap smears, prostate specific antigen and digital rectal exams, reconstructive breast surgery)
- Care management and care coordination services (see *Section 4, Care Coordination and Care Management*)
- Clinic services
- Clinical trials (routine patient costs related to participation in a qualifying trial)
- Court-ordered services, emergency custody orders (ECO), and temporary detention orders (TDO)
- Dental services (more on this below)
- Durable Medical Equipment (DME) (respiratory, oxygen, and ventilator equipment and supplies; wheelchairs and accessories; hospital beds; diabetic equipment and supplies; incontinence products; assistive technology; communication devices; rehabilitative equipment and devices)*

- Early and Periodic Screening Diagnostic and Treatment (EPSDT) (more on this below)
- Early Intervention (EI) services (more on this below)
- Emergency and post-stabilization services
- Gender dysphoria treatment services*
- Glucose test strips
- Hearing services
- Home and community-based waiver services (more on this below)*
- Home health*
- Hospice
- Hospital care (inpatient and outpatient)*
- Human Immunodeficiency Virus (HIV) services (testing and treatment counseling)
- Immunizations (adult and child)
- Laboratory, radiology, and anesthesia services
- Lead investigations
- Oral services (hospitalizations, surgeries, services billed by a medical provider)
- Organ transplants (for all children and for adults who are in intensive rehabilitation)
- Orthotics (children under age 21)
- Nutritional counseling for chronic disease
- Podiatry services (foot care)
- Prenatal and maternal services (pregnancy/postpartum care) (more on this below)
- Prescription drugs (see *Section 6, Your Prescription Drugs*)
- Preventive care (regular check-ups, screenings, well-baby/child visits)
- Prosthetics (arms/legs and supportive attachments, breasts, and eye prostheses)
- Regular medical care (PCP office visits, referrals to specialists, exams)
- Radiology services
- Rehabilitation services (inpatient and outpatient, including physical/ occupational therapy and speech pathology/audiology services)*
- Renal services (dialysis, End Stage Renal Disease services)
- School health services (more on this below)
- Surgery services
- Telehealth services (more on this below)
- Tobacco cessation services
- Transportation services (see *Section 3, Providers and Getting Care*)
- Tribal clinical provider type services
- Vision services (eye exams/treatment/ glasses to replace those lost, damaged, or stolen for children under age 21 (under EPSDT)
- Well visits

Remember, services marked with an asterisk (*) may require service authorization.

The Department contracts with a dental benefits administrator, DentaQuest, to provide dental services to all Medicaid/FAMIS members. See the table below for dental services available to you. You are not responsible for the cost of dental services received from a participating dental provider. Some dental services will require prior approval. The Anthem HealthKeepers Plus plan will work with the Department's dental administrator to authorize some services,

including anesthesia when medically necessary. For questions about your dental benefits or to find a participating dentist near you, call DentaQuest Member Services at **888-912-3456 (TTY: 800-466-7566)** or visit dmas.virginia.gov/dental.

Dental Service	Children/Youth Under Age 21	Pregnant/ Postpartum People	Adults Age 21 and Older
Braces	Covered	Not Covered	Not Covered
Cleanings	Covered (including fluoride)	Covered	Covered
Crowns	Covered	Covered	Limited Coverage
Dentures	Covered (including partials)	Covered (including partials)	Covered
Exams	Covered (including regular check-ups)	Covered	Covered
Extractions and Oral Surgeries	Covered	Covered	Covered
Fillings	Covered	Covered	Covered
Gum Treatment	Covered	Covered	Covered
Root Canals	Covered (including treatment)	Covered	Covered
Sealants	Covered	Not Covered	Not Covered
Space Maintainers	Covered	Not Covered	Not Covered
X-Rays	Covered	Covered	Covered

Behavioral Health Services

The Anthem HealthKeepers Plus plan, the Department, or its contractor covers the behavioral health treatment services in the table below for the Anthem HealthKeepers Plus plan members. Behavioral health refers to mental health and addiction services. In Virginia, treatment for addiction is called "Addiction and Recovery Treatment Services" (ARTS). The Anthem HealthKeepers Plus plan's Member Services, your PCP, and your care manager can help you get the behavioral health services you need.

Mental Health Services
• 23-hour observation during a behavioral health crisis • Applied Behavior Analysis • Assertive Community Treatment • Community Stabilization • Functional Family Therapy • Intensive In-Home

Mental Health Services

- Mental Health Case Management
- Mental Health Intensive Outpatient services
- Mental Health Partial Hospitalization Programs
- Mental Health Peer Recovery Support Services
- Mental Health Skill-Building Services
- Mobile Crisis Response
- Multisystemic Therapy
- Psychiatric Residential Treatment Facility +
- Psychosocial Rehabilitation
- Residential Crisis Stabilization
- Therapeutic Day Treatment
- Therapeutic Group Home +
- Inpatient Psychiatric Services
- Outpatient Psychiatric Services (this includes psychotherapy and medication management)

+ Services that are managed by the Department's behavioral health administrator contractor. Your care manager will work with the Department's behavioral health administrator contractor to help you get these services if you need them.

Addiction and Recovery Treatment Services (ARTS)

- Screening, Brief Intervention, and Referral to Treatment
- Substance Use Case Management Services
- Outpatient Services
- Intensive Outpatient Services
- Partial Hospitalization Programs
- Substance Use Residential Treatment
  - ASAM 3.1
  - ASAM 3.3
  - ASAM 3.5
- Substance Use Inpatient Treatment
  - ASAM 3.7
  - ASAM 4.0
- Medication Assisted Treatment
- Substance Use Peer Recovery Support Services
- Opioid Treatment Services
- Office Based Addiction Treatment

The Mental Health Parity and Addiction Act of 2008 mandates coverage for mental health and substance use treatment services. Accordingly, the Contractor is responsible for covering medically necessary outpatient individual, family, and group mental health and substance use

treatment services. We will provide coverage to members for mental health and substance use treatment services.

We may choose to cover your treatment at a free-standing hospital or Institution of Mental Disease (IMD) if you are between the ages of 21 and 64. This coverage will be limited to 15 calendar days in any calendar month. We will cover this service if you are admitted to an IMD for Addiction Recovery Treatment Services. If you are admitted to a free-standing hospital or Institution of Mental Disease under a Temporary Detention Order, the TDO days are covered by the state. If you are less than 21 and over 64, your treatment is covered at a free-standing hospital or Institution of Mental Disease including while you are under a Temporary Detention Order. We are responsible for all TDO admissions to an acute care facility regardless of age.
Some behavioral health services are covered for you through the DMAS behavioral health services administrator (BHSA). Your care coordinator will work closely with the BHSA to coordinate the services you need, including those that are provided through the BHSA. Some behavioral health services you need to get a service authorization for include inpatient behavioral health services.

Call our Member Services team if you have questions about which services you may need prior approval for.

For questions about addiction and recovery services, call the ARTS Medical Advice Line at **800-901-0020 (TTY 711)**24 hours a day, seven days a week. This call is free.

If you are thinking of harming yourself or someone else, call the Behavioral Health Crisis Line **844-429-9620 (TTY 711)** 24 hours a day, seven days a week. This call is free. Remember, if you need help right away, call **911**.

Long-Term Services and Supports (LTSS)
The Anthem HealthKeepers Plus plan and the Department cover LTSS, such as private duty nursing, personal care, and adult-day healthcare services, to help people meet their daily needs and maintain independence living in the community or a facility. Before receiving LTSS, a community-based or hospital team will conduct a screening to see if you meet "level of care" criteria — in other words, whether you qualify for and need LTSS. Contact your care manager to learn about the screening process to receive LTSS.

You can get LTSS in the setting that is right for you: your home, the community, or a nursing facility. Members who are interested in moving from the nursing facility into their home or the community should talk with their care manager. However, it is important to know that receiving certain types of care will end your enrollment with managed care and the Anthem HealthKeepers Plus plan, but you will still have Medicaid. These types of care include:

- Intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- Care from one of the following nursing facilities:
    - Bedford County Nursing Home

- Birmingham Green
- Dogwood Village of Orange County Health
- Lake Taylor Transitional Care Hospital
- Lucy Corr Nursing Home
- The Virginia Home Nursing Facility
- Virginia Veterans Care Center
- Sitter and Barfoot Veterans Care Center

Braintree Manor Nursing Facility and Rehabilitation Center

- Care from Piedmont, Hiram Davis, or Hancock state-operated, long-term care facility.
- Program of All-Inclusive Care for the Elderly (PACE) care.

If you get LTSS, you may need to pay for part of your care (see *Section 9, Cost Sharing*). If you have Medicare, the Anthem HealthKeepers Plus plan will cover nursing facility care after you have used all of the skilled nursing care that was available to you.

The following LTSS must be authorized before you get them:

- CCC Plus Waiver services, including:
  - Adult day healthcare
  - Environmental modifications
  - Transition coordination
  - Personal care
  - Respite care
  - Assistive technology
  - Some care coordinator visits
- EPSDT personal care and private duty nursing
- Skilled nursing facility services (custodial care services in nursing facilities do not need a service authorization)
- Long stay hospitalization
- Hospice

Benefits for Home and Community Based Services (HCBS) Waiver Enrollees

Some members may qualify for HCBS waiver services (see table below). To learn more or to find out if you are eligible, contact the Anthem HealthKeepers Plus plan or your care manager. Developmental Disability waiver services are managed through the Department of Behavioral Health and Developmental Services (DBHDS). You can also find more information about Developmental Disability waiver services on the DBHDS website mylifemycommunityvirginia.org or by calling **844-603-9248**.

Waiver	Description	Examples of Covered Benefits
Commonwealth Coordinated Care (CCC) Plus Waiver	Provides care in your home and community instead of a nursing facility. You can choose to receive agency-directed or consumer-directed services, or both.	➢ Adult Day Healthcare ➢ Assistive technology ➢ Environmental modifications ➢ Personal care ➢ Personal Emergency Response System ➢ Private duty nursing ➢ Respite ➢ Transition services

Waiver	Description	Examples of Covered Benefits
Developmental Disability Waivers: Building Independence (BI) Community Living (CL) Family and Individual Supports (FIS)	Provides supports and services to members with developmental disabilities to help with successful living, learning, physical and behavioral health, employment, recreation, and community inclusion. Waivers may have a waiting list. You should put your name on the waiting list if you need to so that when space opens up, you can start receiving these services.	➢ Assistive technology ➢ Benefits planning services ➢ Electronic home-based services ➢ Employment and day supports ➢ Environmental modifications ➢ Personal emergency response system ➢ Crisis supports ➢ Residential options

Condition Care

A Condition Care (CNDC) program can help you receive more out of life. As part of your Anthem HealthKeepers Plus benefits, we are here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called CNDC case managers. They will help you learn how to better manage your condition or health issue. You can choose to join a CNDC program at no cost to you.

What programs do we offer?

You can join a CNDC program to get healthcare and support services if you have any of these conditions:

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

How it works
When you join one of our CNDC programs, a CNDC case manager will:
- Help you create health goals and make a plan to reach them.
- Coach you and support you through one-on-one phone calls.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition and/or treatment plan (ways to help health issues).
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your healthcare providers, like helping you with:
    - Making appointments.
    - Transportation to healthcare provider visits.
    - Referring you to specialists in our health plan, if needed.
    - Receiving any medical equipment you may need.
- Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco, like quitting smoking).

Our CNDC team and your primary care provider are here to help you with your healthcare needs.

How to join
We will send you a letter welcoming you to a CNDC program if you qualify. Or you can call us toll free at **800-901-0020 (TTY: 711)** Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time.

When you call, we will:
- Set you up with a CNDC case manager to get started.
- Ask you some questions about your or your child's health.
- Start working together to create your or your child's plan.

You can choose to opt-out (we will take you out of the program) of the program at any time. Please call us toll free at **800-901-0020 (TTY: 711)** from 8:30 a.m. to 5:30 p.m. Eastern time Monday through Friday to opt-out. You may also call this number to leave a private message for your CNDC case manager 24 hours a day.

Benefits for Children/Youth Under Age 21

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)
Benefits are not the same for all Cardinal Care members. Medicaid children and youth under age 21 are entitled to EPSDT, a federally-required benefit. EPSDT provides comprehensive services to identify a child's condition, treat it, and make it better or prevent it from getting worse. Covered services include any medically necessary healthcare, even if the service is not normally available to adults or other Medicaid members. EPSDT services are available at no cost. Examples of EPSDT services include:

- Screenings/well-child visits and immunizations
- Periodic screening services (vision, hearing, and dental)
- COVID-19 counseling visits
- Developmental services
- Eyeglasses (including a replacement for glasses that are lost, broken, or stolen) and other vision services
- Orthotics (braces, splits, supports)
- Personal care or personal assistance services (for example, help with bathing, dressing, and feeding)
- Private duty nursing
- Foster care case management

Clinical trials may be considered on a case-by-case basis

FAMIS children are eligible for well-child visits and immunizations, but not all EPSDT services. For more information on accessing EPSDT services, contact the Anthem HealthKeepers Plus plan's Member Services or your care manager.

EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid. You may need to get a service authorization (or prior approval) from us for some EPSDT services, so we can make sure they're medically necessary for your child's care. Talk to your doctor if your child needs EPSDT services.

Early Intervention (EI) Services
If you have a baby under the age of three that is not learning or developing like other babies, your child may qualify for EI services. EI services include, for example:
- Speech therapy.
- Physical therapy.
- Occupational therapy.
- Service coordination.
- Developmental services to support the child's learning and development.

EI services do not require service authorization from the Anthem HealthKeepers Plus plan. There is no cost to you for EI services. Contact the Anthem HealthKeepers Plus plan's Member Services for a list of EI providers, specialists, and case managers. Your care manager can connect you to your local Infant and Toddler Connection program to help you access these services. You can also call the Infant and Toddler Connection program directly at **800-234-1448 (TTY: 711)** or visit itcva.online.

School Health Services
The Department covers the cost of some healthcare or health-related services provided to Cardinal Care-enrolled children at their school. School health services can include certain medical, behavioral health, hearing, personal care, or rehabilitation therapy services, such as occupational therapy, speech therapy, and physical therapy services and are based on your child's individualized education plan (IEP), as determined by the school. Your child's school will arrange for these services and your child can get them for free. Children may also receive covered EPSDT services while they are at school (see *Section 5, Your Benefits*). Contact your child's school administrator if you have questions about school health services.

Benefits for Family Planning and Pregnant/Postpartum People

You can get free healthcare services to help you have a healthy pregnancy and a healthy baby. This includes healthcare services for up to 12 months after you give birth. The Anthem HealthKeepers Plus plan and the Department cover the following services:

- Labor and delivery services
- Doula services
- Family planning (services, devices, drugs – including long-acting reversible contraception – and supplies for the delay or prevention of pregnancy)
- Lactation consultation and breast pumps
- Nurse midwife/provider services
- Pregnancy-related services
- Prenatal/infant services and programs (New Baby, New Life℠, My Advocate, WIC)
- Postpartum services (including postpartum depression screening)
- Services to treat any medical condition that could complicate pregnancy
- Smoking cessation services
- Substance Use Treatment Services
- Abortion services (only if a doctor certifies in writing that there is a substantial danger to the mother's life)

Remember, you do not need a service authorization or a referral for family planning services. You can get family planning services from any provider even if they are not in the Anthem Health Keepers Plus plan's network. 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 Anthem HealthKeepers Plus Plan's New Baby, New Life℠ Program

New Baby, New Life℠ is a program for pregnant members. It is very important to see your primary care provider (PCP) or obstetrician or gynecologist (OB/GYN) for care when you are pregnant. This kind of care is called prenatal care. It can help you to have a healthy baby. Prenatal care is always important even if this is not your first baby. Our

program helps pregnant members with complicated healthcare needs. A nurse care coordinator works closely with pregnant members to provide:

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

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

When you become pregnant

If you think you are pregnant:

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

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

Your pregnancy education package

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

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

Get to know My Advocate®

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

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

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

- No cost to you.

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

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

My Advocate topics include:
- Pregnancy and postpartum care.
- Well-child care.
- Dental care.
- Immunizations.
- Healthy living tips.

* Phone or text rates may apply.

During your pregnancy

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

When you are pregnant, it's important to see your PCP or OB/GYN at least:

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

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

When you have a new baby

When you deliver your baby, you and your baby may stay in the hospital at least:
- 48 hours after a vaginal delivery.
- 72 hours after a cesarean section (C-section).

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

After you have your baby

After you have your baby, it's important for you to:

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

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

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

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

It's important to set up a visit with your PCP or OB/GYN after you have your baby for a postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery. The visit should be done between seven and 84 days after you deliver.

If you delivered by C-section, your PCP or OB/GYN may ask you to come back for a one- or two-week post-surgery checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within seven and 84 days after your delivery for your postpartum checkup.

Newborn Coverage

If you have a baby, report the birth to the Department as quickly as possible so that your child can get health insurance. You can do this by either:

- Calling Cover Virginia at **833-5CALLVA** or by contacting your local DSS.
- Calling the Anthem HealthKeepers Plus Care Management team at **800-901-0020 option 6** Monday to Friday from 8 a.m. to 6 p.m.

You will be asked to provide your name and Medicaid ID number, as well as your baby's:

- Name.
- Date of birth.
- Race.
- Gender.

Added Benefits for the Anthem HealthKeepers Plus Plan Members

The Anthem HealthKeepers Plus plan provides some added benefits for members. These include:

- Adult eye exams, $150 for lenses and frames or contacts per year
- Adult hearing exam, $1,000 for hearing aids, and 60 batteries per year*

- Books for Kids Program, $35 Barnes and Noble gift card
- Boys & Girls Club membership at participating locations
- Coupon book up to $1,000+ in savings
- Postpartum moms can select two baby essential items such as highchair, portable crib, car seat, diapers, and more
- Refurbished Chromebook for high school seniors with a 3.5 GPA
- Sports physicals for members 19 and under
- $25 gift card for good grades to middle, high school, and college students
- Up to four (4) GED test vouchers
- ChooseHealthy program, offering online health classes and articles
- Free smartphone with unlimited minutes and texts, 25 GB of data, and hotspot monthly
- 24/7 physician video visits
- Up to 12 rides a year per member to grocery stores, farmers markets, and local foodbanks
- 13 Weight Watchers meeting vouchers and 14-week e-voucher
- 14 prepared meals delivered after hospital stay or nursing facility discharge
- $20 Walmart gift card to members who complete their annual Health Screener
- Select two items under the assistive devices and wheelchair accessories catalog*
- Select two items from an asthma and COPD relief catalog

** Eligible for specific plan members*

6. Your Prescription Drugs

Understanding Your Prescription Drug Coverage

Prescription drugs are medicine your provider orders ("prescribes") for you. Usually, the Anthem HealthKeepers Plus plan will cover ("pay for") your drugs if your PCP or another provider writes you a prescription and your prescription is on the Preferred Drug List. If you are new to the Anthem HealthKeepers Plus plan, you can keep getting the drugs you are already taking for a minimum of 30 days. If a prescription you need is not on the Preferred Drug List, you can still get it if it is medically necessary.

To know which prescriptions are covered by the Anthem HealthKeepers Plus plan and the Department, see the Preferred Drug List at **anthem.com/vamedicaid**, you can call Member Services at **800-901-0020 (TTY: 711)** Monday through Friday from 8 a.m. to 8 p.m., or we can mail you a paper copy of the list of covered drugs. The Preferred Drug List can change during the year, but the Anthem HealthKeepers Plus plan will always have the most up-to-date information.

We'll send you a letter to let you know if there are changes to the list of covered drugs or if any drugs you're taking come off the list. If you do not see your medication in our Preferred Drug List (PDL), you can look to see if it is in our Formulary. Our Formulary is a comprehensive list of all the drugs we pay for.

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

By law there are some drugs that cannot be covered. Drugs that cannot be covered include experimental drugs, drugs for weight loss or weight gain, drugs used to promote fertility or for the treatment of sexual or erectile dysfunction, and drugs used for cosmetic purposes.

Prescription Drugs for FAMIS Members

Generic outpatient prescription drugs are covered. If you choose a brand drug, you are responsible for 100% of the difference between the allowable charge of the generic drug and the brand drug.

Drugs That Require You or Your Provider to Take Extra Steps

Some drugs have rules or restrictions on them that limit how and when you can get them. For example, a drug may have a quantity limit, which means you can only get a certain amount of the drug each time you fill your prescription. For drugs with special rules, you may need a service authorization from the Anthem HealthKeepers Plus plan before you can get your

prescription filled (see *Section 7, Getting Approval for Your Services, Treatments, and Drugs*). If you do not get approval, the Anthem HealthKeepers Plus plan may not cover the drug. To find out if the drug you need has a special rule, check the Preferred Drug List. If the Anthem HealthKeepers Plus plan denies or limits your coverage for a drug and you disagree with the decision, you have the right to appeal (see *Section 8, Appeals and Complaints*).

In some cases, the Anthem HealthKeepers Plus plan may require "step therapy." This is when you try a drug (usually one that is less expensive) before the Anthem HealthKeepers Plus plan will cover another drug (usually one that is more expensive) for your medical condition. If the first drug does not work, then you can try the second drug.

Therapeutic substitution is a program that tells you and your providers about alternatives to certain prescribed drugs. We may contact you and your provider to make you aware of these choices. Only you and your provider can decide if the therapeutic substitute is right for you.

Emergency Supply of Drugs
If you ever need a drug and you cannot get a service authorization quickly enough (like over the weekend or a holiday), you can get a short-term supply of your drug by getting the Anthem HealthKeepers Plus plan approval. You can get the Anthem HealthKeepers Plus plan approval if a pharmacist believes that your health would be at-risk without the benefit of the drug. When this happens, the Anthem HealthKeepers Plus plan may authorize your pharmacist to dispense a 72-hour emergency supply. Have your pharmacist call us at **833-207-3120 (TTY 711)**.

Long-Term Supply of Drugs
You can get up to a 90-day supply of certain medications, and all other drugs are limited to a 34-day supply.

Getting Your Drugs from a Network Pharmacy

Once your provider orders a prescription for you, you will need to get your prescription drugs filled at a network pharmacy (except during an emergency). A network pharmacy is a drug store that agrees to fill drugs for the Anthem HealthKeepers Plus plan's members. To find a network pharmacy, use your Provider Directory available at **anthem.com/vamedicaid**. You can use any of the Anthem HealthKeepers Plus plan's network pharmacies.

If you need to change pharmacies, you can ask your pharmacy to transfer your prescription to another network pharmacy. If your pharmacy leaves the Anthem HealthKeepers Plus plan's network, you can find a new pharmacy in the Provider Directory or by calling the Anthem HealthKeepers Plus plan's Member Services at **800-901-0020 (TTY: 711)**.

When you go to the network pharmacy to drop off a prescription or pick up your drugs, show your Anthem HealthKeepers Plus plan member ID card. If you have Medicare, show both your

Medicare Card and the Anthem HealthKeepers Plus plan member ID card. Call the Anthem HealthKeepers Plus plan's Member Services or your care manager if you have questions or need help getting a prescription filled or finding a network pharmacy.

Getting Your Drugs Mailed to Your Home

Sometimes you may need a drug that is not available at a pharmacy near you, such as a drug used to treat a complex condition or one that requires special handling and care. If this happens, a specialized pharmacy will ship these drugs to your home or your provider's office.

As a member of the Anthem HealthKeepers Plus plan, you can have some drugs mailed to your home. You can receive up to a 90-day supply of certain medications, and all other drugs are limited to a 34-day supply. Two prior refills of the same medication are required to be eligible for a 90-day supply.

If you want to switch to home-delivery pharmacy through CarelonRx, our pharmacy benefits manager, you can call **833-203-1737 (TTY 711)** Monday through Friday from 8 a.m. to 6 p.m. Eastern time. They will help you sign up, including calling your doctor to transfer prescriptions.

Patient Utilization Management and Safety Program

Some members who need additional support with their medication management may be enrolled in the Patient Utilization Management and Safety Program. The program helps coordinate your drugs and services so that they work together in a way that will not harm your health. Members in the Patient Utilization Management and Safety Program may be restricted (or locked in) to only using one pharmacy to get their drugs.

The Anthem HealthKeepers Plus plan will send you a letter with more information if you are in the Patient Utilization Management and Safety Program. If you are placed in the program but do not think you should have been, you can appeal within 60 days of receiving the letter (see *Section 8, Appeals and Complaints*).

7. Getting Approval for Your Services, Treatments, and Drugs

Second Opinions

If you disagree with your provider's opinion about the services you need, you have the right to a second opinion. You can get a free second opinion from a network provider without a referral. When network providers are not accessible or when they cannot meet your needs, the Anthem HealthKeepers Plus plan can refer you to an out-of-network provider for a second opinion at no cost.

Service Authorization

There are some services, treatments, and drugs that require service authorization before you receive them or to continue receiving them. A service authorization helps to figure out if certain services are medically necessary and if the Anthem HealthKeepers Plus plan can cover them for you. After assessing your needs and making a care recommendation, your provider must submit a request for a service authorization to the Anthem HealthKeepers Plus plan with information that explains why you need the service. This helps make sure that they can be paid for the services they provide to you.

New medical treatments

Healthcare is always changing. We want you to benefit from any new treatments, so we review them often. A group of doctors, specialists, and medical directors decide if the treatment:

- Is approved by the government.
- Has shown in a reliable study how it affects patients.
- Will help patients as much as or more than treatments we use now.
- Will improve a patient's health.
- Is still being tested.

The review group looks at all of the data and decides if the treatment is medically necessary. If your doctor asks us about a treatment the review group has not looked at yet, they will look at it. They will let your doctor know if the treatment is medically necessary and if we approve it.

If you are new to the Anthem HealthKeepers Plus plan, the Anthem HealthKeepers Plus plan will honor any service authorizations made by the Department or another health plan for up to 30 days (or until the authorization ends if that is sooner) or up to 60 days if you are pregnant or have significant health or social needs.

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 and health benefits

The Anthem HealthKeepers Plus 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 do not have coverage.

You can request your doctor's incentive plans. See *Section 5, Your Benefits* for the specific services that require service authorization.

Service authorization is never required for primary care services, emergency care, preventive services, Early Intervention (EI) services, family planning services, basic prenatal care, or Medicare-covered services.

How to Get a Service Authorization
The Anthem HealthKeepers Plus plan's Member Services or your care manager can answer your questions and share more about how to request a service authorization. If you want to request a specific service that requires a service authorization, your care manager can help you find the right provider who can help figure out if you need the service.

Timeframe for Service Authorization Review
After receiving your service authorization request, the Anthem HealthKeepers Plus plan will make a decision whether to approve or deny a request. Normally, the Anthem HealthKeepers Plus plan will give written notice as quickly as needed, and within 14 calendar days (for physical and behavioral health services). If waiting that long could seriously harm your health or ability to function, the Anthem HealthKeepers Plus plan will decide more quickly. the Anthem HealthKeepers Plus plan will instead give written notice within three calendar days. Post-service authorization requests are reviewed in 30 calendar days with a possible 14 calendar day extension.

The Anthem HealthKeepers Plus plan will make any decisions about pharmacy services within 24 hours. On weekends or a holiday, the Anthem HealthKeepers Plus plan may authorize a 72-hour emergency supply of your prescribed drugs. This gives your provider time to submit a service authorization request and for you to potentially receive an additional supply of your prescribed drug after the 72-hour emergency supply is done.

The Anthem HealthKeepers Plus plan will contact your provider if the Anthem HealthKeepers Plus plan needs more information or time to make a decision about your service authorization. You will be informed of the communication to your requesting provider. If you disagree with the Anthem HealthKeepers Plus plan taking more time to review your request or if you do not like the way the Anthem HealthKeepers Plus plan handled your request, see *Section 8, Appeals*

and Complaints, on how to file a complaint. You can talk to your care manager about your concerns, or you may call the Cardinal Care Managed Care Enrollment Helpline at **800-643-2273 (TTY: 800-817-6608)**. If you have more information to share with the Anthem HealthKeepers Plus plan to help decide your case, then you, an authorized representative, or your provider can ask the Anthem HealthKeepers Plus plan to take more time to make a decision in order to include the additional information.

Adverse Benefit Determinations

If the Anthem HealthKeepers Plus plan denies a service authorization request, this is called an adverse benefit determination. An adverse benefit determination can also occur when the Anthem HealthKeepers Plus plan approves only part of the care request or a service amount that is less than what your provider requested. Examples of adverse benefit determinations include when the Anthem HealthKeepers Plus plan:

- Denies or limits a request for healthcare or services your provider or you think you should be able to get, including services outside of your provider's network.
- Reduces, pauses, or stops healthcare or services you were already receiving.
- Fails to provide services in a timely manner.
- Fails to act in a timely manner to address grievances and appeals.
- Denies your request to reconsider a financial liability.
- Does not pay for all or part of your healthcare or services.

If the Anthem HealthKeepers Plus plan makes an adverse benefit determination, the Anthem HealthKeepers Plus plan will usually notify your provider and you in writing at least 10 days before making changes to your service. But, if you do not hear from the Anthem HealthKeepers Plus plan, contact the Anthem HealthKeepers Plus plan Member Services or the provider who would be providing you the service to follow up. When the Anthem HealthKeepers Plus plan tells you the decision in writing, the Anthem HealthKeepers Plus plan will tell you what the decision was, why the decision was made, and how to appeal if you disagree. You should share a copy of the decision with your provider. If you disagree with the decision, you can request an appeal. See *Section 8, Appeals and Complaints*, for more information on the appeal process.

8. Appeals and Complaints

Appeals

When to File an Appeal with the Anthem HealthKeepers Plus Plan

You have the right to file an appeal if you disagree with an adverse benefit determination (see *Section 7 Getting Approval for Your Services, Treatments, and Drugs*) that the Anthem HealthKeepers Plus plan makes about your health coverage or covered services. You must appeal within 60 calendar days after hearing the Anthem HealthKeepers Plus plan's decision about your service authorization request. You can allow an authorized representative (provider, family member, etc.) or your attorney act on your behalf. If you choose to let someone file the appeal on your behalf, you must call the Anthem HealthKeepers Plus plan's Member Services at **800-901-0020 (TTY: 711)** to let the Anthem HealthKeepers Plus plan know. See *Section 7, Getting Approval for Your Services, Treatments, and Drugs,* for more information on service authorizations and adverse benefit determinations. If you need assistance with an appeal, you may talk to your care manager.

You will not lose coverage if you file an appeal. In some cases, you may be able to keep getting services that were denied while you wait for a decision on your appeal. Contact the Anthem HealthKeepers Plus plan's Member Services if your appeal is about a service you get that is scheduled to end or be reduced. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

How to Submit Your Appeal to the Anthem HealthKeepers Plus Plan

You can file your appeal by phone or in writing. You can submit either a standard (regular) or an expedited (fast) appeal request. You might decide to submit an expedited appeal if you or your provider believe your health condition or need for the services requires urgent review.

Phone Requests	**800-901-0020** **(TTY: 711)**
Written Requests	Mail: Grievance and Appeals Department HealthKeepers, Inc. P.O. Box 62429 Virginia Beach, VA 23464 Fax: 855-832-7294

Timeframe for Appeal to the Anthem HealthKeepers Plus Plan

When you file an appeal, be sure to let the Anthem HealthKeepers Plus plan know of any new or additional information that you want to be used in making the appeal decision.. You can also call the Anthem HealthKeepers Plus plan's Member Services if you need help. Within five (5) days, the Anthem HealthKeepers Plus plan will send you a letter to let you know that the Anthem HealthKeepers Plus plan received your appeal.

If the Anthem HealthKeepers Plus plan needs more information to help make an appeal decision, the Anthem HealthKeepers Plus plan will send you a written notice to tell you what information is needed. For expedited appeals (meaning appeals that need to happen on a faster than normal timeline), the Anthem HealthKeepers Plus plan will also call you right away. If the Anthem HealthKeepers Plus plan needs more information, the decision about your standard or expedited appeal could be delayed by up to 14 days from the respective timeframes.

If the Anthem HealthKeepers Plus plan has all the information needed from you:

- Within 72 hours of receiving your *expedited* appeal request, the Anthem HealthKeepers Plus plan will send you a written notice and try to provide verbal notice to tell you the decision.
- Within 30 days of receiving your *standard* appeal request, the Anthem HealthKeepers Plus plan will send you a written notice to tell you the decision.

If You Are Unhappy with the Anthem HealthKeepers Plus Plan's Appeal Decision

You can file an appeal to the Department through what is called the State Fair Hearing process after filing an appeal with the Anthem HealthKeepers Plus plan if:

- You disagree with the final appeal decision you receive from the Anthem HealthKeepers Plus plan; or
- The Anthem HealthKeepers Plus plan does not respond to your appeal in a timely manner.

Like the Anthem HealthKeepers Plus plan's appeals process, you may be able to keep getting services that were denied while you wait for a decision on your State Fair Hearing appeal (but may ultimately have to pay for these services if your State Fair Hearing appeal is denied).

How to Submit Your State Fair Hearing Appeal

You (or your authorized representative) must appeal to the state within 120 calendar days from when the Anthem HealthKeepers Plus plan issues its final appeal decision. You can appeal by phone, in writing, or electronically. If you appeal in writing, you can write your own letter or use the Department's appeal request form. Be sure to include a full copy of the final written notice showing the Anthem HealthKeepers Plus plan's appeal decision and any documents you want the Department to review. If you have chosen an authorized representative, you must provide documents that show that individual can act on your behalf.

If you want your State Fair Hearing to be handled quickly, you must clearly state "EXPEDITED REQUEST" on your State Fair Hearing request. You must also ask your provider to send a letter to the Department that explains why you need an expedited State Fair Hearing request.

Phone Requests	**804-371-8488** **TTY: 800-828-1120**
Written Requests	Mail: Appeals Division, DMAS, 600 E. Broad Street, Richmond, VA 23219 Fax: 804-452-5454
Electronic Requests	Website: dmas.virginia.gov/appeals Email: appeals@dmas.virginia.gov

Timeframe for State Fair Hearing Appeal
After you file your State Fair Hearing appeal, the Department will tell you the date, time, and location of the scheduled hearing. Most hearings can be done by phone. You may also request an in-person hearing.

If you qualify for an *expedited* State Fair Hearing appeal, the hearing will usually take place within one to two days of the Department receiving the expedited request letter from your provider. The Department will issue a written appeal decision within 72 hours of receiving the expedited request letter from your provider.

For *standard* State Fair Hearing appeals, the Department will usually issue a written appeal decision within 90 days of you filing your appeal with the Anthem HealthKeepers Plus plan. The 90-day timeframe does not include the number of days between the Anthem HealthKeepers Plus plan's decision on your appeal and the date you sent your State Fair Hearing request to the Department. You will have the chance to participate in a hearing and present your position.

State Fair Hearing Outcome
If the State Fair Hearing reverses the Anthem HealthKeepers Plus plan's appeal decision, the Anthem HealthKeepers Plus plan must authorize or provide the services as quickly as your condition requires and no later than 72 hours from the date the Department gives notice to the Anthem HealthKeepers Plus plan. If you continued to get services while you waited for a decision on your State Fair Hearing appeal, the Anthem HealthKeepers Plus plan must pay for those services. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed. The State Fair Hearing decision is the Department's final decision. If you disagree, you may appeal to your local circuit court.

How FAMIS Members Ask for an External Review
FAMIS members can request an external review instead of a State Fair Hearing. You or your authorized representative must submit a written request for external review within 30 calendar days of receipt of the Anthem HealthKeepers Plus plan's final appeal decision. Please mail external review requests to:

FAMIS External Review
c/o Kepro
2810 N. Parham Road, Suite 305
Henrico, VA 23294
Or submit online at dmas.kepro.com

Please include: your name, your child's name and ID number, your phone number with area code, and copies of any relevant notices or information.

Complaints

When to File a Complaint

You have the right to file a complaint (a "grievance") at any time. You will not lose your coverage for filing a complaint.

You can complain about anything except a decision about your health coverage or covered services. (For those types of issues, you will need to submit an appeal – see above). You can file a complaint to either the Anthem HealthKeepers Plus plan or an outside organization if you are unhappy. You can make complaints about:

- Accessibility: For example, if you cannot physically access your provider's office/facilities or you need language assistance and did not get it.
- Quality: For example, if you are unhappy with the quality of care you got in the hospital.
- Customer Service: For example, if your provider or healthcare staff was rude to you.
- Wait Times: For example, if you have trouble getting an appointment or have to wait a long time to see your provider.
- Privacy: For example, if someone did not respect your right to privacy or shared your confidential information.

How to File a Complaint with the Anthem HealthKeepers Plus Plan

To file a complaint with the Anthem HealthKeepers Plus plan, call Anthem HealthKeepers Plus Member Services at **800-901-0020 (TTY: 711)** or file a complaint in writing by mailing it to:
Member Services
HealthKeepers, Inc.
P.O. Box 27401
Mail Drop VA2002-N500
Richmond, VA 23279

OR

faxing it to **800-964-3627**. Be sure to include details on what the complaint is about so that the Anthem HealthKeepers Plus plan can help.

The Anthem HealthKeepers Plus plan will tell you our decision within 90 calendar days after getting your complaint. If your complaint is about your request for an expedited appeal (see above), the Anthem HealthKeepers Plus plan will respond within 24 hours of getting your complaint.

How to File a Complaint with an Outside Organization

To file a complaint with an outside organization that is not affiliated with the Anthem HealthKeepers Plus plan, you can:

- Call the Cardinal Care Managed Care Enrollment Helpline at **800-643-2273 (TTY: 800-817-6608)**.
- Contact the U.S. Department of Health and Human Services' Office for Civil Rights:
  - Phone Requests: **800-368-1019 (TTY: 800-537-7697)**.
  - Written Requests: 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; or fax to **215-861-4431**.
- Contact the Virginia Long-Term Care Ombudsman (for complaints, concerns or assistance with nursing facility care or long-term services and supports in the community:
  - Phone Requests: **800-552-5019 (TTY: 800-464-9950)**.
  - Written Requests: Virginia Office of the State Long-Term Care Ombudsman, Virginia Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Henrico, Virginia 23229.
- Contact the Office of Licensure and Certification at the Virginia Department of Health (for complaints specific to nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and health plans):
  - Phone Requests: **800-955-1819 (TTY: 711)**.
  - Written Requests: Virginia Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233-1463; or email: mchip@vdh.virginia.gov.

9. Cost Sharing

Copayments

Copayments are when you pay a fixed amount for certain services covered by the Anthem HealthKeepers Plus plan or the Department. Most the Anthem HealthKeepers Plus plan members will not owe copayments for covered services. However, there are some exceptions (see below). If you receive a bill for a covered service, contact the Anthem HealthKeepers Plus plan's Member Services for help at **800-901-0020 (TTY: 711)**. Remember, if you get services that are not covered through the Anthem HealthKeepers Plus plan or the Department, you must pay the full cost yourself.

If you have Medicare, you may have copayments for prescription drugs covered under Medicare Part D.

Patient Pay

If you get LTSS, you may need to pay for part of your care. This is called your patient pay amount. If you have Medicare, you may also have a patient pay responsibility toward skilled nursing facility care. Your local DSS will notify you if you have a patient pay responsibility and can answer questions about your patient pay amount.

Premiums

You do not need to pay a premium for your coverage. However, the Department pays the Anthem HealthKeepers Plus plan a monthly premium for your coverage. If you are enrolled in the Anthem HealthKeepers Plus plan but do not actually qualify for coverage because information you provided to the Department or to the Anthem HealthKeepers Plus plan was false or because you did not report a change (like an increase in your income, which may impact whether you qualify for Medicaid/FAMIS), you may have to pay the Department back the cost of the monthly premiums. You will have to pay the Department even if you did not get services during those months.

10. Your Rights

General Rights

As a Cardinal Care member, you have the right to:

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status, or disability.
- Be treated with respect and consideration for your privacy and dignity.
- Get information (including through this handbook) about your health plan, provider, coverage, and benefits.
- Get information in a way you can easily understand. Remember: interpretation, written translation, and auxiliary aids are available free of charge.
- Access healthcare and services in a timely, coordinated, and culturally competent way.
- Get information from your provider and health plan about treatment choices.
- Participate in all decisions about your healthcare, including the right to say "no" to any treatment offered.
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Ask your health plan for help if your provider does not offer a service because of moral or religious reasons.
- Get a copy of your medical records and ask that they be changed or corrected in accordance with State and Federal Law.
- Have your medical records and treatment be confidential and private. The Anthem HealthKeepers Plus plan will only release your information if it is allowed under federal or state law, or if it is required to monitor quality of care or protect against fraud, waste, and abuse.
- Live safely in the setting of your choice. If you or someone you know is being abused, neglected, or financially taken advantage of, call your local DSS or Virginia DSS at **888-832-3858**. This call is free.
- Receive information on your rights and responsibilities and exercise your rights without being treated poorly by your providers, the Anthem HealthKeepers Plus plan, or the Department.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- File appeals and complaints and ask for a State Fair Hearing (see *Section 8, Appeals and Complaints*).
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example).

Advance Directives

Advance directives are written instructions to those caring for you that tell them what to do if you are unable to make healthcare decisions for yourself. Your advance directive lists the type of care you do or do not want if you become so ill or injured that you cannot speak for yourself. It is your right and choice about whether to fill out an advance directive. The Anthem HealthKeepers Plus plan is responsible for providing you with written information about advance directives and your right to create an advance directive under Virginia law. The Anthem HealthKeepers Plus plan must also help you understand why the Anthem HealthKeepers Plus plan may not be able to follow your advance directive.

If you want an advance directive, you can fill out an advance directive form. You can get an advance directive form from:

- Virginiaadvancedirectives.org.
- Your care manager, if you have one.
- Your provider, a lawyer, a legal services agency, a social worker, the hospital.

Organizations that give people information about Medicaid like the Virginia Department for Aging and Rehabilitative Services (DARS) and the Virginia Association of Area Agencies on Aging may also have advance directive forms.

You can cancel or change your advance directive or power of attorney if your decisions or preferences about your healthcare decisions or authorized representative change. If your provider is not following your advance directive, complaints can be filed with the Enforcement Division at the Virginia Department of Health Professions:

- **800-533-1560 (TTY: 711)**.
- Email enfcomplaints@dhp.virginia.gov.
- Write Virginia Department of Health Professions, Enforcement Division, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233-1463.

If you believe the Anthem HealthKeepers Plus plan has not provided you with the information you need about advance directives, or you are concerned that the Anthem HealthKeepers Plus plan is not following your advance directive, you can contact the Department to file a complaint:

- **800-643-2273 (TTY: 711)**
- Email DMAS-Info@dmas.virginia.gov, or
- Write to the Department at Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.

Member Advisory Committee

You have the right to let us know how the Department and the Anthem HealthKeepers Plus plan can better serve you. The Anthem HealthKeepers Plus plan invites you to join the Member Advisory Committee. As a member of the committee, you can participate in educational meetings that happen once every three months. You can attend in-person or virtually. Attending committee meetings will give you and your caregiver or family member the chance to provide input on Cardinal Care and meet other members. If you would like more information or want to attend, contact Anthem HealthKeepers Plus Member Services.

11. Your Responsibilities

General Responsibilities

As a Cardinal Care member, you have some responsibilities. This includes the responsibility to:

- Follow this handbook, understand your rights, and ask questions when you do not understand or want to learn more.
- Treat your providers, Anthem HealthKeepers Plus staff, and other members with respect and dignity.
- Choose your PCP and, if needed, change your PCP (see *Section 3, Providers and Getting Care*).
- Be on time for appointments and call your provider's office as soon as possible if you need to cancel or if you are going to be late.
- Show your member ID card whenever you get care and services (see *Section 2, Cardinal Care Managed Care Overview*).
- Provide (to the best of your ability) complete and accurate information about your medical history and your symptoms that the organization and its practitioners and providers need in order to provide care.
- Understand your health problems and talk to your providers about treatment goals, when possible.
- Work with your care manager and care team to create and follow a care plan that is best for you (see *Section 4, Care Coordination and Care Management*).
- Invite people to your care team who will be helpful and supportive to be included in your treatment.
- Tell the Anthem HealthKeepers Plus plan when you need to change your care plan.
- Get covered services from the Anthem HealthKeepers Plus plan's network when possible (see *Section 3, Providers and Getting Care*).
- Get approval from the Anthem HealthKeepers Plus plan for services that require a service authorization (see *Section 7, Getting Approval for Your Services, Treatments, and Drugs*).
- Use the emergency room for emergencies only.
- Pay for services you get that are not covered by the Anthem HealthKeepers Plus plan or the Department.
- Report suspected fraud, waste, and abuse (see below).

Call Anthem HealthKeepers Plus Member Services at 800-901-0020 (TTY 711) to let them know if:

- Your name, address, phone number, or email have changed (*see Section 1, Let's Get Started*).
- Your health insurance changes in any way (from your employer or workers' compensation, for example) or you have liability claims, like from a car accident.

- Your member ID card is damaged, lost, or stolen.
- You have problems with healthcare providers or staff.
- You are admitted to a nursing facility or the hospital.
- Your caregiver or anyone responsible for you changes.
- You join a clinical trial or research study.

First Line of Defense Against Fraud

As a Cardinal Care member, you are responsible for reporting suspected fraud, waste, and abuse concerns and making sure you do not participate in or create fraud, waste, and abuse.

Combating fraud, waste, and abuse begins with knowledge and awareness.

- *Fraud* – Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. This includes any act that constitutes fraud under applicable Federal or State law.
- *Waste* – Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- *Abuse – behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.*

Examples of *member* fraud, waste, and abuse include:

- Falsely reporting income and/or assets to qualify for Medicaid.
- Permanently living in a state other than Virginia while receiving Cardinal Care benefits.
- Using another person's member ID card to get services.

Examples of provider fraud, waste, and abuse include:

- Altering medical records to misrepresent actual services provided
- Providing services that are not medically necessary.
- Changing medical records to cover up illegal activity.
- Billing for services that were not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code

- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Reporting Fraud, Waste and Abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting our fighthealthcarefraud.com education site; at the top of the page, click "Report it" and complete the "Report Waste, Fraud and Abuse" form
- Calling the SIU fraud hotline **866-847-8247**
- Calling Member Services

Any incident of fraud, waste, or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud but know that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

There are other ways you can report

Department of Medical Assistance Services

Phone	**804-786-1066** **Toll free: 866-486-1971** **TTY: 711**
Email	RecipientFraud@DMAS.virginia.gov

Mail	Department of Medical Assistance Services, Recipient Audit Unit 600 East Broad St., Suite 1300 Richmond, VA 23219

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

Phone	**804-371-0779** **Toll free: 800-371-0824** **TTY: 711**
Fax	**804-786-3509**
Email	MFCU_mail@oag.state.va.us
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	**800-723-1615** **TTY: 711**
Email	covhotline@osig.virginia.gov
Mail	State Fraud, Waste, and Abuse Hotline 101 N. 14th Street The James Monroe Building 7th Floor Richmond, VA 23219

12. Key Words and Definitions in This Handbook

- **Addiction and Recovery Treatment Services (ARTS):** A substance use disorder treatment benefit for members with addiction. Members can access a comprehensive continuum of addiction treatment services, such as inpatient services, residential treatment services, partial hospitalization, intensive outpatient treatment, Medication Assisted Treatment (MAT), substance and opioid use services, and peer recovery support services.

- **Adverse Benefit Determination:** Any decision by the health plan to deny a service or a service authorization request for a member. This includes an approval for a service amount that is less than requested.

- **Appeal:** A request by an individual (or someone they trust acting on their behalf) for the health plan to review a service request again and consider changing an adverse benefit determination made by the health plan about health coverage or covered services.

- **Authorized Representative:** A person who can make decisions and act on a member's behalf. Members can select a trusted family member, guardian, or friend to be their authorized representative.

- **Brand Name Drug:** A medication that is made and sold by a single company. Generic versions of these drugs are sometimes available with the same ingredients but made by a different company.

- **Cardinal Care Managed Care Enrollment Helpline:** Assistance provided by an organization that contracts with the Department to help individuals with enrollment activities and choosing a health plan. Cardinal Care Managed Care Enrollment Helpline services are free and may be provided by phone or online.

- **Cardinal Care:** Virginia's Medicaid/FAMIS program, which includes the state's two prior Medicaid managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus), fee-for-service (FFS) Medicaid members, FAMIS Children, FAMIS MOMS and FAMIS Prenatal Coverage.

- **Care Coordination:** Help that the health plan provides to members so that members understand what services are available and how to get the healthcare or social services that they need. Care coordination is available to all members, including those who are not assigned a care manager and do not need or want care management.

- **Care Management:** Ongoing support provided to members with significant health, social, and other needs by a health plan's care manager. Care management services include a careful review a member's needs, development of a Care Plan, regular communication with

a care manager and the member's care team and help with getting healthcare and social services transitions between different healthcare settings.

- **Care Manager:** A health professional that works for the health plan with special healthcare expertise that is assigned to and works closely with certain members with more significant needs. The Care Manager works with the member, the member's providers, and their family members/caregivers to understand what healthcare and social services the member needs, help them get the services that they need and to support them making decisions about their care.

- **Care Plan:** A plan that is developed and updated regularly by a member and their care manager that describes a member's healthcare and social needs, the services the member will get to meet their needs, how they will get these services, by whom, and in some cases, how frequently.

- **Care Team:** A group of healthcare providers, including a member's doctors, nurses, and counselors, as selected by the member, who help the member get the care they need. The member and their caregivers are part of the Care Team.

- **CCC Plus Waiver:** A home and community-based services (HCBS) waiver program in Virginia that provides care in the home and community instead of a nursing facility to members who qualify.

- **Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of the Medicaid and Medicare programs.

- **Copayment:** A fixed dollar amount that a member may be required to pay for certain services. Most Cardinal Care members will not have to pay copayments for covered services.

- **Cover Virginia:** Virginia's statewide support center. Individuals can call **833-5CALLVA (TTY: 888-221-1590)** for free or visit coverva.org/en to learn about and apply for health insurance, renew their coverage, update information, and ask questions.

- **Covered Benefits:** Healthcare services and prescription drugs covered by the health plan or the Department, including medically necessary physical health services, behavioral health services, and LTSS.

- **Doulas:** A trained individual in the community who provides support to members and their families throughout pregnancy, during labor and birth, and up to one year after giving birth.

- **Dual Eligible Member:** A person who has Medicare and full Medicaid coverage.

- **Durable Medical Equipment (DME):** Medical equipment and appliances, such as walkers, wheelchairs, or hospital beds, that members can get and use at home when medically necessary.

- **Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT):** A federally-required benefit that Medicaid members under age 21 are entitled to get. EPSDT provides comprehensive services to identify a child's condition, treat it, and make it better or prevent it from getting worse. EPSDT makes sure children and youth get needed preventive, dental, mental health, developmental, and specialty services.

- **Early Intervention (EI):** Services for babies under the age of three who are not learning or developing like other babies. Services may include speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to support learning and development.

- **Eligible:** Meeting conditions or requirements for a program.

- **Emergency Care (or Emergency Services):** Treatment or services an individual gets for an emergency medical condition.

- **Emergency Medical Condition:** When an illness or injury is so serious that an individual (or, as applicable, their unborn baby's) health, bodily functions, body organs, or body parts may be in danger if they do not get medical care right away.

- **Emergency Medical Transportation:** Transportation in an ambulance or emergency vehicle to an emergency room to receive medical care. Members can get emergency medical transportation by calling **911**.

- **Emergency Room Care:** A hospital room staffed and equipped for the treatment of individuals that require immediate medical care and/or services.

- **Excluded Services:** Services that are not covered under Cardinal Care by the health plan or the Department.

- **Family Access to Medical Insurance Security (FAMIS) Plan or FAMIS Children:** A comprehensive health insurance program run by the federal and state government for uninsured children from birth through age 18 not eligible for Medicaid with income less than 200% of the federal poverty level.

- **FAMIS MOMS**: A health insurance program run by the federal and state government for uninsured pregnant individuals with income eligibility the same as FAMIS children.

- **FAMIS Prenatal Care (FAMIS PC)**: A health insurance program run by the federal and state government for pregnant individuals who do not meet eligibility for Medicaid or FAMIS MOMS because of their citizenship or immigration status. Coverage begins during pregnancy and lasts through two months after the baby is born.

- **Fraud, Waste, and Abuse:** Fraud is an intentional deception or misrepresentation by a person who knows the action could result in an unauthorized benefit to themselves or someone else. Waste is overusing, underusing, or misusing Medicaid resources. Abuse is member or provider practice of causing unnecessary cost to the Medicaid program or payment for services that are not medically necessary or that do not meet certain healthcare standards.

- **Generic Drug:** A medication that is approved by the federal government to use in place of a brand name medication because they have the same ingredients and work equally.

- **Good Cause Reasons:** Acceptable reasons to change health coverage. Examples of good cause reasons are: (1) an individual moves out of the state, or (2) the health plan is not able to provide the required medical services.

- **Grievance (or Complaint):** A written or verbal complaint that an individual makes to their health plan or an outside organization. Complaints can be concerns about accessibility, the quality of care, customer service, wait times, and privacy.

- **Habilitation Services and Devices:** Services and devices that help individuals keep, learn, or improve skills and functioning for daily living.

- **Health Assessment:** An in-depth assessment completed by the care manager to help identify a member's health, social, and other needs, goals, and preferences. The Health Assessment helps guide the development of the Care Plan for members receiving care management.

- **Health Insurance:** A type of insurance coverage that pays for some or all of the member's healthcare costs. A company or government agency makes the rules for when and how much to pay.

- **Health Plan (or Plan):** A Cardinal Care Medicaid/FAMIS managed care organization that contracts with a group of doctors, hospitals, pharmacies, other providers, and care managers. They all work together to get members the care and care coordination they need.

- **Health Screening:** A screening administered to all members by the health plan to help understand if the member would benefit from Care Management. The screening asks

members about their health needs, social needs, medical conditions, ability to do everyday things, and living conditions.

- **Home Health Aide:** Short term services provided to Medicaid members to support them with personal care. Home health aides do not have a nursing license or provide therapy.

- **Home Healthcare:** Healthcare services a member receives at home, including nursing care, home health aide services, physical/occupational therapy and other services.

- **Hospice Services:** Care to provide comfort and support for members (and their families) with a terminal prognosis – meaning the individual is expected to have six months or less to live. A member with a terminal prognosis has the right to choose to stay in hospice. In hospice, a specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

- **Hospital Outpatient Care:** Care or treatment in a hospital that usually does not require an overnight stay.

- **Hospitalization:** When an individual is admitted to a hospital as a patient to receive care. This is also known as inpatient hospital care.

- **Long-Term Services and Supports (LTSS):** Services and supports that help elderly individuals and children or adults with disabilities meet their daily needs and maintain independence. Examples include assistance with bathing, dressing, eating, and other basic activities of daily life and self-care, as well as support for everyday activities such as laundry, shopping, and transportation. Members can get LTSS in the setting that is right for them: the home, the community, or a nursing facility.

- **Medicaid or FAMIS Fee-for-Service (FFS):** The way in which the Department pays providers for Medicaid or FAMIS services. Cardinal Care members who are not enrolled in managed care are enrolled in FFS.

- **Medicaid/FAMIS Managed Care:** When the Department contracts with a health plan to provide Medicaid/FAMIS benefits to members.

- **Medicaid:** A health insurance program run by the federal and state government that provides free or low-cost health coverage and care to low-income individuals. In Virginia, Medicaid is called Cardinal Care.

- **Medically Necessary:** Services, supplies, or drugs needed to prevent, diagnose, or treat a medical condition or its symptoms. Medically necessary also means that services, supplies,

or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

- **Medicare:** The federal health insurance program for individuals 65 years of age or older, some individuals under age 65 with certain disabilities, and individuals with end-stage renal disease (generally meaning those with permanent kidney failure who need dialysis or a kidney transplant) or Amyotrophic Lateral Sclerosis (ALS).

- **Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

- **Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and provider visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

- **Medicare Part C:** The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

- **Medicare Part D:** The Medicare prescription drug benefit program. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A, Medicare Part B, or Medicaid.

- **Medicare-Covered Services:** Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and Part B.

- **Member Services:** A department at the health plan responsible for answering questions about membership, benefits, appeals, and complaints.

- **Network:** A group of doctors, clinics, hospitals, pharmacies, and other providers contracted with the health plan to provide care to members.

- **Network Provider (or Participating Provider):** A provider or facility that contracts with the health plan to provide covered healthcare services to members.

- **Network Pharmacy:** A drugstore that has agreed to fill prescription drugs for the health plan's members. In most cases, prescription drugs are covered only if they are filled at one of the health plan's network pharmacies.

- **Nursing Facility:** A medical care facility that provides care for individuals who cannot get their care at home but who do not need to be in the hospital. Members must meet specific criteria to live in a nursing facility.

- **Out-of-Network Provider (or Non-Participating Provider):** A provider or facility that is not employed, owned, or operated by the health plan and is not under contract to provide covered healthcare services to members.

- **Patient Pay:** The amount a member may have to pay for LTSS based on their income. The local DSS calculates the member's patient pay amount if they live in a nursing facility or receive CCC Plus waiver services and have an obligation to pay a portion of care.

- **Personal Care Aide Services:** Services provided by a Personal Care Aide that help members with personal care (bathing, using the toilet, dressing, or carrying out exercises) on an ongoing or long-term basis.

- **Premium:** The monthly amount a member may be required to pay for their health insurance every month. Cardinal Care Medicaid managed care members do not need to pay any premiums for coverage. If a member is enrolled in a health plan but does not qualify for coverage because information they reported to the Department or the health plan was false or because they did not report a change, the member may have to pay the Department back the cost of the monthly premiums. The member will have to repay the Department even if they did not get services during those months.

- **Prescription Drug Coverage (or Covered Drugs):** Prescription medications covered (paid for) by the health plan. The health plan also covers some over-the-counter medications.

- **Prescription Drugs:** Medications that by law, members can only obtain through a provider prescription.

- **Primary Care Provider (PCP) (or Primary Care Physician):** A doctor or nurse practitioner who helps members get and stay healthy by taking care of their needs. PCPs provide and coordinate healthcare services.

- **Private Duty Nursing Services:** Skilled in-home nursing services provided by a licensed registered nurse (RN), or by licensed practical nurse under the supervision of an RN, to CCC Plus waiver members who have serious medical conditions or complex healthcare needs. Medicaid children and youth under age 21 can also get private duty nursing services under the EPSDT benefit.

- **Prosthetics and Orthotics:** Medical devices ordered by a member's 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:** Doctors, nurse practitioners, specialists, and other individuals who are authorized to provide healthcare or services to members. Many kinds of providers participate in each health plan's network.

- **Provider Services (or Physician Services):** Care provided by an individual licensed under Virginia state law to practice medicine, surgery, or behavioral health.

- **Referral:** Approval from a PCP to use other providers in the health plan's network. A PCP's referral is required before a member can see other network providers.

- **Rehabilitation Services and Devices:** Treatment to help individuals recover from an illness, accident, injury, or major operation.

- **Service Authorization (or Preauthorization):** Approval that may be needed before a member can get certain services, treatments, or prescription drugs. Service authorizations are requested by providers to the health plan to help make sure that the provider can be paid for the services they provide to the member.

- **Skilled Nursing Care:** Skilled care or treatment that can only be provided by licensed nurses. Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings, or rapidly changing health status.

- **Skilled Nursing Facility (SNF):** A facility with staff and equipment to provide skilled nursing care, in most cases, skilled rehabilitative services and other related health services.

- **Specialist:** A provider who has additional training on services in a specific area of medicine, like a surgeon. The care members receive from a specialist is called specialty care.

- **State Fair Hearing:** The process where a member appeals to the state about a decision made by the health plan. Individuals can file a State Fair Hearing appeal if the health plan does not respond to or provide a decision on an individual's appeal on time, or if the individual does not agree with the plan's appeal decision.

- **Urgent Care:** Care an individual gets for a sickness or an injury that needs medical care quickly and could turn into an emergency.

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in June 2022.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

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

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

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

- On paper (called physical), we:
  - Lock our offices and files.
  - Destroy paper with health information so others can't get it.
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in.
  - Use special programs to watch our systems.
- Used or shared by people who work for us, doctors, or the state, we:
  - Make rules for keeping information safe (called policies and procedures).
  - Teach people who work for us to follow the rules.

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

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

- **For your medical care**
  - To help doctors, hospitals, and others get you the care you need

- **For payment, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care
  - When we say we'll pay for healthcare or services before you get them
  - To find ways to make our programs better, and to support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you don't want this, please visit **anthem.com/vamedicaid** for more information.
- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you

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

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

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

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners, or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you.

If we need more time, we have to let you know. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**

- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of healthcare, payment, everyday healthcare business, or some other reasons we didn't list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call **844-203-3796** to add your phone number to our Do Not Call list.

What if you have questions?
If you have questions about our privacy rules or want to use your rights, please call Member Services at **800-901-0020**. If you're deaf or hard of hearing, call **TTY 711**.

To see more information
To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy web page at **anthem.com/privacy**.

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

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

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

Race, ethnicity, language, sexual orientation, and gender identity
We get race, ethnicity, language, sexual orientation, and gender identity information about you from the state Medicaid agency and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:

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

Your personal information

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

- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact our Member Services number at **800-901-0020 (TTY 711)** Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Call toll free for translation or oral interpretation at no cost/Llame a la línea gratuita para servicios de traducción o interpretación sin cargo: 800-901-0020; TTY 711.

anthem.com/vamedicaid

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

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