COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

Cardinal Care Model Member Handbook

(Effective October 1, 2023)

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1. Let's Get Started

Welcome to Cardinal Care

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

This Member Handbook explains benefits and how to access services for Cardinal Care, Virginia's Medicaid/FAMIS program. For questions, call [Plan's] Member Services at [phone number] (TTY: [phone number]) [date/hours of operation], visit our website at [Plan website], or call your care manager.

Other Languages and Formats

If you need this handbook in large print, in other formats or languages, read aloud, or if you need a paper copy, call [Plan's] Member Services [phone number] (TTY: [phone number]). You can get what you need for free. Members with alternative hearing or speech communication needs can dial 711 to reach a Telecommunications Relay Services (TRS) operator who can help you. Auxiliary aids and services are available upon request at no cost. Visit us online anytime at [Plan website] or [DMAS website].

English
ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

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

Spanish
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al [1-xxx-xxx-xxxx] (TTY: [1-xxx-xxx-xxxx]).

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

Korean
주의**:** 한국어를 사용하시는 경우**,** 언어 지원 서비스를 무료로 이용하실 수 있습니다**. 1-xxxxxx-xxxx (TTY: 1-xxx-xxx-xxxx)**번으로 전화해 주십시오**.**

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

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số [1-xxxxxx-xxxx] (TTY: [1-xxx-xxx-xxxx]).

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

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-xxx-xxx-xxxx（TTY：1- xxx-xxx-xxxx）

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

Arabic
ملحوظة: إذا كنت تتحدث اللغة اذكر ،فإن خدمات المساعدة اللغوية المتوافر لك تتوافر بالمجان. برقم اتصل [1-xxxx-xxx-xxx] رقم ه الصم والبكم : ([xxx-xxx-xxxx-1])

[Plan] بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أويلتزم الأصل الوطني أو السن أو الإعاقة أو الجنس.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

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

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید تماس 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) با .باشد می فر

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

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ [1-xxx-xxx-xxxx] (መስማት ለተሳናቸው: [1-xxx-xxx-xxxx]).

[Plan] የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በኣካል ጉዳት ወይም በጾታ ማንኛውንም ሰው ኣያገልም።

Urdu
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-xxx-xxx-xxxx- رقم هاتف الصم والبكم: 1 (xxx-xxx-xxxx.

[Plan] قاب ِل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے
اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا.

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-xxx-xxx-xxxx (ATS : 1-xxx-xxx-xxxx).

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

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-xxx-xxx-xxxx (телетайп: 1-xxx-xxx-xxxx).

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

Hindi
ध्यान द: यद आप हदी बोलते ह तो आपके ि लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) पर कॉल कर।

[Plan] लागूहोने योग्य संघीय नागरक अिधकार क़ाननू का पालन करता ह और जात, रंग, राय मूल, आयु, वकलांगता, या लग के आधार पर भेदभाव नह करता ह।

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

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

Bengali
লয্ করনঃ যিদ আিন বাংলা, কথা বললত ি াল রন, তালেল য নঃখরচায় ভাষা সোয়তা যিলরষবা ডিল আআছ্। আ ফান করন ১-xxx-xxx-xxxx (TTY: ১-xxx-xxx-xxxx)।

[Plan] যাজয্ ফডারল নাগিরক অিধকার আইন মেন চেল এবং জাত, রঙ, জাতীয় উৎপিত্ত, বয়স, অমতা, বা লের ভিত্তেত বষময্ কের না।

Bassa
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ ké m̀ [B̀àsɔ́ ò -wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ ìn m̀ gbo kpáa. Đá 1-xxx-xxx-xxxx (TTY:1-xxx-xxx-xxxx)

[Plan] Nyɔ ɓɛ̌è kpɔ̃ nyɔŭn-dyù gbo-gmɔ̀ -gmà ɓɛ̌ɔ̀ dyi ké wa ní ge nyɔŭn-dyù mú dyììn ɖé ɓóɖó-dù nyɔɔ̀ sɔ̀ kɔ̃ ɛ mú, mɔɔ kà nyɔɔ̀ dyɔɔ̀ -kù nyu nìè kɛ mú, mɔɔ ɓóɖó ɓɛ́ nyɔɔ̀ sɔ̀ kɔ̃ ɛ mú, mɔɔ zɔ̃jĭ̌ kà nyɔɔ̀ ɖă̌ nyuɛ mú, mɔɔ nyɔɔ̀ mɛ kɔ́ dyíɛ mú, mɔɔ nyɔɔ̀ mɛ mɔ̀ gàa, mɔɔ nyɔɔ̀ mɛ mɔ̀ màa kɛɛ mú.

Notice of Nondiscrimination

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

[Plan] provides:

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

If you need these services, contact [Plan's] Member Services at [phone number] (TTY: [phone number]). This call is free.

If you think the [Plan's] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: [Plan's Civil Rights Coordinator address, phone number and TTY).

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://hhs.gov/ocr/office/file/index.html.

Important Contact Information

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

Entity Name	Contact Information
[Plan's] Member Services	[Phone number] TTY: [Phone number] [Plan website] [Days/hours of operation, including information on alternative technologies for afterhours] [Plan mobile app, if applicable] [High-level information on how to access care management]
[Plan's] Medical Advice Line	[Phone number] TTY: [Phone number] 24 hours a day, seven days a week
[Plan's] Behavioral Health Crisis Line	[Phone number] TTY: [Phone number] 24 hours a day, seven days a week
Addiction and Recovery Treatment Services (ARTS) Medical Advice Line	[Phone number] TTY: [Phone number] 24 hours a day, seven days a week
Department of Behavioral Health and Developmental Services (DBHDS) for DD Waiver Services	My Life My Community Helpline 1-844-603-9248 TTY: 804-371-8977 Monday through Friday, 9 a.m. to 4:30 p.m. https://www.mylifemycommunityvirginia.org/
Cardinal Care Dental Benefits Administrator	1-888-912-3456 TTY: 1-800-466-7566 https://dentaquest.com/state-plans/regions/virginia/ Monday through Friday, 8:00 a.m. to 6:00 p.m.
[Plan's] Vision Services	
[Plan's] Transportation Services	[Phone number] TTY: [Phone number] [Days/hours of operation]
Cardinal Care Transportation for Developmental Disability Waiver Services	1-866-386-8331 TTY: 1-866-288-3133 Dial 711 to reach a TRS operator 24 hours a day, seven days a week

Entity Name	Contact Information
Cardinal Care Managed Care Enrollment Helpline	1-800-643-2273 TTY: 1-800-817-6608 Monday through Friday, 8:30 a.m. to 6:00 p.m.
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019 TTY: 1-800-537-7697 hhs.gov/ocr
Office of the State Long-Term Care Ombudsman	1-800-552-5019 TTY: 1-800-464-9950 elderrightsva.org

Staying Connected

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

You can update your contact information today:

- ✓ By calling Cover Virginia at 1-833-5CALLVA.
- ✓ Online at commonhelp.virginia.gov.
- ✓ By calling [Plan's] Member Services.
- ✓ By calling your local Department of Social Services (DSS).

2. Cardinal Care Managed Care Overview

Health Plan Enrollment

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

If you move out-of-state you will no longer be eligible for Cardinal Care in Virginia, but you may be eligible for the Medicaid program in the state where you live. If you have questions about your eligibility for Cardinal Care, contact your local DSS or call Cover Virginia at 1-833-5CALLVA (TTY: 1-888-221-1590). This call is free.

[*Optional Information for Plan to Include:* Additional information about the health plan and a high-level description of what new members should do now that they are enrolled – e.g., top three to five steps new members should take, like choosing a PCP].

[Plan's] Member Services is available to help if you have any questions or concerns. Call [phone number] (TTY: [phone number]) [date/hours of operation] or visit us at [Plan website].

You can change your health plan:

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

Call the Cardinal Care Managed Care Enrollment Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) Monday through Friday, 8:30 a.m. to 6:00 p.m. for information about your open enrollment period, or "good cause," or to help you choose or change your health plan. Cardinal Care Managed Care Enrollment Helpline services are free. FAMIS members can call Cover Virginia at 1-833-5CALLVA to change health plans.

Welcome Packet

You should have received a welcome packet that includes your Member ID Card, information on [Plan's] Provider Directory, and the Preferred Drug List. If you did not receive your welcome packet, call [Plan's] Member Services. [Information on (1) other ways to access these resources if the Member did not receive them or wants to access them electronically – e.g., through a mobile application; and (2) other resources sent to the Member].

[Plan] Member ID Card

You must show your [Plan] Member ID card to get services or prescription drugs covered by [Plan] (see sample Member ID card below) when you go to your provider or pharmacy. If you have not received your card, or if your card is damaged, lost, or stolen, call [Plan's] Member Services right away to get a new one.

[Picture of front and back of Member ID Card marked with the word "sample" on the image. Include information about rollout of new ID cards].

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

[Plan's] Provider Directory

The provider directory lists providers and pharmacies that participate in [Plan's] network of contracted providers. It also includes information on the accommodations each provider has for members with disabilities or who do not speak English. [More information about where the Provider Directory is located, how to access it in paper and electronic form, and what is included. For NCQA, health plans need to describe how members find provider contact info, qualifications, specialty, medical school/residency/board certification status].

Preferred Drug List

This list tells you which prescription drugs are covered by [Plan] and the Department. It also tells you if there are any rules or restrictions on the drugs, like a limit on the amount you can get (see *Section 6, Your Prescription Drugs*). Call [Plan's] Member Services to find out if your drugs are on the list or check online at [website]. [Plan] can also mail you a paper copy at your request.

Other Insurance

If you have more than one health insurance plan, then Medicaid pays for services after your other insurance plans have paid your provider. This means that if you have other insurance, are in a car accident, or if you are injured at work, then your other insurance or workers compensation must pay for your services first. Let [Plan's] Member Services know if you have other insurance so that [Plan] can coordinate your benefits. The Virginia Insurance Counseling and Assistance Program (VICAP) can also help. Call 1-800-552-3402 (TTY: 711) for health insurance counseling available to people with Medicare. This call is free.

3. Providers and Getting Care

[Plan's] Provider Network

It is important that the providers you choose accept Cardinal Care members and participate in [Plan's] network. [Plan's] network includes access to care 24 hours a day, seven days a week. [Plan] provides you with a choice of providers that are located near you. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, you should not have to travel more than 60 miles or 75 minutes to receive services. To find providers, such as primary care providers (PCPs), specialists, and hospitals, you can:

- Search for providers in the Provider Directory (see *Section 2, Cardinal Care Managed Care Overview*).
- Call [Plan's] Member Services at [phone number] (TTY: [phone number]) or visit us at [Plan website].

[Describe how members access network providers, including specialists, and the role of PCPs in referring members to specialists and other providers; and any restrictions on the member's freedom of choice among network providers].

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

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

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

Primary Care Providers (PCPs)

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

- For physical exams and routine checkups.
- For preventive care services.

- When you have questions or concerns about your health.
- When you are not feeling well and need medical help.

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

Choosing Your PCP

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

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

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

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

Changing Your PCP

You can change your PCP at any time. Call [Plan's] Member Services to choose another PCP in [Plan's] network. [*Optional Information for Plan to Include:* Additional detail on changing a PCP and when the change will take effect – e.g., on the first day of the month following the date of the request].

Specialists

If you need care that your PCP cannot provide, [Plan] or your PCP may refer you to a specialist. A specialist is a provider who has additional training on services in a specific area of medicine, like a surgeon. The care you receive from a specialist is called specialty care. If you need ongoing specialty care, your PCP may be able to refer you for a specified number of visits or length of time (a "standing referral").

Out-Of-State Providers

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

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

[Plan] may need to give you authorization to see a provider who is out-of-state. [Plan] does not cover any health care services outside of the U.S.

When a Provider Leaves the Network

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

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

Getting Care Outside of [Plan's] Network

You can get the care you need from a provider outside of [Plan's] network in any of the following circumstances:

- If [Plan] does not have a network provider to give you the care you need.

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

[Additional information on the circumstances under which members can obtain services from out-of-network providers].

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

Choices for Nursing Facility Members

If you are in a nursing facility at the time you enroll in [Plan], you may choose to:

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

Making Appointments with Providers

Call your provider's office to make an appointment. For help with making an appointment, call [Plan's] Member Services. If you need a ride to your appointment, call [Plan's Transportation Reservation Line phone number] (TTY: [Plan's Transportation Reservation Line phone number]). If you call after hours, leave a message explaining how to reach you. Your PCP or other provider will call you back as quickly as possible. If you have difficulty getting an appointment with a provider, contact [Plan's] Member Services. Remember to tell [Plan] when you plan to be out of town so [Plan] can help you arrange your services.

Telehealth

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

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

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

Getting Care from the Right Place When You Need it Quickly

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

Type of Care	How to Get Care	Examples of When to Get This Type of Care	Need a Referral?
PCPs can provide care for when you get sick or injured and preventive care that keeps you healthy	Contact your PCP's office or [Plan] to schedule an appointment	• Minor illness/injury • Flu/fever • Vomiting/diarrhea • Sore throat, earache, or eye infection • Sprains/strains • Possible broken bones	No
Urgent care is care you get for a sickness or an injury that needs medical care	Check the Provider Directory at [Plan website] to find an urgent care clinic	Urgent care can manage similar things as your PCP, but is available when other offices are unavailable	No, but make sure to go to an urgent care clinic that is in [Plan's] network if you

Type of Care	How to Get Care	Examples of When to Get This Type of Care	Need a Referral?
quickly and could turn into an emergency			can. [Any exceptions to this requirement]
Emergency care (or care for an emergency medical condition) is care you get when an illness or injury is so serious that your (or, as applicable, your unborn baby's) health, bodily functions, body organs or body parts may be in danger if you do not get medical care right away	Call 911 and go to the nearest hospital. You have the right to get emergency care 24 hours a day, seven days a week from any hospital or other setting, even if you are in another city or state. [Plan] will provide follow-up care after the emergency	• Unconsciousness • Difficulty breathing • Serious head, neck, or back injury • Chest pain/pressure • Severe bleeding • Severe burns • Convulsions/seizures • Broken bones • Fear you might hurt yourself or someone else ("behavioral health emergency") • Sexual assault	No. You can get emergency care from network providers or out-of-network providers. You do not need a referral or service authorization.

Getting Care After Hours

If you need non-emergency care after normal business hours, call [Plan's Medical Advice Line]. A nurse or behavioral health professional can:

- Answer medical questions and give you advice for free.
- Help you decide if you should see a provider right away.
- Help with medical conditions.
- [*Optional Information for Plan to Include:* Additional information about what the Medical Advice Line can help with].

Transportation to Care

Non-Emergency Medical Transportation

If you need transportation to receive covered benefits such as medical, behavioral, dental, vision and pharmacy services, call [Plan's] Transportation Reservation line. [Plan] covers non-emergency transportation for covered services. If you have trouble getting an appointment, call [Plan's] Transportation Where's My Ride/Ride Assist, Member Services or your care manager. If you have your own ride to your appointment, your driver may be paid back at a

set rate per mile (limits apply). Members, family, friends and caregivers are eligible for mileage reimbursement through [health plan]. You must call [Plan transportation phone number] before your appointment to be eligible for reimbursement. [Include additional instructions about forms, etc]

FAMIS children are not eligible for Non-Emergency Medical Transportation.

If you need transportation to developmental disability waiver services, contact the Cardinal Care Transportation for Developmental Disability Waiver Services Contractor at 1-866-386-8331 (TTY: 1-866-288-3133) or visit transportation.dmas.virginia.gov/. If you have problems getting transportation to your developmental disability waiver services, call Where's My Ride at 1-866-246-9979 or your developmental disability waiver Case Manager.

Emergency Medical Transportation
If you are experiencing an emergency medical condition and need transportation to the hospital, call 911 for an ambulance. [Plan] will cover an ambulance if you need it.

4. Care Coordination and Care Management

Care Coordination

All members can get help finding the right health care or community resources by calling [Plan's] Member Services. [Information explaining how members can access care coordination assistance and supports]. You can also call [phone number] (TTY: [phone number]) 24 hours a day, seven days a week to talk to an on-call nurse or other licensed health professional.

What is Care Management?

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

How to Get a Care Manager

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

If you have questions or need help with the Health Screening, contact Member Services at [phone number] (TTY: [phone number]). This call is free.

How Your Care Manager Can Help You

Your care manager is someone from [Plan] with special health care expertise who can help you manage your health and social needs. Your care manager can:

- Assess your health and social needs.
- Answer questions about your benefits, like physical health services, behavioral health services, and long-term services and supports (LTSS) (see *Section 5, Your Benefits*).
- Help connect you to community resources (for example, programs that can support your housing and food needs).
- Support you in making informed decisions about your care and what you prefer.

- Assist you with scheduling appointments when needed and find available providers in [Plan's] network, and make referrals to other providers, as needed.
- Help you get transportation to your appointments (see *Section 3, Providers and Getting Care*).
- Make sure you get your prescription drugs and help if you feel side effects.
- Share your test results and other health care information with your providers so your care team knows your health status.
- Help with moving between health care settings (like from a hospital or nursing facility to home or another facility).
- Make sure your needs are met once you leave a hospital or nursing facility and on an ongoing basis.

How to Contact Your Care Manager

[Information on how members can contact their care manager and how they can change their care manager if they want to.] Free interpreter services are available in all languages for people who do not speak English.

Contact Method	Contact Information
Call	[Phone number] TTY: [phone number] [Information on the use of alternative technologies] [Days/hours of operation]
Fax	[Fax number]
Write	[Mailing address]
Email	[Email address]
Website	[Website]

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

Health Risk Assessment

After [Plan] assigns you a care manager and conducts the Health Screening, [Plan] will contact you to conduct a more in-depth Health Risk Assessment. During the Health Risk Assessment, your care manager or another health care professional will ask you more questions about your physical health, behavioral health, social needs, and your goals and preferences. The Health Risk Assessment helps your care manager to understand your needs and get you the right care. You can choose to do the Health Risk Assessment in-person, over the phone, or by videoconference. Over time, your care manager will check-in with you to repeat the Health Risk Assessment questions to find out if your needs are changing.

Your Care Plan

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

Your Care Team

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

Coordination with Medicare or Other Health Plans

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

Additional Care Management Services

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

- Are in foster care or were in foster care.
- Are pregnant and are at higher risk for complications during and after pregnancy.
- Receive services in your home or the community, such as a home health, personal care, or respite services.

- Have a substance use disorder.
- Use a ventilator.
- Are homeless.

If you need a care manager, call your [Plan's Member Services] for assistance.

5. Your Benefits

Overview of Covered Benefits

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

You can also access the full list of covered benefits at: [Plan website]. Call [Plan's] Member Services at [phone number] (TTY: [phone number]) or your care manager, if you have one, for more information about your services and how to get them.

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

[Information on benefits, including counseling or referral services that are not covered by [Plan] due to moral or religious objections, if applicable; and information on how members can get information from the Department about how to access such services].

Benefits for All Members

Physical Health Services

[Plan] and the Department cover physical health services (including dental and vision) for Cardinal Care members:

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

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

Remember, services marked with an asterisk (*) may require service authorization. [Additional information on service authorization requirements for physical health services, as needed. Describe hospital services and concurrent review process, as applicable].

The Department contracts with a Dental Benefits Administrator, DentaQuest, to provide dental services to all Medicaid/FAMIS members. See the table below for dental services available to you. You are not responsible for the cost of dental services received from a participating dental provider. Some dental services will require prior approval. [Plan] will work with the Department's Dental Administrator to authorize some services, including anesthesia when medically necessary. For questions about your dental benefits or to find a participating dentist near you, call DentaQuest Member Services at 1-888-912-3456 (TTY: 1-800-466-7566) or visit dmas.virginia.gov/dental.

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

Behavioral Health Services

[Plan], the Department or its contractor covers the behavioral health treatment services in the table below for [Plan] members. Behavioral health refers to mental health and addiction services. In Virginia, treatment for addiction is called "Addiction and Recovery Treatment

Services" (ARTS). [Plan's] Member Services, your PCP, and your care manager can help you get the behavioral health services you need.

Mental Health Services
• 23-hour observation • Applied behavior analysis • Assertive community treatment • Community stabilization • Functional family therapy • Intensive in-home • Mental health case management • Mental health intensive outpatient • Mental health partial hospitalization program • Mental health peer recovery supports services • Mental health skill-building services • Mobile crisis • Multisystemic therapy • Psychiatric residential treatment facility [+] • Psychosocial rehabilitation • Residential crisis stabilization • Therapeutic day treatment • Therapeutic group home [+] • Inpatient psychiatric services • Outpatient psychiatric services
[+] Services that are managed by the Department's behavioral health administrator contractor. Your care manager will work with the Department's behavioral health administrator contractor to help you get these services if you need them.

Addiction and Recovery Treatment Services (ARTS)
• Screening, Brief Intervention and Referral to Treatment • Substance Use Case Management Services • Outpatient Services • Intensive Outpatient Services • Partial Hospitalization • Substance Use Residential Treatment   ○ ASAM 3.1

Addiction and Recovery Treatment Services (ARTS)

  - ASAM 3.3
  - ASAM 3.5
  - ASAM 4.0
- Medication Assisted Treatment
- Peer Recovery Support Services
- Opioid Treatment Services
- Office Based Addiction Treatment

[Additional information on service authorization requirements for behavioral health services – including reference to Mental Health Parity and Addiction Equity Act (MHPAEA) requirements].

For questions about addiction and recovery services, call the ARTS Medical Advice Line at [phone number] (TTY: [phone number]) 24 hours a day, seven days a week. This call is free. [*Optional Information for Plan to Include*: More information on the ARTS Medical Advice Line].

If you are thinking of harming yourself or someone else, call the Behavioral Health Crisis Line [phone number] (TTY: [phone number]) 24 hours a day, seven days a week. This call is free. [*Optional Information for Plan to Include*: More information on the Behavioral Health Crisis Line]. Remember, if you need help right away, call 911.

Long-Term Services and Supports (LTSS)

[Plan] and the Department cover LTSS such as private duty nursing, personal care, and adult-day health care services to help people meet their daily needs and maintain independence living in the community or a facility. Before receiving LTSS, a community-based or hospital team will conduct a screening to see if you meet "level of care" criteria – in other words, whether you qualify for and need LTSS. Contact your care manager to learn about the screening process to receive LTSS.

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

- Intermediate care facility for individuals with intellectual disabilities (ICF/IID).

- Care from one of the following nursing facilities:
  - Bedford County Nursing Home
  - Birmingham Green
  - Dogwood Village of Orange County Health
  - Lake Taylor Transitional Care Hospital
  - Lucy Corr Nursing Home
  - The Virginia Home Nursing Facility
  - Virginia Veterans Care Center
  - Sitter and Barfoot Veterans Care Center
  - Braintree Manor Nursing Facility and Rehabilitation Center
- Care from Piedmont, Hiram Davis, or Hancock state operated long term care facility.
- Program of All Inclusive Care for the Elderly (PACE) care.

If you get LTSS, you may need to pay for part of your care (see *Section 9, Cost Sharing*). If you have Medicare, [Plan] will cover nursing facility care after you have used all of the skilled nursing care that was available to you. [Additional information on service authorization requirements for LTSS, as needed].

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

Some members may qualify for HCBS waiver services (see table below). To learn more or to find out if you are eligible, contact [Plan] or your care manager. Developmental Disability waiver services are managed through the Department of Behavioral Health and Developmental Services (DBHDS). You can also find more information about Developmental Disability waiver services on the DBHDS website mylifemycommunityvirginia.org or by calling 1-844-603-9248.

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

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

[Additional information on service authorization requirements for waiver members, as needed].

Benefits for Children/Youth Under Age 21

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

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

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

- Treatment foster care case management

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

FAMIS children are eligible for well-child visits and immunizations, but not all EPSDT services. For more information on accessing EPSDT services, contact [Plan's] Member Services or your care manager. [Additional information on service authorization requirements for EPSDT].

Early Intervention (EI) Services
If you have a baby under the age of three that is not learning or developing like other babies, your child may qualify for EI services. EI services include, for example:

- Speech therapy.
- Physical therapy.
- Occupational therapy.
- Service coordination.
- Developmental services to support the child's learning and development.

EI services do not require service authorization from [Plan]. There is no cost to you for EI services. Contact [Plan's] Member Services for a list of EI providers, specialists, and case managers. Your care manager can connect you to your local Infant and Toddler Connection program to help you access these services. You can also call the Infant and Toddler Connection program directly at 1-800-234-1448. (TTY: 711) or visit itcva.online.

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

Benefits for Family Planning and Pregnant/Postpartum People

You can get free health care services to help you have a healthy pregnancy and a healthy baby. This includes health care services for up to 12 months after you give birth. [Plan] and the Department cover the following services:

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

Remember, you do not need a service authorization or a referral for family planning services. You can get family planning services from any provider, even if they are not in [Plan's] network. [Additional information on service authorization requirements for benefits for pregnant people and mothers, as needed].

Newborn Coverage

If you have a baby, report the birth to the Department as quickly as possible so that your child can get health insurance. Do this by calling Cover Virginia at 1-833-5CALLVA or by contacting your local DSS.

Added Benefits for [Plan] Members

[Plan] provides some added benefits for members. These include: [detailed information on Plan's enhanced benefits (e.g., social determinants of health interventions, educational or job training referrals, chiropractic care) and any in lieu of services].

6. Your Prescription Drugs

Understanding Your Prescription Drug Coverage

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

To know which prescriptions are covered by [Plan] and the Department, see the Preferred Drug List at [website]. The Preferred Drug List can change during the year, but [Plan] will always have the most up-to-date information. [Information on how to contact Plan for the current Preferred Drug Lists. Description of how members are notified of changes to the Preferred Drug List, including if a drug a member is taking is removed from the list].

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

Prescription Drugs for FAMIS Members

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

Drugs that Require You or Your Provider to Take Extra Steps

Some drugs have rules or restrictions on them that limit how and when you can get them. For example, a drug may have a quantity limit, which means you can only get a certain amount of the drug each time you fill your prescription. For drugs with special rules, you may need a service authorization from [Plan] before you can get your prescription filled (see *Section 7, Getting Approval for Your Services, Treatments, and Drugs*). If you do not get approval, [Plan] may not cover the drug. To find out if the drug you need has a special rule, check the Preferred Drug List. If [Plan] denies or limits your coverage for a drug and you disagree with the decision, you have the right to appeal (see *Section 8, Appeals and Complaints*).

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

Emergency Supply of Drugs
If you ever need a drug and you cannot get a service authorization quickly enough (like over the weekend or a holiday), you can get a short-term supply of your drug by getting [Plan] approval. You can get [Plan] approval if a pharmacist believes that your health would be at-risk without the benefit of the drug. When this happens, [Plan] may authorize a 72-hour emergency supply. [Information on how members can get an emergency supply of drugs].

Long-Term Supply of Drugs
[Information on whether and how members can get a long-term supply of drugs, as applicable].

Getting Your Drugs from a Network Pharmacy

Once your provider orders a prescription for you, you will need to get your prescription drugs filled at a network pharmacy (except during an emergency). A network pharmacy is a drug store that agrees to fill drugs for [Plan's] members. To find a network pharmacy, use your Provider Directory available at [website]. You can use any of [Plan's] network pharmacies.

If you need to change pharmacies, you can ask your pharmacy to transfer your prescription to another network pharmacy. If your pharmacy leaves [Plan's] network, you can find a new pharmacy in the Provider Directory or by calling [Plan's] Member Services at [phone number] (TTY: [phone number]).

When you go to the network pharmacy to drop off a prescription or pick up your drugs, show your [Plan] Member ID Card. If you have Medicare, show both your Medicare Card and [Plan] Member ID Card. Call [Plan's] Member Services or your care manager if you have questions or need help getting a prescription filled or finding a network pharmacy.

Getting Your Drugs Mailed to Your Home

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

[Information on mail order services for members to get drugs, as applicable].

Patient Utilization Management and Safety Program

Some members who need additional support with their medication management may be enrolled in the Patient Utilization Management and Safety Program. The program helps coordinate your drugs and services so that they work together in a way that will not harm your

health. Members in the Patient Utilization Management and Safety Program may be restricted (or locked in) to only using one pharmacy to get their drugs.

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

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

Second Opinions

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

Service Authorization

There are some services, treatments, and drugs that require service authorization before you receive them or to continue receiving them. A service authorization helps to figure out if certain services are medically necessary and if [Plan] can cover them for you. After assessing your needs and making a care recommendation, your provider must submit a request for a service authorization to [Plan] with information that explains why you need the service. This helps make sure that they can be paid for the services they provide to you. [Plan describes how it evaluates new technology as a covered benefit per NCQA ME 2A).

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

Decisions are based on what is right for each member and on the type of care and services that are needed. We look at standards of care based on:

- Medical policies
- National clinical guidelines
- Medicaid guidelines and health benefits

[Plan] does not reward employees, consultants, or other providers to:

- Deny care or services that you need
- Support decisions that approve less than what you need
- Say you do not have coverage

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

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

How to Get a Service Authorization
[Instructions on how to obtain a service authorization]. [Plan's] Member Services or your care manager can answer your questions and share more about how to request a service authorization. If you want to request a specific service that requires a service authorization, your care manager can help you find the right provider who can help figure out if you need the service.

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

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

[Plan] will contact your provider if [Plan] needs more information or time to make a decision about your service authorization. You will be informed of the communication to your requesting provider. If you disagree with [Plan] taking more time to review your request or if you do not like the way [Plan] handled your request, see *Section 8, Appeals and Complaints,* on how to file a complaint. You can talk to your care manager about your concerns, or you may call the Cardinal Care Managed Care Enrollment Helpline at 1-800-643-2273 (TTY: 1-800-817-6608). If you have more information to share with [Plan] to help decide your case, then you, or your provider can ask [Plan] to take more time to make a decision in order to include the additional information.

Adverse Benefit Determinations

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

- Denies or limits a request for health care or services your provider or you think you should be able to get, including services outside of your provider's network.

- Reduces, pauses, or stops health care or services you were already receiving.
- Fails to provide services in a timely manner.
- Fails to act in a timely manner to address grievances and appeals.
- Denies your request to reconsider a financial liability.
- Does not pay for all or part of your health care or services.

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

8. Appeals and Complaints

Appeals

When to File an Appeal with [Plan]

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

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

How to Submit Your Appeal to [Plan]

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

Phone Requests	[Plan phone number] TTY: [phone number]
Written Requests	Mail: [Plan address] Fax: [Plan fax number]

Timeframe for Appeal to [Plan]

When you file an appeal, be sure to let [Plan] know of any new or additional information that you want to be used in making the appeal decision. [Instructions for how members can provide this information]. You can also call [Plan's] Member Services if you need help. Within [timeframe], [Plan] will send you a letter to let you know that [Plan] received your appeal.

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

If [Plan] has all the information needed from you:

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

If You Are Unhappy with [Plan's] Appeal Decision

You can file an appeal to the Department through what is called the State Fair Hearing process after filing an appeal with [Plan] if:

- You disagree with the final appeal decision you receive from [Plan].

OR

- [Plan] does not respond to your appeal in a timely manner.

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

How to Submit Your State Fair Hearing Appeal

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

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

Phone Requests	1-804-371-8488 TTY: 1-800-828-1120
Written Requests	Mail: Appeals Division, DMAS, 600 E. Broad Street, Richmond, VA 23219 Fax: 804-452-5454
Electronic Requests	Website: dmas.virginia.gov/appeals Email: appeals@dmas.virginia.gov

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

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

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

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

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

FAMIS External Review
c/o Kepro
2810 N. Parham Road Suite 305
Henrico, VA 23294
Or submit online at www.DMAS.KEPRO.COM

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

Complaints

When to File a Complaint

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

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

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

How to File a Complaint with [Plan]

To file a complaint with [Plan], call [Plan's] Member Services at [phone number] ([TTY: phone number]) or file a complaint in writing by mailing it to [Plan address] or faxing it to [Plan fax number]. Be sure to include details on what the complaint is about so that [Plan] can help.

[Plan] will tell you our decision within 90 calendar days after getting your complaint. If your complaint is about your request for an expedited appeal (see above), [Plan] will respond within 24 hours of getting your complaint.

How to File a Complaint with an Outside Organization

To file a complaint with an outside organization that is not affiliated with [Plan], you can:

- Call the Cardinal Care Managed Care Enrollment Helpline at 1-800-643-2273 (TTY: 1-800-817-6608).
- Contact the U.S. Department of Health and Human Services' Office for Civil Rights:
  - Phone Requests: 1-800-368-1019 (TTY: 800-537-7697).
  - Written Requests: Office of Civil Rights – Region III, Department of Health and Human Services, 150 S Independence Mall West Suite 372, Public Ledger Building, Philadelphia, PA 19106; or fax to 215-861-4431.
- Contact the Virginia Long-Term Care Ombudsman (for complaints, concerns or assistance with nursing facility care or long-term services and supports in the community:
  - Phone Requests: 1-800-552-5019 (TTY: 1-800-464-9950).
  - Written Requests: Virginia Office of the State Long-Term Care Ombudsman, Virginia Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive Henrico, Virginia 23229.
- Contact the Office of Licensure and Certification at the Virginia Department of Health (for complaints specific to nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and health plans):
  - Phone Requests: 1-800-955-1819 (TTY: 711).
  - Written Requests: Virginia Department of Health, Office of Licensure and Certification, 9960 Maryland Drive, Suite 401, Richmond, Virginia 23233-1463; or email: mchip@vdh.virginia.gov.

9. Cost Sharing

Copayments

Copayments are when you pay a fixed amount for certain services covered by [Plan] or the Department. Most [Plan] members will not owe copayments for covered services. However, there are some exceptions (see below). If you receive a bill for a covered service, contact [Plan's] Member Services for help at [phone number] (TTY: [phone number]). Remember, if you get services that are not covered through [Plan] or the Department, you must pay the full cost yourself.

If you have Medicare, you may have copayments for prescription drugs covered under Medicare Part D. [*Optional Information for Plan to Include:* Revisions to this bullet if plan covers Part D copayments as an enhanced benefit].

Patient Pay

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

Premiums

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

10. Your Rights

General Rights

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

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status, or disability.
- Be treated with respect and consideration for your privacy and dignity.
- Get information (including through this handbook) about your health plan, provider, coverage, and benefits.
- Get information in a way you can easily understand. Remember: interpretation, written translation, and auxiliary aids are available free of charge.
- Access health care and services in a timely, coordinated, and culturally competent way.
- Get information from your provider and health plan about treatment choices.
- Participate in all decisions about your health care, including the right to say "no" to any treatment offered.
- Ask your health plan for help if your provider does not offer a service because of moral or religious reasons.
- Get a copy of your medical records and ask that they be changed or corrected in accordance with State and Federal Law.
- Have your medical records and treatment be confidential and private. [Plan] will only release your information if it is allowed under federal or state law, or if it is required to monitor quality of care or protect against fraud, waste, and abuse. [Plan can choose to include PHI Use and Disclosure statement]
- Live safely in the setting of your choice. If you or someone you know is being abused, neglected, or financially taken advantage of, call your local DSS or Virginia DSS at 1-888-832-3858. This call is free.)
- Receive information on your rights and responsibilities and exercise your rights without being treated poorly by your providers, [Plan], or the Department.
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- File appeals and complaints and ask for a State Fair Hearing (see *Section 8, Appeals and Complaints*).
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example).

Advance Directives

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

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

- Virginiaadvancedirectives.org.
- Your care manager, if you have one.
- Your provider, a lawyer, a legal services agency, a social worker, the hospital.
- [[Plan's] Member Services, if applicable].

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

- 1-800-533-1560 (TTY: 711).
- Email enfcomplaints@dhp.virginia.gov.
- Write Virginia Department of Health Professions, Enforcement Division, 9960 Maryland Drive, Suite 300, Henrico, Virginia 23233-146.

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

- 1-800-643-2273 (TTY: 711)
- Email DMAS-Info@dmas.virginia.gov, or
- Write to the Department at Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.

Member Advisory Committee

You have the right to let us know how the Department and [Plan] can better serve you. [Plan] invites you to join the Member Advisory Committee. As a member of the committee, you can participate in educational meetings that happen once every three months. You can attend in-

person or virtually. Attending committee meetings will give you and your caregiver or family member the chance to provide input on Cardinal Care and meet other members. If you would like more information or want to attend, contact [Plan's] Member Services.

11. Your Responsibilities

General Responsibilities

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

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

Call [Plan's] Member Services at [phone number] [(TTY: phone number)] to let them know if:

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

- You have problems with health care providers or staff.
- You are admitted to a nursing facility or the hospital.
- Your caregiver or anyone responsible for you changes.
- You join a clinical trial or research study.

Reporting Fraud, Waste, and Abuse

As a Cardinal Care member, you are responsible for reporting suspected fraud, waste, and abuse concerns and making sure you do not participate in or create fraud, waste, and abuse. Fraud is an intentional deception or misrepresentation by a person who knows the action could result in an unauthorized benefit to themselves or someone else. Waste is overusing, underusing, or misusing Medicaid resources. Abuse is the practice of causing unnecessary cost to the Medicaid program or payment for services that are not medically necessary or that do not meet certain health care standards.

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

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

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

- Providing services that are not medically necessary.
- Billing for services that were not provided.
- Changing medical records to cover up illegal activity.

Information on how to report suspected fraud, waste, or abuse is included in the table below:

The Department's Fraud and Abuse Hotline

Phone	**1-804-786-1066** **Toll free: 1-866-486-1971** **TTY: 711**
Email	RecipientFraud@DMAS.virginia.gov
Mail	Department of Medical Assistance Services, Recipient Audit Unit 600 East Broad St Suite 1300 Richmond, VA 23219

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

Phone	**1-804-371-0779** **Toll free: 1-800-371-0824** **TTY: 711**

Fax	804-786-3509
Email	MFCU_mail@oag.state.va.us
Mail	Office of the Attorney General, Medicaid Fraud Control Unit 202 North Ninth Street Richmond, VA 23219

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

Phone	**1-800-723-1615** **TTY: 711**
Email	covhotline@osig.virginia.gov
Mail	State Fraud, Waste, and Abuse Hotline 101 N. 14th Street The James Monroe Building 7th Floor Richmond, VA 23219

12. Key Words and Definitions in This Handbook

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Cover Virginia:** Virginia's statewide support center. Individuals can call 1-833-5CALLVA (TTY: 1-888-221-1590) for free or visit coverva.org/en to learn about and apply for health insurance, renew their coverage, update information, and ask questions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Health Screening:** A screening administered to all members by the health plan to help understand if the member would benefit from Care Management. The screening asks members about their health needs, social needs, medical conditions, ability to do everyday things, and living conditions.

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

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

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

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

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

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

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

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

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

- **Medically Necessary:** Services, supplies, or drugs needed to prevent, diagnose, or treat a medical condition or its symptoms. Medically necessary also means that services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Prosthetics and Orthotics:** Medical devices ordered by a member's provider. Covered items include, but are not limited to arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.

- **Provider:** Doctors, nurse practitioners, specialists, and other individuals who are authorized to provide health care or services to members. Many kinds of providers participate in each health plan's network.

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

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

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

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

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

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

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

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

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