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Anthem HealthKeepers Plus
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Anthem HealthKeepers Plus
Member Handbook
Commonwealth Coordinated Care Plus

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Member Handbook

Commonwealth Coordinated Care Plus

855-323-4687 (**TTY 711**)

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Where To Find Information

Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including online, in large print, braille or audio CD. To request the handbook in an alternate format and or language, call our Member Services team at **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m.

If you have any problems reading or understanding this information, please contact our Member Services staff at **855-323-4687** (**TTY 711**) for help at no cost to you.

We provide reasonable accommodations and communications access to persons with disabilities. Individuals who are deaf or hard of hearing or who are speech-impaired, who want to speak to a Member Services representative and who have a TTY or other assistive device can dial **711** to reach a relay operator. They will help you reach our Member Services staff. If you don't have a TTY device, you can get in touch with Member Services on your secure online account at **anthem.com/vamedicaid** or have a designated representative call Member Services for you.

Help in Other Languages

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **855-323-4687** (**TTY 711**).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **855-323-4687** (**TTY 711**).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **855-323-4687** (**TTY 711**)번으로 전화해 주십시오.

Vietnamese
CHÚ Ý: Nếu quý vị không nói Tiếng Anh, thì có sẵn các dịch vụ hỗ trợ ngôn ngữ, miễn phí cho quý vị. Gọi **855-323-4687** (**TTY 711**).

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

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

855-323-4687 (**TTY 711**)。

Arabic
تنبيه :إذا كنت لا تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك مجانًا، اتصل برقم
(**TTY 711**) **855-323-4687**.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa
855-323-4687 (**TTY 711**).

Farsi
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با
855-323-4687 (**TTY 711**) تماس بگیرید.

Amharic
ትኩረት፥ ኢንግሊዝኛ ቋንቋ የማይናገሩ ከሆነ፣ የቋንቋ እርዳታ አገልግሎቶች፣ ከክፍያ ነጻ፣
ሊያግዝዎት ተዘጋጀተዋል። ወደ ሚከተለው ቁጥር ይደውሉ፥ **855-323-4687** (**TTY 711**)።

Urdu
اطلاع :اگر آپ انگریزی نہیں بولتے/بولتیں تو مندرجہ ذیل نمبر پرآپ کے لیے زبان کی معاونت کی
خدمات مفت دستیاب ہیں (**TTY 711**) کال کریں،**855-323-4687**

French
ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le **855-323-4687** (**TTY 711**).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните по телефону **855-323-4687** (**TTY: 711**).

Hindi
यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ़्त में भाषा सहायता सेवाएं उपलब्ध हैं। **855-323-4687** (**TTY 711**) पर कॉल करें।

German

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

ACHTUNG: Wenn Sie kein Englisch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **855-323-4687** (**TTY 711**).

Bengali
লক্ষ্য করুন: আপনি যদি ইংরেজিভাষী না হন, তাহলে আপনার জন্য, বিনামূল্যে ভাষা সহায়তা পরিষেবাগুলি উপলভ্য রয়েছে। কল করুন **855-323-4687** (**TTY 711**) নম্বরে।

Bassa
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ ké m̀ Ɓàsɔ́ ɔ̀ -wùɖù-po-nyɔ̀ jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ ìn m̀ gbo kpáa. Đá **855-323-4687** (**TTY 711**).

Important phone numbers

Your care coordinator		**855-323-4687** (**TTY 711**) Or call your care coordinator's direct number
Anthem CCC Plus Member Services		**855-323-4687** (**TTY 711**)
Anthem CCC Plus 24/7 NurseLine for medical and behavioral health advice		**855-323-4687** (**TTY 711**)
DMAS Dental Benefits Administrator		For questions or to find a dentist in your area, call the DMAS Dental Benefits Administrator at **888-912-3456**. Information is also available on the DMAS website at **dmas.virginia.gov/for-members/benefits-and-services/dental** or the DentaQuest website at **dentaquestgov.com**.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

Anthem CCC Plus transportation		Access2Care: **855-325-7581** (**TTY 711**)
DMAS Transportation Contractor for transportation to and from DD waiver services		**866-386-8331** **TTY 866-288-3133** Or dial **711** to reach a relay operator
CCC Plus Helpline		**844-374-9159** TDD **800-817-6608** or visit the website at **cccplusva.com**
Department of Health and Human Services' Office for Civil Rights		**800-368-1019** or visit the website at **hhs.gov/ocr**
Cover VA for Medicaid Renewal/Address Change		**833-5CALLVA** (Toll Free) **888-221-1590** (**TDD**) Renew online **commonhelp.virginia.gov**.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

1. Commonwealth Coordinated Care Plus (CCC Plus)

Welcome to the Anthem CCC Plus plan

Thank you for being a member of the Anthem HealthKeepers Plus Commonwealth Coordinated Care Plus (Anthem CCC Plus) plan. If you are a new member, we will get in touch with you in the next few weeks to go over some very important information with you. You can ask us any questions you have, or get help making appointments. If you need to speak with us right away or before we contact you, call us at the number listed below.

Working to make healthcare less complicated for you

We're here to guide you through your plan and help you get the benefits and services you need. And that's easier when you know what to do from the very start. Here's what you should do first as a new Anthem CCC Plus member:

- Look for your member ID card in the mail if you haven't gotten it yet.
- Expect your care coordinator to get in touch with you soon. Your care coordinator will also help you fill out your health assessment to help us learn more about you.
- Keep important phone numbers, like your care coordinator's contact information, where you can find them easily.
- Update us right away if you move or your contact information changes. Call Member Services or go to your secure online account to let us know and also notify your local Department of Social Services. If they don't have the right address on file, you could lose your benefits.
- Look for doctors, specialists, hospitals and other providers in your plan with our online Find a Doctor search tool. Choose from a lot of providers near you to get care when you need it.

Don't forget to renew your benefits each year. The state will send you a reminder letter and form when it is time to renew. Fill out the form and return it to your local Department of Social Services. Call Cover Virginia at **833-5CALLVA** if you need help renewing.

How to use this handbook

This handbook will help you understand your Commonwealth Coordinated Care Plus (CCC Plus) benefits and how you can get help from your Anthem CCC Plus plan. This handbook is your guide to health services.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

It explains your healthcare, behavioral health, prescription drug, and long-term services and supports coverage under the CCC Plus program. It tells you the steps you can take to make your health plan work for you. Feel free to share this handbook with a family member or someone who knows your healthcare needs. When you have a question, check this handbook, call Member Services, visit our website at **anthem.com/vamedicaid** or call your care coordinator.

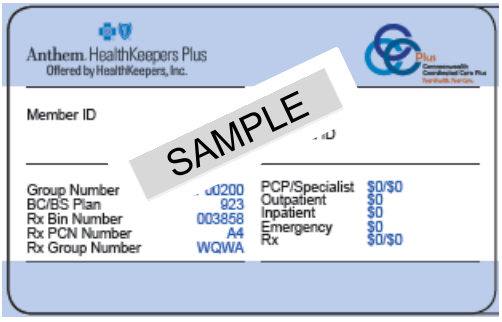
Member Services, our website, and your care coordinator can also provide the latest information related to COVID-19.

Other information we will send to you

You should have already received your Anthem CCC Plus member ID card and information on how to access a provider and pharmacy directory and a list of covered drugs. In your new member packet, you'll also get a quick start guide. Use this booklet for easy reference when you have questions about your plan. Visit **anthem.com/vamedicaid** to find all your resources online or order a replacement member ID card. If you'd like us to send you hard copies of anything, call Member Services.

Anthem CCC Plus member ID card

Show your Anthem CCC Plus member ID card when you receive Medicaid services, including when you get long-term services and supports, at doctor visits and when you pick up prescriptions. You must show this card when you get any services or prescriptions. If you have Medicare and Medicaid, show your Medicare and Anthem CCC Plus ID card when you receive services. Below is a sample card to show you what yours will look like:



If you haven't received your card, or if your card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away and we will send you a new card. In addition to your Anthem CCC Plus card, keep your Commonwealth of Virginia Medicaid ID card to access services that are covered by the State under the Medicaid fee-for-service program. These services are

described in **Services Covered through Medicaid Fee-For-Service** in Section 11 of this handbook.

Provider and pharmacy directory

The provider and pharmacy directory provides information on healthcare professionals (such as doctors, nurse practitioners, psychologists, etc.), facilities (hospitals, clinics, nursing facilities, etc.), support providers (such as adult day health, home health providers, etc.) and pharmacies in the Anthem CCC Plus network. While you are a member of our plan, you generally must use one of our network providers and pharmacies to get covered services. There are some exceptions, including:

- When you first join our plan (see **Continuity of Care Period** in Section 3 of this handbook).
- If you have Medicare (see **How to get care from your primary care physician** in Section 6 of this handbook).
- In several other circumstances (see **How to get care from out-of-network providers** in Section 6 of this handbook).

You can ask for a paper copy of the provider and pharmacy directory or list of covered drugs by calling Member Services at the number at the bottom of the page. You can also see the provider and pharmacy directory and list of covered drugs at **anthem.com/vamedicaid** or download it from this website. Refer to **List of covered drugs** in Section 9 of this handbook. Use your provider directory to find:

- Doctors, hospitals, specialists, pharmacies, and other healthcare providers near you.
- Contact information for all the providers in your plan.
- Details about different types of services and which providers you can get them from, including behavioral health, long-term services and supports, transportation, and more.

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

2. What is Commonwealth Coordinated Care Plus?

The Commonwealth Coordinated Care Plus (CCC Plus) program is a Medicaid managed care program through the Department of Medical Assistance Services (DMAS). The Anthem HealthKeepers Plus plan was approved by DMAS to provide Care coordination and healthcare services. Our goal is to help you improve your quality of care and quality of life.

What makes you eligible to be a CCC Plus member?

You are eligible for CCC Plus when you have full Medicaid benefits and meet one of the following categories:

- You are age 65 and older.
- You are an adult or child with a disability.
- You reside in a nursing facility (NF).
- You receive services through the CCC Plus home- and community-based services waiver, formerly referred to as the Technology Assisted and Elderly or Disabled with Consumer Direction (EDCD) waivers.
- You receive services through any of the three waivers serving people with developmental disabilities (Building Independence, Family and Individual Supports and Community Living waivers), also known as the DD waivers.

CCC Plus enrollment

Eligible individuals must enroll in the CCC Plus program. DMAS and the CCC Plus Helpline manage the enrollment for the CCC Plus program. To participate in CCC Plus, you must be eligible for Medicaid.

Reasons you would not be eligible to participate in CCC Plus

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

- You lose/lost Medicaid eligibility.
- You do not meet one of the eligible categories listed above.
- You are enrolled in hospice under the regular fee-for-service Medicaid program prior to any CCC Plus benefit assignment.
- You enroll in the Medicaid Health Insurance Premium Payment (HIPP) program.

- You enroll in PACE (Program of All-Inclusive Care for the Elderly). For more information about PACE, talk to your care coordinator or visit **www.pace4you.org**.
- You reside in an Intermediate Care Facility for individuals with intellectual and developmental disabilities (ICF/IID).
- You are receiving care in a Psychiatric Residential Treatment Facility (children under age 21).
- You reside in a veteran's nursing facility.
- You reside in one of these State long term care facilities: Piedmont, Catawba, Hiram Davis or Hancock.
- You live on Tangier Island.

What if I am pregnant?

If you're pregnant, you should see your primary care provider (PCP) or obstetrician or gynecologist (OB/GYN) for care. This kind of care is called **prenatal care.** Prenatal care is always important, even if this is not your first baby.

New Baby, New Life[SM] is a program for pregnant members to help you and your baby stay healthy. If you're pregnant, you'll get a care coordinator from our Maternal Child Services (MCS) team. Your MCS care coordinator will help make sure you have:

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

Your regular care coordinator, your MCS care coordinator and your doctors will all work together during your pregnancy and after your baby is born to make sure you get the services you need. If you're within your first 90 days of initial enrollment, and in your 3rd trimester of pregnancy, and your provider is not participating with the Anthem HealthKeepers Plus plan, you may request to move to another MCO where your provider participates. If your provider does not participate with any of the CCC Plus health plans, you may request to receive coverage through fee-for-service Medicaid until after delivery of your baby. Contact the CCC Plus Helpline at **844-374-9159** or TDD: **800-817-6608** to make this request.

When you become pregnant

If you think you're pregnant:

- Call your PCP or OB/GYN doctor right away. You don't need a referral from your PCP to see an OB/GYN doctor.
- Call our Member Services team if you need help finding an OB/GYN in the Anthem CCC Plus plan or use our Find a Doctor tool to search for one close to you.

When you find out you're pregnant, call Member Services to let us know. We'll send you some information with helpful resources and programs we offer.

While you're pregnant, you need to take good care of your health. You may be able to get healthy food from the WIC program. Look on our website at **anthem.com/vamedicaid** or call Member Services to get the phone number for the WIC program closest to you.

During your pregnancy, go to your PCP or OB/GYN at least:

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

Your PCP or OB/GYN may want you to visit more often 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 might spend less time in the hospital if your PCP or OB/GYN and the baby's doctor see 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, you need to:

- Call Member Services as soon as you can to let your care coordinator know you had your baby. We'll need details about your baby.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- Contact your local Department of Social Services to apply for Medicaid benefits for your baby. See the section **Coverage for newborns born to moms covered under CCC Plus** to learn more.

After you have your baby

Set up a visit with your PCP or OB/GYN within 7 to 84 days after you have your baby for a postpartum checkup. You may feel well and think you're healing, but it can take several weeks to heal after delivery. If you had a C-section, your doctor may ask you to come back for a post-surgery checkup. This isn't the same thing as a postpartum checkup, so you should still go back to your doctor within 7 to 84 days after your delivery.

Coverage for newborns born to moms covered under CCC Plus:
If you have a baby, you will need to report the birth of your child as quickly as possible to enroll your baby in Medicaid by:

- Calling the Cover Virginia Call Center at **833-5CALLVA** to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child

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

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

When first enrolled in Medicaid, your baby will be able to access healthcare through the Medicaid fee-for-service program. This means that you can take your baby to any provider in the Medicaid fee-for-service network for covered services. Look for additional information in the mail about how your baby will receive Medicaid coverage from DMAS.

Medicaid eligibility

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at **833-5CALLVA** or **TDD**: **888-221-1590** about any Medicaid eligibility questions. The call is free. For more information, you can visit Cover Virginia at **coverva.org**.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

Choosing or changing your health plan

Health plan assignment

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

You may have chosen us to be your health plan. If not, DMAS may have assigned you to our health plan based upon your history with us as your managed care plan. For example, you may have been enrolled with us before either through Medicare or Medicaid. You may also have been assigned to us if certain providers you see are in our network. These include nursing facilities, adult day healthcare and private duty nursing providers.

You can change your health plan through the CCC Plus Helpline

The CCC Plus Helpline can help you choose the health plan that is best for you. For assistance, call the CCC Plus Helpline at **844-374-9159** or **TDD 800-817-6608**, or visit the website at **cccplusva.com**. The CCC Plus Helpline is available Monday through Friday (except on state holidays) from 8:30 a.m. to 6 p.m. The CCC Plus Helpline can help you understand your health plan choices and answer your questions about which doctors and other providers participate with each health plan. The CCC Plus Helpline services are free and are not connected to any CCC Plus health plan.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between October and December. You will get a letter from DMAS during open enrollment with more information.

You may also ask to change your health plan at any time for "good cause," which can include when:

- You move out of the health plan's service area.
- You need multiple services provided at the same time but cannot access them within the health plan's network.
- Your residency or employment would be disrupted as a result of your residential, institutional or employment supports provider changing from an in-network to an out-of-network provider.
- You have other reasons determined by DMAS, including poor quality of care

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

and lack of access to appropriate providers, services and supports, including specialty care.

The CCC Plus Helpline handles good cause requests and can answer any questions you may have. Contact the CCC Plus Helpline at **844-374-9159** or TDD **800-817-6608**, or visit the website at **cccplusva.com**.

Automatic re-enrollment

If your enrollment ends with us and you regain eligibility for the CCC Plus program within 60 days or less, you will automatically be re-enrolled with the Anthem HealthKeepers Plus plan. You will also be sent a re-enrollment letter from DMAS.

What is the Anthem CCC Plus service area?

Our service area includes the cities and counties below.

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

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

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

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

Roanoke/Alleghany region: Alleghany, Bath, Bedford Co., Botetourt, Buena

Vista, Covington, Craig, Floyd, Franklin Co., Giles, Henry, Highland, Lexington, Martinsville, Montgomery, Patrick, Pulaski, Radford, Roanoke City, Roanoke Co., Rockbridge, Salem, Wythe

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

Only people who live in our service area can enroll with us. If you move outside of our service area, you cannot stay in this plan. If this happens, you will receive a letter from DMAS asking you to choose a new plan. You can also call the CCC Plus Helpline if you have any questions about your health plan enrollment. Contact the CCC Plus Helpline at **844-374-9159** (**TDD 800-817-6608**) or visit the website at **cccplusva.com**.

If you have Medicare and Medicaid

If you have Medicare and Medicaid, some of your services will be covered by your Medicare plan and some will be covered by the Anthem HealthKeepers Plus plan. We are your CCC Plus Medicaid plan.

Types of services under Medicare

- Inpatient hospital care (medical and psychiatric)
- Outpatient care (medical and psychiatric)
- Physician and specialist services
- X-ray, lab work and diagnostic tests
- Skilled nursing facility care
- Home healthcare
- Hospice care
- Prescription drugs
- Durable medical equipment
- For more information, contact your Medicare plan, visit **Medicare.gov** or call Medicare at **800-633-4227**

Types of services under CCC Plus (Medicaid)

- Medicare copayments
- Hospital and skilled nursing when Medicare benefits are exhausted
- Long-term nursing facility care (custodial)
- Home- and community-based waiver services like personal care and respite care, environmental modifications and assistive technology services
- Community-based behavioral health services
- Medicare non-covered services, like some over the counter medicines, medical equipment and supplies, and incontinence products

You can choose the same health plan for Medicare and Medicaid

You have the option to choose the same health plan for your Medicare and CCC Plus Medicaid coverage. The Medicare plan is referred to as a Dual Special Needs Plan (D-SNP). Having the same health plan for Medicare and Medicaid will enhance and simplify the coordination of your Medicare and Medicaid benefits. There are benefits to you if you are covered by the same health plan for Medicare and Medicaid. Some of these benefits include you:

- Receiving better coordination of care through the same health plan.
- Having one health plan and one number to call for questions about all of your benefits.
- Working with the same care coordinator for Medicare and Medicaid. This person will work with you and your providers to make sure you get the care you need.

When you choose us as your plan for both Medicare and Medicaid, we can help make sure all your benefits are working together. With the Anthem HealthKeepers MediBlue Dual Advantage (HMO SNP) Medicare plan, you'll get all your Medicare and Medicaid benefits and prescribed drugs from us. Plus, with Anthem MediBlue Dual Advantage, you get extra benefits beyond what Medicare covers, like:

- A plan with doctors who are mostly the same as those in your CCC Plus Medicaid plan.
- No plan premium.*
- No deductible.
- No copay for covered care.
- Pay nothing for covered services.**
- Part D coverage.
- Routine dental: Two oral exams and two cleanings every year, if you use a provider in the plan's supplemental dental network, at no cost to you.
- Routine hearing: One hearing exam and one hearing aid fitting every year, if you use a Hearing Care Solutions Network provider, at no cost to you.
- Routine eye care: One eye exam every year, eyewear (glasses and frames), contact lenses, if you use a Blue View Vision provider, at no cost to you.
- Video doctor visits: Visit a doctor online via a computer or a mobile device anytime, anywhere by signing up on **livehealthonline.com**, at no cost to you. It's ideal care option for colds, the flu, allergies, pink eye, coughs, fever, and headaches.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- 24/7 NurseLine: Toll-free phone access to a registered nurse to help answer your health-related questions 24 hours a day, seven days a week year-round, at no cost to you.
- SilverSneakers® fitness program: Access to more than 13,000 SilverSneakers fitness locations nationwide, group classes and activities or at-home exercise kits, at no cost to you.
- Care coordination: Access to a care team of doctors, nurses, therapists, pharmacists and social workers if you have chronic conditions, or need transition help after a hospital discharge, at no cost to you.
- My Advocate™: Helps you find local, state and federal programs to help with your healthcare costs and general expenses such as utilities, transportation, property taxes, and more, at no cost to you.

* You must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

** Some members have Patient Pay. If the Department of Social Services has determined that you have a Patient Pay amount, you must pay this amount to your long-term service provider and Medicaid pays any remainder balance for your covered long-term care claims.

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LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem HealthKeepers Plus plan.

Want to choose Anthem MediBlue Dual Advantage? Call **800-Medicare** (**800-633-4227**) or our Medicare Member Services team at **855-306-9357** to switch.

You can change your Medicaid health plan enrollment to match your Medicare health plan choice, or you can change your Medicare health plan enrollment to match your Medicaid health plan choice. This is called aligned enrollment. Aligned enrollment is voluntary at this time.

If you choose Medicare fee-for-service or a Medicare plan other than our Medicare D-SNP plan, we will work with your Medicare plan to coordinate your benefits.

How to contact the Medicare State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP). You can contact the Virginia Insurance Counseling Assistance Program if you need assistance with your Medicare health insurance options. VICAP can help you understand your Medicare plan choices and answer your questions about changing to a new Medicare plan. VICAP is an independent program that is free and not connected to any CCC Plus health plans.

CALL	**800-552-3402** This call is free.
TTY	TTY users dial **711**
WRITE	Virginia Insurance Counseling and Assistance Program 1610 Forest Avenue, Suite 100 Henrico, Virginia 23229
EMAIL	aging@dars.virginia.gov
WEBSITE	**vda.virginia.gov/vicap.htm**

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

3. How CCC Plus Works

The Anthem HealthKeepers Plus plan contracts with doctors, specialists, hospitals, pharmacies, providers of long-term services and supports, and other providers. These providers make up our provider network. You will also have a care coordinator. Your care coordinator will work closely with you and your providers to understand and meet your needs. Your care coordinator will also provide you with information about your covered services and the choices that are available to you. Refer to **Your care coordinator** in Section 4 of this handbook.

What are the advantages of CCC Plus?

CCC Plus provides person-centered supports and coordination to meet your individual needs. Some of the advantages of CCC Plus include:

- You will have a care team that you help put together. Your care team may include doctors, nurses, counselors or other health professionals who are there to help you get the care you need.
- You will have a care coordinator. Your care coordinator will work with you and with your providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator will work with you to come up with a care plan specifically designed to meet your health and/or long-term support needs. Your care team will be in charge of coordinating the services you need. This means, for example:
  - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - Your care team will make sure your test results are shared with all your doctors and other providers, so they can be kept informed of your health status and needs.
- Treatment choices that include preventive, rehabilitative and community-based care.
- An on-call nurse or other licensed staff is available 24 hours per day, seven days per week to answer your questions. We are here to help you. You can reach us by calling the number at the bottom of this page. Also refer to the 24/7 NurseLine, **available 24 hours a day, seven days a week** in Section 5 of this handbook.

What are the advantages of choosing the Anthem CCC Plus plan?

Our experienced team finds the ways to get you what you need, while keeping you and your choices in mind. We work with a lot of doctors, hospitals, and specialists across the state, so you can pick the doctors to fit you and your health needs. And with us, you get extra benefits you can really use at no cost, like:

- $100 for glasses every year for adults 21 and older.
- Hearing exams, hearing aids, and hearing aid batteries for adults 21 and older (prior approval required).
- Rides to places of worship, grocery stores, libraries, the DMV, hair salons, and other wellness activities and events near you.
- $100 worth of assistive devices/wheelchair accessories mailed right to your door.
- Smartphone with monthly data, minutes, and texts, plus free calls to Member Services and health coaching.
- Community Resource Link to search online for jobs, food, housing, and more.
- Online peer support to discuss behavioral health challenges with people who share similar experiences.
- Online tools to make life easier — log in to your secure account to print your member ID card, update your address or contact information and change your PCP.
- Mobile app.
- HEPA-grade air purifier (prior approval required).

Transition of care policy: continuity of care period

The continuity of care period is 30 days. If the Anthem CCC Plus plan is new for you, you can keep seeing the doctors you go to now for the first 30 days. You can also keep getting your authorized services for the duration of the authorization or for 30 days after you first enroll, whichever is sooner. After 30 days in our plan, you will need to see doctors and other providers in our network.

A network provider is a provider who contracts and works with our health plan. You can call your care coordinator or Member Services for help finding a network provider. Your new provider can get a copy of your medical records from your previous provider if needed.

If you are in a nursing facility at the start of the CCC Plus Program, you may

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

choose to:

- Remain in the facility as long as you continue to meet the Virginia DMAS criteria for nursing facility care,
- Move to a different nursing facility, or
- Receive services in your home or other community-based setting.

The continuity of care period may be longer than 30 days. We may extend this time frame until the health risk assessment is completed. We'll also extend this time frame for you to have a safe and effective transition to a qualified provider within our network. Talk to your care coordinator if you want to learn more about these options.

If you have other coverage

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

We have the right and responsibility to collect payment for covered Medicaid services when Medicaid is not the first payer. We will not attempt to collect any payment directly from you. Contact Member Services if you have other insurance so that we can best coordinate your benefits. Your care coordinator will also work with you and your other health plan to coordinate your services.

4. Your care coordinator

You have a dedicated care coordinator who can help you to understand your covered services and how to access these services when needed. Your care coordinator will also help you to work with your doctor and other healthcare professionals (such as nurses and physical therapists) to provide a health risk assessment, and develop a care plan that considers your needs and preferences. We provide more information about the health risk assessment and the care plan below.

How your care coordinator can help

Your care coordinator can:

- Answer questions about your healthcare.
- Provide assistance with appointment scheduling.
- Answer questions about getting any of the services you need. For example, behavioral health services, transportation, and long-term services and supports (LTSS).
  - Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives and facilitate maximum independence. Examples include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as meal preparation, laundry, and shopping. LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities.
- Help with arranging transportation to your appointments when necessary. If you need a ride to receive a Medicaid covered service and cannot get there, non-emergency transportation is covered. Just call **855-323-4687** (**TTY 711**) (toll-free) or call your care coordinator for assistance.
- Answer questions you may have about your daily healthcare and living needs including these services:
  - Skilled nursing care
  - Physical therapy
  - Occupational therapy
  - Speech therapy
  - Home healthcare
  - Personal care services
  - Mental health services
  - Services to treat addiction
  - Other services you may need

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

What is a Health Screening?

Within three months after you enroll with the Anthem HealthKeepers Plus plan, a 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. These questions will make up what is called the "Health Screening." The representative will ask about any medical conditions you currently have or have had in the past, your ability to do everyday things, and your living conditions.

Your answers will help us understand your needs, identify whether or not you have medically complex needs and to determine when your Health Risk Assessment is required. We'll use your answers to develop your care plan (for more information on your care plan, see below).

Please contact us if you need accommodations to participate in the health screening. If you have questions about the health screening, please contact **855-323-4687**, option 4. The call is free.

What is a Health Risk Assessment?

After you enroll with the Anthem HealthKeepers Plus plan, your care coordinator will meet with you to ask you some questions about your health, needs and choices. Your care coordinator will talk with you about any medical, behavioral, physical, and social service needs that you may have. This meeting may be in-person or by phone and is known as a Health Risk Assessment (HRA). An HRA is a complete, detailed assessment of your medical, behavioral, social, emotional and functional status. The HRA is typically completed by your care coordinator. This health risk assessment will enable your care coordinator to understand your needs and help you get the care that you need.

What is a care plan?

A care plan includes the types of health services that are needed and how you will get them. It is based on your Health Risk Assessment. After you and your care coordinator complete your HRA, your care team will meet with you to talk about what health and/or long-term services and supports you need and want, as well as your goals and preferences.

Together, you and your care team will make a personalized care plan specific to your needs. This is also referred to as a person-centered care plan. Your care team will work with you to update Your Care Plan when the health services you need or

choose change and at least once per year.

How to contact your care coordinator

Your care coordinator should give you contact information to get in touch with them directly. You can also reach your care coordinator any of the ways below. Be sure to reach out to your care coordinator if you need help, have questions about your care, or if your preferences change.

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

CALL	**855-323-4687** This call is free. Monday through Friday from 8 a.m. to 8 p.m. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. Monday through Friday from 8 a.m. to 8 p.m.
FAX	**800-359-5781**
WRITE	Anthem CCC Plus Member Services P.O. Box 27401 Mail Drop VA2002-N500 Richmond, VA 23279
WEBSITE	**anthem.com/vamedicaid** Sign into Your Care Plan to send secure messages directly to your care coordinator.

5. Help from Member Services

Our Member Services staff is available to help you if you have any questions about your benefits, services, procedures, or if you have a concern about the Anthem HealthKeepers Plus plan. Member Services is available Monday through Friday from 8 a.m. to 8 p.m. If you need help after hours or on the weekend, you can call Member Services to talk with a nurse on 24/7 NurseLine any time, day or night.

How to contact Anthem CCC Plus Member Services

CALL	**855-323-4687** This call is free. Monday through Friday from 8 a.m. to 8 p.m. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. Monday through Friday from 8 a.m. to 8 p.m.
FAX	**800-359-5781**
WRITE	Anthem CCC Plus Member Services P.O. Box 27401 Mail Drop VA2002-N500 Richmond, VA 23279
WEBSITE	**anthem.com/vamedicaid** Sign into your secure account to send messages to Member Services or schedule a callback time.

How Member Services can help

Member Services can:

- Answer questions you have about the Anthem CCC Plus plan.
- Answer questions you have about claims, billing, or your member ID card.
- Help you find a doctor or see if a doctor is in the Anthem CCC Plus network.
- Help you change your primary care physician (PCP).
- Answer questions about your PCP and other doctors or specialists, including names, specialties, addresses, phone numbers, and professional qualifications.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- Provide information on coverage decisions about your healthcare services (including medications).
  - A coverage decision about your healthcare is a decision about:
    - Your benefits and covered services **or**
    - The amount we will pay for your health services
- Provide information on how you can submit an appeal about a coverage decision on your healthcare services (including medications). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake. (See Your Right to Appeal in Section 15 of this handbook.)
- Grievances about your healthcare services (including medications). You can file a grievance about us or any provider (including a non-network or network provider). A network provider is a provider who contracts and works with the health plan. You can also file a grievance about the quality of the care you received to us or to the CCC Plus Helpline at **844-374-9159** or **TDD 800-817-6608**. (See **Your right to file a grievance** in Section 15 of this handbook.)

24/7 NurseLine available 24 hours a day, seven days a week

If you are unable reach your care coordinator, you can reach a nurse or behavioral health professional 24 hours a day, seven days a week to answer your questions toll free at **855-323-4687** (**TTY 711**).

Call the 24/7 NurseLine for help with:
- Any medical questions or concerns you have.
- Finding where to go when you need care.
- What to do next when you need care.
- Tips to help you stay healthy.
- More.

CALL	**855-323-4687** This call is free. Available 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free.

Behavioral Health Crisis Line available 24 hours a day, seven days a week

Contact us if you do not know how to get services during a crisis. We will help

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

find a crisis provider for you. Call **855-323-4687**. If you have thoughts about harming yourself or someone else, you should:

- Get help right away by calling 911.
- Go to the closest hospital for emergency care.

CALL	**855-323-4687** This call is free. Available 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free.

Addiction and Recovery Treatment Services (ARTS) Advice Line available 24 hours a day, seven days a week.

If you are unable reach your care coordinator, you can reach an ARTS health professional 24 hours a day, seven days a week to answer your questions at **855-323-4687**. The call is free.

Our Behavioral Services team will connect you with someone who can help you with any addiction or substance use questions or concerns.

CALL	**855-323-4687** This call is free. Available 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free.

If you do not speak English

We can provide you with translation services. Anthem CCC Plus Member Services has employees who speak your language and we are able to access interpreter services. We also have written information in many languages for our members.

Currently, written materials are available in English and Spanish. If you need interpretation, please call Member Services (at no charge) at **855-323-4687** and request to speak to an interpreter or request written materials in your language.

If you have a disability and need assistance in understanding information or working with your care coordinator

We provide reasonable accommodations to people with disabilities in compliance with the Americans with Disabilities Act. This includes but is not limited to accessible communications (such as a qualified sign language interpreter), braille or large print materials, etc. If you need a reasonable accommodation please call Member Services (at no charge) at **855-323-4687** to ask for the help you need.

If you have questions about your Medicaid eligibility

If you have questions about your Medicaid eligibility, contact your Medicaid eligibility worker at the Department of Social Services in the city or county where you live. If you have questions about the services you get under the Anthem CCC Plus plan, call Member Services at the phone number below.

6. How to Get Care and Services

How to get care from your primary care physician (PCP)

Your primary care physician (PCP)

A primary care physician (PCP) is a doctor selected by you who meets state requirements and is trained to give you basic medical care. You will usually see your PCP for most of your routine healthcare needs. Your PCP will work with you and your care coordinator to coordinate most of the services you get as a member of our plan. Coordinating your services or supplies includes checking or consulting with other plan providers about your care. If you need to see a doctor other than your PCP, you may need a referral (authorization) from your PCP. You may also need to get approval in advance from your PCP before receiving certain types of covered services or supplies. In some cases, your PCP will need to get authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Contact Member Services or your care coordinator with any questions you have about getting your medical records transferred to your PCP or about your care and services.

Choosing your PCP

New members have the right to choose a PCP in our network soon after joining the Anthem CCC Plus plan by logging into your secure account online or calling Member Services. If you do not already have a PCP, you must request one prior to the 25th day of the month before your effective enrollment date or else we may assign you a PCP. You have the right to change your PCP at any time by calling Member Services at the number listed at the bottom of this page or online on your secure online account.

If you do not have a PCP in our network, we can help you find a highly-qualified PCP in your community. For help locating a provider:

- Use the Find a Doctor tool on our website **or**
- Look in the PDF of our provider directory at **anthem.com/vamedicaid**

The provider directory includes a list of all of the doctors, clinics, hospitals, labs, specialists, long-term services and supports providers, and other providers who work with the Anthem CCC Plus plan.

The directory also includes information on the accommodations each provider has for individuals who have disabilities or who do not speak English. We can also

provide you with a paper copy of the provider directory. You can call Member Services at the number on the bottom of this page or call your care coordinator for assistance.

You may want to find a doctor:

- Who knows you and understands your health condition.
- Who is taking new patients.
- Who can speak your language.
- Who has appropriate accommodations for people with physical or other disabilities.

If you have a disability or a chronic illness, you can ask us if your specialist can be your PCP. We also contract with Federally Qualified Health Centers (FQHC) that provide primary and specialty care. Another clinic can also act as your PCP if the clinic is a network provider.

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

Use our Find a Doctor tool online for the most up-to-date list of doctors and providers near you — we update it daily.

If you have Medicare, tell us about your PCP

If you have Medicare, you do not have to choose a PCP in the Anthem CCC Plus network. Simply call Member Services or your care coordinator to let us know the name and contact information for your PCP. We will coordinate your care with your Medicare assigned PCP.

If your current PCP is not in our network

If you do not have Medicare, you need to choose a PCP that is in the Anthem CCC Plus network. You can continue to see your current PCP during the continuity of care period even if they are not in the Anthem CCC Plus network. The continuity of care period is 30 days. Your care coordinator can help you find a PCP in our network. At the end of the continuity of care period, if you do not choose a PCP in the Anthem CCC Plus network, we will assign a PCP to you.

Changing your PCP

You can call Member Services to change your PCP at any time to another PCP in

our network. Also, it is possible that your PCP might leave our network. We will tell you within 15 days from when we know about this. We can help you find a new PCP.

It's even easier to switch PCPs online — our web option for finding and choosing a PCP is fast, convenient and available 24/7. First, use our Find a Doctor tool to find a PCP in your plan. Then, log in to your secure account at **anthem.com/vamedicaid** to change your PCP. When you switch PCPs online or over the phone, the change will take affect 24 hours from when you made the request.

Getting an appointment with your PCP

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

Appointment standards

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

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

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

- First trimester (first three months) — within 14 calendar days of request
- Second trimester (3 to 6 months) — within seven calendar days of request
- Third trimester (6 to 9 months) — within five business days of request
- High-risk pregnancy — within three business days or immediately if an emergency exists

If you are unable to get an appointment within the times listed above, call Member Services at the number below and they will help you get the appointment. Please keep your scheduled appointments. If you can't, call your PCP's office to cancel at least 24 hours before your appointment.

How to get care from network providers

Our provider network includes access to care 24 hours a day, seven days per week and includes hospitals, doctors, specialists, urgent care facilities, nursing facilities, home- and community-based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health and hospice providers, durable medical equipment providers, and other types of providers. We provide you with a choice of providers and where they are located, so that you do not have to travel very far to see them. On rare occasions there may be special circumstances where longer travel time is required.

Travel time and distance standards

We will provide you with the services you need within the travel time and distance standards described in the table below. These standards apply for services that you travel to in order to receive care from network providers. These standards do not apply to providers who provide services to you at home. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, in the Roanoke/Alleghany Region, or the Southwest Region, 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

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

Accessibility

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

Telehealth visits

The Anthem HeathKeepers Plus plan provides members access to telehealth, when available. To learn more, visit **anthem.com/vamedicaid** or call Anthem CCC Plus Member Services at **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

What are network providers?

Anthem CCC Plus network providers include:

- Doctors, nurses, and other healthcare professionals that you can go to as a member of our plan.
- Clinics, hospitals, nursing facilities, and other places that provide health services in our plan.
- Early intervention providers, home health agencies, and durable medical equipment suppliers.
- Long-term services and supports (LTSS) providers including nursing facilities, hospice, adult day healthcare, personal care, respite care, and other LTSS providers.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

What are network pharmacies?

Network pharmacies are pharmacies (drugstores) that have agreed to fill prescriptions for our members. Use the provider and pharmacy directory to find the network pharmacy you want to use. Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them. Call Member Services at the number at the bottom of the page for more information.

Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers. Call Member Services at the number at the bottom of this page or visit our website at

anthem.com/vamedicaid for the most recent list of providers and pharmacies in your plan.

What are specialists?

If you need care your PCP cannot provide, your PCP may send you to a specialist. Most of the specialists are in the Anthem CCC Plus network. A specialist is a doctor who provides healthcare for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

You don't need a referral from your PCP to see a specialist in our network, but you can reach out to your PCP for help finding a specialist we work with. Or you can search for different kinds of specialists in our network online with the Find a Doctor Finder tool. If you have a disabling condition or chronic illnesses, you can ask us if your specialist can be your PCP.

If your provider leaves our plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 15 days' notice so you have time to select a new provider.
- We'll help you select a new qualified provider to continue managing your healthcare needs.
- If you're undergoing medical treatment, you have the right to ask and we will work with you to ensure that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a grievance or request a new provider.
- If you're pregnant and in your second trimester at the time your OB/GYN leaves the network, you can keep seeing your current provider for postpartum care.
- If you find out one of your providers is leaving our plan, please contact your

care coordinator so we can assist you in finding a new provider and managing your care.

Medical advances and new technology

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

- Medical procedures
- Behavioral health procedures
- Medicines
- Medical devices

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

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

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

How to get care from out-of-network providers

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

- When we have approved a doctor out of its established network
- When emergency and family planning services are rendered to you by an out-of-network provider or facility
- When you receive emergency treatment by providers not in the network
- When the needed medical services are not available in the Anthem CCC Plus network
- When we cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas
- When the type of provider needed and available in the Anthem CCC Plus network does not, because of moral or religious objections, furnish the service you need
- Within the first 30 days of your enrollment, when your provider is not part of the Anthem CCC Plus network but has treated you in the past

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- If you're in a nursing facility when you enroll with the Anthem CCC Plus plan and the nursing facility is not in the Anthem CCC Plus network

If the Anthem HealthKeepers Plus plan or your PCP refers you to a provider outside of our network, you are not responsible for any of the costs, except for your patient pay towards long-term services and supports. See Section 13 of this handbook for information about what a patient pay is and how to know if you have one.

If you need to see a doctor or other provider outside of our network, you'll need to ask us for a service authorization (or prior approval). You, your PCP, or someone you trust can get a service authorization request form on our website or by calling Member Services.

Care from out-of-state providers

The Anthem HealthKeepers Plus plan is not responsible for services you obtain outside Virginia except under the following circumstances:

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

Network providers cannot bill you directly

Network providers must always bill the Anthem HealthKeepers Plus plan. Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. This is known as balanced billing. This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.

If you receive a bill for covered services

If you are billed for any of the services covered by our plan, you should not pay the bill. If you do pay the bill, we may not be able to pay you back.

Whenever you get a bill from a network provider or for services that are covered outside of the network (example: emergency or family planning services), send us the bill. We will contact the provider directly and take care of the bill for covered services.

If you receive care from providers outside of the United States

Our plan does not cover any care that you get outside the United States.

7. How to Get Care for Emergencies

What is an emergency?

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

What to do in an emergency

Call **911** right away. You do not need to call us first. You do not need an authorization or a referral for emergency services.

Go to the closest hospital. Calling **911** will help you get to a hospital. You can use any hospital for emergency care, even if you are in another city or state. If you are helping someone else, try to stay calm.

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

What is a medical emergency?

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

- Serious risk to your health.
- Serious harm to bodily functions.
- Serious dysfunction of any bodily organ or part.
- In the case of a pregnant woman in active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer you to another hospital before delivery.
  - The transfer may pose a threat to your health or safety or to that of your unborn child.

What is a behavioral health emergency?

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

Nonemergency examples

Nonemergency examples are colds, sore throat, upset stomach, minor cuts and

bruises, or sprained muscles. If you are not sure, call your PCP or the Anthem CCC Plus 24/7 NurseLine at **855-323-4687** (**TTY 711**).

If you have an emergency when away from home

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

What is covered if you have an emergency?

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

Notifying us about your emergency

Notify your doctor and us as soon as possible about the emergency or within 48 hours if you can. However, you will not have to pay for emergency services because of a delay in telling us. We need to follow up on your emergency care. Your care coordinator will assist you in getting the correct services in place before you are discharged to ensure that you get the best care possible. Please call Member Services at **855-323-4687** (**TTY 711**). This number is also listed on the back of your Anthem CCC Plus member card.

After an emergency

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

If you are hospitalized

If you are hospitalized, a family member or a friend should contact the Anthem

HealthKeepers Plus plan as soon as possible. By keeping us informed, your care coordinator can work with the hospital team to organize the right care and services for you before you are discharged. Your care coordinator will also keep your medical team including your home care services providers informed of your hospital and discharge plans.

If it wasn't a medical emergency

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care, and the doctor may say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care. However, after the doctor says it was not an emergency, we will cover your additional care only if you follow the **General coverage rules** described in Section 10 of this handbook.

8. How to Get Urgently Needed Care

What is urgently needed care?

Urgently needed care is care you get for a non-life-threatening, sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have an existing condition that worsens and you need to have it treated right away. Other examples of urgently needed care include sprains, strains, skin rashes, infection, fever, flu, etc. In most situations, we will cover urgently needed care only if you get this care from a network provider.

You can find a list of urgent care centers we work with in our provider and pharmacy directory, available on our website at **anthem.com/vamedicaid**.

How to get healthcare when your doctor's office is closed

Except in the case of an emergency or when you need care that doesn't need a referral, you should always call your PCP **first** before you get medical care. If you call your PCP's office when it is closed, leave a message with your name and a phone number where you can be reached. If it isn't an emergency, someone should call you back soon to tell you what to do. You can also call our 24/7 NurseLine to speak to a nurse 24 hours a day, seven days a week.

If you think you need emergency services, call **911** or go to the nearest emergency room right away.

9. How to Get Your Prescription Drugs

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

Rules for Anthem CCC Plus outpatient drug coverage

The Anthem CCC Plus plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other authorized provider write your prescription. This person often is your primary care physician (PCP). It could also be another provider if your primary care physician has referred you for care. Prescriptions for controlled substances must be written by an in network doctor or provider.
2. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on the Anthem CCC Plus list of covered drugs. If it is not on the list of covered drugs, we may be able to cover it by giving you a service authorization.
4. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical reference books.
5. If you have Medicare, most of your drugs are covered through your Medicare carrier. We cannot pay for any drugs that are covered under Medicare Part D, including copayments.
6. The Anthem CCC Plus plan can provide coverage for coinsurance and deductibles on Medicare Part A and B drugs. These include some drugs given to you while you are in a hospital or nursing facility.

Getting your prescriptions filled

In most cases, your Anthem CCC Plus plan will pay for prescriptions only if they are filled at Anthem CCC Plus network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our members. You may go to any of our network pharmacies.

To find a network pharmacy, you can look in the provider and pharmacy directory, visit our website, contact your care coordinator, or call Member Services at the number at the bottom of the page.

To fill your prescription, show your member ID card at your network pharmacy. If you have Medicare, show your Medicare Part D and Anthem CCC Plus ID cards.

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

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

List of covered drugs

We have a list of covered drugs that we select with the help of a team of doctors and pharmacists. The Anthem CCC Plus list of covered drugs also includes all of the drugs on the DMAS preferred drug list (PDL). The list of covered drugs can be found at **anthem.com/vamedicaid**. The list of covered drugs tells you which drugs are covered by the Anthem CCC Plus plan and also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get.

You can call Member Services to find out if your drugs are on the list of covered drugs, check online at **anthem.com/vamedicaid** or we can mail you a paper copy of the list of covered drugs. The list of covered drugs may change during the year. 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.

To get the most up-to-date list of covered drugs, visit **anthem.com/vamedicaid** or call Member Services at **855-323-4687** (TTY **711**) Monday through Friday from 8 a.m. to 8 p.m.

We will generally cover a drug on the Anthem CCC Plus list of covered drugs as long as you follow the rules explained in this section.

If you don't see your medicine listed on the drug list, you may ask for an exception at submitmyexceptionreq@anthem.com.

You can also get drugs that are not on the list when medically necessary. Your physician may have to obtain a service authorization from us in order for you to receive some drugs.

Limits for coverage of some drugs

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

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may need to request a service authorization for you to receive the drug. We may or may not agree to approve the request without taking extra steps. Refer to **Service Authorization and Benefit Determination and Service authorizations and continuity of care** in Section 14 of this handbook.

If the Anthem CCC Plus plan is new for you, you can keep getting your authorized drugs for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. The continuity of care period is 30 days. Refer to **Continuity of care period** in Section 3 of this handbook.

If we deny or limit coverage for a drug, and you disagree with our decision, you have the right to appeal our decision. Refer to **Your right to appeal** in Section 15 of this handbook. If you have any concerns, contact your care coordinator. Your care coordinator will work with you and your PCP to make sure that you receive the drugs that work best for you.

Getting approval in advance

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

Trying a different drug first

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

Quantity limits

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

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

Emergency supply

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

Non-covered drugs

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

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- Drugs used for treatment of anorexia, weight loss, or weight gain
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective, including prescriptions that include a DESI drug
- Drugs that have been recalled
- Experimental drugs or approved drugs not approved by the FDA
- Any drugs marketed by a manufacturer who does not participate in the Virginia Medicaid Drug Rebate program

Changing pharmacies

If you need to change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy. If you need help changing your network pharmacy, you can contact Member Services at the number at the bottom of the page or your care coordinator.

If the pharmacy you use leaves the Anthem CCC Plus network, you will have to find a new network pharmacy. To find a new network pharmacy, you can look in the provider and pharmacy directory, visit our website, or contact Member Services at the number at the bottom of the page or your care coordinator. Member Services can tell you if there is a network pharmacy nearby.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy.

Specialty drugs are used for treatment of complex diseases and when prescribed the medications required special handling or clinical care support prior to dispensing. Only a limited number of pharmacies are contracted by each health plan to provide these drugs. These medications will be shipped directly to your home or the prescriber office and cannot be picked up at all retail outlets.

Also, these drugs usually require a service authorization prior to dispensing. Be sure to check with the formulary of your plan regarding coverage of these specialty drugs and allow time for shipment deliveries.

Can you use mail-order services to get your drugs?

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 fills of the same medication are required to be eligible for a 90-day supply.

If you want to switch to home-delivery pharmacy through IngenioRx, 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.

Can you get a 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.

Can you use a pharmacy that is not in the Anthem CCC Plus network?

You need to use a pharmacy in our network to get your drugs at no cost to you. Use the Find a Doctor tool to find a pharmacy in the Anthem CCC Plus network near you.

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

Some members who require additional monitoring may be enrolled in the Patient Utilization Management and Safety (PUMS) program. The PUMS program is required by DMAS and helps make sure your drugs and health services work together in a way that won't harm your health. As part of this program, we may check the Prescription Monitoring Program (PMP) tool that the Virginia

Department of Health Professions maintains to review your drugs.

This tool uses an electronic system to monitor the dispensing of controlled substance prescription drugs.

If you are chosen for PUMS, you may be restricted to, or locked into, only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works.

The lock-in period is for 12 months. At the end of the lock-in period, we'll check in with you to see if you should continue the program. If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to **Appeals, State Fair Hearings and Grievances** in Section 15 of this handbook.

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

Members who are enrolled in PUMS will receive a letter from us that provides additional information on PUMS including all of the following information:

- A brief explanation of the PUMS program
- A statement explaining the reason for placement in the PUMS program
- Information on how to appeal to the Anthem HealthKeepers Plus plan if placed in the PUMS program
- Information regarding how request a State Fair Hearing after first exhausting the Anthem CCC Plus appeals process
- Information on any special rules to follow for obtaining services, including for emergency or after hours services
- Information on how to choose a PUMS provider

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

10. How to Access Your CCC Plus Benefits

CCC Plus benefits

As an Anthem CCC Plus member, you have a variety of healthcare benefits and services available to you. You will get most of your services through your Anthem CCC Plus plan, but may receive some through DMAS or a DMAS contractor.

- Services provided through the Anthem CCC Plus plan are described in Section 10 of the handbook.
- Services covered by DMAS or a DMAS contractor are described in Section 11 of this handbook.
- Services that are not covered through the Anthem CCC Plus plan or DMAS are described in Section 12 of this handbook.

Services you receive through the Anthem CCC Plus plan or through DMAS will not require you to pay any costs other than your patient pay towards long-term services and supports. Section 13 of this handbook provides information on what a patient pay is and how you know if you have one.

General coverage rules

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

1. Your services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means you need the service or supplies to prevent, diagnose, or treat a medical condition or its symptoms based on accepted standards of medical practice.
2. In most cases, you must get your care from a network provider. A network provider is a provider who works with the Anthem HealthKeepers Plus plan. In most cases, we will not pay for care you get from an out-of-network provider unless the service is authorized by us. Section 6 has more information about using network and out-of-network providers.
3. Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called a service authorization. Section 14 includes more information about service authorizations.

4. If the Anthem CCC Plus plan is new for you, you can keep seeing the doctors you go to now during the 30-day continuity of care period. You can also keep getting your authorized services for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. Also see **Continuity of care period** in Section 3 of this handbook.

Benefits covered through the Anthem CCC Plus plan

The Anthem CCC Plus plan covers all of the following services for you when they are medically necessary. If you have Medicare or another insurance plan, we will coordinate these services with your Medicare or other insurance plan. Refer to Section 11 of this handbook for **Services Covered through the DMAS Medicaid Fee-For-Service Program.**

- Addiction and Recovery Treatment Services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services, and case management. Services may require authorization. Additional information about ARTS services is provided below in this section of the handbook.
- Adult day healthcare services (see CCC Plus waiver).
- Care coordination services, including assistance connecting to CCC Plus covered services and to housing, food, and community resources. See Section 4 of this handbook for more information about your care coordinator.
- Clinic services, including renal dialysis.
- CCC Plus Home- and Community-Based waiver services, (formerly known as the EDCD and Technology Assisted waivers), including: adult day healthcare, assistive technology, environmental modifications, personal care services, personal emergency response systems (PERS), private duty nursing services, respite services, services facilitation, transition services. Additional information about CCC Plus waiver services is provided later in this section. Section 11 of this handbook provides information about DD waiver services.
- Colorectal cancer screening.
- Court-ordered services.
- Durable medical equipment (DME) and supplies including medically necessary respiratory, oxygen, and ventilator equipment and supplies, wheelchairs and accessories, hospital beds, diabetic equipment and supplies, incontinence products, assistive technology, communication devices, and rehabilitative equipment and devices and other necessary equipment and supplies.

- Early and Periodic Screening, Diagnosis and Treatment services (EPSDT) for children under age 21. Additional information about EPSDT services is provided later in this section of the handbook.
- Early Intervention services for children from birth to age 3. Additional information about early intervention services is provided later in this section of the handbook.
- Electroconvulsive therapy (ECT).
- Emergency custody orders (ECO).
- Emergency services including emergency transportation services (ambulance, etc.).
- Emergency and post-stabilization services. Additional information about emergency and post-stabilization services is provided in Section 7 of this handbook.
- End-stage renal disease services.
- Eye examinations.
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of the Anthem CCC Plus network. We do not require you to obtain a service authorization or a PCP referral for family planning services.
- Gender dysphoria treatment services.
- Glucose test strips.
- Hearing (audiology) services.
- Home health services.
- Hospice services.
- Hospital care — inpatient/outpatient.
- Human immunodeficiency virus (HIV) testing and treatment counseling.
- Immunizations.
- Inpatient psychiatric hospital services.
- Laboratory, radiology and anesthesia services.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- Lead investigations.
- Mammograms.
- Maternity care — includes: pregnancy care, doctors/certified nurse-midwife services. Additional information about maternity care is provided in Section 6 of this handbook.
- Mental health services, including outpatient psychotherapy services, community-based, crisis and inpatient services. Community and facility-based services include:
    - Mental health case management
    - Therapeutic Day Treatment (TDT) for children
    - Mental Health Skill-building Services (MHSS)
    - Intensive in-home
    - Psychosocial rehabilitation
    - Applied Behavior Analysis (ABA)
    - Mental health peer recovery supports services
    - Mental health partial hospitalization program
    - Mental health intensive outpatient
    - Assertive community treatment
    - Multisystemic Therapy (MST)
    - Functional Family Therapy (FFT)
    - Mobile crisis
    - Community stabilization
    - 23-hour observation
    - Residential crisis stabilization
- Nursing facility — includes skilled, specialized care, long stay hospital and custodial care. Additional information about nursing facility services is provided later in this section of the handbook.
- Nurse-midwife services through a certified nurse-midwife provider.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- Organ transplants.
- Orthotics, including braces, splints and supports — for children under 21, or adults through an intensive rehabilitation program.
- Outpatient hospital services.
- Pap smears.
- Personal care or personal assistance services (through EPSDT or through the CCC Plus waiver).
- Physician's services or provider services, including doctor's office visits.
- Physical, occupational, and speech therapies.
- Podiatry services (foot care).
- Prenatal and maternal services.
- Prescription drugs. See Section 9 of this handbook for more information on pharmacy services.
- Preventive care, including regular checkups, screenings, and well-baby/child visits. See Section 6 of this handbook for more information about PCP services.
- Private duty nursing services (through EPSDT and through the CCC Plus HCBS Waiver).
- Prostate specific antigen (PSA) and digital rectal exams.
- Prosthetic devices (including arms, legs, and their supportive attachments, breasts, and eye prostheses).
- Psychiatric or psychological services.
- Radiology services.
- Reconstructive breast surgery.
- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. See Section 6 of this handbook for more information about PCP services.
- Renal (kidney) dialysis services.
- Rehabilitation services — inpatient and outpatient (including physical therapy, occupational therapy, speech pathology, and audiology services).
- Second opinion services from a qualified healthcare provider within the

network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out-of-network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.

- Surgery services when medically necessary and approved by the Anthem HealthKeepers Plus plan.
- Telemedicine services.
- Temporary Detention Orders (TDO).
- Tobacco cessation services, education and pharmacotherapy for all members.
- Transportation services, including emergency and nonemergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). The Anthem CCC Plus plan will also provide transportation to/from most "carved-out" and enhanced services. Additional information about transportation services is provided later in this section of the handbook. Transportation services for DD waiver services are covered through DMAS, as described in Section 11 of this handbook.
- Routine eye care: one routine comprehensive eye exam every year and $100 toward eyewear (one frame and two lenses) every year.
- Well-visits — we cover all preventive doctor visits to help you stay healthy.
- Abortion services — coverage is only available in cases where there would be a substantial danger to the life of the mother.

Extra benefits we provide that are not covered by Medicaid

As an Anthem CCC Plus member, you have access to services that are not generally covered through Medicaid fee-for-service. These are known as "enhanced benefits." Members can request a these by calling Member Services or contacting their care coordinator. We provide the following enhanced benefits:

- Meals delivered to your home after you leave the hospital or a nursing facility—one meal each day for seven days.
- $100 for glasses (lenses and frames) every year for adults 21 and older
- One hearing exam and $1,000 for hearing aids and 60 batteries per year for adults 21 and older (prior approval required).
- Rides to places of worship, grocery stores, libraries, the DMV, hair salons, and other wellness activities or events near you. You're covered for three round-trip

non-medical transportation rides every three months (not to exceed 12 round trips annually). You'll need to call Access2Care at **855-325-7581** 48 business hours in advance for both medical and non-medical rides. Urgent trips can also be scheduled with Access2Care.

- Coupon booklet with over $1,000 in savings at retail stores like Dick's Sporting Goods, Barnes & Noble, Ruby Tuesday, and more,
- $100 worth of assistive devices (dressing aids, reachers, non-slip jar openers, and more) and wheelchair accessories (safety lights, seat cushions, wheelchair gloves, and more) mailed right to your door. Login or create a secure account at **anthem.com/vamedicaid** and visit the Benefit Reward Hub to order your devices. If you don't already have a secure account, choose Register to create one. Or call your care coordinator or Member Services for help placing an order.
- Cellphone with monthly data, minutes, and texts, plus free calls to Member Services and health coaching
- Community Resource Link — search online by ZIP code for food, housing, help finding a job, and more
- Online tools to make life easier — use your secure account to view details about Your Care Plan, download materials, get in touch with your care coordinator, and more
- Mobile app
- Air purifier (prior approval required)

How to access Early and Periodic Screening, Diagnosis and Treatment Services

What is EPSDT?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated Medicaid benefit that provides comprehensive and preventive healthcare services for children under age 21.

If you have a child that is under age 21, EPSDT provides appropriate preventive, dental, behavioral health, developmental, and specialty services. It includes coverage for immunizations, well-child visits, lead investigations, private duty nursing, personal care, and other services and therapies that treat or make a condition better.

It will also cover services that keep your child's condition from getting worse. EPSDT can provide coverage for medically necessary services even if these are not

normally covered by Medicaid.

Getting EPSDT services

We provide most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by us. For any services not covered by the Anthem HealthKeepers Plus plan, you can get these through the Medicaid fee-for-service program. Additional information about services provided through Medicaid fee-for-service is provided in Section 11 of this handbook.

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. See Section 14 **Service Authorization and Benefit Determination** to learn more about service authorizations.

Getting early intervention services

If you have a baby under the age of three, and you believe they are not learning or developing like other babies and toddlers, your child may qualify for early intervention services. Early intervention includes services such as speech therapy, physical therapy, occupational therapy, service coordination, and developmental services to help families support their child's learning and development during everyday activities and routines. Services are generally provided in your home.

The first step is meeting with the local Infant and Toddler Connection program in your community to see if your child is eligible. A child from birth to age 3 is eligible if he or she has:

- A 25% developmental delay in one or more areas of development.
- Atypical development.
- A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

For more information, call your care coordinator. Your care coordinator can help. If your child is enrolled in the Anthem CCC Plus plan, we provide coverage for early intervention services. Your care coordinator will work closely with you and the Infant and Toddler Connection program to help you access these services and any other services that your child may need. Information is also available at **infantva.org** or by calling **800-234-1448**.

How to access behavioral health services

Behavioral health services offer a wide range of treatment options for individuals

with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other issues, as well as using substances at some time in their lives. These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible.

Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in your home or in the community, for a short or long time frame, and all are performed by qualified individuals and organizations.

Contact your care coordinator if you are having trouble coping with thoughts and feelings. Your care coordinator will help you make an appointment to speak with a behavioral healthcare professional.

Some behavioral health services are covered for you through Magellan, 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, including inpatient behavioral health services.

Call our Member Services team if you have questions about which services you may need prior approval for. Also see the section **Service Authorization and Benefit Determination** to learn more about how service authorizations work.

How to access Addiction and Recovery Treatment Services (ARTS)

Your Anthem CCC Plus plan offers a variety of services that help individuals who are struggling with using substances, including drugs and alcohol.

Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment no matter how bad the problem may seem. If you need treatment for addiction, we provide coverage for services that can help you. These services include settings in inpatient, outpatient, residential and community-based treatment. Medication assisted treatment options, counseling services, and behavioral therapy options are also available if you are dealing with using prescription or non-prescription drugs. Other options that are helpful include peer recovery services (someone who has experience similar issues and in recovery), as well as case management services.

Talk to your PCP or call your care coordinator to determine the best option for you and how to get help in addiction and recovery treatment services. To find an ARTS

provider, you can look in the provider and pharmacy directory, visit our website, call your care coordinator, or contact Member Services at one of the numbers below.

You need a service authorization for some ARTS services, including:

- Inpatient substance use services
- Residential substance use services
- Intensive outpatient program

See the section **Service Authorization and Benefit Determination** to learn more about how service authorizations work.

How to access long-term services and supports (LTSS)

We provide coverage for long-term services and supports (LTSS) including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. LTSS can provide assistance that helps you live in your own home or other setting of your choice and improves your quality life. Examples of services include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over a long period of time, usually in homes and communities (through a home- and community-based waiver), but also in nursing facilities. If you need help with these services, please call your care coordinator who will help you in the process to find out if you meet the Virginia eligibility requirements for these services. Also see the sections: **Commonwealth Coordinated Care Plus waiver, Nursing facility services** and **How to get services if you are in a DD waiver** described later in this section of the handbook.

Commonwealth Coordinated Care Plus waiver

Some members may qualify for home- and community-based care waiver services through the Commonwealth Coordinated Care Plus waiver (formerly known as the Elderly or Disabled with Consumer Direction and Technology Assistance waivers).

The Commonwealth Coordinated Care Plus (CCC Plus) waiver is meant to allow a member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus waiver services, you may choose how to receive personal assistance services.

You have the option to receive services through an agency (known as agency-directed) or you may choose to serve as the employer for a personal assistance

attendant (known as self-directed). Information on self-directed care is described in more detail below in this section of the handbook. CCC Plus waiver services may include:

- Private duty nursing services (agency-directed)
- Personal care (agency- or self-directed)
- Respite care (agency- or self-directed)
- Adult day healthcare
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for members transitioning to the community from a nursing facility or long stay hospital
- Assistive technology
- Environmental modifications

Individuals enrolled in a DD waiver should see **How to get services if you are in a DD waiver** described later in this section.

How to self-direct your care

Self-directed care refers to personal care and respite care services provided under the CCC Plus waiver. These are services in which the member or their family/caregiver is responsible for hiring, training, supervising, and firing of their attendant. You will receive financial management support in your role as the employer to assist with enrolling your providers, conducting provider background checks, and paying your providers.

If you have been approved to receive CCC Plus waiver services and would like more information on the self-directed model of care, please contact your care coordinator who will assist you with these services.

Your care coordinator will also monitor your care as long as you are receiving CCC Plus waiver services to make sure the care provided is meeting your daily needs. Once your care coordinator assesses your current needs to learn more about if LTSS could make a difference in your daily life, we'll use those assessments to make sure you're getting the CCC Plus waiver services you need. Your care coordinator can also help you get other services to fit your needs outside of the CCC Plus waiver. To learn more about service authorizations, see the section **Service Authorization and Benefit Determination**.

Nursing facility services

If you are determined to meet the coverage criteria for nursing facility care, and choose to receive your long-term services and supports in a nursing facility, we

will provide coverage for nursing facility care. If you have Medicare, we will provide coverage for nursing facility care after you exhaust your Medicare covered days in the nursing facility, typically referred to as skilled nursing care. If you are in a nursing facility, you may be able to move from your nursing facility to your own home and receive home- and community-based services if you want to. If you are interested in moving out of the nursing facility into the community, talk with your care coordinator.

Your care coordinator is available to work with you, your family and the discharge planner at the nursing facility if you are interested in moving from the nursing facility to a home or community setting. If you choose not to leave the nursing facility, you can remain in the nursing facility for as long as you are determined to meet the coverage criteria for nursing facility care.

Screening for long-term services and supports

Before you can receive long-term services and supports (LTSS), you must be screened by a community-based or hospital screening team. A screening is used to determine if you meet the level of care criteria for LTSS. Contact your care coordinator to find out more about the screening process in order to receive LTSS.

Freedom of choice

If you are approved to receive long-term services and supports, you have the right to receive care in the setting of your choice:

- In your home
- In another place in the community
- In a nursing facility

You can choose the doctors and health professionals for your care from our network. If you prefer to receive services in your home under the CCC Plus waiver, for example, you can choose to directly hire your own personal care attendant(s), known as self-directed care. Another option you have is to choose a personal care agency in our network, where the agency will hire, train and supervise personal assistance workers on your behalf, known as agency direction. You also have the option to receive services in a nursing facility from our network of nursing facility providers.

How to get services if you are in a Developmental Disability waiver

If you are enrolled in one of the DD waivers, you will be enrolled in CCC Plus for your non-waiver services. The DD waivers include:

- The Building Independence (BI) waiver.
- The Community Living (CL) waiver.
- The Family and Individual Supports (FIS) waiver.

We will only provide coverage for your non-waiver services. Non-waiver services include all of the services listed in Section 10 **Benefits covered through your Anthem CCC Plus plan.** Exception: If you are enrolled in one of the DD waivers, you would not also be eligible to receive services through the CCC Plus waiver.

DD waiver services, DD and ID targeted case management services, and transportation to/from DD waiver services will be paid through Medicaid fee-for-service as carved-out services. The carve-out also includes any DD waiver services that are covered through EPSDT for DD waiver-enrolled individuals under the age of 21.

If you have a developmental disability and need DD waiver services, you will need to have a diagnostic and functional eligibility assessment completed by your local Community Services Board (CSB). All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in your person-centered individualized service plan.

The DD waivers have a wait list. Individuals who are on the DD waiver waiting list may qualify to be enrolled in the CCC Plus waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in your community.

For more information on the DD waivers and the services that are covered under each DD waiver, visit the Department of Behavioral Health and Developmental Services (DBHDS) website at **mylifemycommunityvirginia.org** or call

844-603-9248. Your care coordinator will work closely with you and your DD or ID case manager to help you get all of your covered services. Contact your care coordinator if you have any questions or concerns.

How to get nonemergency transportation services

Nonemergency transportation services covered by the Anthem HealthKeepers Plus plan

Nonemergency transportation services are covered by the Anthem HealthKeepers Plus plan for covered services, carved-out services and enhanced benefits.

Exception: If you are enrolled in a DD waiver, we provide coverage for your transportation to/from your non-waiver services. (Refer to **Transportation to/from DD waiver services** below.)

Transportation may be provided if you have no other means of transportation and need to go to a physician or a healthcare facility for a covered service. For urgent or nonemergency medical appointments, call the reservation line at

855-325-7581. If you are having problems getting transportation to your appointments, call Access2Care at **855-325-7581** or call Member Services at the number below. Member Services is here to help.

In case of a life-threatening emergency, call **911**. Refer to **How to Get Care for Emergencies** in Section 7 of this handbook.

Set up a ride by calling Access2Care at least two business days before your appointment. You can also get mileage reimbursement for approved appointments, and bus tickets are available, too. To get bus tickets, call at least seven days before your appointment.

Non-medical rides can be scheduled between 8 a.m. and 5 p.m. seven days a week. There is a mileage limitation including urban areas (30 miles round trip) and rural areas (60 miles round trip). These trips shouldn't be scheduled with a medical trip.

If you have an urgent request for a same-day appointment, contact Access2Care. They will verify your urgent request and help you set up your ride. Assistance for urgent and same-day reservations is available anytime. Just call **855-325-7581**.

For emergencies, call 911.

Transportation to and from DD waiver services

If you are enrolled in a DD waiver, we provide coverage for your transportation to and from your non-waiver services. Call the number above for transportation to your non-waiver services.

Transportation to your DD waiver services is covered by the DMAS Transportation Contractor. You can find out more about how to access transportation services through the DMAS Transportation Contractor on the website at **transportation.dmas.virginia.gov** or by calling the transportation contractor. Transportation for routine appointments are taken Monday through Friday between the hours of 6 a.m. to 8 p.m.

The DMAS Transportation Contractor is available 24 hours a day, seven days a week to schedule urgent reservations at **866-386-8331**, TTY **866-288-3133**, or TTY **711** to reach a relay operator.

If you have problems getting transportation to your DD waiver services, you may call your DD or ID waiver case manager or the DMAS Transportation Contractor at the number above. You can also call your care coordinator. Your care coordinator will work closely with you and your DD or ID waiver case manager to help get the services that you need. Member Services is also available to help at the number below.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

11. Services Covered Through the DMAS Medicaid Fee-For-Service Program

Carved-out services

The Department of Medical Assistance Services will provide you with coverage for the services listed below. These services are known as "carved-out services." Your provider bills fee-for-service Medicaid (or a DMAS Contractor) for these services.

Your care coordinator can also help you to access these services if you need them.

- Dental services are provided through the DMAS Dental Benefits Administrator. DMAS has contracted with its Dental Benefits Administrator to coordinate the delivery of all Medicaid dental services. The dental program provides coverage for the following populations and services:
  - For children under age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services.
  - For pregnant women: X-rays and examinations, cleanings, fillings, root canals, gum-related treatment, crowns, partials, dentures, tooth extractions and other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. The dental coverage ends 60 days after the baby is born.
  - For adults age 21 and over, coverage will include cleanings, X-rays, exams, fillings, dentures, root canals, gum-related treatment, oral surgery, and more.

If you have any questions about your dental coverage through the DMAS Dental Benefits Administrator, you can reach DentaQuest Member Services at

888-912-3456, Monday through Friday, 8 a.m. to 6 p.m. Eastern time. The **TTY/TDD** number is **800-466-7566**. Additional information is provided at **dmas.virginia.gov/for-members/benefits-and-services/dental/**.

The Anthem HealthKeepers Plus plan provides coverage for nonemergency transportation for any dental services covered through the DMAS Dental Benefits Administrator as described above. Contact Member Services at **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. if you need assistance.

Anthem HealthKeepers Plus provides coverage for oral services such as hospitalizations, surgeries or services billed by a medical doctor not a dentist.

- Developmental Disability (DD) waiver services, including case management for DD waiver services are covered through DBHDS. The carve-out includes any DD waiver services that are covered through EPSDT for DD waiver-enrolled individuals and transportation to/from DD waiver services. Also see **How to get**

Services if you are in a Developmental Disability waiver in Section 10 of this handbook.

- School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.
- Treatment Foster Care Case Management is managed by Magellan of Virginia and more information is available at **magellanofvirginia.com**. You can also call **800-424-4046** (**TDD 800-424-4048**; **TTY 711**) or your care coordinator for assistance.
- Therapeutic Group Home Services for children and adolescents younger than the age of 21. This is a place where children and adolescents live while they get treatment. Children under this level of care have serious mental health concerns. These services provide supervision and behavioral healthcare toward therapeutic goals. These services also help the member and their family work towards discharge to the member's home. Additional information about Therapeutic Group Home Services is available on the Magellan website at **magellanofvirginia.com** or by calling **800-424-4046**, **TDD 800-424-4048**, or **TTY 711**. You can also call your care coordinator for more information.
- For members age 21 through 64, where the member goes into a private or state freestanding Institution for Mental Disease (IMD) for a Temporary Detention Order (TDO), the state TDO program will pay for the service.

Services that will end your CCC Plus enrollment

If you receive any of the services below, your enrollment with the Anthem CCC Plus plan will end. You will receive these services through DMAS or a DMAS Contractor.

- PACE (Program of All Inclusive Care for the Elderly). For more information about PACE, talk to your care coordinator or visit **pace4you.org**.
- You reside in an Intermediate Care Facility for individuals with intellectual and

developmental disabilities (ICF/IID).

- You are receiving care in a Psychiatric Residential Treatment Facility (children under 21). Additional information about Psychiatric Residential Treatment Facility Services is available on the Magellan website at **magellanofvirginia.com** or by calling **800-424-4046**, **TDD 800-424-4048**, or **TTY 711**. You can also call your care coordinator for assistance.
- You reside in a veteran's nursing facility.
- You reside in one of these State long-term care facilities: Piedmont, Catawba, Hiram Davis or Hancock.

12. Services Not Covered by CCC Plus

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

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Cosmetic treatment or surgery
- Daycare, including companion services for the elderly (except in some home- and community-based service waivers)
- Drugs prescribed to treat hair loss or to bleach skin
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by us)
- Medical care other than emergency services, or family planning services, received from providers outside of the network unless authorized by us
- Personal care services (except through some home- and community-based service waivers or under EPSDT)
- Prescription drugs covered under Medicare Part D, including the Medicare copayment
- Private duty nursing (except through some home- and community-based service waivers or under EPSDT)
- Weight loss clinic programs unless authorized
- Care outside of the United States

If you receive non-covered services

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

- Services are medically necessary.
- Services are listed as **Benefits covered through the Anthem CCC Plus plan** in Section 10 of this handbook.
- You receive services by following plan rules.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we will pay

for any medical service or care, you have the right to ask us. You can call Member Services or your care coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Section 15 provides instructions for how to appeal Anthem CCC Plus coverage decisions. You may also call Member Services to learn more about your appeal rights or to obtain assistance in filing an appeal.

13. Member Cost Sharing

There are no copayments for services covered through the CCC Plus program. This includes services that are covered through the Anthem CCC Plus plan or services that are carved-out of the CCC Plus contract. The services provided through the Anthem CCC Plus plan or through DMAS will not require you to pay any costs other than your patient pay towards long-term services and supports. See the **Member patient pay** section below.

CCC Plus does not allow providers to charge you for covered services. We pay providers directly and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. If you receive a bill for a covered service, contact Member Services and they will help you.

If you get services that aren't covered by our plan or covered through DMAS, you must pay the full cost yourself. If you are not sure and want to know if we will pay for any medical service or care, you have the right to ask us. You can call Member Services or your care coordinator to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision. See Section 12 of this handbook for a list of non-covered services.

Member patient pay towards long-term services and supports

You may have a patient pay responsibility towards the cost of nursing facility care and home- and community-based waiver services. A patient pay is required to be calculated for all members who get nursing facility or home- and community-based waiver services. When your income exceeds a certain amount, you must contribute toward the cost of your long-term services and supports. If you have a patient pay amount, you will receive notice from your local Department of Social Services (DSS) of your patient pay responsibility. DMAS also shares your patient pay amount with us if you are required to pay towards the cost of your long-term services and supports. If you have questions about your patient pay amount, contact your Medicaid eligibility worker at the local Department of Social Services.

Medicare members and Part D drugs

If you have Medicare, you get your prescription medicines from Medicare Part D, not from the CCC Plus Medicaid program. CCC Plus does not pay the copayment for the medicines that Medicare Part D covers.

14. Service Authorization and Benefit Determination

Service authorization

There are some treatments, services, and drugs that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called a service authorization. You, your doctor or someone you trust can ask for a service authorization.

If the services you require are covered through Medicare, then a service authorization from us is not required. If you have questions regarding what services are covered under Medicare, please contact your Medicare health plan. You can also contact your Anthem CCC Plus care coordinator.

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

We look at standards of care based on:

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

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

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

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

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

- Behavioral health services — inpatient and outpatient services
- Addiction and Recovery Treatment Services (ARTS)
  - Inpatient substance abuse services
  - Residential substance abuse services
  - Intensive outpatient program
- Care from a provider who's not in our network (see the section **How to get care from out-of-network providers**)
- Certain types of medical supplies and equipment (DME)

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- Court-ordered services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Hospital services, including inpatient services for nonemergency situations and certain outpatient
- Long-term services and supports
  - 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
  - Home health services
- Nurse-midwife services
- Nurse practitioner services
- Organ transplants, such as:
  - Bone marrow and high-dose chemotherapy for members 21 and older diagnosed with breast cancer, leukemia, lymphoma, and myeloma.
  - Liver, heart, and lung medically necessary transplants for members of all ages, including coverage of partial or whole:
    - Orthotropic or heterotopic liver transplantation.
    - Single or double lung or lung lobe transplants for children and adults.
    - Heart and lung transplants for children only.
    - Liver or liver lobe transplants (living or cadaver donor) for children and adults.
  - Pancreas transplants done at the same time as covered kidney transplants (children only).
- Pharmacy services for:
  - Drugs not on our list of covered drugs.
  - Certain drugs on our list when specified.
- Non-emergent inpatient hospitalizations
- Hearing exams and hearing aids if you're 21 or older

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- HEPA-grade air purifier

This list may change. To get the most up-to-date and detailed list of services requiring service authorization, call Member Services. To find out more about how to request approval for these treatments or services, you can contact Member Services at the number below or call your care coordinator.

Service authorizations and continuity of care

If you are new to the Anthem CCC Plus plan, we will honor any service authorization approvals made by DMAS or issued by another CCC Plus plan during the continuity of care period or until the authorization ends if that is sooner. The continuity of care period is 30 days. Refer to Continuity of Care Period in Section 3 of this handbook.

How to submit a service authorization request

You, your doctor, or someone you trust can submit a service authorization request by calling Member Services at the number below. You or your doctor can also ask for an authorization for prescription drugs or pharmacy benefits by emailing authowrkgp-submitmyexceptionreq@anthem.com.

What happens after we get your service authorization request?

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

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

Time frames for service authorization review

We follow National Committee for Quality Assurance service authorization standards and timeframes. We're responsible for deciding how quickly the

authorization is needed depending on the urgency and type of service requested. For standard authorization decisions, we'll provide written notice as quickly as needed, and within fourteen calendar days. For urgent decisions, we'll provide written notice within three calendar days.

Urgent requests include requests for medical or behavioral healthcare or services where waiting fourteen days could seriously harm your health or ability to function in the future. Care or services to help with transitions from inpatient hospital or institutional setting to home are also urgent requests. You or your doctor can ask for an urgent request if you believe that a delay will cause serious harm to your health. For standard or urgent decisions, if the Anthem HealthKeepers Plus plan, you or your provider request an extension, or more information is needed, an extension of up to fourteen additional calendar days is allowed.

For pharmacy services, we must provide decisions by telephone or other telecommunication device within 24 hours.

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

If we need more information to make a decision about your service request, we will:

- Write and tell you and your provider what information is needed. If your request is in an urgent request, we will call you or your provider right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

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

This can be done by calling **855-323-4687** (**TTY 711**) or writing to:

Central Appeals Processing
HealthKeepers, Inc.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

P.O. Box 62429
Virginia Beach, VA 23466-2429

You or someone you trust can file a grievance with us if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a grievance about the way your Anthem CCC Plus plan handled your service authorization request to the State through the CCC Plus Helpline at

844-374-9159 or **TDD 800-817-6608**. Also see **Your right to file a grievance** in Section 15 of this handbook.

Benefit determination

We will notify you with our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you disagree with our decision, you have the right to file an appeal with us. Also see **Your right to appeal** in Section 15 in this handbook.

We will tell you and your provider in writing if your request is denied. A denial includes when the request is approved for an amount that is less than the amount requested. We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain what options for appeals you have if you do not agree with our decision. Also see **Your right to appeal** in Section 15 of this handbook.

Advance notice

In most cases, if we make a benefit determination to reduce, suspend or end a service we have already approved and that you are now getting, we must tell you at least 10 days before we make any changes to the service. Also see **Continuation of benefits** in Section 15 of this handbook.

Post payment review

If we are checking on care or services that you received in the past, we perform a provider post payment review. If we deny payment to a provider for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the Anthem CCC Plus plan even if we later deny payment to the provider.

15. Appeals, State Fair Hearings and Grievances

Your right to appeal

You have the right to appeal any adverse benefit determination (decision) by the Anthem HealthKeepers Plus plan that you disagree with that relates to coverage or payment of services.

For example, you can appeal if we deny:

- A request for a healthcare service, supply, item, or drug that you think you should be able to get **or**
- A request for payment of a healthcare service, supply, item, or drug that we denied

You can also appeal if the Anthem HealthKeepers Plus plan stops providing or paying for all or a part of a service or drug you receive through CCC Plus that you think you still need.

Authorized representative

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

Adverse benefit determination

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision we make to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. Refer to **Service Authorization and Benefit Determination** in Section 14 of this handbook.

How to submit your appeal

If you are not satisfied with a decision we made about your service authorization request, you have 60 calendar days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you.

You can call Member Services at one of the numbers below if you need help filing an appeal or if you need assistance in another language or require an alternate

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

format. We will not treat you unfairly because you file an appeal.

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

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

Send your appeal request by phone at **855-323-4687** (**TTY 711**) or mail to:

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

If you send your standard appeal by phone, it must be followed up in writing. Expedited process appeals submitted by phone do not require you to submit a written request.

Continuation of benefits

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

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

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

What happens after we get your appeal

We will send you a letter to let you know we have received and are working on your appeal. Appeals of clinical matters will be decided by qualified healthcare professionals who did not make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your

case file, including medical records and any other documents and records being used to make a decision on your case. This information is available at no cost to you.

You can also provide information that you want to be used in making the appeal decision in person or in writing. You can reach us at the Member Services number below or send any information to:

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

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

Time frames for appeals

Standard appeals

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

Expedited appeals

If we have all the information we need, expedited appeal decisions will be made within **72 hours** of receipt of your appeal and we will send a written notice and attempt to provide oral notice within this timeframe. If there is a need for additional documentation or if a delay in rendering a decision is in your interest the timeframe for an expedited appeal decision, the timeframe may be increased up to an additional 14 days. You, your provider or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give us to help decide your case. This can be done by calling Member Services or writing to:

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

You or someone you trust can file a grievance with the Anthem HealthKeepers

Plus plan if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a grievance about the way we handled your appeal to the State through the CCC Plus Helpline at

844-374-9159 or **TDD 800-817-6608**.

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

Written notice of appeal decision

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

Your right to a State Fair Hearing

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

If we do not respond to your appeal request timely, DMAS will count this as an exhausted appeal. State fair hearings can be requested for an adverse benefit decision related to Medicaid covered services. You cannot appeal to DMAS for an adverse benefit decision related to extra benefits we provide that are not covered by Medicaid (see Section 10 for a list of extra benefits).

Standard or expedited review requests

For standard requests, appeals will be heard and DMAS will give you an answer generally within 90 days from the date you filed your appeal. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited appeal within 72 hours of receiving the letter from

your doctor.

Authorized representative

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

Where to send the State Fair Hearing request

There are a few ways to ask for an appeal with DMAS. Your deadline to ask for an appeal with DMAS is 120 calendar days from when we issue our final HealthKeepers, Inc. internal appeal decision.

1. **Electronically.** Online at **dmas.virginia.gov/#/appealsresources** or email to appeals@dmas.virginia.gov.
2. **By fax.** Fax your appeal request to DMAS at **804-452-5454**.
3. **By mail or in person.** Send or bring your appeal request to
   Appeals Division, Department of Medical Assistance Services
   600 E. Broad Street
   Richmond, VA 23219
4. **By phone.** Call DMAS at **804-371-8488** (**TTY**: **800-828-1120**).

To help you, an appeal request form is available from DMAS at **dmas.virginia.gov/#/appealsresources.** You can also write your own letter. Include a full copy of our final denial letter when you file your appeal with DMAS. Also include any documents you would like DMAS to review during your appeal. All information submitted during the initial request **and** during the DMAS appeal process will be considered to determine if the individual meets the criteria for approval of the requested eligibility/service(s).

After you file your State Fair Hearing appeal

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

State Fair Hearing time frames

Expedited appeal

If you qualify for an expedited appeal, DMAS will give you an answer to your appeal within 72 hours of receiving the letter from your doctor. If DMAS decides

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

Standard appeal

If your request is not an expedited appeal or if DMAS decides that you do not qualify for an expedited appeal, DMAS will generally give you an answer within 90 days from the date you filed your appeal. You will have an opportunity to participate in a hearing to present your position before a decision is made.

Continuation of benefits

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

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

Your services will continue until you withdraw the appeal, the original authorization period for your service ends or the State Fair Hearing Officer issues a decision that is not in your favor.

You may, however, have to repay us for any services you receive during the continued coverage period if our adverse benefit determination is upheld and the services were provided solely because of the requirements described in this section.

If the State Fair Hearing reverses the denial

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

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

If services were provided while the State Fair Hearing was pending

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

If you disagree with the State Fair Hearing decision

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

Your right to file a grievance

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

Timeframe for grievances

You can file a grievance with us at any time.

What kinds of problems should be grievances?

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

Grievances about quality

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

Grievances about privacy

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

Grievances about poor customer service

- A healthcare provider or staff was rude or disrespectful to you.
- Anthem CCC Plus staff treated you poorly.
- Anthem CCC Plus staff is not responding to your questions.
- You are not happy with the assistance you are getting from your care coordinator.

Grievances about accessibility

- You cannot physically access the healthcare services and facilities in a doctor or provider's office.
- You were not provided requested reasonable accommodations that you needed in order to participate meaningfully in your care.

Grievances about communication access

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

Grievances about waiting times

- You are having trouble getting an appointment or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists or other health professionals, or by Member Services or other Anthem CCC Plus staff.

Grievances about cleanliness

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

Grievances about communications from us

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

There are different types of grievances

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

Internal grievances

To file an internal grievance, call Member Services at the number below. You can also write your grievance and send it to us. If you put your grievance in writing, we will respond to your grievance in writing. You can file a grievance in writing, by mailing or faxing it to us at:

HealthKeepers, Inc.
P.O. Box 62429

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

Virginia Beach, VA 23466-2429
Fax: **800-359-5781**

So that we can best help you, include details on who or what the grievance is about and any information about your grievance. We will review your grievance and request any additional information. You can call Member Services at the number below if you need help filing a grievance or if you need assistance in another language or format. We will notify you of the outcome of your grievance within a reasonable time, but no later than 90 calendar days after we receive your grievance. If your grievance is related to your request for an expedited appeal, we will respond within 24 hours after the receipt of the grievance.

External grievances

You can file a grievance with the CCC Plus Helpline.

You can file a grievance about the Anthem HealthKeepers Plus plan to the CCC Plus Helpline. Contact the CCC Plus Helpline at **844-374-9159** or TDD **800-817-6608**.

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

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

You may contact the local Office for Civil Rights office at:

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
You may call us at:
800-368-1019
Fax: **215-861-4431**
TDD: **800-537-7697**

You can file a grievance with the Office of the State Long-Term Care Ombudsman.

The State Long-Term Care Ombudsman serves as an advocate for older persons receiving long-term care services. Local ombudsmen provide older Virginians and their families with information, advocacy, grievance counseling, and assistance in resolving care problems.

The State's Long-Term Care Ombudsman program offers assistance to persons receiving long-term care services, whether the care is provided in a nursing facility, assisted living facility or through community-based services to assist persons still living at home.

A Long-Term Care Ombudsman does not work for the facility, the State, or the Anthem HealthKeepers Plus plan. This helps them to be fair and objective in resolving problems and concerns. The program also represents the interests of long-term care consumers before state and federal government agencies and the General Assembly.

The State Long-Term Care Ombudsman can help you if you are having a problem with the Anthem HealthKeepers Plus plan or a nursing facility. The State Long-Term Care Ombudsman is not connected with us or with any insurance company or health plan. The services are free.

You can reach the State Long-Term Care Ombudsman any of the ways below:

- **800-552-5019** (This call is free.)
- **800-464-9950** (This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.)

- By mail or in person to:

Virginia Office of the State Long-Term Care Ombudsman
Virginia Department for Aging and Rehabilitative Services
8004 Franklin Farms Drive
Henrico, VA 23229
804-662-9140
elderrightsva.org

16. Member Rights

Your rights

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

- Receive timely access to care and services.
- Take part in decisions about your healthcare, including your right to choose your providers from Anthem CCC Plus network providers and your right to refuse treatment.
- Choose to receive long-term services and supports in your home or community or in a nursing facility.
- Confidentiality and privacy about your medical records and when you get treatment.
- Receive information and to discuss available treatment options and alternatives presented in a manner and language you understand and regardless of cost or benefit coverage.
- Get information in a language you understand. You can get oral translation services free of charge.
- Receive reasonable accommodations to ensure you can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services.
- Receive information necessary for you to give informed consent before the start of treatment.
- Be treated with respect and dignity, in recognition of your right to privacy.
- Get a copy of your medical records and ask that the records be amended or corrected.
- Participate in decisions regarding your healthcare, including the right to refuse treatment.
- Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to you or others or when there is a specific medical necessity. Seclusion and restraint will never be used as a means of coercion, discipline, retaliation, or convenience.
- Get care in a culturally competent manner including without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status, or religion.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- Be informed of where, when and how to obtain the services you need from your Anthem CCC Plus plan, including how you can receive benefits from out-of-network providers if the services are not available in the Anthem CCC Plus network.
- Complain about the Anthem HealthKeepers Plus plan to the State. You can call the CCC Plus Helpline at **844-374-9159** (**TDD 800-817-6608**) to file a grievance about us.
- Appoint someone to speak for you about your care and treatment and to represent you in an appeal.
- Make advance directives and plans about your care in the instance that you are not able to make your own healthcare decisions. See Section 17 of this handbook for information about advance directives.
- Change your CCC Plus health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference Section 2 of this handbook, call the CCC Plus Helpline at **844-374-9159** (**TDD 800-817-6608**) or visit the website at **cccplusva.com** for more information.
- Appeal any adverse benefit determination (decision) by the Anthem HealthKeepers Plus plan that you disagree with that relates to coverage or payment of services. See **Your right to appeal** in Section 15 of the handbook.
- File a grievance about any concerns you have with our customer service, the services you have received, or the care and treatment you have received from one of our network providers. See **Your right to file a grievance** in Section 15 of this handbook.
- To receive information from us about our plan, your covered services, providers in our network, and about your rights and responsibilities.
- To make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this section of the handbook).
- Exercise your rights and to know that you will not have any retaliation against you by Anthem HealthKeepers Plus, any of our doctors/providers or state agencies.

Your right to be safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers, and by others responsible for their

well-being.

If you or someone you know is being abused physically, is being neglected, or is being taken advantage of financially by a family member or someone else, you should call your local Department of Social Services or the Virginia Department of Social Services' 24-hour, toll-free hotline at **888-832-3858**. You can make this call anonymously. You do not have to provide your name. The call is free.

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

Your right to confidentiality

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

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

If you're getting treatment for substance use disorder or addiction, we need your written consent to:

- Release any of your records related to your recovery, even if they're needed for your treatment.
- Help you get recovery services as part of ARTS. Your doctor can also send us a written consent if you want to get help for substance use through ARTS.

Your right to privacy

You can find our Notice of Privacy Practices at the end of this book. It includes a list of all your privacy rights and our policies.

How to join the Member Advisory Committee

We would like you to help us improve our health plan. We invite you to join our Member Advisory Committee. On the committee, you can let us know how we can better serve you.

Going to these meetings will give you and your caregiver or family member the chance to help plan meetings and meet other members in the community. These educational meetings are held once every three months. If you would like to attend or would like more information, please contact Anthem CCC Plus Member Services using one of the numbers below.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

We follow non-discrimination policies

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

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

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

Spanish

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

Korean

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

Vietnamese

HealthKeepers, Inc. 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

HealthKeepers, Inc. 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

تمتثل HealthKeepers, Inc. لقوانين الحقوق المدنية الفيدرالية المعمول بها ولا تقوم بالتمييز على أساس العرق أو اللون أو الأصل القومي أو العمر أو الإعاقة أو الجنس.

Tagalog

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

Farsi

HealthKeepers, Inc. 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

የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።

Urdu

HealthKeepers, Inc. قابِل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

French

HealthKeepers, Inc. 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

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

Hindi

लाग ूहोनेयोग्य संघीय नागरक िधकार क़ानन ू का पालन करता ह और जात, रंग, राय म ू ल, आय ु, वकलांगता, या लग केआधार पर भेदभाव नह करता ह।

German

HealthKeepers, Inc. erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Bengali

িাজয্ ফডারল নাযিরক যিধকার আইন অোন আচল এবাং জাত, রঙ, জাতীয় উৎযিত্ত, বয়স, িেতা, বা আলর যভলত্তত বষেয্ আকর না।

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

Bassa

HealthKeepers, Inc. Nyɔ ɓɛ̌ɛ̀ kpɔ̃ nyɔŭn-dyù gbo-gmɔ̀ -gmà ɓɛ̌ɔ̀ dyi ké wa ní ge nyɔŭn-dyù mú dyìin 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 zɔ̃jɔ̃̌ kà nyɔɔ̀ ɖă nyuɛ mú, mɔɔ nyɔɔ̀ mɛ kɔ́ dyíɛ mú, mɔɔ nyɔɔ̀ mɛ mɔ̀ gàa, mɔɔ nyɔɔ̀ mɛ mɔ̀ màa kɛɛ mú.

17. Member Responsibilities

Your responsibilities

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

- Present your Anthem CCC Plus member ID card whenever you seek medical care.
- Provide complete and accurate information to the best of your ability on your health and medical history.
- Participate in your care team meetings, develop an understanding of your health condition, and provide input in developing mutually agreed upon treatment goals to the best of your ability.
- Follow plans and instructions you have agreed to with your care team.
- Keep your appointments. If you must cancel, call as soon as you can.
- Receive all of your covered services from the Anthem CCC Plus network.
- Obtain authorization from the Anthem HealthKeepers Plus plan prior to receiving services that require a service authorization review (see Section 14).
- Call Anthem CCC Plus Member Services whenever you have a question regarding your membership or if you need assistance toll-free at one of the numbers below.
- Tell us when you plan to be out of town so we can help you arrange your services.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after hours.
- Tell us when you believe there is a need to change your plan of care.
- Tell us if you have problems with any healthcare staff. Call Member Services at one of the numbers below.
- Call Member Services at one of the phone numbers below about any of the following:
    - If you have any changes to your name, address, or phone number. Report these also to your case worker at your local Department of Social Services.
    - If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation.
    - If you have any liability claims, such as claims from an automobile accident.
    - If you are admitted to a nursing facility or hospital.
    - If you get care in an out-of-area or out-of-network hospital or emergency room.
    - If your caregiver or anyone responsible for you changes.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

- If you are part of a clinical research study.

Advance directives

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

- Fill out a written form to give someone the right to make healthcare decisions for you if you become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your healthcare if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. An advance directive goes into effect only if you are unable to make healthcare decisions for yourself. Any person age 18 or over can complete an advance directive. There are different types of advance directives and different names for them. Examples are a living will, a durable power of attorney for healthcare, and advance care directive for healthcare decisions. You do not have to use an advance directive, but you can if you want to. Here is what to do:

Where to get the advance directives form

You can get the Virginia Advance Directives form at **virginiaadvancedirectives.org/the-virginia-hospital---healthcares-association--vhha--form.html**. You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicaid 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.

Completing the advance directives form

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

Share the information with people you want to know about it

Give copies to people who need to know about it. You should give a copy of the living will, advance care directive, or power of attorney form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members.

Be sure to keep a copy at home.

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

We can help you get or understand advance directives documents

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

Other resources

You may also find information about advance directives in Virginia at virginiaadvancedirectives.org. You can store your advance directive at the Virginia Department of Health Advance Healthcare Directive Registry: **connectvirginia.org/adr**.

If your advance directives are not followed

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

CALL	Virginia Department of Health Professions: Toll-free phone: **800-533-1560** Local phone: **804-367-4691**
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
FAX	**804-527-4424**
EMAIL	enfcomplaints@dhp.virginia.gov

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

WEBSITE	**dhp.virginia.gov/Enforcement/complaints.htm**

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

CALL	Toll-free phone: **800-955-1819** Local phone: **804-367-2106**
WRITE	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, VA 23233-1463
FAX	**804-527-4503**
EMAIL	OLC-Complaints@vdh.virginia.gov
WEBSITE	**vdh.virginia.gov/licensure-and-certification**

18. Fraud, Waste and Abuse

What is fraud, waste, and abuse?

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

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

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

Common types of healthcare fraud, waste and abuse include:

- Medical identity theft.
- Billing for unnecessary items or services.
- Billing for items or services not provided.
- Billing a code for a more expensive service or procedure than was performed (known as up-coding).
- Charging for services separately that are generally grouped into one rate (unbundling).
- Items or services not covered.
- When one doctor receives a form of payment in return for referring a patient to another doctor. These payments are called “kickbacks.”

How do I report fraud, waste, or abuse?

If you suspect another member or a provider of fraud, waste, or abuse, you should gather as much information as possible and report it. You can report your concerns directly to us by calling **800-368-3580** or writing to:

Government Business Division Special Investigations Unit
HealthKeepers, Inc.
P.O. Box 66407
Virginia Beach, VA 23462

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

Department of Medical Assistance Services Fraud Hotline

Phone: **800-371-0824**, **866-486-1971** or **804-786-1066**

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

Email: MFCU_mail@oag.state.va.us

Fax: **804-786-3509**

Mail: Office of the Attorney General
Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, VA 23219

Virginia Office of the State Inspector General Fraud, Waste and Abuse Hotline

Phone: **800-723-1615**

Fax: **804-371-0165**

Email: covhotline@osig.virginia.gov

Mail: State FWA Hotline
101 N. 14th Street
The James Monroe Building 7th Floor
Richmond, VA 23219

19. Other Important Resources

Virginia Department for Aging and Rehabilitative Services (DARS) provides resources and services to help with employment, quality of life, security and independence for older and disabled Virginians and their families.

800-552-5019 (**TTY 800-464-9950**)

Virginia Association of Area Agencies on Aging

vaaaa.org

The Virginia Department for the Deaf and Hard of Hearing (VDDHH)

The Technology Assistance Program (TAP) provides telecommunication equipment to qualified applicants whose disabilities prevent them from using a standard telephone. VDDHH outreach specialists can also provide information and referral for assistive technology devices.

804-662-9502 (Voice/TTY)
800-552-7917 (Voice/TTY)
Fax: **804-662-9718**
1602 Rolling Hills Drive, Suite 203
Richmond, VA 23229-5012

vddhh.org

20. Information for Medicaid expansion members

What makes you eligible to be a Medicaid expansion member?

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

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

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at **833-5CALLVA** or **TDD**: **888-221-1590** about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at **coverva.org.**

Enrollment for a Medicaid expansion member

Within three months after you enroll with the Anthem HealthKeepers Plus plan, a health plan 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. If you don't meet the medically complex criteria, you may transfer from CCC Plus to the Medicaid Managed Care Medallion 4.0 program. If we're unable to contact you, or you refuse to participate in the entire health screening, you may be transferred to the Medallion program. You'll stay with the Anthem HealthKeepers Plus plan no matter which program you are in. If you prefer to change health plans, you can change within the first 90 days of enrolling into the Medallion 4.0 program. For more information on the Health Screening, see section 4.

If you do not meet medically complex criteria and do not agree, you have a right to submit a grievance to us. See the Your Right to File a Grievance section for details. You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between November 1st and December 31st. You will get a letter from DMAS during open enrollment with more information.

You may also ask to change your health plan at any time for "good cause," which

can include:

- You move out of the health plan's service area
- You need multiple services provided at the same time but cannot access them within the health plan's network
- Your residency or employment would be disrupted as a result of your residential, institutional, or employment supports provider changing from an in-network to an out-of-network provider
- Other reasons determined by DMAS, including poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care.
- You do not meet medically complex criteria and transfer to the Medallion 4.0 Medicaid Managed Care program.

The CCC Plus Helpline handles good cause requests and can answer any questions you may have. Contact the CCC Plus Helpline at **844-374-9159** or **TDD 800-817-6608**, or visit the website at **cccplusva.com**.

Medicaid expansion benefits and services

As a Medicaid expansion member, you have a variety of healthcare benefits and services available to you. You will receive most of your services through us, but may receive some through DMAS or a DMAS Contractor.

- Services provided through the Anthem HealthKeepers Plus plan are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 10.
- Services covered by DMAS or a DMAS Contractor are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 11.
- Services that are not covered through the Anthem HealthKeepers Plus plan or DMAS are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 12.

If you're an eligible Medicaid expansion member, in addition to the services listed above (in the same amount, duration, and scope of services as other CCC Plus Program Members) you will also receive the following three additional health benefits:

- Annual adult wellness exams
- Nutritional counseling if you are diagnosed with obesity or chronic medical diseases

- Recommended adult vaccines or immunizations

We'll also encourage you to take an active role in your health. For more information, see the Healthy Rewards section below. If you frequently visit the emergency room, we'll reach out to you to help you address your needs. There may be opportunities to address your needs outside of the emergency room, like in physician offices and clinics.

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

21. Healthy Rewards program

Our Healthy Rewards program rewards you for doing things that are good for your health. You can earn gift cards for doing things like getting your flu shot or going for a checkup. To enroll in Healthy Rewards and see which activities you qualify for, log in to your secure account at **anthem.com/vamedicaid** and visit the Benefit Reward Hub to navigate to the Healthy Rewards portal. Or to find out more about the Healthy Rewards program, you can also call **888-990-8681** (**TTY 711**), Monday through Friday from 9 a.m. to 8 p.m. Eastern time.

Check the list below and see which healthy activities you may qualify for.

Healthy activity	**Age range of eligible members**	**Reward**	**Limit**
High-blood pressure medicine refill	18 to 75	$10, max $40	Four per year, once per quarter
Lead screening	0 to 2	$25	One per member
Childhood wellness visit	3 to 21	$25	One per 12 months
Childhood immunizations	0 to 1	$25	One per member (stops at 2nd birthday)
Adolescent immunizations	11 to 12	$25	One per member (stops at 13th birthday)
Human papillomavirus (HPV) vaccine	11 to 13	$25	One per member
Adult wellness visit	22 and older	$25	One per 12 months
Breast cancer screening	50 to 74	$50	One per 24 months
Chlamydia screening	16 to 24	$25	One per 12 months

Cervical cancer screening	21 to 64	$50	One per 36 months
Diabetic retinal eye exam	18 to 75	$25	One per 12 months
Diabetic A1c screening	18 to 75	$25	One per 12 months
Diabetes management quiz	18 to 75	$5	One per 12 months
Being discharged from the ER	18 and older	$25	Three per 12 months
Institutional care program completion	18 and older	$25	One per member
30-day follow-up after behavioral health discharge	6 and older	$25	Three per 12 months
Flu shot	18 and older	$10	One per 12 months
Colorectal screening	50 to 74	$50	One per 36 months
Vaccination importance quiz	0 to 2	$5	One per 12 months

Limits and restrictions may apply.

To find out more about the Healthy Rewards program and enroll, call **888-990-8681** (**TTY 711**) or visit us online at **anthem.com/vamedicaid.** You must enroll in the program before completing the healthy activities to earn rewards.

22. Important Words and Definitions Used in this Handbook

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

- Coinsurance: See the definition for cost sharing.
- Copayment: See the definition for cost sharing.
- Cost sharing: The costs that members may have to pay out of pocket for covered services. This term generally includes deductibles, coinsurance, and copayments, or similar charges. Also see the definition for patient pay.
- Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services.
- Covered drugs: The term we use to mean all of the prescription drugs covered by your Anthem CCC Plus plan.
- Covered services: The general term we use to mean all of the healthcare, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by your Anthem CCC Plus plan.
- Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs or hospital beds.
- Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to your health or the health of your unborn baby.
- Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.
- Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.
- Emergency services: Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.
- Excluded services: Services that are not covered under the Medicaid benefit.
- Fair hearing: See State Fair Hearing. The process where you appeal to the State on a decision made by us that you believe is wrong.
- Fee-for-service: The general term used to describe Medicaid services covered by the Department of Medical Assistance Services (DMAS).

- Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.
- Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.
- Habilitation services and devices: Services and devices that help you keep, learn, or improve skills and functioning for daily living.
- Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.
- Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.
- Health Risk Assessment (HRA): A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.
- Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.
- Home healthcare: Healthcare services a person receives in the home including nursing care, home health aide services and other services.
- Hospice services: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- Hospitalization: The act of placing a person in a hospital as a patient.
- Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.

- List of covered drugs (drug list): A list of prescription drugs covered by the Anthem CCC Plus plan. The drugs on the Anthem CCC Plus drug list are chosen with the help of doctors and pharmacists. The drug list tells you if there are any rules you need to follow to get your drugs. The drug list is sometimes called a "formulary."
- Long-term services and supports (LTSS): A variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives and maintain maximum independence. Examples include assistance with bathing, dressing, toileting, eating and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital.
- Medicaid (or Medical Assistance): A program run by the federal and the state government that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Most healthcare costs are covered if you qualify for both Medicare and Medicaid.
- Medically necessary: This describes the needed services to prevent, diagnose or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.
- Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through original Medicare or a managed care plan (see "Health plan").
- 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.

- Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."
- 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 (like lab tests, surgeries and doctor 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. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid.
- Member Services: An Anthem CCC Plus department responsible for answering your questions about your membership, benefits, grievances and appeals.
- Model of care: A way of providing high-quality care. The CCC Plus model of care includes Care coordination and a team of qualified providers working together with you to improve your health and quality of life.
- Network: "Provider" is the general term we use for doctors, nurses and other people who give you services and care. The term also includes hospitals, home health agencies, clinics and other places that provide your healthcare services, medical equipment and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide healthcare services. We call them "network providers" when they agree to work with the Anthem CCC Plus plan and accept our payment and not charge our members an extra amount. While you are a member of the Anthem CCC Plus plan, you must use network providers to get covered services. Network providers are also called "plan providers."

- Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for Anthem CCC Plus members. We call them "network pharmacies" because they have agreed to work with us. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- Non-participating provider: A provider or facility that is not employed, owned or operated by the Anthem CCC Plus plan and is not under contract to provide covered services to members of the Anthem CCC Plus plan.
- Nursing facility: A medical care facility that provides care for people who cannot get their care at home but who do not need to be in the hospital. Specific criteria must be met to live in a nursing facility.
- Ombudsman: An office in your state that helps you if you are having problems with the Anthem HealthKeepers Plus plan or with your services. The ombudsman's services are free.
- Out-of-network provider or out-of-network facility: A provider or facility that is not employed, owned or operated by the Anthem HealthKeepers Plus plan and is not under contract to provide covered services to Anthem CCC Plus members.
- Participating provider: Providers, hospitals, home health agencies, clinics and other places that provide your healthcare services, medical equipment and long-term services and supports that are contracted with the Anthem HealthKeepers Plus plan. Participating providers are also "in-network providers" or "plan providers."
- Patient pay: The amount you may have to pay for long-term care services based on your income. The Department of Social Services (DSS) must calculate your patient pay amount if you live in a nursing facility or receive CCC Plus waiver services and have an obligation to pay a portion of your care. DSS will notify you and the Anthem HealthKeepers Plus plan if you have a patient pay, including the patient pay amount (if any).
- Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery or behavioral health.

- Plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.
- Premium: A monthly payment a health plan receives to provide you with healthcare coverage.
- Prescription drug coverage: Prescription drugs or medications covered (paid) by your plan. Some over-the-counter medications are covered.
- Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.
- Primary care physician (PCP): Your primary care physician (also referred to as your primary care provider) is the doctor who takes care of all of your health needs. They are responsible to provide, arrange and coordinate all aspects of your healthcare. Often they are the first person you should contact if you need healthcare. Your PCP is typically a family practitioner, internist or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.
- Private duty nursing services: Skilled in-home nursing services provided by a licensed RN, or by an LPN under the supervision of an RN, to waiver members who have serious medical conditions or complex healthcare needs.
- Prosthetics and orthotics: These are medical devices ordered by your doctor or other healthcare provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.
- Provider: A person who is authorized to provide your healthcare or services. Many kinds of providers participate with the Anthem CCC Plus plan, including doctors, nurses, behavioral health providers and specialists.
- Referral: In most cases you PCP must give you approval before you can use other providers in the Anthem CCC Plus network. This is called a referral.
- Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, injury or major operation.
- Service area: A geographic area where a plan is allowed to operate. It is also generally the area where you can get routine (non-emergency) services.

- Service authorization: Also known as preauthorization. Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from the Anthem HealthKeepers Plus plan.
- Skilled nursing care: Care or treatment that can only be done 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 nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.
- Specialist: A doctor who provides healthcare for a specific disease, disability or part of the body.
- Urgently needed care (urgent care): Care you get for a non-life-threatening sudden illness, injury or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Anthem CCC Plus Member Services

CALL	**855-323-4687** Calls to this number are free. Monday through Friday from 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Monday through Friday from 8 a.m. to 8 p.m.
FAX	**800-359-5781**
WRITE	HealthKeepers, Inc. P.O. Box 27401 Mail Drop VA2002-N500 Richmond, VA 23279 Send us a message by logging in to your secure account on our website below.
WEBSITE	**anthem.com/vamedicaid**

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you:

- **Who can see your protected health information (PHI).**
- **When we have to ask for your OK before we share your PHI.**
- **When we can share your PHI without your OK.**
- **What rights you have to see and change your PHI.**

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 are 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 is 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 cannot 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 it is 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 is 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 will pay for healthcare or services before you get them (called prior authorization or preapproval)
  - To find ways to make our programs better, as well as 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 do not 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 is OK
  - With someone who helps with or pays for your healthcare, if you cannot speak for yourself and it is 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 cannot 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 are asked
- To answer legal documents
- To give information to health oversight agencies for things such as audits or exams
- To help coroners, medical examiners, or funeral directors find out your name and cause of death
- To help when you 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 worker's compensation if you get sick or hurt at work

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 do not 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 do not 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 shared your PHI with someone else. This will not list the times we shared it because of healthcare, payment, everyday healthcare business, or some other reasons we did not 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 we have to do

- The law says we must keep your PHI private except as we 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 will 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, such as if you are in danger.
- We must tell you if we have to share your PHI after you asked us not to.
- If state laws say we have to do more than what we said here, we will 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 vendors, may call or text you using an automatic telephone dialing system 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 will not contact you in this way anymore. Or you may call 844-203-3796 (TTY 711) toll free to add your phone number to our Do Not Call list.

What to do if you have questions
If you have questions about our privacy rules or want to use your rights, please call Member Services toll free at 800-901-0020 (TTY 711) for Medallion Medicaid or 855-323-4687 (TTY 711) for CCC Plus Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

What to do if you have a complaint
We are here to help. If you feel your PHI has not 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.

You may 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 will tell you about the changes in a letter. We also will post them on the web at anthem.com/vamedicaid.

Anthem CCC Plus Member Services: **855-323-4687** (**TTY 711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

Race, ethnicity, and language
We get race, ethnicity, and language information about you from state agencies for Medicaid 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 is 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 such as:
  - Doctors.
  - Hospitals.
  - Other insurance companies.
- We may share PI with people or groups outside of our company without your OK in some cases.
- We will let you know before we do anything where we have to give you a chance to say no.
- We will tell you how to let us know if you do not 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.

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 (Medallion Medicaid, FAMIS); 855-323-4687 (CCC Plus); TTY 711.

anthem.com/vamedicaid

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Revised March 2021.

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

855-323-4687 (TTY 711)

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