COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Medicaid Managed Care Member Handbook

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Table of Contents

Help in Other Languages or Alternate Formats.......7

1. Medicaid Managed Care Plan.......11

Welcome to Virginia Premier in Collaboration with Kaiser Permanente.......11
How to Use This Handbook.......11
Your Welcome Packet.......13
Member ID Card.......13
Provider and Pharmacy Directories.......14
What Is Our Service Area?.......14
List of Covered Drugs.......14
List of Covered and Non-Covered Services.......15
Information About Eligibility.......15
Getting Help Right Away.......15
Member Services.......15
How to Contact Member Services.......15
How Our Member Services Representatives Can Help You:.......16
How to Contact a Care Manager.......16
Medical Advice Line Available 24 Hours A Day, 7 Days A Week.......17
Behavioral Health Crisis Line.......19

2. How Managed Care Works.......21

What Makes You Eligible to be a Member?.......21
What Makes You NOT Eligible To Be A Member?.......21
Third Party Liability.......22
Comprehensive Health Coverage.......22
Enrollment.......23
Health Plan Assignment.......23
Changing Your Health Plan.......23
Automatic Re-Enrollment.......24
What Are the Advantages of Choosing Virginia Premier in Collaboration with Kaiser Permanente?.......24
What is a Health Risk Assessment?.......24
Continuity of Care Period.......25
What If I Have Other Coverage?.......25

3. How to Get Regular Care and Services 26

How to Get Care From A Primary Care Provider (PCP) 26
Provider Directory 26
Choosing Your PCP 26
You can choose to see an Indian Health Care Provider if: 27
If Your Current PCP Is Not in Our Network 27
How to Get Care From Other Network Providers 28
Changing Your PCP 28
Getting an Appointment with Your PCP 28
Appointment Standards 28
Travel Time and Distance Standards 29
Accessibility 30
What If A Provider Leaves The Network? 30
What Types of People and Places Are Network Providers? 30
What Are Network Pharmacies? 31
Services You Can Get Without a Referral or Prior Authorization 31

4. How to Get Specialty Care and Services 32

What are Specialists? 32
How Do I Access A Network Specialist? 32
How to Get Care from Out-Of-Network Providers 33
How to Get Care From Out of State Providers 34

5. How to Get Emergency Care and Services 35

What is an Emergency? 35
What to do in an Emergency? 35
What is a Medical Emergency? 35
What is a Behavioral Health Emergency? 35
Examples of Non-Emergencies 35
If You Have an Emergency When you are Away from Home? 36
What is Covered If You Have an Emergency? 36
After An Emergency 36
If You Are Hospitalized 36
What If It Wasn't A Medical Emergency After All? 37

6. How to Get Urgently Needed Care 39

What is Urgently Needed Care? 39

7. How to Get Prescription Drugs 42

Rules for Virginia Premier's Outpatient Drug Coverage 42
Getting Your Prescriptions Filled 43
List of Covered Drugs 44
Limits for Coverage of Some Drugs 44
Getting Approval in Advance 45
Trying a Different Drug First 45
Quantity Limits 45
Emergency Supply 45
Non Covered Drugs 46
Changing Pharmacies 46
Can You Use Mail-Order Services To Get Your Prescriptions? 47
You may use mail-order services to get prescriptions filled and delivered to your home at no extra cost. You can order your refills online at kp.org. You can also call the EZ Refill number toll-free at 1-800-700-1479 (TTY 703-466-4805) to fill a prescription 24 hours a day, 7 days a week, Monday through Friday, 8 a.m. to 7 p.m. 47
Can You Get a Long-Term Supply of Drugs? 47
Can You Use a Pharmacy that is not in the Network? 47
What is the Patient Utilization Management and Safety (PUMS) Program 47

8. Benefits 49

General Coverage Rules 49
Benefits Covered through Us (Medallion 4.0) 49
Extra Benefits Included in Your Plan 53
What Is Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)? 55
How to Access EPSDT Service Coverage 56
How to Access Early Intervention Service Coverage 56
Foster Care and Adoption Assistance 57
How to Access Maternal and Child Health Services 57
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 57
Enrollment for Newborns 59
How to Access Family Planning Services 59
How to Access Behavioral Health Services 60
How to Access Addiction and Recovery Treatment Services (ARTS) 60
How to Access Non-Emergency Transportation Services 61
Transportation Services Covered by Virginia Premier 61

9. Services Not Covered 63

If You Receive Non-Covered Services 64

10. Services Covered Through Medicaid Fee-For-Service 65

Carved Out services: 65
Services That Will End Your Enrollment 66

11. Services Covered Through FAMIS 67

12. Service Authorization Procedure 96

Service Authorizations Explained 96
Service Authorizations and Transition of Care 98
How to Submit a Service Authorization Request 98
What Happens After Submitting A Service Authorization Request? 98
Timeframes for Service Authorization Review 99
Benefit Determination 100
Continuation of Care 100
Post Payment Review 101

13. Appeals, State Fair Hearings, and Complaints (Grievances) 102

Your Right To Appeal 102
Authorized Representative 102
Adverse Benefit Determination 102
How to Submit Your Appeal 103
Continuation of Benefits 103
What Happens After We Get Your Appeal 104
Timeframes for Appeals 104
Standard Appeals 104
Expedited Appeals 105
If We Need More Information 105
Written Notice of Appeal Decision 105
Your Right to a State Fair Hearing 106
Standard or Expedited Review Requests 106
Authorized Representative 106
Where to Send the State Fair Hearing Request 106
After You File Your State Fair Hearing Appeal 107
State Fair Hearing Timeframes 107

Expedited Appeal 107
Standard Appeal 107
Continuation of Benefits 107
If the State Fair Hearing Reverses the Denial 108
If services were not continued while the State Fair Hearing was pending 108
If services were provided while the State Fair Hearing was pending 108
If You Disagree with the State Fair Hearing Decision 108
Your Right to File a Complaint 108
What Kinds of Problems Should be Complaints 108
Complaints about quality 108
Complaints about privacy 108
Complaints about poor customer service 108
Complaints about accessibility 109
Complaints about communication access 109
Complaints about waiting times 109
Complaints about cleanliness 109
Complaints about communications from us 109
There Are Different Types of Complaints 109
Internal Complaints 109
External Complaints 110
You Can File a Complaint with the Managed Care Helpline 110
You Can File a Complaint with the Office for Civil Rights 110

14. Member Rights 111

Your Rights 111
Your Right to be Safe 112
Your Right to Confidentiality 112
Your Right to Privacy 113
Notice of Privacy Practices 114
USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION 114
Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object 116
MEMBERSHIPS 118
YOUR RIGHTS 118
COMPLAINTS 120
OTHER USES OF MEDICAL INFORMATION 120
CHANGES TO THIS NOTICE 120

How to Join the Member Advisory Committee.....121
We Follow Non-Discrimination Policies.....121

15. Member Responsibilities.....122

Your Responsibilities.....122
Advance Directives.....123
Where to Get the Advance Directives Form.....123
Completing the Advance Directives Form.....123
Share the Information with People You Want to Know About It.....124
We Can Help You Get or Understand Advance Directives Documents.....124
Other Resources.....124
If Your Advance Directives Are Not Followed.....124

16. Fraud, Waste, and Abuse.....126

What is Fraud, Waste, and Abuse.....126
How Do I Report Fraud, Waste, or Abuse.....126

17. Other Important Resources.....128

18. Key Words and Definitions Used in this Handbook.....130

19. Medicaid Expansion Addendum.....136

Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including on-line, large print, braille or audio CD. To request this handbook in an alternate format and/or language call Member Services at 855-249-5025 (TTY 711) and one will be provided within 5 business days.
If you are having difficulty understanding this information, please contact our Member Services staff at 855-249-5025 (TTY 711) for help at no cost to you.
Additionally, Members with alternative hearing or speech communication needs can dial 711 to reach a Telecommunications Relay Services (TRS) operator who will help you reach Kaiser Permanente's Member Services staff. Voice and TRS users can make a 711 call from any telephone anywhere in the United States free of charge.

"If you do not speak English, call us at 855-249-5025 (TTY 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language."

Spanish: Si no habla inglés, llámenos a 855-249-5025 (TTY 711). Tenemos acceso a servicios de intérprete y podemos ayudar a responder sus preguntas en su idioma de forma gratuita. También podemos ayudarle a encontrar un proveedor de atención médica que pueda comunicarse con usted en su idioma.

Korean: 영어로 말할 수 없다면855-249-5025 (TTY 711).로 전화하십시오. 저희는 통역 서비스를 이용할 수 있으며 귀하의

언어로 된 질문에 무료로 답변 할 수 있습니다. 우리는 또한 귀하의 언어로 의사 소통 할 수있는 의료 서비스 제공자를 찾도록 도울 수 있습니다.

Vietnamese: Nếu bạn không nói được tiếng Anh, hãy gọi cho chúng tôi tại 855-249-5025 (TTY 711). Chúng tôi có quyền truy cập vào các dịch vụ phiên dịch và có thể giúp trả lời câu hỏi của bạn trong ngôn ngữ của bạn miễn phí. Chúng tôi cũng có thể giúp bạn tìm thấy một nhà cung cấp chăm sóc sức khỏe người có thể giao tiếp với bạn bằng ngôn ngữ của bạn.

Chinese: 如果您不会说英语，请致电855-249-5025 (TTY 711).。 **我**们可以使用翻译服务，并可以用您的语言免费回答您的问题。 **我**们还可以帮助您找到一个能用您的语言与您沟通的医疗保健提供者。

Arabic: **إذا كنت لا يتjلمون الإنكsرية، اتصل بنا على <1-الثلاثون-الثلاثون1**-855-249-5025 (TTY 711). **الحصول على خدمات مqجم شفوي، ويمكن أن تساعدs الإجابة على أسئلتك باللغة الخاصة بك. يمكننا أيضا مساعدتك العثور على موفر الرعاية الصحxة الذين يمكن التواصل معك باللغة الخاصة بك.**

Tagalog:
kung ikaw ay hindi nagsasalita ng ingles , mo sa amin & lt ; 855-249-5025 (TTY 711). & gt ; . kami ay ng interpreter paglilingkod at makakatulong ang sagot sa tanong na ang wika ng katungkulan . at kami ay tulungan ka ng ng pangangalaga sa kalusugan nagkakaloob na ang pamamahagi sa inyo sa inyong mga wika.

Farsi:

اگر انگ§ی © صحبت با ما تماس بگqید در .(TTY 711) 855-249-5025. ما دسqی به خدمات مqجم شفاهی و سئوالات زبان شما   تواند کمک کند. ما همچن§ن   توانید کمک ارائه دهنده مراقبت های بهداشتی است که   تواند ارتباط با شما زبان خود را پیدا کنید.

Amharic: እንግሊዝኛ መናገር የማይችሉ ከሆነ, 855-249-5025 (TTY 711). ይደውሉልን. እኛ የአስተርጓሚ አገልግሎቶች መዳረሻ ያላቸው እና ከክፍያ ነጻ በራስዎ ቋንቋ ውስጥ የእርስዎን ጥያቄዎች መልስ ለማግኘት ይችላሉ. እኛ ደግሞ እንደ እናንተ የእርስዎን ቋንቋ ከአንተ ጋር መገናኘት የሚችል የጤና እንክብካቤ አቅራቢ እንዲያገኙ ሊረዱዎት ይችላሉ.

Urdu: اگر آپ انگریزی نہیں بولتے، تو 855-249-5025 (TTY 711). پر ہمیں کال کریں. ہم مترجم کی خدمات تک رسائی حاصل ہے اور مفت کے انچارج اپنی زبان میں آپ کے سوالات کا جواب دینے میں مدد کر سکتے .ہم نے بھی آپ جو آپ کی زبان میں آپ کے ساتھ بات چیت کر سکتے ایک صحت کی دیکھ بھال فراہم کی تلاش میں مدد کر سکتے ہیں.

French: Si vous ne parlez pas anglais, appelez-nous à 855-249-5025 (TTY 711). Nous avons accès à des services d'interprètes et pouvons vous aider à répondre à vos questions dans votre langue gratuitement. Nous pouvons également vous aider à trouver un fournisseur de soins de santé qui peut communiquer avec vous dans votre langue.

Russian: Если вы не говорите по-английски, позвоните нам по телефону 855-249-5025 (TTY 711). Мы имеем доступ к услугам переводчика и может помочь ответить на ваши вопросы на вашем языке бесплатно. Мы также можем помочь вам найти поставщика медицинских услуг, которые могут общаться с вами на вашем языке.

Hindi: आप अंग्रेजी नहीं बोलते हैं, तो 855-249-5025 (TTY 711). पर कॉल करें। हम दुभाषिया सेवाओं के लिए उपयोग किया है और नि: शुल्क अपनी भाषा में आपके सवालों के जवाब कर सकते हैं। हम यह भी मदद कर सकता है आप एक स्वास्थ्य देखभाल प्रदाता जो आपकी भाषा में आप के साथ संवाद कर सकते हैं।

German: Wenn Sie kein Englisch sprechen, rufen Sie uns unter 855-249-5025 (TTY 711). an. Wir haben Zugang zu Dolmetscherdiensten und können Ihnen helfen, Ihre Fragen in Ihrer Sprache kostenlos zu beantworten. Wir können Ihnen auch helfen, einen Arzt zu finden, der mit Ihnen in Ihrer Sprache kommunizieren kann.

Bengali: আপনি ইংরেজি বলতে পারি না, তাহলে 855-249-5025 (TTY 711)আমাদের সঙ্গে যোগাযোগ করুন. আমরা দোভাষীর পরিষেবাগুলিতে অ্যাক্সেস আছে এবং নিখরচা আপনার ভাষায় আপনার প্রশ্নের উত্তর সাহায্য করতে পারেন. আমরা সাহায্য করতে পারেন একটি স্বাস্থ্যের যত্ন প্রদানকারী যারা আপনার ভাষায় আপনার সাথে যোগাযোগ করতে পারেন.

Portuguese: Se você não fala inglês, ligue para 855-249-5025 (TTY 711). Temos acesso a serviços de intérprete e podemos ajudar a responder às suas perguntas no seu idioma gratuitamente. Também podemos ajudá-lo a encontrar um profissional de saúde que possa se comunicar com você em seu idioma.

1. Medicaid Managed Care Plan

Welcome to Virginia Premier in Collaboration with Kaiser Permanente

Thank you for choosing Virginia Premier as your preferred Medicaid Managed Care plan. Virginia Premier and Kaiser Permanente are joining together in Northern Virginia to offer you expanded access to health care services. Virginia Premier is one of the participating Managed Care organizations serving Virginia. As a Managed Care organization, Virginia Premier covers your medical and behavioral health benefits. With this relationship, Virginia Premier members can receive quality health care services through the Mid-Atlantic Permanente Medical Group, Inc. (MAPMG). We work together to give you the medical care you need.

If you are a new member, we will get in touch with you in the next few weeks to go over some very important information with you. You can ask us any questions you may have or get help making appointments. If you need to speak with us right away or before we contact you, call our Member Services at 1-855-249-5025 (TTY 711) Monday through Friday, 7:30 a.m. to 9 p.m., except holidays; visit our website at kp.org/medicaid/va, or call the Virginia Medicaid Managed Care Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) Monday – Friday, 8:30 a.m. – 6:00 p.m. for help. This handbook is also available on the our website at kp.org/medicaid/va.

What makes our collaboration special is how we coordinate your care

Most of our members in Northern Virginia receive care from the doctors of MAPMG. These doctors have their offices in Kaiser Permanente medical centers, most of which include pharmacy, lab, and X-ray services all under the same roof. This makes getting care simple and easy. This is called "Managed Care."

Our electronic health record system lets you email your doctor, make appointments, read most lab test results, order prescription refills, read about medical conditions, and much more. You can do all this on a computer or smartphone.

Each member has a primary care provider (PCP) who checks your medical and behavioral health needs and provides/directs the services required to meet those needs. Most of the PCPs are MAPMG doctors who practice in our medical centers.

At the end of this handbook, we have included a key words and definitions section, which defines terms that may be new to you. If you have questions about any section of this handbook, contact Member Services at 1-855-249-5025 (TTY 711).

How to Use This Handbook

This handbook will help you understand your benefits and how you can get help from us. This handbook is a health care and member guide that explains health care services, behavioral

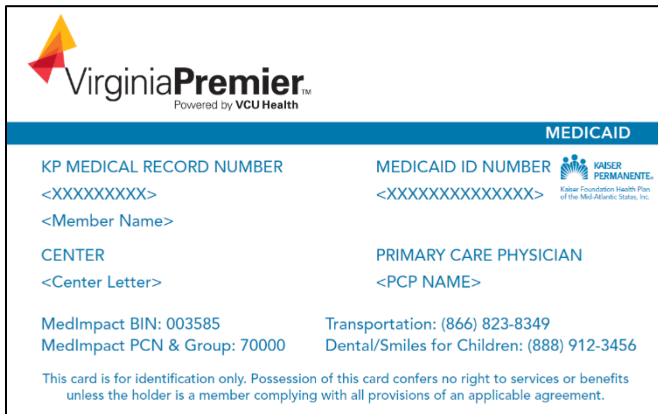
health coverage, prescription drug coverage, and other services and supports covered under the program. This guide will help you take the best steps to make our health plan work for you.

Feel free to share this handbook with a family member or someone who knows your health care needs. When you have a question or need guidance, please check this handbook, call our Member Services at 1-855-249-5025 (TTY 711), visit our website at kp.org/medicaid/va, or call Virginia Medicaid Managed Care Helpline free of charge at 1-800-643-2273 (TTY: 1-800-817-6608) Monday – Friday, 8:30 a.m. – 6:00 p.m.

Your Welcome Packet

Member ID Card

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



kp.org 3100 - VA PREMIER MEDALLION

If you have a medical emergency, call 911 or go to the nearest emergency room.

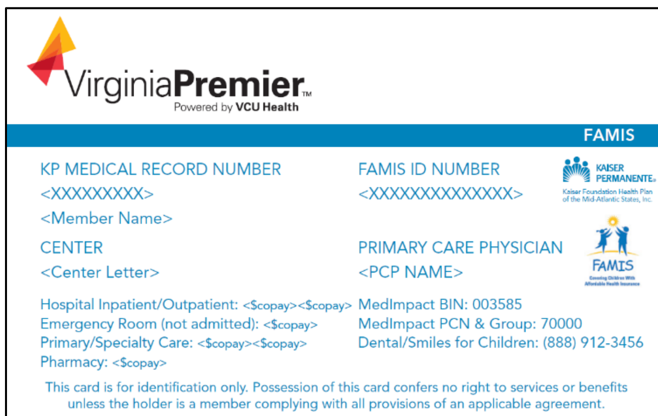
Medical Advice/Appts/Cancel Appts (24 hours a day) **TTY**
Northern Virginia (703) 359-7878 711
Outside Northern Virginia (800) 777-7904 711

If you are unsure of your condition and require immediate medical advice, call (800) 677-1112.

Member Services Contact Center: **TTY**
Northern Virginia and toll free (855) 249-5025 711
Pharmacy Helpdesk (800) 788-2949 711
Behavioral Health Access Line (866) 530-8778 711

Claims for services must be submitted to:
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
PO Box 371860, Denver, CO 80237-9998

Providers: For authorizations, contact Utilization Management at (800) 810-4766.
Call Medical Advice as soon as possible after you have an emergency hospital admission.



kp.org 3100 - VA PREMIER FAMIS

If you have a medical emergency, call 911 or go to the nearest emergency room.

Medical Advice/Appts/Cancel Appts (24 hours a day) **TTY**
Northern Virginia (703) 359-7878 711
Outside Northern Virginia (800) 777-7904 711

If you are unsure of your condition and require immediate medical advice, call (800) 677-1112.

Member Services Contact Center: **TTY**
Northern Virginia and toll free (855) 249-5025 711
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PO Box 371860, Denver, CO 80237-9998

Providers: For authorizations, contact Utilization Management at (800) 810-4766.
Call Medical Advice as soon as possible after you have an emergency hospital admission.

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

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

Provider and Pharmacy Directories

You should have received information about our Provider and Pharmacy Directories. These directories list the providers and pharmacies that participate in Virginia Premier in collaboration with Kaiser Permanente's network. While you are a member of our plan, and in most cases, you must use one of our network providers to get covered services.

You may ask for a paper copy of our Provider and Pharmacy Directory by calling Member Services at the number at the bottom of the page. You can also see or download the Provider and Pharmacy Directory at kp.org/medicaid/va.

For help locating a provider, you can use our online provider directory at: kp.org/doctor. The provider directory includes names of doctors, pharmacies, hospitals, labs, radiology, behavioral health, and other health care providers and facilities in your area.

What Is Our Service Area?

Our service area includes these cities and counties:

- Alexandria
- Arlington County
- Fairfax
- Fairfax County
- Falls Church
- Loudoun County
- Manassas
- Manassas Park
- Prince William County

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 Department of Medical Assistance Services (DMAS) asking you to choose a new plan. You can also call the Managed Care Helpline if you have any questions about your health plan enrollment. Contact the Managed Care Helpline at 1-800-643-2273 or visit the website at virginiamanagedcare.com.

List of Covered Drugs

We cover drugs on the preferred drug list. The preferred drug list is approved and updated regularly by our doctors, pharmacists, and other health care professionals. This list allows us to

choose drugs that are safe and effective.

If you would like to check on the coverage of a specific drug, please contact Member Services at 1-855-249-5025 (TTY 711). You may get a copy of the Preferred Drug List at kp.org/formulary or by calling Member Services.

For more information on covered drugs, see section 7, "How to Get Prescription Drugs," on page 45.

List of Covered and Non-Covered Services

See Section 8 of this handbook or you can access or download our Covered Services at kp.org/medicaid/va or receive a printed copy by calling 1-855-249-5025 (TTY 711).

See Transition of Care Period in section 2 of this handbook.

Information About Eligibility

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

Getting Help Right Away

Member Services

Our Member Services staff are available to help you if you have any questions about your benefits, services, or procedures or have a concern about us.

How to Contact Member Services

Call	1-855-249-5025 This call is free.

TTY	711 This call is free. Monday-Friday, except holidays, 7:30 a.m.- 9 p.m. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Write	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Attn: Appeals and Correspondence Unit 2101 E. Jefferson St. Rockville, MD 20852
Website	kp.org/medicaid/va

How Our Member Services Representatives Can Help You:

- Answer questions about your health plan
- Answer questions about claims, billing or Member ID Cards
- Assistance finding or checking to see if a doctor is in our network
- Assistance with changing your Primary Care Provider (PCP)
- Help you understand your benefits and covered services including the amount that we will pay so that you can make the best decisions about your health care.
- Appeals about your health care services (including prescriptions). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
- Complaints about your health care services (including prescriptions). You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you received from us to the Managed Care Helpline at 1-800-643-2273.

How to Contact a Care Manager

Care Management Services

Sometimes there are health conditions beyond your control. You may need a little help, but you do not know where to turn. Our medical assistance program can support you with Care Management Services.

Who can participate in Care Management?

You are encouraged to participate if:

- You have been hospitalized or have used the emergency room several times
- You have a chronic or life-threatening illness
- You have a high-risk pregnancy
- You have children with special health care needs

What does the program include?

- A Registered Nurse care manager who determines your needs
- Referrals to community resources, specialists, counseling and a Social Worker
- Educational materials
- Follow-up calls and home visits will be scheduled, as needed

How do I get more information?

CALL	1-866-223-2347. This call is free. This line is monitored Monday through Friday 8 a.m. to 4:30 p.m. We have free interpreter services for people who do not speak English.
TTY	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. This call is free. Reach us Monday through Friday, 8 a.m. to 4:30 p.m.

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

You can reach a nurse or behavioral health professional 24 hours a day, 7 days a week to answer your questions toll-free at: 1-800-777-7904 (TTY 711)

If you would like to leave a nonurgent message for a medical advice nurse, you can do so at kp.org if you are registered. You will receive an answer within one business day.

CALL	1-800-777-7904 This call is free. Available 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Behavioral Health Crisis Line

If you are having an emotional crisis, family crisis, or are having suicidal thoughts, talking to someone may help. Contact us if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call 1-866-530-8778. If your symptoms include thoughts about harming yourself or someone else, you should:

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

CALL	1-866-530-8778 (TTY: 711) This call is free. Available 24 hours a day, 7 days a week Members should call their local relay number (1-800-201-7165 or 1-800-828-1140) and then provide the following number: 1-855-632-8278. This call is free. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Smiles for Children through DentaQuest, DMAS Dental Benefits Administrator	For questions or to find a dentist in your area, call *Smiles for Children* at 1-888-912-3456. Information is also available on the DMAS website at: http://www.dmas.virginia.gov/#/dentalservices or the DentaQuest website at: http://www.dentaquestgov.com/
Transportation	Call LogistiCare at: 1-866-823-8349 You must call at least three business days before your visit or we will not be able to guarantee that a ride will be available. We must approve the service.

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

2. How Managed Care Works

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

What Makes You Eligible to be a Member?

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

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

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

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

What Makes You NOT Eligible To Be A Member?

- You would not be able to participate if any of the following apply to you:
- You lose Medicaid eligibility.
- You do not meet one of the eligible categories above
- You meet exclusionary criteria 12VAC30-120-370
- You are hospitalized at the time of enrollment
- You are enrolled in a Home and Community Based (HCBS) waiver

- You are admitted to a free standing psychiatric hospital
- You are receiving care in a Psychiatric Residential Treatment Level C Facility (children under 21)
- You meet the criteria for another Virginia Medicaid program
- Hospice
- Virginia Birth-Related Neurological Injury Compensation Act

Third Party Liability

Comprehensive Health Coverage

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

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

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

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

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

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

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

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

1. Those services federally required to be provided at public expense as is the case for
    a. assessment/EI evaluation,
    b. development or review of the Individual Family Service Plan (IFSP); and,
    c. targeted case management/service coordination;

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

Enrollment

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

Health Plan Assignment

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

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

Changing Your Health Plan

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

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

Automatic Re-Enrollment

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

What Are the Advantages of Choosing Virginia Premier in Collaboration with Kaiser Permanente?

Some of the advantages include:

- Access to our Care Managers. Our Care Manager works with you and with your providers to make sure you get the care you need.
- Control over your care with help from our care team and Care Managers.
- Care team and Care Managers who work with you to come up with a care plan specifically designed to meet your health needs.
- An on-call nurse or other licensed staff available 24 hours a day, 7 days a week to answer your questions. We are here to help you. You can reach us by calling 1-800-777-7904 (TTY 711) at any time.

We work to improve the quality of health by focusing on:

- Preventive measures: supporting your health and keeping you from getting sick in the first place.
- Early intervention: if you do get sick, tackling the problem right away, hopefully while it's still small.
- Chronic care management: assisting members who have persistent health issues like heart disease or diabetes and showing them how to reduce the problems these conditions can cause in everyday life.

What is a Health Risk Assessment?

Within the first few weeks after you enroll with us**,** a Care Manager will reach out to you to ask you some questions about your needs and choices. They will talk with you about any medical, behavioral, physical, and social service needs that you may have. This meeting may be in-person or by phone and is known as a health risk assessment (HRA). A HRA is a very complete assessment of your medical, psychosocial, cognitive, and functional status. The HRA is generally completed by a Care Manager within the first 30 to 60 days of your enrollment with Virginia Premier depending upon the type of services that you require. This health risk assessment will enable your Care Manager to help you get the care that you need.

Continuity of Care Period

If we are new for you, you can keep previously authorized and/or scheduled doctor's appointments and prescriptions for the first 30 days. If your provider is not currently in our network, then you may be asked to select a new provider that is in our provider network. If your doctor leaves our network, we will notify you within 15 days so that you have time to select another provider. This applies to any Behavioral Health and Substance Abuse Treatment authorizations as well. Please reach out to our Member Services for assistance with transferring your care to an in-network provider.

What If I Have Other Coverage?

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

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

3. How to Get Regular Care and Services

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

- Your care must be medically necessary.
- The services you get must be needed:
  - To prevent, or diagnose and correct what could cause more suffering, or
  - To deal with a danger to your life, or
  - To deal with a problem that could cause illness, or
  - To deal with something that could limit your normal activities.

How to Get Care From A Primary Care Provider (PCP)

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

Provider Directory

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

Choosing Your PCP

It is important for you to have a PCP. When you enroll with us, we will assign you a PCP. If you do not want the PCP we have assigned you, you can change PCPs at any time by calling

Member Services. When you see a PCP regularly, you will get consistent, personalized care. The PCP helps you stay healthy and treats you when you are sick. This doctor is responsible for coordinating your health care, including any hospital or specialty care that is needed.

If you do not have a PCP, we can help you find a highly-qualified PCP in in your community. For help locating a provider you can use our on-line provider directory at: kp.org/doctor.

You may want to find a doctor:

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

If you have a disabling condition or chronic illness you can ask us if your specialist can be your PCP. Another clinic can also act as your PCP if the clinic is a network provider.

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

If you do not select a PCP by the 25th of the month before the effective date of your coverage, we will auto-enroll you with a PCP. We will notify you in writing of the assigned PCP. You will need to call the Member Services number at the bottom of the page to select a new PCP. 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, you can use our online provider directory found at: kp.org/doctor, or call Member Services for assistance.

You can choose to see an Indian Health Care Provider if:

- You are an Indian (Native American), and
- The Indian Health Care Provider is with a tribe recognized by the Federal government, and
- The Indian Health Care Provider is able to provide the necessary services.

If Your Current PCP Is Not in Our Network

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

How to Get Care From Other Network Providers

Our provider network includes access to care 24 hours a day 7 days per week and includes hospitals, doctors, specialists, urgent care facilities, nursing facilities, home and community based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health and hospice providers, durable medical equipment providers, and other types of providers. We provide you with a choice of providers and they are located so that you do not have to travel very far to see them. There may be special circumstances where longer travel time is required; however, that should be only on rare occasions.

Changing Your PCP

You may call Member Services to change your PCP at any time to another PCP in the network. Please understand that it is possible your PCP will leave the network. We will tell you within 30 days of the provider's intent to leave the network. We are happy help you find a new PCP. The change will be effective immediately upon request and a new insurance card will be issued in 7 -10 business days.

Changing your PCP or ob-gyn

You may change your PCP or ob-gyn at any time for any reason. Simply:

- Visit kp.org or
- Call Member Services at 1-855-249-5025 (TTY 711)

Getting an Appointment with Your PCP

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

Appointment Standards

You should be able to get an appointment with your PCP within the same amount of time as any other patient seen by the PCP.

Online

Using the Medical Record Number on your ID card, register on kp.org, where you can make routine appointments 24 hours a day, 7 days a week.

By phone

Call appointment staff, Monday through Friday, 7 a.m. to 8 p.m., at 800-777-7904 (TTY 711).

If you have a participating provider as your doctor, call that doctor's office directly to make an appointment.

You need your Medical Record Number on your ID card to make an appointment. If your doctor is not available on the day and time you need, you can ask for an appointment with another doctor.

Expect the following times to see a provider:

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

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

- First trimester (first 3 months) - Within seven (7) calendar days of request.
- Second trimester (3 to 6 months) - Within seven (7) calendar days of request.
- Third trimester (6 to 9 months) - Within three (3) business days of request.
- High Risk Pregnancy - Within three (3) business days or immediately if an emergency exists.
- If you are unable to receive an appointment within the times listed above, call Member Services at the number below and they will help you get the appointment.

Travel Time and Distance Standards

Virginia Premier will provide you with the services you need within the travel time and distance standards described in the table below. These standards apply for services that you travel to receive from network providers. These standards do not apply to providers who provide services to you at home. If you live in an urban area, you should not have to travel more than 30 miles or 30 minutes to receive services. If you live in a rural area you should not have to travel more than 60 miles or 60 minutes to receive services.

Member Travel Time & Distance Standards		
Standard	**Distance**	**Time**
Urban		
• PCP	15 Miles	30 Minutes
• Specialists	30 Miles	30 Minutes

Rural • PCP • Specialists	 30 Miles 60 Miles	 60 Minutes 60 Minutes

Accessibility

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

What If A Provider Leaves The Network?

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out one of your providers is leaving our plan, please contact your Care Manager so we can assist you in finding a new provider and managing your care.

What Types of People and Places Are Network Providers?

Our network providers include:

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

What Are Network Pharmacies?

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

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.

Services You Can Get Without a Referral or Prior Authorization

In most cases, you will need an approval from your PCP before seeing other providers. This approval is called a referral. You can get services like the ones listed below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers.
- Family Planning Services and Supplies.
- Routine women's health care services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral.
- Post Stabilization Care. Following an emergency, you may need further care to stabilize (steady) your condition. If this care is medically necessary, we will cover it, even if it is outside of our network. And you won't need to get any prior approval from us.

4. How to Get Specialty Care and Services

What are Specialists?

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

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

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

How Do I Access A Network Specialist?

Every member must select a PCP who assumes responsibility for the management of the member's health care needs. An Obstetrician may assume care for a member during pregnancy, but generally will be referred back to the PCP for health care issues unrelated to the pregnancy.

If a PCP determines that a member requires the services of a specialist or other treatment that they are unable to provide, then the PCP must make a recommendation to the appropriate specialist for the services.

Pre-authorization is required for services including, but not limited to, the following:

- All inpatient hospitalizations (and extensions beyond original LOS)
- Observation admission (Most in or out of network facilities do not require an authorization)
- Chemotherapy
- Chiropractic (This is a FAMIS Benefit Only)
- Cosmetic Surgery (e.g. Keloid & Scar Revisions, Varicose Veins, Mammoplasty, Reduction and Augmentation)
- Durable Medical Equipment (DME)(Includes Orthotics and Prosthetics when applicable*)
- Enteral Nutrition* and Total Parenteral Nutrition

- Health Education & Training Services
- Home Health Services
- Hyperbaric Therapy
- Infusion Services
- Organ Transplant
- Outpatient Surgical Procedures done in a Hospital/Ambulatory Surgical Setting
- Out of Network Referrals
- Pain Management (e.g. joint injection, spinal cord stimulator)
- Rehab Therapy (e.g., Physical Therapy, Occupational Therapy)
- Radiological
- Radiation Therapy
- Specialty Drugs
- Second opinion to receive specialty care

*Age Requirements

How to Get Care from Out-Of-Network Providers

If a Member requires Specialist services and a Participating Specialist is not available, the PCP shall obtain authorization from us to refer member to a non-participating specialist. Referrals to non-participating specialists are permitted only if the required specialty service is not available through the network and the service is pre-authorized by the Plan.

If we do not have a specialist in the network to provide the care you need, we will get you the care you need from a specialist outside of the network. We will also get you care outside of the 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 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 network does not, because of moral or religious objections, furnish the service you need.

- Within the first thirty (90) calendar days of your enrollment, where your provider is not part of our network but he has treated you in the past; and
- If you are in a nursing home when you enroll with us, and the nursing home is not in the network.

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

How to Get Care From Out of State Providers

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

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

5. How to Get Emergency Care and Services

What is an Emergency?

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

What to do in an Emergency?

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

Tell the hospital that you are a Virginia Premier member. Ask them to call the member services at the number on the back of your ID Card.

What is a Medical Emergency?

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

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

What is a Behavioral Health Emergency?

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

Examples of Non-Emergencies

Examples of non-emergencies are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. If you are not sure, call your PCP or our 24/7 medical advice line at: 800-777-7904.

If You Have an Emergency When you are Away from Home?

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

What is Covered If You Have an Emergency?

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

Notify your doctor and us as soon as possible about the emergency, within 48 hours if you can. However, you will not have to pay for emergency services because of a delay in telling us. We simply need to follow up on your emergency care. Your Care Manager 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 1-855-249-5025 (TTY 711). This number is also listed on the back of your ID card. If after hours, on the weekends, or holidays please contact the Medical Advice Line at 1-800-777-7904 (TTY 711).

After An Emergency

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

If You Are Hospitalized

Hospital care

Sometimes you may need to be in the hospital. The doctor will check your condition and decide when hospital care is necessary. Your doctor arranges your hospital care and will send you to a hospital where MAPMG doctors or participating providers practice.

A MAPMG doctor or participating provider will be in charge of your care when you are at the hospital. He or she will be in contact with your PCP during your stay. A MAPMG doctor or participating provider will work closely with you to plan your discharge from the hospital. Your

doctor will also decide the best place for you to get follow-up care. You will have a case manager who will help make follow-up appointments.

Case managers are nurses or social workers who can help you get the care you need.

These are the area hospitals where MAPMG doctors practice.

In Virginia:

- Reston Hospital Center, Reston, VA (labor and delivery services only)
- Stafford Hospital, Stafford, VA
- Virginia Hospital Center, Arlington, VA

In nearby areas:

- Anne Arundel Medical Center, Annapolis, MD
- Children's National Medical Center, Washington, DC
- Franklin Square Hospital Center, Baltimore, MD (behavioral health services only)
- Greater Baltimore Medical Center, Baltimore, MD
- Holy Cross Germantown Hospital, Germantown, MD
- Holy Cross Hospital, Silver Spring, MD
- MedStar Washington Hospital Center, Washington, DC
- Potomac Ridge at Shady Grove Adventist Hospital, Rockville, MD (behavioral health services only)
- Sibley Memorial Hospital, Washington, DC (labor and delivery services only)
- Suburban Hospital, Bethesda, MD
- University of Maryland Baltimore Washington Medical Center, Glen Burnie. MD
- Washington Adventist Hospital, Takoma Park, MD (behavioral health services only)

If you are hospitalized, a family member or a friend should contact us as soon as possible. By keeping us informed, your Care Coordinator can work with the hospital team to organize the right care and services for you before you are discharged. Your Care Coordinator will also keep your medical team including your home care services providers informed of your hospital and discharge plans.

What If It Wasn't A Medical Emergency After All?

Sometimes it can be hard to know if you have a medical emergency. You might go in for

emergency care, and the doctor may say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

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

- You go to a network provider, or
- The additional care you get is considered "urgently needed care" and you follow the rules for getting urgently needed care. (See Urgently Needed Care in section 6 of this handbook.)

6. How to Get Urgently Needed Care

What is Urgently Needed Care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have an existing condition that worsens and you need to have it treated right away. In most situations, we 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 kp.org/facilities.

When you are outside the service area, you will not be able to get care without a referral from your PCP. Our plan will cover urgently needed care. Out of area, non-emergent care requires a prior authorization. A referral from your PCP must be routed or have the provider fax the referral (uniform referral form) to Utilization Management Operation Center fax: 1-855-414-1693.

• During regular business hours

If you have a MAPMG doctor, you may be given an appointment with him or her to address an urgent condition. If you have a participating provider, you may call your doctor's office directly.

• Outside regular business hours

During weekends, evenings, and holidays, you may get an Urgent Care appointment at one of the Kaiser Permanente medical centers in Virginia listed below. You may also go to other Kaiser Permanente or participating Urgent Care facilities.

For a complete list of Urgent Care facilities in our network, go to kp.org/facilities or look in your provider directory.

Fredericksburg Medical Center

1201 Hospital Drive

Fredericksburg, VA 22401

Hours: 5:30 p.m. – 1 a.m. Mon–Fri

9 a.m. – 5 p.m. Sat, Sun, holidays

Manassas Medical Center

10701 Rosemary Drive

Manassas, VA 20109

Hours: 5 p.m. – 1 a.m. Mon–Fri

9 a.m. – 5 p.m. Sat, Sun

Reston Medical Center

1890 Metro Center Drive

Reston, VA 20190

Hours: 5 p.m. – 1 a.m. Mon–Fri

9 a.m. – 9 p.m. Sat, Sun, holidays

Tysons Corner Medical Center

8008 Westpark Drive

McLean, VA 22102

Hours: 24/7, Mon–Sun

Woodbridge Medical Center

14139 Potomac Mills Road

Woodbridge, VA 22192

Hours: 24/7, Mon–Sun

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider. Call Member Services at 1-855-249-5025 (TTY 711) as soon as you can so we can help coordinate your care. We will not approve continued out-of-area services if you are able to come home for the needed care.

In adults, some examples of urgent medical conditions are:

- Sudden drooping of the face, slurred speech, and/or difficulty walking
- Persistent vomiting and/or diarrhea
- Sudden changes in vision or hearing

- Difficulty breathing or shortness of breath
- Sudden dizziness and/or confusion
- Pain or pressure in the chest or abdomen
- The flare-up of a condition you and your PCP already know about

In children, some examples of urgent medical conditions are:

- Fast breathing or trouble breathing
- Bluish or gray skin color
- Not drinking enough fluids
- Severe or persistent vomiting
- Not waking up or not interacting

7. How to Get Prescription Drugs

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

Rules for Virginia Premier's Outpatient Drug Coverage

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

- You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP) or a specialist to whom you've been referred to by us. It could also be another provider if your primary care provider has referred you for care.
- You generally must use a network pharmacy to fill your prescription.
- Your prescribed drug must be on our List of Covered Drugs. If it is not on the Drug List, we may be able to cover it by giving you an authorization if the drug is determined to be medically necessary by your provider. You may contact
    - Member Services at 1-855-249-5025,
    - Request your provider to fax a prior authorization form by calling the Pharmacy Benefit Helpdesk at 1-866-331-2104
    - Email through kp.org
- Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

Like many health care organizations, we have a formulary, or a set list of preferred medicines, accessories, and supplies to help your doctor choose the best medicine for you.

A formulary, or preferred drug list, also helps make sure that safe and cost-effective medicines are available. The formulary includes those medicines that have been reviewed and approved by the Pharmacy and Therapeutics Committee for use by our doctors and network doctors. The preferred medicines on our formulary include both brand name and generic medicines approved by the Food and Drug Administration as safe and effective for use (a generic drug contains the same active ingredient as a brand name medicine). When the safety, effectiveness, and side effect profiles of two medicines are the same, the cost of the medicine would be considered when adding a medicine to the formulary. For most prescription benefit plans, a copay will be collected at the pharmacy, and the cost may vary depending on the type of product. However, Medicaid enrollees will not be charged a copay for medicines.

If you think you need a medicine that is not on the formulary, speak with your doctor or contact Member Services via telephone or email through kp.org to request the non-formulary exception process. This process is available so patients and doctors can access medically

necessary medicines under the prescription benefit, even if the medicine is not on the formulary. These non-formulary prescriptions are covered by your prescription benefit only if your doctor requests an exception to the formulary and provides specific information on why no formulary medicines are acceptable. If the criteria for formulary exception are not met, you will be required to pay full price for a non-formulary medicine. If you have questions or concerns, or wish to appeal the cost of a prescription or the decision on a non-formulary medicine that your doctor did not consider medically necessary, you must contact Member Services via telephone or email through kp.org.

We can require prior authorization for some medicines, for which your doctor will fill out paperwork, that will be reviewed and approved by the pharmacy department before these medicines can be dispensed. The prior authorization process is approved by the Pharmacy and Therapeutics Committee. Examples of medicines that require prior authorization are those used to promote growth (growth hormones), opioid medications used for pain, medicines to treat hepatitis C, benzodiazepines when used in combination with opioid therapy, and medications used to manage substance use disorder

Switching from one medicine to another medicine in the same or similar therapeutic class is called therapeutic substitution. Kaiser Permanente pharmacists will not perform therapeutic substitution without the approval of your doctor.

To learn which medicines are on the formulary, please go online and visit

kp.org/formulary or contact Member Services.

Getting Your Prescriptions Filled

In most cases, we will pay for prescriptions only if they are filled at Kaiser Permanente medical centers, mail order or participating network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our Members. You may go to any of our network pharmacies.

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

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

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

You can fill prescriptions from any doctor (including dentists) or other prescribers at the pharmacies located in Kaiser Permanente medical centers. There is a pharmacy in almost

every Kaiser Permanente medical center. Your MAPMG doctor can send most prescriptions by computer from his or her office directly to the medical center pharmacy, where you can pick up your medicine right after your visit.

When you use any Kaiser Permanente medical center pharmacy, we maintain a record of your medications. As prescriptions are entered, your personal drug profile is updated. In addition, you may fill prescriptions at participating pharmacies such as Giant, Safeway, Rite Aid, Walmart, and Kmart. You can find a list of all participating pharmacies in the provider directory or by calling Member Services. Be sure to show the pharmacist your Virginia Premier ID card when filling your prescription.

If you are away from home and need an emergency supply of medication, call our pharmacy benefits manager, MedImpact, at 1-800-788-2949. MedImpact can help you find a participating pharmacy nearby. If you are in another Kaiser Permanente region, you can also go to another Kaiser Permanente pharmacy. If you go to a non-participating pharmacy, call Member Services for help with submitting a claim.

List of Covered Drugs

We have a List of Covered Drugs that are selected with the help of a team of doctors and pharmacists. The 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 kp.org/formulary.
The List of Covered Drugs tells you which drugs are covered by Virginia Premier and also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get.

You can call Member Services to find out if your drugs are on the List of Covered Drugs or check on-line at kp.org/formulary, or we can mail you a paper copy of the List of Covered Drugs. The List of Covered Drugs may change during the year. To get the most up-to-date List of Covered Drugs, visit kp.org/formulary or call Member Services at 1-855-249-5025 (TTY 711), Monday through Friday, 7:30 a.m. to 9 p.m.

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

Limits for Coverage of Some Drugs

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

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may need to request a service authorization for you to receive the drug. Refer to Service Authorization and Benefit Determination and Service Authorizations and Transition of Care in section 11 of this handbook.

If Virginia Premier is new for you, you can keep getting your authorized drugs for the duration of the authorization or for 90 days after you first enroll, whichever is sooner. Refer to Transition of Care Period in section 11 of this handbook.

If we deny or limit coverage for a drug, and you disagree with our decision, you have the right to appeal our decision. Refer to Your Right to Appeal in section 12 of this handbook. If you have any concerns, contact Member Services, 855-249-5025 (TTY 711).

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, Virginia Premier may not cover the drug.

Trying a Different Drug First

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

Quantity Limits

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

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

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 at a minimum a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term

supply of the medications you need and gives time for your physician to submit a service authorization request for the prescribed medication.

Non Covered Drugs

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

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

Changing Pharmacies

If you need to change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy.

If the pharmacy you use leaves the 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. Member Services can tell you if there is a network pharmacy nearby.

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

You may use mail-order services to get prescriptions filled and delivered to your home at no extra cost. You can order your refills online at kp.org. You can also call the EZ Refill number toll-free at 1-800-700-1479 (TTY 703-466-4805) to fill a prescription 24 hours a day, 7 days a week, Monday through Friday, 8 a.m. to 7 p.m.

Can You Get a Long-Term Supply of Drugs?

You may receive a long-term supply of your chronic drugs, up to 90 days when there are available refills, if it is prescribed by your doctor and it is ordered through the mail order pharmacy. You may order your long-term medication supply on kp.org or by calling the EZ Refill number at 1-800-700-1479.

Can You Use a Pharmacy that is not in the Network?

If you go to a non-participating pharmacy, be sure to show them your Medicaid ID card or call Member Services for help with submitting a claim.

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

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

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works. The inclusion period is for 12 months. At the end of the lock in period, we'll check in with you to see if you should continue the program. If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to Appeals, State Fair Hearings, and Complaints in section 12 of this handbook.

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

Members who are enrolled in PUMS will receive a letter from 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 Virginia Premier if placed in the PUMS program;
- Information regarding how request a State Fair Hearing after first exhausting the Virginia Premier's appeals process;
- Information on any special rules to follow for obtaining services, including for emergency or after hours services; and
- Information on how to choose a PUMS provider.
- Contact Member Services at the number below if you have any questions on PUMS.

8. Benefits

General Coverage Rules

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

1. Your services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means you need the services to prevent, diagnose, or treat a medical condition or prevent a condition from getting worse.
2. In most cases, you must get your care from a network provider. A network provider is a provider who works with us. In most cases, we will not pay for care you get from an out-of-network provider unless the service is authorized by us. Section 3 has information about Services You Can Get Without First Getting Approval From Your PCP. Section 4 has more information about using network and out-of-network providers.
3. Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called service authorization. Section 11 includes more information about service authorizations
4. If Virginia Premier is new for you, you can keep seeing the doctors you go to now for the first 30 days. You can also keep getting your authorized services for the duration of the authorization or for 30 days after you first enroll, whichever is sooner. Also see Transition of Care Period in section 11.

Benefits Covered through Us (Medallion 4.0)

We cover all of the following services for you when they are medically necessary. Please see the information in Section 17 for details related to the benefits for FAMIS plan members.

- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. See section 3 of this handbook for more information about PCP services.
- Preventive care, including regular check-ups, well baby/child care. See section 3 of this handbook for more information about PCP services.
- Addiction, recovery, and treatment services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services, and case management. Some of these services may require a registration or authorization. Additional information about accessing your ARTS benefit is provided later in this handbook.
- Behavioral health services, including inpatient and outpatient psychotherapy individual, family, and group are covered including community mental health rehabilitation services (CMHRS), beginning August 1, 2018. Additional information about accessing

your behavioral health benefit is provided later in this handbook.

- In accordance with the Mental Health Parity and Addiction Equity Act, criteria for requiring prior authorization will be applied consistently across ARTS services, behavioral health services, and physical health services.
- Colorectal cancer screening
- Community Mental Health and Rehabilitative Services (Beginning August 1, 2018)
- CMHRS services covered for FAMIS members is limited to the following services:
    - Intensive In-Home
    - Therapeutic Day Treatment
    - Mental Health Crisis Intervention
    - Substance Abuse Crisis Intervention
    - Mental Health Case Management Services
- Court ordered services
- Durable medical equipment and supplies (DME)
- Early and periodic screening diagnostic and treatment services (EPSDT) for children under age 21. Additional information about EPSDT services is provided later in this section of the handbook.
- Early intervention services designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third birthday. Additional information about early intervention services is provided later in this section of the handbook.
- Electroconvulsive therapy (ECT)
- Emergency custody orders (ECO)
- Emergency services including emergency transportation services (ambulance, etc.)
- Emergency and post stabilization services. Additional information about emergency and post stabilization services is provided in section 5 and 6 of this handbook.
- End stage renal disease services
- Eye examinations
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of the network. We do not require you to obtain service authorization or PCP

referrals on family planning services.

- Glucose test strips
- Hearing (audiology) services
- Home health services
- Hospice services
- Hospital care – inpatient/outpatient
- Human Immunodeficiency Virus (HIV) testing, treatment, and treatment counseling
- Immunizations
- Inpatient psychiatric hospital services
- Laboratory, Radiology and Anesthesia Services
- Lead investigations
- Mammograms
- Maternity care- includes: pregnancy care, doctors/certified nurse-midwife services. Additional information about maternity care is provided in section 6 of this handbook.
- Nurse Midwife Services through a Certified Nurse Midwife provider
- Organ transplants
- Orthotics, including braces, splints and supports - for children under 21, or adults through an intensive rehabilitation program
- Outpatient hospital services
- Pap smears
- Physician's services or provider services, including doctor's office visits
- Physical, occupational, and speech therapies
- Podiatry services (foot care)
- Prenatal and maternal services
- Prescription drugs. See section 7 of this handbook for more information on pharmacy services.
- Private duty nursing services (through EPSDT) Under Age 21
- Prostate specific antigen (PSA) and digital rectal exams
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses)

- Psychiatric or psychological services
- Radiology services
- Reconstructive breast surgery
- Renal (kidney) dialysis services
- Rehabilitation services – inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services)
- Second opinion services from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.
- Surgery services when medically necessary and approved by us
- Telemedicine services
- Temporary detention orders (TDO)
- Tobacco Cessation Services
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). We will also provide transportation to/from most carved-out services. Additional information about transportation services is provided later in this section of the handbook. Transportation services are not provided for routine access to and from covered medical services to recipients of the FAMIS health plan.
    - Vision services
    - Well Visits
    - Abortion services- coverage is only available in cases where there would be a substantial danger to life of the mother.

Extra Benefits Included in Your Plan

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

Dental services

We provide coverage for some dental-related services for adults and children when it is medically necessary, appropriate, and approved, including:

- Anesthesia and hospitalization services for medically necessary dental services
- Dental services performed by a medical doctor or dentist as a result of a dental accident
- Preparation of the mouth for radiation therapy
- Medication for covered dental services
- Repair of cleft lip or cleft palate or both

We provide dental services for pregnant women. You must tell the dentist when you think your baby is due. You will be able to see a dentist for 60 days after your baby is born. We will cover the following dental services:

- X-rays and examinations
- Cleanings
- Fillings
- Root canals
- Gum-related treatment
- Crowns, bridges, partials, and dentures
- Tooth extractions and other oral surgeries
- Other appropriate general services

Prevention

Your benefits include services to help keep you healthy and to help prevent serious health problems. Children and adults of different ages have different needs. The doctor will work with you to order the tests and exams that are best for your age and based on your health history. For a copy of our preventive care clinical guidelines, call Member Services. Preventive services are to find problems early and help to keep you from getting sick.

Our Health Education Department offers a variety of classes, online programs, and coaching to

help you. All classes are free. For more information, pick up a Healthy Living Programs booklet at any Kaiser Permanente medical center or visit kp.org/healthyliving.

Disease management

We have disease management programs to help you live well with a chronic condition. Enrollment in these programs is voluntary and can be discontinued at any time. For a copy of our disease management clinical guidelines, call Member Services. Some of the disease management services offered are for:

- Asthma
- Depression
- Diabetes
- Coronary artery disease
- Congestive heart failure
- Chronic obstructive pulmonary disease

If you have any of these conditions, you can self-refer to our disease management program. Leave a message anytime at 703-536-1465 with your name, medical record number, address, and the condition for which you are requesting information. You are automatically enrolled in a disease management program if you are diagnosed with any of the chronic conditions for which we have a program, but you have the right to opt out at any time.

TracFone

We are proud to be working with SafeLink Wireless to offer you this special federal program. With SafeLink Health Solutions® you will get the following benefits:

- A free phone with 350 monthly minutes
- Unlimited text messages
- Free calls to Member Services that will not count toward your 350 minutes
- Text messages with health tips and reminders

There are no bills, so there are no surprises. If you run out of minutes, you can buy extra for just $0.10 a minute. You will always be able to call 911 or Member Services for free, even if you run out of minutes.

There are 3 ways to enroll in the SafeLink Phone Program:

1. Visit www.safelink.com to apply online.
2. Fill out the application you received with your welcome packet and mail it back (no postage

needed).

3. Call SafeLink at 877-631-2550.

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

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly.

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

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

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

How to Access EPSDT Service Coverage

We provide most of the Medicaid EPSDT covered service such as behavioral therapy (Applied Behavioral Analysis [ABA]). Behavioral Therapy Services must be designed to enhance communication skills and decrease maladaptive patterns of behavior before there is a need for more restrictive level of care.

- The goal of the ABA services is to ensure the member's family or caregiver is trained to support the member in the home and community using the skills learned while actively participating in behavioral therapy.
- Available to members under 21 years of age.
- Assessments are allowed up to 5 hours per child, per provider.
- The service provider must provide documentation that lesser services like CMHRS services are not the best option.

However, some EPSDT services, like pediatric dental care, are not covered by us. For any services not covered by our plan, you can get these through the Medicaid fee-for-service program. Additional information is provided in section 11 of this handbook. Please reach out to care management for assistance with accessing EPSDT services. Care Manager contact number 866-223-2347 for assistance.

How to Access Early Intervention Service Coverage

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

For more information call your Care Manager. Your Care Manager can help. If your child is enrolled with us we provide coverage for early intervention services. If the family requests assistance with transportation and scheduling to receive Early Intervention services, we provide this assistance.

Your Care Manager 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 http://www.infantva.org/or by calling 1-800-234-1448.

Foster Care and Adoption Assistance

We can provide individuals who are in foster care or are receiving adoption assistance with assistance in referrals to providers, transition planning (for youth about to leave the foster care system) and care coordination. In fact, we have a care management team that specializes in these services and in working with local Departments of Social Services to help navigate medical and/or behavioral health care and other resources. For more information about these resources, please call the Foster Care Management Team. Please note: Any person or child admitted to a Therapeutic Group Home (TGH) will not be excluded from the Medallion 4.0 Program; however, the TGH per diem service is “carved out” of the Medallion 4.0 contract and will be administered through Magellan of Virginia until April 1, 2019. Any professional medical services rendered to individuals in the TGH will be administered by us. The Medallion 4.0 case management team will be managing Foster Care care coordination for any pediatric case management needs. Care Manager contact number 1-866-223-2347 for assistance.

How to Access Maternal and Child Health Services

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

We have programs for pregnant women that include:

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid’s child health program for children under the age of 21. It is available to Medallion 4.0/FAMIS Plus Members. The program gives children a full set of screenings, interventions and other support services. By law, EPSDT sets out periodic screenings along with vision, dental and hearing services.

Any medically necessary health care service listed in EPSDT must be given to an EPSDT member. This is true even if the service is not available to the rest of the state's Medicaid population. Here are some of the EPSDT benefits:

- Services for nursing care including private duty nursing
- Individualized treatments specific to developmental issues
- Access to carved-out services
- Pharmacy services
- Treatment for obesity

EPSDT exams (check-ups) are done by your child's doctor. These must be a part of your child's check-ups:

- A complete history of your child's health, nutrition and developmental/behavioral health assessments
- A head-to-toe physical exam
- Health education
- A growth and development check
- Lab tests
- All children must be screened for lead poisoning twice; once between 9 and 23 months and once between 24 and 35 months
- Immunizations (shots), as needed
- Age-appropriate counseling
- Vital sign measurements (blood pressure, pulse rate, etc.)
- Eye exam
- Hearing test
- Tobacco cessation services
- Dental check-up and a referral to a dentist by the age of three
- Dental check-ups with a dentist should be done every 6 months (covered under the Department of Medical Assistance Services' (DMAS) *Smiles for Children* program)

This chart tells you when your child should get regular check-ups:

Age	Check-up Schedule
less than 1 year old (infants)	check-up needed for newborns, ages 3-5 days, 1 month, 2 months, 4 months, 6 months, and 9 months
1-2 years old (toddlers)	check-up needed at ages 12, 15, and 18 months
2-4 years old (early childhood)	check-up needed at ages 24 and 30 months, 3 and 4 years; schedule dental visits every 6 months after your child's third birthday
5-10 years old (late childhood)	check-up needed once every year
11-21 years old (teens)	check-up needed once every year

Enrollment for Newborns

- Once you have your baby, you will need to report the birth of your child as quickly as possible to enroll your baby for Medicaid. You can do this by:
- Calling the Cover Virginia Call Center at 1 (855) 242-8282 to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child.

You will be asked to provide your information and your infant's:

- Name
- Date of Birth
- Race
- Sex
- The infant's mother's name and Medicaid ID number

How to Access Family Planning Services

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 network.

How to Access Behavioral Health Services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues as well as using substances at some time in their lives. These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in your home or in the community, for a short or long timeframe, and all are performed by qualified individuals and organizations.

Some Behavioral Health services such as children's residential treatment are covered for you through Magellan of Virginia, the DMAS Behavioral Health Services Administrator (BHSA), until April 2019. Member Services can help coordinate the services you need, including those that are provided through the BHSA.

We provide coverage for traditional inpatient and partial psychiatric hospitalization as well as behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS) for members with the Medallion 4.0.

These CMHRS services are also available for members who have experienced potentially traumatic events in their lifetime. Trauma refers to intense and overwhelming experiences that involve serious loss, threat or harm to a person's physical and/or emotional well-being. These experiences may occur at any time in a person' life. They may involve a single traumatic event or may be repeated over many years. These trauma experiences often overwhelm the persons coping resources. This often leads the person to find a way of coping that may work in the short run but may cause serious harm in the long run. In-network providers deliver services to members through Trauma-Informed Care.

To access Behavioral Health services members are encouraged to contact Member Services at 1-855-249-5025 (TTY 711). The call is free and you can also be connected to your Care Manager during the call.

How to Access Addiction and Recovery Treatment Services (ARTS)

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

If you need treatment for addiction, we provide coverage for services that can help you. Our plan covers the following ARTS services: Inpatient acute detoxification hospitalization; Partial Hospitalization; Group Home/Halfway House; Residential treatment facility services;

Substance Abuse Intensive Outpatient Treatment; Outpatient (individual, family, and group) substance abuse treatment; Opioid Treatment services (includes individual, group counseling; family therapy and medication administration); and Substance abuse peer specialist services. Medication assisted treatment options are also available if you are dealing with using prescription or non-prescription drugs. Peer services are provided by someone who has experienced similar issues and in recovery. Case management services are also available. Talk to your PCP or call a Care Manager to determine the best option for you and how to get help in addiction and recovery treatment services. To find an ARTS provider, you can look in the Provider and Pharmacy Directory, visit our website, call your Care Coordinator, or contact Member Services at
1-855-249-5025 (TTY 711). If you have any questions or if you are interested in finding out more about ARTS please do not hesitate to reach out to us. We hope you will take advantage of these services that are a benefit and are available at no cost to you.

How to Access Non-Emergency Transportation Services

Transportation Services Covered by Virginia Premier

Non-Emergency transportation services are covered by us for covered services, carved out services, and enhanced benefits, as well as company sponsored educational events and Member Advisory Committee meetings.

Transportation may be provided if you have no other means of transportation and need to go to a physician or a health care facility for a covered service. For urgent or non-emergency medical appointments, call LogistiCare at 1-866-823-8349 or Member Services at the number below.

You must call at least three business days before your visit or we will not be able to guarantee that a ride will be available. We must approve the service. Members can ask for medical transportation to get to their covered vision, dental, behavioral health, and medical visits.

Transportation to medical and dental appointments is a covered benefit. All you have to do is call LogistiCare to schedule transportation to your medical and dental appointments. If you need a ride to a medical appointment, please call the transportation company using the number shown on your ID card. You must call at least three business days before your visit or we will not be able to guarantee that a ride will be available. We must approve the service. Members can ask for medical transportation to get to their vision, dental, behavioral health, and medical visits.

Transportation is not covered for picking up prescriptions and refills at a pharmacy when drugs can mailed. This transportation must be used only when:

- The visit is for care covered by the Medicaid program, and
- The member does not have his or her own transportation.

If you have any questions about transportation services, please call Member Services at the phone number on the back of your Virginia Premier ID card.

In case of a life-threatening emergency, call 911. Refer to How to Get Care for Emergencies in section 5 of this handbook.

9. Services Not Covered

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

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Assisted suicide
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Christian Science nurses
- Cosmetic treatment or surgery
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers)
- Dentures for Members age 21 and over
- Drugs prescribed to treat hair loss or to bleach skin
- Elective Abortions
- Erectile Dysfunction Drugs
- Experimental or Investigational Procedures
- Eyeglasses or their repair for Members age 21 or older
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by Virginia Premier)
- Medical care other than emergency services, urgent services, or family planning services, received from providers outside of the network unless authorized by Virginia Premier
- Routine dental care if you are age 21 or older
- Services rendered while incarcerated
- Weight loss clinic programs unless authorized
- Care outside of the United States
- Any person or child admitted to a Psychiatric Residential Treatment Facility will be

temporarily excluded from the Medallion 4.0 program until they are discharged. Effective April 1, 2019 we will be responsible for the coverage of the Residential Treatment services consisting of Psychiatric Residential Treatment Facility Services. Medallion 4.0 members. However any professional medical services rendered to individuals in the Psychiatric Residential Treatment Facility will be administered by us.

If You Receive Non-Covered Services

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

- Services are medically necessary, and
- Services are listed as Benefits Covered Through us in section 8 of this handbook, and
- You receive services by following plan rules.

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

10. Services Covered Through Medicaid Fee-For-Service

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

Carved Out services:

- Dental Services provided through the *Smiles For Children* program

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

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

If you have any questions about your dental coverage through *Smiles For Children*, you can reach DentaQuest Member Services at 1-888-912-3456, Monday through Friday, 8:00 AM - 6:00 PM EST. The TTY/TDD number is 1-800-466-7566. Additional *Smiles For Children* program information is provided at: https://www.coverva.org/programs_smiles.cfm.

- We provide coverage for non-emergency transportation for any dental services covered through *Smiles for Children*, as described above. Contact Member Services at the number below if you need assistance.
- Any person or child admitted to a Therapeutic Group Home (TGH) will not be excluded from the Medallion 4.0 Program; however, the TGH per diem service is "carved out" of the Medallion 4.0 contract and will be administered through Magellan of Virginia until April 1, 2019. Effective April 1, 2019 we will be responsible for the coverage of the Residential Treatment services consisting of TGH for Medallion 4.0 members. However any professional medical services rendered to individuals in the TGH will be administered by us.
- School health services including certain medical, mental health, hearing, or

rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.

Services That Will End Your Enrollment

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

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

11. Services Covered Through FAMIS

SUMMARY OF FAMIS COVERED SERVICES – PART 4				
SERVICE	**FAMIS COVERED**	**NETWORK COST SHARING & BENEFIT LIMITS**		**NOTES AND DAY LIMITATIONS**
		<150%	**>150%**	
Inpatient Hospital Services	Yes	$15 per confine-ment	$25 per confine-ment	The Contractor shall cover inpatient stays in general acute care and rehabilitation hospitals for all members up to 365 days per confinement in a semi-private room or intensive care unit for the care of illness, injury, or pregnancy (includes medically necessary ancillary services). The Contractor shall cover alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. The Contractor must approve in advance the alternative treatment plan.

Outpatient Hospital Services	Yes	$2 per visit (waived if admitted)	$5 per visit (waived if admitted)	The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. Outpatient services include emergency services, surgical services, diagnostic, and professional provider services. Facility charges are also covered.

Chiropractic Services	Yes	$2 (limited to $500 per calendar year)	$5 (limited to $500 per calendar year)	The Contractor shall provide $500.00 per calendar year coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.
Clinic Services Outpatient physician visit in the office or hospital Primary care Specialty care Maternity Services	Yes	$2 $0	$5 $0	The Contractor shall cover clinic services that are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician or a dentist. Renal dialysis clinic visits are also covered. There are no copayments for maternity services.
Court Ordered Services	No			The Contractor is not required to cover this service unless the service is both medically necessary and is a FAMIS covered service.

Dental Services	No except in certain circum-stances			The Contractor shall cover CPT codes billed by an MD as a result of an accident. The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care. Pediatric dental services (for eligible children up to age 21) are covered through the *Smiles for Children* Program through the Department's Dental Benefit Administrator (DBA). For more information regarding SFC benefits, call 1-888-912-3456.

Early Intervention Services	Yes			The Contractor is required to provide coverage for Early Intervention services as defined by 12 VAC 30-50-131. EI services for children who are enrolled in a contracted Contractor are covered by the Department within the Department's coverage criteria and guidelines. Early intervention billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual The Contractor shall cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.
Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)	No			The Contractor is not required to cover this service. The Contractor is required to cover well-baby and well child care services.

Emergency Services using Prudent Layperson Standards for Access	Yes	$2 per visit	$25 per visit	The Contractor shall provide for the reasonable reimbursement of services needed to ascertain whether an emergency exists in instances in which the clinical circumstances that existed at the time of the beneficiary’s presentation to the emergency room indicate that an emergency may exist. The Contractor shall ensure that all covered emergency services are available twenty-four (24) hours a day and seven (7) days a week. The Contractor shall cover all emergency services provided by out-of- network providers. The Contractor may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services that a member seeks in an emergency. Members who present to the emergency room shall pay the emergency room co-payment. If it is determined that the visit was a non-emergency, the hospital may bill the member only for the difference between the emergency room and non-emergency co-payments, i.e. $8.00 for <150% and $20.00 for >150%. The hospital may not bill for additional charges
Hospital emergency room		$2 per visit waived if part of ER visit for true emergency	$5 per visit waived if part of ER visit for true emergency	
Physician Care				
Non-Emergency use of the Emergency Room		$10 for visit	$25 per visit	

Post Stabilization Care Following Emergency Services	Yes			The Contractor shall cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized. The Contractor must cover the following services without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor's network.
Experimental and Investigational Procedures	No			The Contractor is not required to cover this service.
Hearing Aids	Yes	$2	$5	The Contractor shall cover hearing aids as outlined under Durable Medical Equipment. Hearing aids shall be covered twice every five years.

Hospice Services	Yes	$0	$0	The Contractor shall cover hospice care services to include a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a Provider licensed to do so; furnished and billed by a licensed hospice; and medically necessary. Hospice care services are available if the member is diagnosed with a terminal illness with a life expectancy of six months or fewer. Hospice care is available concurrently with care related to the treatment of the child’s condition with respect to which a diagnosis of terminal illness has been made.

Home Health Services	Yes	$2	$5	The Contractor shall cover home health services, including nursing and personal care services, home health aide services, PT, OT, speech, hearing and inhalation therapy up to 90 visits per calendar year. Personal care means assistance with walking, taking a bath, dressing; giving medicine; teaching self-help skills; and performing a few essential housekeeping tasks. The Contractor is not required to cover the following home health services: medical social services, services that would not be paid for by FAMIS if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery.

Immunizations	Yes	$0	$0	The Contractor shall cover immunizations. The Contractor shall ensure that providers render immunizations, in accordance with the most current Advisory Committee on Immunization Practices (ACIP). The Contractor shall work with the Department to achieve its goal related to increased immunization rates. The Contractor is responsible for educating providers, parents and guardians of members about immunization services, and coordinating information regarding member immunizations. FAMIS eligible members shall not qualify for the Free Vaccines for Children Program.

Inpatient Mental Health Services	Yes	$15 per confine-ment	$25 per confine-ment	Inpatient mental health services are covered for 365 days per confinement, including partial day treatment services. Inpatient hospital services may include room, meals, general-nursing services, prescribed drugs, and emergency room services leading directly to admission. The Contractor is not required to cover any services rendered in free-standing psychiatric hospitals to members up to nineteen (19) years of age. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS members. All inpatient mental health admission for individuals of any age to general acute care hospitals shall be approved by the Contractor using its own prior authorization criteria. The Contractor may cover services rendered in free-standing psychiatric hospitals as an enhanced benefit. Psychiatric residential treatment (level C) is not a covered service under FAMIS.
Inpatient Rehabilitation Hospitals	Yes	$15 per confine-ment	$25 per confine-ment	The Contractor shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and which have been certified by the Department of Health.

Inpatient Substance Abuse Services	Yes	$15 per confine-ment	$25 per confine-ment	The Mental Health Parity and Addiction Act of 2008 mandate coverage for mental health and substance abuse treatment services. Inpatient substance abuse services in a substance abuse treatment facility are covered.
Laboratory and X-ray Services	Yes	$2 per visit	$5 per visit	The Contractor shall cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner in appropriate settings, including physician office, hospital, independent and clinical reference labs. No co-pay shall be charged for laboratory or x-ray services that are performed as part of an encounter with a physician.
Lead Testing	Yes	$0	$0	The Contractor shall cover blood lead testing as part of well baby, well childcare.

Lead Investigations	Yes	$0	$0	The Contractor shall provide coverage for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels. Environmental investigations are coordinated by local health departments. Coverage includes costs that are eligible for Federal funding participation in accordance with current Federal regulations and does not include the testing of environmental substances such as water, paint, or soil which are sent to a laboratory for analysis. Contact the Member's local health department to see if a Member qualifies for a risk assessment. More information is available at: www.vdh.virginia.gov/environmental-epidemiology/fact-sheets-for- publichealth/elevated-blood-lead-levels-in-children Payments for environmental investigations shall be limited to no more than two visits per residence.
Mammograms	Yes	$0	$0	Contractor shall cover low-dose screening mammograms for determining presence of occult breast cancer

Medical Supplies *Medical Equipment*	Yes	$0 for Supplies $2 per item for equipment	$0 for Supplies $5 per item for equipment	The Contractor shall cover durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). Durable medical equipment and prosthetic devices and eyeglasses are covered when medically necessary. The Contractor shall cover supplies and equipment necessary to administer enteral nutrition. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the Contractor.

Medical Transportation	Yes	$2	$5	Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary; if prearranged by the Primary Care Physician and authorized by the Contractor if, because of the member's medical condition, the member cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the member's condition suddenly becomes worse and must go to a local hospital's emergency room. For coverage of ambulance services, the trip to the facility or office must be to the nearest one recognized by the Contractor as having services adequate to treat the member's condition; the services received in that facility or provider's office must be covered services; and if the Contractor or the Department requests it, the attending provider must explain why the member could not have been transported in a private car or by any other less expensive means. Transportation services are not provided for routine access to and from providers of covered medical services.

Organ Transplant-ation	Yes	$15 per confine-ment and $2 per out-patient visit (Services to identify donor limited to $25,000 per member)	$25 per confine-ment and $5 per out-patient visit (Services to identify donor limited to $25,000 per member)	The Contractor shall cover organ transplantation services as medically necessary and per industry treatment standards for all eligible individuals, including but not limited to transplants of tissues, autologous, allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue for children with lymphoma and myeloma. The Contractor shall cover kidney transplants for patients with dialysis dependent kidney failure, heart, liver, pancreas, and single lung transplants. The Contractor shall cover necessary procurement/donor related services. The Contractor is not required to cover transplant procedures determined to be experimental or investigational.

Outpatient Mental Health and Substance Abuse Services	Yes	$2 per visit	$5 per visit	*The Mental Health Parity and Addiction Act of 2008 mandates coverage for mental health and substance abuse treatment services. Accordingly, the Contractor is responsible for covering medically necessary outpatient individual, family, and group mental health and substance abuse treatment services.* The Contractor shall provide coverage to members, for mental health and substance abuse treatment services. Emergency counseling services, intensive outpatient services, day treatment, and substance abuse case management services are carved-out of this contact and shall be covered by the Department.

Community Mental Health Rehabilitative Services (CMHRS)	Yes			No later than December 1, 2018, the following behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS), shall be covered under the MEDALLION 4.0 Program for FAMIS and FAMIS MOMs MEDALLION 4.0 enrollees: • Intensive In-Home Services for Children and Adolescents • Therapeutic Day Treatment for Children and Adolescents • Mental Health Crisis Intervention • Mental Health Case Management for Children at Risk of Serious Emotional Disturbance, Children with Serious Emotional Disturbance in accordance with the DMAS Community Mental Health Rehabilitative Services Manual, Chapter IV and Virginia State Regulation The Department's BHSA will continue to provide these services for MEDALLION 4.0/FAMIS Members through the fee-for-service program until the services transition to MEDALLION 4.0.The Contractor shall provide coverage for CMHRS within the Department's coverage criteria and and guidelines and consistent with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001). CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitation guidelines and consistent with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001). CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.

Pap Smears	Yes	$0	$0	Virginia Premier shall cover annual pap smears

Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	Yes	$2 per visit	$5 per visit	The Contractor shall cover therapy services that are medically necessary to treat or promote recovery from an illness or injury, to include physical therapy, speech therapy, occupational therapy, inhalation therapy, and intravenous therapy. The Contractor shall not be required to cover those services rendered by a school health clinic when included in the IEP.

Physician Services *Inpatient physician care* *Outpatient physician visit in the office or hospital* *Primary Care* *Specialty care* *Maternity services*	Yes	$0 $2 per visit $2 per visit $0 per visit	$0 $2 per visit $2 per visit $0 per visit	The Contractor shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses. Cosmetic services are not covered unless performed for medically necessary physiological reasons. Physician services include services while admitted in the hospital, outpatient hospital departments, in a clinic setting, or in a physician's office.
Pregnancy Related Services	Yes	$0	$0	The Contractor shall cover services to pregnant women, including prenatal services for FAMIS and FAMIS MOMS. There is no co-pay for pregnancy related services. No cost sharing at all will be charged to members enrolled in FAMIS MOMS.

Prescription Drugs *Retail up to 34-day supply* *Retail 35-90-day supply* *Mail service up to 90-day supply*	Yes	 $2 per prescript-tion $4 per prescript-tion $4 per prescription	 $5 per prescript-tion $10 per prescript-tion $10 per prescription	The Contractor shall cover all medically necessary drugs for its members that by Federal or State law requires a prescription. The Contractor shall cover all FAMIS covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The Contractor is required to cover prescription drugs prescribed by the outpatient mental health provider. The Contractor is not required to cover Drug Efficacy Study Implementation (DESI) drugs or over the counter prescriptions. If a generic is available, member pays the copayment plus 100% of the difference between the allowable charge of the generic drug and the brand drug.
Private Duty Nursing Services	Yes	$2 per visit	$5 per visit	The Contractor shall cover private duty nursing services for children up to age 19 only if the services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN); must be medically necessary; the nurse may not be a relative or member of the member's family; the member's provider must explain why the services are required; and the member's provider must describe the medically skilled service provided. Private duty nursing services must be pre-authorized.

Prosthetics/ Orthotics	Yes	$2 per item	$5 per item	The Contractor shall cover prosthetic services and devices (at minimum, artificial arms, legs and their necessary supportive attachments) for all members. At a minimum, the Contractor shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc. add items listed in Handbook) for members. The Contractor shall cover medically necessary orthotics for members when recommended as part of an approved intensive rehabilitation program.
Psychiatric Residential Treatment Services	No			This service is non-covered under FAMIS.
School Health Services	*Yes			*The Contractor is not required to cover school-based services provided by a local education agency or public school system. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies at school. School health services that meet the Department's criteria will continue to be covered as a carve-out service. The Contractor shall not be required to cover these services rendered by a school health clinic when included in the IEP.

Second Opinions	Yes	$2 per visit	$5 per visit	The Contractor shall provide coverage for second opinions when requested by the member for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The Contractor must provide for second opinions from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member. The Contractor may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.
Skilled Nursing Facility Care	Yes	$15 per confine-ment	$25 per confine-ment	The Contractor shall cover medically necessary services that are provided in a skilled nursing facility for up to 180 days per confinement.

Telemedicine Services	Yes			The Contractor shall provide coverage for medically necessary telemedicine services. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. Currently the Department recognizes only physicians and nurse practitioners for medical telemedicine services and requires one of these types of providers at the main (hub) satellite (spoke) sites for a telemedicine service to be reimbursed. Additionally, the Department currently recognizes three telemedicine projects.
Temporary Detention Orders	No			The Contractor is not required to cover this service. Coverage may be available through the State TDO program.

Therapy Services	Yes	$15 per confine-ment if inpatient	$25 per confine-ment if inpatient	The Contractor shall cover the costs of renal dialysis, chemotherapy and radiation therapy, and intravenous and inhalation therapy.
Tobacco Dependence Treatment (i.e., Tobacco or Smoking Cessation) for Pregnant Women	Yes	$2 per visit outpatient	$5 per visit outpatient	The Contractor shall provide coverage for tobacco dependence treatment for pregnant women without cost sharing. Treatment includes counseling and pharmacotherapy.
Transportation	No			Transportation services are not provided for routine access to and from providers of covered medical services.

Well Baby and Well Child Care	Yes	$0	$0	The Contractor shall cover all routine well baby and well childcare recommended by the American Academy of Pediatrics Advisory Committee, including routine office visits with health assessments and physical exams, as well as routine lab work and age appropriate immunizations. The following services rendered for the routine care of a well child: Laboratory services: blood lead testing, HGB, HCT or FEP (maximum of 2, any combination); Tuberculin test (maximum of 3 covered); Urinalysis (maximum of 2 covered); Pure tone audiogram for age 3-5 (maximum of 1); Machine vision test (maximum of 1 covered). Well child visits rendered at home, office and other outpatient provider locations are covered at birth and months, according to the American Academy of Pediatrics recommended periodicity schedule. Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth.

Vision Services *Once every 24 months: Routine Eye Exam* *Eyeglasses frames (1 pair)* *Eyeglass Lenses (1 pair)* *Single vision* *Bifocal* *Trifocal* *Contacts*	Yes	 $2 member payment $25 reimbursed by plan $35 reimbursed by plan $50 reimbursed by plan $88.50 reimbursed by plan $100 reimbursed by plan	 $5 member payment $25 reimbursed by plan $35 reimbursed by plan $50 reimbursed by plan $88.50 reimbursed by plan $100 reimbursed by plan	The Contractor shall cover vision services that are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all members, shall be allowed at least once every two (2) years. Virginia Premier shall cover eyeglasses (one pair of frames and one pair of lenses) or contact lenses prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist for members.

Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	No			The Contractor is not required to cover this service. However, the Contractor may cover services rendered in free-standing psychiatric hospitals to members up to nineteen (19) years of age as an enhanced benefit offered by the Contractor. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS members
Abortions	No			The Contractor is not required to cover services for abortions.
COST SHARING *Annual Co-Payment Limit*		Calendar year limit: $180 per family	Calendar year limit: $350 per family	Plan pays 100% of allowable charge once limit is met for covered services.
FAMIS MOMS				Benefits are the same as those available under MEDALLION 4.0

12. Service Authorization Procedure

Service Authorizations Explained

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

If the services you require are covered through Medicare then a service authorization from 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 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

Virginia Premier does not reward employees, consultants, or other providers to:

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

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

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

Virginia Premier requires a prior service authorization for all inpatient behavioral health and substance abuse admissions to hospitals as well as to partial hospitalization, residential treatment, substance abuse group home/halfway house treatment, intensive outpatient substance abuse services and the following Community Mental Health and Rehabilitation services (CMHRS) services if you need them.

CMHRS are listed below.

- Mental Health Case management

- Therapeutic Day Treatment (TDT) for Children
- Day Treatment/Partial Hospitalization for Adults
- Crisis Intervention and Stabilization
- Intensive Community Treatment
- Mental Health Skill-building Services (MHSS)
- Intensive In-Home
- Psychosocial Rehab
- Mental Health Peer Support Services- Individual
- Mental Health Peer Support Services –Group

Residential Treatment Services include Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) for the Department's Medallion 4.0 Program members and are administered through Magellan of Virginia, the DMAS Behavioral Health Services Administrator, until April 1, 2019.

Any person or child admitted to a Psychiatric Residential Treatment Facility will be temporarily excluded from the Medallion 4.0 program until they are discharged. Any person or child admitted to a Therapeutic Group Home (TGH) will not be excluded from the Medallion 4.0 Program; however, the TGH per diem service is "carved out" of the Medallion 4.0 contract and will be administered through Magellan of Virginia until April 1, 2019. Any professional medical services rendered to individuals in the TGH will be administered by us.

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 Manager. Your Care Manager can help you access these services.

Authorization is also required for:

- Diagnostic Imaging
- Durable Medical Equipment
- Home Health
- Infusion Services
- Inpatient admission
- Laboratory
- Outpatient Procedures

- Private duty nursing (through EPSDT) under age 21
- Personal Care (through EPSDT) under age 21
- Therapy
- All Out of Network

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 Transition of Care

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

How to Submit a Service Authorization Request

If your PCP decides you need a service that requires prior approval, he/she will send a request to us for you to receive this service. We will review the request and notify you and your PCP of the decision when the review is completed.

Talk to your PCP if you need a prior approval for any covered service or medical equipment. If you have a question or are not sure if a certain benefit requires prior approval, call Member Services at 1-855-249-5025 (TTY 711) for help. If your benefits change, we will notify you 30 calendar days before the change.

For chemical dependency, service authorization requests should be faxed to 1-855-414-1703.

What Happens After Submitting A Service Authorization Request?

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

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

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

Timeframes for Service Authorization Review

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

Physical Health Services	Service Authorization Review Timeframes
Inpatient Hospital Services (Standard or Expedited Review Process)	Within 14 calendar days or as quickly as your condition requires.
Outpatient Services (Standard Review Process)	Within 14 calendar days or as quickly as your condition requires.
Outpatient Services (Expedited Review Process)	Within 72 hours from receipt of your request; or, as quickly as your condition requires.

Behavioral Health Services	Service Authorization Review Timeframes
Outpatient (Standard Review Process)	Within 14 calendar days or as quickly as your condition requires.
Inpatient (Standard Review)	Within 14 calendar days or as quickly as your condition requires.

Pharmacy Services	Service Authorization Review Timeframes
Pharmacy services	We must provide decisions by telephone or other telecommunication device within 24 hours.
There may be an instance where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit an authorization request for the prescribed medication.	

If we need more information to make either a standard or expedited decision about your service request we will:

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give us to help decide your case. This can be done by calling Member Services at 1-855-249-5025 (TTY 711) Monday through Friday, 7:30 a.m. to 9 p.m., except holidays. You or someone you trust can file a complaint with us if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the way we handled your service authorization request to the State through the Managed Care Helpline at 1-800-643-2273. Also see Your Right to File a Complaint, in section 12 of this handbook.

Benefit Determination

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

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

Continuation of Care

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

Post Payment Review

If we are checking on care or services that you received in the past, we perform a provider post payment review. If we deny payment to a provider for a service, we 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 us even if we later deny payment to the provider.

13. Appeals, State Fair Hearings, and Complaints (Grievances)

Your Right To Appeal

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

For example, you can appeal if we deny:

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

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

Authorized Representative

You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform us of the name of your authorized representative. You can do this by calling our Member Services Department at one of the phone numbers below. We 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 Determinations in section 11 of this handbook.

How to Submit Your Appeal

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

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

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

Send your Appeal request to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Attn: Appeals and Correspondence Unit

2101 E. Jefferson St.

Rockville, MD 20852

Fax: 866-640-9826

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

Continuation of Benefits

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

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

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

What Happens After We Get Your Appeal

Within 5 calendar days, we will send you a letter to let you know we have received and are working on your appeal.

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

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

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

You can call or send information to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Attn: Appeals and Correspondence Unit

2101 E. Jefferson St.

Rockville, MD 20852

By fax to: 866-640-9826

By telephone: 855-249-5025

TTY/TDD: 866-513-0008

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

Timeframes for Appeals

Standard Appeals

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

If We Need More Information

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

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

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Attn: Appeals and Correspondence Unit

2101 E. Jefferson St.

Rockville, MD 20852

Fax: 1-866-640-9826

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

Written Notice of Appeal Decision

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

We 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) our appeals process before you can file an appeal request through the State Fair Hearing process. If we do not respond to your appeal request timely DMAS will count this as an exhausted appeal.

Standard or Expedited Review Requests

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

Authorized Representative

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

Where to Send the State Fair Hearing Request

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

You may write a letter or complete a Virginia Medicaid Appeal Request Form. The form is available at your local Department of Social Services or on the internet at http://www.dmas.virginia.gov/files/links/9/Client%20Appeal%20Request%20Form.pdf. You should also send DMAS a copy of the letter we sent to you in response to your Appeal.

You must sign the appeal request and send it to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Fax: (804) 452-5454

Standard and Expedited Appeals may also be made by calling (804) 371-8488

After You File Your State Fair Hearing Appeal

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

State Fair Hearing Timeframes

Expedited Appeal

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

Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will give you an answer within 90 days from the date you filed your appeal with us. The 90 day timeframe does not include the number of days between our decision on your appeal and the date you sent your State fair hearing request to DMAS. 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 receives notice from the State reversing the denial.

If services were provided while the State Fair Hearing was pending

If the State Fair hearing decision is to reverse the denial and services were provided while the appeal is pending, 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 Complaint

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 complaint or as an appeal.

What Kinds of Problems Should be Complaints

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

Complaints about quality

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

Complaints about privacy

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

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Virginia Premier or Kaiser Permanente staff treated you poorly.
- Virginia Premier or Kaiser Permanente is not responding to your questions.

- You are not happy with the assistance you are getting from your Care Coordinator.

Complaints about accessibility

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

Complaints about communication access

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

Complaints about waiting times

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

Complaints about cleanliness

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

Complaints about communications from us

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

There Are Different Types of Complaints

You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by us An external complaint is filed with and reviewed by an organization that is not affiliated with Virginia Premier or Kaiser Permanente.

Internal Complaints

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Attn: Appeals and Correspondence Unit

2101 E. Jefferson St.

Rockville, MD 20852

Fax: 1-866-640-9826

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

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

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

External Complaints

You Can File a Complaint with the Managed Care Helpline

You can make a complaint about Virginia Premier to the Managed Care Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) Monday – Friday, 8:30 a.m. – 6:00 p.m.

You Can File a Complaint with the Office for Civil Rights

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

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

14. Member Rights

Your Rights

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

- Receive timely access to care and services;
- Take part in decisions about your health care, including your right to choose your providers from Kaiser Permanente 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;
- Get information in a language you understand - you can get oral translation services free of charge;
- Receive reasonable accommodations to ensure you can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services;
- Receive information necessary for you to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of your medical records and ask that the records be amended or corrected;
- Have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to you or others or when there is a specific medical necessity. Seclusion and restraint will never be used a s a means of coercion, discipline, retaliation, or convenience;
- Get care without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be informed of where, when and how to obtain the services you need from Virginia Premier or Kaiser Permanente, including how you can receive benefits from out-of-network providers if the services are not available in Kaiser Permanente's network

- Complain about us to the State. You can call the Helpline at 1-800-643-2273 to make a complaint about us.
- Appoint someone to speak for you about your care and treatment and to represent you in an Appeal;
- Make advance directives and plans about your care in the instance that you are not able to make your own health care decisions. See section 14 of this handbook for information about Advance Directives.
- Change your health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference section 2 of this handbook or call the Managed Care Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) or visit the website at virginiamanagedcare.com for more information.
- Appeal any adverse benefit determination (decision) by us that you disagree with that relates to coverage or payment of services. See Your Right to Appeal in this section 15 of the handbook.
- File a complaint about any concerns you have with our customer service, the services you have received, or the care and treatment you have received from one of our network providers. See Your Right to File a Complaint in section 15 of this handbook.
- To receive information from us about our plan, your covered services, providers in our network, and about your rights and responsibilities.
- To make recommendations regarding our Member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this section of the handbook.)

Your Right to be Safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If you, or someone you know, is being abused, physically, is being neglected, or is being taken advantage of financially by a family member or someone else, you should call your local department of social services or the Virginia Department of Social Services' 24-hour, toll-free hotline at: 1-888-832-3858. You can make this call anonymously; you do not have to provide your name. The call is free.

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

Your Right to Confidentiality

We 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. We will follow the additional privacy requirements outlined in 42 CFR

Part 2 regarding the release of records related to substance use disorder and addiction, recovery, and treatment, including the additional member consent and disclosure requirements. We take additional measures to protect data related to medical record documents, appointment records for treatment of sexually transmitted infections, files, and other related confidential information.

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

Your Right to Privacy

Your health care and personal records are private. We will not share them unless you allow us to. If you cannot give your consent, we will only share your records if doing so protects your health and well-being. We know these records belong to you. We know you want to keep them safe and private.

We will only share your information with others in a way that keeps it safe. Whether we are contacting someone in person, in writing, by phone, fax, email or any other method, we will take steps to make sure your records are only received by those who are supposed to get them.

By law we have to give you the Notice of Privacy Practices. The Notice of Privacy Practices can be found in the handbook. (You can also ask for a copy of this notice by calling Member Services. And you can find the notice on our website, kp.org.

The Notice of Privacy Practices outlines how your health care information is being used or shared to carry out treatment, payment or health care operations and for other purposes that are allowed or required by state or federal law. We have to keep your information private and notify you of duties and privacy practices.

This notice also tells you about your rights to get and control your Protected Health Information (PHI). PHI is information that has to do with your past, present or future physical or mental health or condition and has to do with health care services, like demographics, that may identify you. Our privacy policies will always reflect the most protective laws that apply.

Your doctor's office will label your medical records with your unique identification number. They will store your records in a safe place where other people will not be able to get to your personal information. Information in a computer cannot be accessed without a special password.

Your medical records cannot be sent to anyone without your written permission, unless required by law. When you ask your doctor's office to send records, they will give you a release form to sign. It is up to the office to do this for you.

If you have a problem getting your records or having them sent to a doctor, please call Member Services. Member Services will help you get your records within 10 business days of when you ask for the records. Member Services can also help you in the other ways listed

here:

- Get your medical records to a newly assigned Primary Care Physician (PCP).
- Send records to an out-of-network provider for the medical management of your health.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is posted in Kaiser Permanente medical centers. It is also on our website, kp.org. It is our policy to provide you with a privacy notice that explains how your health care information is being used or disclosed. We are required to maintain the privacy of your information and provide a notice of duties and privacy practices pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by state or federal law. It also describes your rights to access and control your protected health information. “Protected health information” is information collected from you or created or received by us that relate to your past, present or future physical or mental health or condition and related health care services, including demographics that may identify you.

We required to abide by the terms of this Notice of Privacy Practices currently in effect. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time and will be sent to you within 60 days of the change. We retain prior versions of the Notice of Privacy Practices for six (6) years from the revision date.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

This Notice of Privacy Practices will tell you the ways in which we may use and disclose medical information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

- **For Treatment:** We may use medical information about you to provide you with medical treatment or services and to work with your doctors to plan for quality care. For example, in a case of diabetes, we would work with your provider to get and give you dietary education and/or home health nursing as needed. Different departments also may share medical information about you in order to coordinate the different things you need, such as authorization review. We also may disclose medical information about you to people outside Virginia Premier or Kaiser Permanente who may be involved with your medical care.

- **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at a treatment facility may be billed and payment made. For example, we may use your medical information from a surgery you received at the hospital so that the hospital can be paid. We may also use your information to approve or decline your eligibility for treatment you may receive.
- **For Health Care Operations:** We may use and disclose medical information about you for medical operations. These uses and disclosures are necessary to make sure all patients receive quality care. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff caring for you. We may also combine medical information about many patients to decide what additional services should be covered, what services are not needed and whether certain new treatments are effective.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may also use or disclose your protected health information in the following situations without your consent or authorization:

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Business associates:** We may use or disclose your protected health information to the business associates that provide services to our organization. Examples include legal services, financial auditing and administrators of health plan subcontracts (prescriptions, vision, dental). When these services are contracted, we may disclose your protected health information to our business associates so that they can perform the job we have asked them to do and file your claims for services rendered. To protect your health information, however, we require the business associates to agree in writing to appropriately safeguard your information.
- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Coroners, Medical Examiners and Funeral Directors:** We may disclose protected health information to a coroner or medical examiner for identification purposes, cause of death determinations or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to funeral directors, as authorized by law, in order to carry out funeral-related duties. We may disclose such information in reasonable anticipation of death.
- **Organ and Tissue Donation:** Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.
- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, biologic product deviations, product defects or problems; to track products; to

enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

- **Health Oversight:** We may disclose protected health information to a health oversight agency, such as the Virginia Department of Health, for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing and coordinating services to you.
- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and purposes otherwise required by law; (2) limited information requests for identification and location purposes; (3) treating victims of a crime; and (4) suspicion that death has occurred as a result of criminal conduct.
- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority, such as the Centers for Disease Control (CDC), which is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Required Uses and Disclosures:** Under the law, we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to

investigate or determine our compliance with the requirements of 45 C.F.R Section 164.500 et. seq.

- **Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- **Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

MEMBERSHIPS

Virginia Premier Health Plan, Inc. is solely owned by Virginia Commonwealth University Health System (VCUHS). The Medical College of Virginia Hospitals (MCV-H) and the Medical College of Virginia Physicians (MCV-P) are also owned by VCUHS. These three groups participate together in an organized health care arrangement for payment activities, utilization review, and quality assessment activities. Additionally, VPHP functions as a business partner of the Virginia Department of Medical Assistance Services (DMAS). Members of VCUHS and DMAS may also use your protected health information solely for your treatment, payment and/or for the health care operations permitted by HIPAA.

YOUR RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your benefits. Usually, this includes medical and billing records but does not include behavioral health management notes.

To inspect and copy your medical information, you must submit your request in writing to the VPHP Office of Privacy and Compliance at the address on the front of this Notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, and other supplies associated with your request. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed by

submitting a written request to the address on the front of this Notice. For more information, call the VPHP Office of Privacy and Compliance at (800) 727 7536 extension 55173.

Right to Amend. If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for Kaiser Permanente. To request an amendment, your request must be made in writing and submitted to the VPHP Office of Privacy and Compliance at the address on the front of this Notice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Kaiser Permanente;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is already accurate and complete.

If we deny your request, you have a right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the VPHP Office of Privacy and Compliance at the address on the front of this Notice. Your request must state a time period for the disclosures, which may not be longer than six (6) years before the date of the request. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first accounting you request within a 12-month period will be provided free of charge. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limit on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the VPHP Office of Privacy and Compliance at the address on the front of this Notice. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both;

and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the VPHP Office of Privacy and Compliance at the address on the front of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or our business associates) discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, call the VPHP Office of Privacy and Compliance at (800) 727-7536 extension 55173. This notice is posted on our website and can be downloaded at: kp.org.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Virginia Premier or with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

All complaints must be submitted in writing. To file a complaint with Virginia Premier, send an e-mail to mailto:compliance@vapremier.com or U.S. mail to the address on the front of this Notice.

To file a complaint with the Secretary, send an e-mail to ocrcomplaint@hhs.gov or U.S. mail to: The U.S. Department of Health and Human Services 150 S. Independence Mall West, Suite 372 Philadelphia, PA 19106-3499

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided to you.

CHANGES TO THIS NOTICE

Virginia Premier is required to abide by the terms of this Notice of Privacy Practices currently in effect. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time and will be sent to you

within 60 days of the change. We retain prior versions of the Notice of Privacy Practices for six (6) years from the revision date.

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 us at KPmembervoices@kp.org.

We Follow Non-Discrimination Policies

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

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

We comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

15. Member Responsibilities

Your Responsibilities

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

- Present your Virginia Premier 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.
- Keep your appointments. If you must cancel, call as soon as you can.
- Receive all of your covered services from our plan's network.
- Obtain authorization from us prior to receiving services that require a service authorization review (see section 14).
- Call us whenever you have a question regarding your Membership or if you need assistance toll-free at one of the numbers below.
- Tell us when you plan to be out of town so we can help you arrange your services.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after hours.
- Tell us when you believe there is a need to change your plan of care.
- Tell us if you have problems with any health care staff. Call Member Services at the number below.
- Call Member Services at the phone number below about any of the following:
- If you have any changes to your name, your address, or your phone number. Report these also to your case worker at your local Department of Social Services.
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation.
- If you have any liability claims, such as claims from an automobile accident.
- If you are admitted to a nursing facility or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study

Advance Directives

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

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

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

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

Where to Get the Advance Directives Form

You can get the Virginia Advance Directives form at:

https://www.vdh.virginia.gov/OLC/documents/2011/pdfs/2011-VA-AMD-Simple.pdf

You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicaid may also have advance directive forms.

You can also visit our Life Care Planning website for additional information on the process of

Advance Care Planning and for Advance Health Care Directives.

Visit kp.org/lifecareplan.

If you have an advance directive:

- Keep a copy for yourself
- Give a copy to the person you choose to be your medical power of attorney
- Give a copy to each of your doctors
- Take a copy with you if you have to go to the hospital or the emergency room

You can ask for a complimentary packet of information about advance directives from Member Services by calling 1-855-249-5025 (TTY 711).

Completing the Advance Directives Form

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

Share the Information with People You Want to Know About It

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

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

We Can Help You Get or Understand Advance Directives Documents

Your Care Coordinator can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Remember, it is your choice to fill out an advance directive or not. You can revoke or change your advance care directive or power of attorney if your wishes about your health care decisions or authorized representative change.

Other Resources

You may also find information about advance directives in Virginia at: http://www.virginiaadvancedirectives.org/

You can store your advance directive at the Virginia Department of Health Advance Healthcare Directive Registry: https://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: 1-800-533-1560 Local Phone: 804-367-4691
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
FAX	804-527-4424
EMAIL	mailto:enfcomplaints@dhp.virginia.gov

WEBSITE	http://www.dhp.virginia.gov/Enforcement/complaints.htm

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

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

Quality care

You can get a copy of Kaiser Permanente's quality report. It's a summary of the quality goals, objectives, and activities. It explains how we improve care and service to our members, providers, and the community. For a complimentary copy of this year's report, call Member Services at 1-855-249-5025 (TTY 711). You can also see the report online at kp.org.

16. Fraud, Waste, and Abuse

We have a strict "zero tolerance" policy for fraud, waste, and abuse. Any and all cases of fraud, waste, and/or abuse will be investigated thoroughly. The Department of Medical Assistance Services (DMAS) will be informed immediately of any member who knowingly makes false statements to fraudulently use or obtain services. Occurrences of fraud, waste, and/or abuse may lead to suspension (a hold) or termination (the end) of medical benefits.

If you think you have knowledge of an occurrence involving fraud, waste, and/or abuse, notify Member Services. We will immediately investigate the matter. In addition, we will notify DMAS within 48 hours.

What is Fraud, Waste, and Abuse

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

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

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

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

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

How Do I Report Fraud, Waste, or Abuse

To report suspected fraud, waste, or abuse, gather as much information as possible. You can report providers or members directly to us by writing to:

Compliance Department

Program Integrity

Kaiser Foundation Health Plan

of the Mid-Atlantic States, Inc.

2101 E. Jefferson St.

Rockville, MD 20852

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

Department of Medical Assistance Services Fraud Hotline

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

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

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

Email: MFCU_mail@oag.state.va.us

Fax: 804-786-3509

Mail: Office of the Attorney General

Medicaid Fraud Control Unit

202 North Ninth Street

Richmond, VA 23219

Virginia Office of the State Inspector General

Fraud, Waste, and Abuse Hotline

Phone: 1-800-723-1615

Fax: 804-371-0165

Email: covhotline@osig.virginia.gov

Mail: State FWA Hotline

101 N. 14th Street

The James Monroe Building 7th Floor

Richmond, VA 23219

17. Other Important Resources

Borromeo Housing, Inc.

Infant Supply Center

St. Charles Borromeo Church

3304 Washington Blvd.

Arlington, VA

Email for assistance:

information@borromeohousing.org.

To empower young single mothers to create a self-sustaining future through education, counseling, and support.

Fairfax Pregnancy Help Center

10380 Democracy Lane, Suite A & B

Fairfax, VA 22030

703-323-8060

To provide free food for women, children, babies, and others. The center may have baby formula and diapers. Hygiene items may also be distributed.

Inova Cares Clinic for Women

6400 Arlington Boulevard, Suite 110

Falls Church, VA 22042

703-531-3014

To provide charity care for residents of Fairfax County with Fairfax County Health Department.

Northern Virginia Family Services:

Healthy Families Virginia

www.nvfs.org

info@nvfs.org

571-748-2500

To provide a variety of assistance programs from mental health to early childhood development.

The Northern Virginia MISS Foundation

Perinatal Concerns Program, Inova Fairfax Hospital

Contact: Kelly Vergot, RN

Falls Church, VA

703-776-6103

To provide family support during pregnancy, postnatal, and postpartum periods.

Postpartum Support Virginia

Arlington, VA

703-829-7152

To help new and expectant mothers and families overcome anxiety, depression, and other mood disorders.

Tepeyac Family Center Kristin Anderson

Perinatal Hospice Program

Fairfax, VA

703-273-9440

To provide care through pregnancy, labor, delivery, postpartum, and first year thereafter.

18. Key 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 us 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 our cost-sharing amount for services. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.
- Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.
- Care 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 Manager: 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.
- Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid programs.
- Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."
- Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services.
- Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

- Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.
- Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.
- Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.
- Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.
- Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.
- Excluded services: Services that are not covered under the Medicaid benefit.
- Fair hearing: See State Fair Hearing. The process where you appeal to the State on a decision made by us that you believe is wrong.
- Fee-for-service: The general term used to describe Medicaid services covered by the Department of Medical Assistance Services (DMAS).
- Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.
- Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.
- Habilitation services and devices: Services and devices that help you keep, learn, or improve skills and functioning for daily living.
- Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.
- Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.
- Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.
- Helpline: an Enrollment Broker that DMAS contracts with to perform choice counseling and enrollment activities.
- Home health aide: A person who provides services that do not need the skills of a

licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

- Home health care: Health care services a person receives in the home including nursing care, home health aide services and other services.
- Hospitalization: The act of placing a person in a hospital as a patient.
- Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.
- List of Covered Drugs (Drug List): A list of prescription drugs covered by Virginia Premier. Virginia Premier chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”
- 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 health care 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.
- Member Services: A department responsible for answering your questions about your Membership, benefits, grievances, and appeals.
- Model of care: A way of providing high-quality care. The model of care includes care coordination and a team of qualified providers working together with you to improve your health and quality of life.
- Network: “Provider” is the general term we use for doctors, nurses, and other people

who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them "network providers" when they agree to work with Virginia Premier and accept our payment and not charge our Members an extra amount. While you are a Member of our 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 Virginia Premier 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 us and is not under contract to provide covered services to Members of our plan.
- Nursing facility: A medical care facility that provides care for people who cannot get their care at home but who do not need to be in the hospital. Specific criteria must be met to live in a nursing facility.
- Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by us and is not under contract to provide covered services to Members of our plan.
- Participating provider: Providers, hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports that are contracted with Virginia Premier. Participating providers are also "in-network providers" or "plan providers."
- Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.
- Prescription drug coverage: Prescription drugs or medications covered (paid) by us. Some over-the-counter medications are covered.
- Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.
- Primary Care Physician (PCP): Your primary care physician is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.
- Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck

braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.

- Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with us, including doctors, nurses, behavioral health providers and specialists.
- Referral: In most cases, your PCP must give you approval before you can use other providers in our network. This is called a referral.
- Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, injury, or major operation.
- Service area: A geographic area where a managed care plan is allowed to operate. It is also generally the area where you can get routine (non-emergency) services.
- Service authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from us.
- Specialist: A doctor who provides health care for a specific disease, disability, or part of the body.
- Urgently needed care: Care you get for a non-life threatening sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Member Services

CALL	855-249-5025 This call is free. Monday-Friday, except holidays, 7:30 a.m.- 5:30 p.m. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. Monday-Friday, except holidays, 7:30 a.m.- 5:30 p.m. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Attn: Appeals and Correspondence Unit 2101 E. Jefferson St. Rockville, MD 20852
WEB SITE	kp.org/medicaid/va

19. Medicaid Expansion Addendum

What Makes You Eligible to be a Medicaid Expansion Member

You are 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 Level (FPL)

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

Enrollment for a Medicaid Expansion Member

You can change your health plan during the first 90 days of your Medallion program enrollment for any reason. You can also change your health plan during your annual open enrollment period for any reason. You may contact the Managed Care Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) or visit www.virginiamanagedcare.com to find out the open enrollment period for your region. You will get a letter from DMAS during the open enrollment period with more information.

Medicaid Expansion Benefits and Services

As a Medicaid expansion Member, you have a variety of health care benefits and services available to you. You will receive most of your services through Virginia Premier and Kaiser Permanente.

If you are an eligible Medicaid expansion Member, in addition to the standard Medicaid services available to all Medicaid members, you will also receive the following four health benefits:

- Annual adult wellness exams,
- Individual and group smoking cessation counseling,
- Nutritional counseling if you are diagnosed with obesity or chronic medical diseases, and
- Recommended adult vaccines or immunizations.

We will also encourage you to take an active role in your health. This may mean taking part in disease management programs, getting a flu shot, quitting smoking or using tobacco/nicotine products, or accessing services that are not typically covered by traditional medical practices like gym memberships or vision services.

If you frequently visit the emergency room, we will 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.

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

What is a Health Screening?

Within four months after you enroll with Virginia Premier, a(n) representative will contact you or your authorized representative via telephone or in person to ask some questions about your health needs and social circumstances. These questions will make up what is called the "Health Screening." The representative will ask about any medical conditions you currently have or have had in the past, your ability to do everyday things, and your living conditions.

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

If you meet the medically complex criteria, you will transfer from the Medicaid Managed Care Medallion 4.0 program to the CCC Plus program. If it is determined you do not have medically complex needs, you will remain in the Medallion 4.0 program. Also, if we are unable to contact you, or you refuse to participate in the entire health screening, you will remain enrolled in the Medallion program. You will stay with Virginia Premier 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.

If you do not meet medically complex criteria and do not agree, you have a right to submit a complaint or grievance to Virginia Premier. See the Your Right to File a Complaint (Grievance) section for details.

Please contact us if you need accommodations to participate in the health screening.

If you have questions about the health screening, please contact 1-855-249-5025 or TTY 711. This call is free.