OptimaHealth

Optima Health Community Care

Member Handbook

optimahealth.com/community-care

Effective July 1, 2022

Updated June 1, 2023

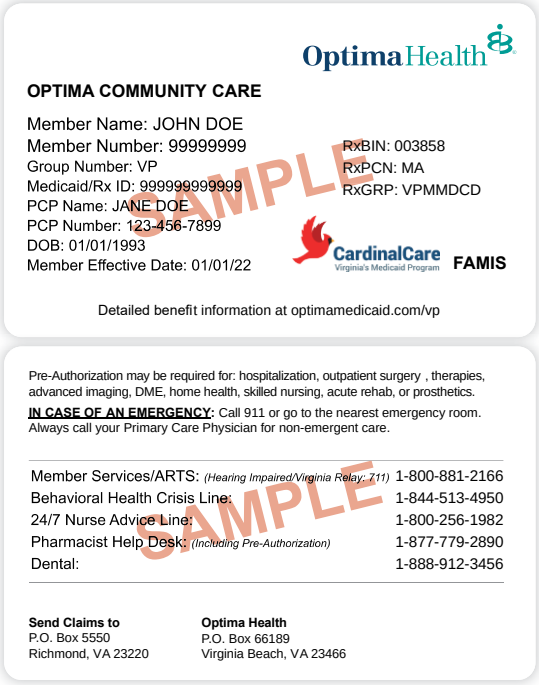
As of July 1, Virginia Premier Medicaid is now a part of Optima Health.

As a former Virginia Premier member, we are excited to serve you as an Optima Health member. You will continue to keep the same great benefits and services you are used to getting from Virginia Premier. You can use the Optima Health member handbook to get answers to all your questions about your benefits, services, and even your rights as a member.

You should have received a new member ID card in the mail sometime around or after June 1, 2023. If you did not, please call Member Services at 1-800-881-2166 (TTY: 711) to request a copy. You will still use your VPHP Advantage Elite (HMO D-SNP) card for your Medicare benefits.

Non-FAMIS

FAMIS



As a former Virginia Premier member, some of the ways you contact us may be slightly different through the end of 2023. The following is a guide for frequently used contact information you may need. Some of this may be different than what is in the Optima Health member handbook. Please use this information to contact us.

You can access more information about your plan at optimamedicaid.com/vp. If you have questions, you can always call Member Services at 1-800-881-2166 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

Department or Service	Contact Information
Member Services Website Landing Page and Member Portal Login	1-800-881-2166 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. Recorded options for self-service features available 24 hours a day, seven days a week. optimamedicaid.com/vp You can contact your care manager by calling 1-866-546-7924 (TTY: 711). Or call your care manager using their direct phone number. You should receive a letter from your care manager explaining how to contact them directly.
24/7 Nurse Advice Line	1-800-256-1982 (TTY: 711)
Behavioral Health Crisis Line	1-844-513-4950 (TTY: 711)
Addiction and Recovery Treatment Services (ARTS) Lines	ARTS: 1-800-881-2166 (TTY: 711), option 6) Behavioral Health/ARTS Direct (Non-crisis line): 1-855-214-3822 (TTY: 711)
Transportation	1-855-880-3480 (TTY: 711)
Pharmacist Help Desk	1-877-779-2890 (TTY: 711)
Member Appeals and Complaints (Grievances)	Phone requests: 1-844-434-2916 (TTY: 711) Mail requests: PO Box 6253 Glen Allen, VA 23058 Faxed requests: 1-866-472-3920

Where To Find Information

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Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including on-line, in large print, Braille or Audio CD. To request the handbook in an alternate format and or language 1-855-687-6260 (TTY 1-844-552-8148).

If you have any problems reading or understanding this information, please contact our Member Services staff at 1-800-881-2166 (TTY 1-844-552-8148) for help at no cost to you.

We provide reasonable accommodations and communications access to persons with disabilities. Individuals who are deaf or hard of hearing or who are speech-impaired, who want to speak to a Member Services representative, and who have a TTY or other assistive device can dial 711 to reach a relay operator. They will help you reach our Member Services staff. Members who call the Telecommunications Relay Service by dialing 711 will be transferred to the Optima Health Community Care Member Services line. Customer Service Representatives who assist members with special communication needs are trained to use all necessary resources to assist with communication.

Help in Other Languages

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260 (TTY: 1-844-552-8148).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-687-6260 (TTY: 1-844-552-8148).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-855-687-6260 (TTY: 1-844-552-8148). 번으로 전화해 주십시오.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-687-6260 (TTY: 1-844-552-8148).

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 1-855-687-6260 (TTY: 1-844-552-8148).

Arabic

ملحوظة:بالمجان لك تتوافر اللغوية المساعدة خدمات فإن ،اللغة اذكر تتحدث كنت إذا . برقم اتصل 1-855-687-6260رقم

ه الصم والبكم: 1-844-552-8148

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-687-6260 (TTY: 1-844-552-8148).

Farsi

(1-855-687-6260 1 تماس بگیرید. شما برای رایگان بصورت زبانی تسهیلات ،کنید می گفتگو فارسی زبان به اگر :توجه
فر می باشد .با (844-552-8148

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-687-6260 **(መስማት ለተሳናቸው:** 1-844-552-8148**).**

Urdu

(رقم 1-855-687-6260ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-
).844-552-8148هاتف الصم والبكم: 1-

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1--855-687-6260 (ATS : 1-844-552-8148).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-687-6260 (телетайп: 1-844-552-8148).

Hindi

ान द: यद आप हदी बोलते ह तो आपके ि लए मु म भाषा सहायता सेवाएं उपल ह। 1-855-687-6260 (TTY: 1-844-552-8148) पर कॉल कर।

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-687-6260 (TTY: 1-844-552-8148).

Bengali

লয্ করনঃ িযদ আিযন বাংলা, কথা বললত িাল রন, তােলল য নঃখরচায় ভাষা েসায়তা িযলরষবা িউল আআছ। আ ফান করন ১-855-687-6260 (TTY: ১-844-552-8148)।

Bassa

Dè dɛ nìà kɛ dyédé gbo: Ɔ jŭ ké m̀ [Ɓàsɔ́ ò -wùdù-po-nyɔ̀] jŭ ní, nìí, à wudu kà kò dò po-poɔ̀ ɓɛ́ ìn m̀ gbo kpáa. Đá 1-855-687-6260 (TTY:1-844-552-8148)

1. Commonwealth Coordinated Care Plus (CCC Plus)

Welcome to Optima Health Community Care

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

As a member of Optima Health Community Care, you will be paired with a personal Care Coordinator. Your Care Coordinator will help guide you and will develop a personalized care plan to meet your healthcare needs.

To help with your care, here are some things you can do to prepare for your meeting with your Care Coordinator:

- Have a list of your current case management services ready
- Have a list of your current doctors and other service providers
- Have a list of family members and care givers, and their contact information, who want to participate in your care plan
- Have a copy of your Advance Directive or living will

Please see *Your Care Coordinator* in Section 4 of this handbook for additional information.

You may also find information about your plan by signing in to your MyOptima account at optimahealth.com/members. If you do not have a MyOptima account, please visit optimahealth.com/members and select Register for Secure Access to create your account (please have your member ID card available).

How to Use This Handbook

This handbook will help you understand your Commonwealth Coordinated Care Plus (CCC Plus) benefits and how you can get help from Optima Health Community Care. This handbook is your guide to health services. It explains your healthcare, behavioral health, prescription drug, and long-term services and supports coverage under the CCC Plus program. It tells you the steps you can take to make your health plan work for you.

Feel free to share this handbook with a family member or someone who knows your healthcare needs. When you have a question, check this handbook, call our Member Services unit, visit our website at optimahealth.com/members or call your Care Coordinator.

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

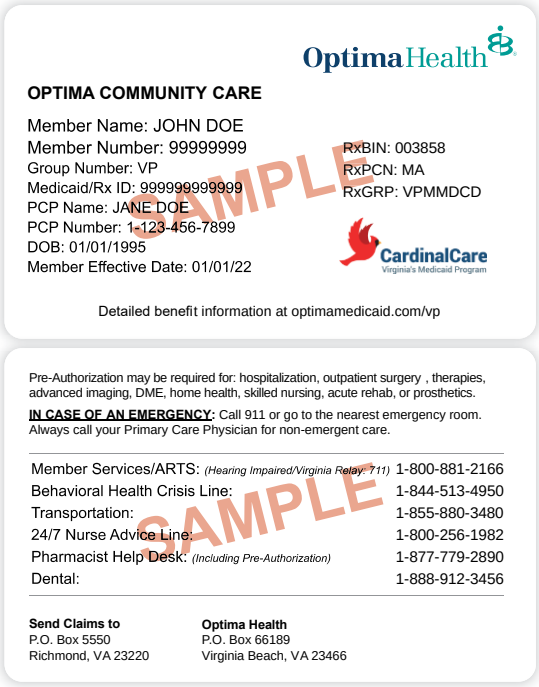
Other Information We Will Send to You

You should have already received your Optima Health Community Care Member ID Card, and information on how to access a Provider and Pharmacy Directory, and a List of Covered Drugs. You can also access this information at optimahealth.com/members or by calling Optima Health Community Care Member Services at 1-800-881-2166 (TTY: 711). The name and contact information for your Optima Health Community Care Coordinator will arrive in a separate letter.

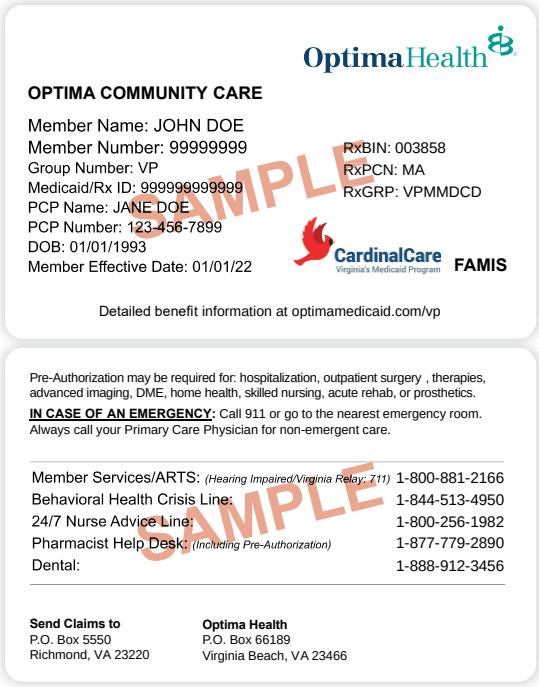
Optima Health Community Care Member ID Card

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

Non-FAMIS



FAMIS



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

In addition to your Optima Health Community Care card, keep your Commonwealth of Virginia Medicaid ID card to access services that are covered by the State, under the Medicaid fee-for-service program. These services are described in *Services Covered through Medicaid Fee-For-Service,* in Section 11 of this handbook.

Provider and Pharmacy Directory

You can find the most up-to-date Provider and Pharmacy Directories at optimahealth.com/communitycare. You can also ask for an annual Provider and Pharmacy Directory by calling Member Services at the number at the bottom of this page.

The *Provider and Pharmacy Directory* provides information on healthcare professionals (such as doctors, nurse practitioners, psychologists, etc.), facilities (hospitals, clinics, nursing facilities, etc.), support providers (such as adult day health, home health providers, etc.), and pharmacies in the Optima Health Community Care network. While you are a member of our plan, you generally must use one of our network providers and pharmacies to get covered services. There are some exceptions, however, including:

1. When you first join our plan (see Transition of Care Policy: *Continuity of Care Period* in Section 3 of this handbook),
2. If you have Medicare (see *How to Get Care From Your Primary Care Physician* in Section 6 of this handbook, and
3. In several other circumstances (see *How to Get Care From Out-of-Network Providers* in Section 6 of this handbook.)

You can ask for a paper copy of the *Provider and Pharmacy Directory or List of Covered Drugs* by calling Member Services at the number at the bottom of the page. You can also see the *Provider and Pharmacy Directory and List of Covered Drugs* at https://www.optimahealth.com or download it from this website. Refer to *List of Covered Drugs* in Section 9 of this handbook.

The Provider Directory will include the following information for all providers in the network as data is available from providers*:

1. Name, address, telephone number
2. Office hours and after-hours provider sites
3. Whether provider has completed cultural competence training
4. Licensing information: number and/or National Provider Identifier
5. Any accommodations for people with physical disabilities
6. Whether provider is accepting new patients
7. Website URL
8. Whether location is on a public transportation route
9. Any cultural and/or linguistic capabilities, including access to languages or interpreter services at office
10. Behavioral health providers—training /experience treating trauma, areas of specialty, specific populations, substance use
11. Restrictions on member's freedom of choice among network providers
12. Name, address, telephone number of current network pharmacies and member instructions on contacting Member Services for finding a pharmacy

13. As applicable, whether the healthcare professional or non-facility based network provider has completed cultural competence training.

*Information available is based on provider-supplied data.

Important Phone Numbers

Your Care Coordinator ***Add contact information when you receive your letter.***	
Optima Health Community Care Member Services	757-552-8360 OR 1-800-881-2166 TTY: 1-844-552-8148
Optima Health Community Care Pharmacy Member Services	757-552-8840 OR 844-724-5576 TTY: 844-522-8148
Optima Health Community Care 24/7 Medical/Behavioral Health Advice Line	757-552-8899 OR 1-844-387-9420
Optima Health Community Care 24/7 Behavioral Health Crisis Line	757-552-8383 OR 1-833-686-1595
Optima Health Community Care Transportation	1-855-325-7558
Welcoming Baby Program	1-800-881-2166
DMAS Dental Benefits Administrator	For questions or to find a dentist in your area, call the DMAS Dental Benefits Administrator at 1-888-912-3456. Information is also available on the DMAS website at: https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/ or the DentaQuest website at: http://www.dentaquestgov.com/
DMAS Transportation Contractor for transportation to and from DD Waiver Services	1-866-386-8331 TTY 1-866-288-3133 Or dial 711 to reach a relay operator
Managed Care Helpline	1-800-643-2273

	TDD: 1-800-817-6608 or visit the website at cccplusva.com.
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019 or visit the website at www.hhs.gov/ocr
Office of the State Long-Term Care Ombudsman	1-800-552-5019

2. What is Commonwealth Coordinated Care Plus

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

What Makes You Eligible to be a CCC Plus Member

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

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

CCC Plus Enrollment

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

Optima Health Community Care will not discriminate against, or use any policy or practice that has the effect of discriminating against, individuals eligible to enroll on the basis of health status or need for healthcare services, race, color, national origin, sex, sexual orientation, gender identity, or disability as specified in 42 CFR§ 438.3 (d)(3-4).

Optima Health Community Care agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction unless authorized by the Department. Optima Health may not prescreen select potential members on the basis of pre-existing health problems.

Reasons You Would Not be Eligible to Participate in CCC Plus

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

- You lose/lost Medicaid eligibility.

- You do not meet one of the eligible categories listed above.
- You are enrolled in hospice under the regular fee-for-service Medicaid program prior to any CCC Plus benefit assignment.
- You enroll in the Medicaid Health Insurance Premium Payment (HIPP) program.
- You enroll in PACE (Program of All-Inclusive Care for the Elderly). *For more information about PACE, talk to your Care Coordinator or visit:* http://www.pace4you.org/
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).
- You are receiving care in a Psychiatric Residential Treatment Facility (children under age 21).
- You reside in a Veteran's Nursing Facility.
- You reside in one of these State long term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.
- You live on Tangier Island.

What if I Am Pregnant

The Welcoming Baby program is available to members enrolled in all Optima Health products. Welcoming Baby program referrals come from provider offices and member self-referrals as well as administrative data, to ensure as many members can be reached as quickly as possible.

Once a referral has been received, the team reaches out to the member by phone to explain the program. When a member elects to participate in the Program, a comprehensive assessment, including an obstetrical assessment, is completed in order to tailor the program to suit the member's individual needs. Risk stratification is conducted using the assessments to allow members to be assigned to the appropriate Welcoming Baby team member. Members who stratify as high risk are assigned to a Case Manager and members who stratify as low risk are assigned to Care Coordinators. Moderate risk members may have a combination of team member types. The team contacts members at regular intervals during their pregnancy to provide prenatal education, mental health screenings and to answer questions regarding benefits and other available services. The team also includes a Licensed Clinical Social Worker who can assist with community resources such as housing, food, etc. The Welcoming Baby program team works closely with your assigned OHCC Care Coordinator.

The Welcoming Baby team can communicate member or Case Manager concerns to a designated person within the provider office to expedite coordination of care. The number for Welcoming Baby is listed on the *Important Phone Numbers* section of this handbook.

If you are within your first ninety (90) days of initial enrollment, and in your third (3rd) trimester of pregnancy, and your provider is not participating with Optima Health Community Care, you may request to move to another MCO where your provider participates. If your provider does not participate with any of the CCC Plus health plans, you may request to receive coverage through fee-for-service Medicaid until after delivery of your baby. Contact the Managed Care Helpline at 1-800-643-2273 or TDD: 1-800-817-6608 to make this request.

Coverage for Newborns Born to Moms Covered Under CCC Plus

If you have a baby, you will need to report the birth of your child as quickly as possible to enroll your baby in Medicaid. You can do this by:

- Calling the Cover Virginia Call Center at 1-833-5CALLVA (TDD: 1-888-221-1590) to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child.

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

- Name
- Date of Birth
- Race
- Gender
- The baby's mother's name and Medicaid ID number

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

Medicaid Eligibility

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at 1-833-5CALLVA or TDD: 1-888-221-1590 about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at www.coverva.org.

CCC Plus Disenrollment

The MCO may not request disenrollment of a member for any reason, including but not limited to:

- An adverse change in the member's health status
- The member's utilization of medical services

- The member's diminished mental capacity
- The member's uncooperative or disruptive behavior resulting from his or her special needs

The MCO provides a copy of the written notice to the Department at the time the notice is sent to the member.

A member may request disenrollment as follows:

- For cause at any time, including:
  - The member has moved out of the MCO's service area
  - The MCO does not cover the service the member seeks due to moral or religious objections
  - The member needs related services to be performed at the same time, not all related services are available from the MCO's plan, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk
  - Poor quality of care
  - Lack of access, or lack of access to providers experienced with dealing with the members specific needs

Choosing or Changing Your Health Plan

Health Plan Assignment

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

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

You Can Change Your Health Plan Through the CCC Plus Helpline

The Managed Care Helpline can help you choose the health plan that is best for you. For assistance, call the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608, or visit the website at cccplusva.com. The Managed Care Helpline is available Monday through Friday (except on State Holidays) from 8:30 am to 6:00 pm. The Managed Care Helpline can help you

understand your health plan choices and answer your questions about which doctors and other providers participate with each health plan. The Managed Care Helpline services are free and are not connected to any CCC Plus health plan.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between October and December. You will get a letter from DMAS during open enrollment with more information. You may also ask to change your health plan at any time for "good cause," which can include:

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

The Managed Care Helpline handles "good cause" requests and can answer any questions you may have. Contact the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608, or visit the website at cccplusva.com.

Automatic Re-Enrollment

If your enrollment ends with us and you regain eligibility for the CCC Plus program within 60 days or less, you will automatically be reenrolled with Optima Health Community Care. You will also be sent a re-enrollment letter from DMAS.

What is Optima Health Community Care Service Area

CENTRAL REGION		
AMELIA	HANOVER	PETERSBURG
BRUNSWICK	HENRICO	POWHATAN
CAROLINE	HOPEWELL	PRINCE EDWARD
CHARLES CITY	KING AND QUEEN	PRINCE GEORGE
CHESTERFIELD	KING GEORGE	RICHMOND CITY
COLONIAL HEIGHTS	KING WILLIAM	RICHMOND CO.
CUMBERLAND	LANCASTER	SOUTHAMPTON
DINWIDDIE	LUNENBURG	SPOTSYLVANIA
EMPORIA	MATHEWS	STAFFORD
ESSEX	MECKLENBURG	SURRY
FRANKLIN CITY	MIDDLESEX	SUSSEX

FREDERICKSBURG	NEW KENT	WESTMORELAND
GOOCHLAND	NORTHUMBERLAND	
GREENSVILLE	NOTTOWAY	
TIDEWATER REGION		
ACCOMACK	JAMES CITY CO.	PORTSMOUTH
CHESAPEAKE	NEWPORT NEWS	SUFFOLK
GLOUCESTER	NORFOLK	VIRGINIA BEACH
HAMPTON	NORTHAMPTON	WILLIAMSBURG
ISLE OF WIGHT	POQUOSON	YORK
NORTHERN & WINCHESTER REGION		
ALEXANDRIA	FALLS CHURCH	PAGE
ARLINGTON	FAUQUIER	PRINCE WILLIAM
CLARKE	FREDERICK	RAPPAHANNOCK
CULPEPER	LOUDOUN	SHENANDOAH
FAIRFAX CITY	MANASSAS CITY	WARREN
FAIRFAX CO.	MANASSAS PARK	WINCHESTER
CHARLOTTESVILLE WESTERN REGION		
ALBEMARLE	DANVILLE	NELSON
AMHERST	FLUVANNA	ORANGE
APPOMATTOX	GREENE	PITTSYLVANIA
AUGUSTA	HALIFAX	ROCKINGHAM
BUCKINGHAM	HARRISONBURG	STAUNTON
CAMPBELL	LOUISA	WAYNESBORO
CHARLOTTE	LYNCHBURG	
CHARLOTTESVILLE	MADISON	
ROANOKE/ALLEGHANY REGION		
ALLEGHANY	FRANKLIN CO.	PULASKI
BATH	GILES	RADFORD
BEDFORD CO.	HENRY	ROANOKE CITY
BOTETOURT	HIGHLAND	ROANOKE CO.
BUENA VISTA	LEXINGTON	ROCKBRIDGE
COVINGTON	MARTINSVILLE	SALEM
CRAIG	MONTGOMERY	WYTHE
FLOYD	PATRICK	
SOUTHWEST REGION		
BLAND	GALAX	SCOTT
BRISTOL	GRAYSON	SMYTH
BUCHANAN	LEE	TAZEWELL
CARROLL	NORTON	WASHINGTON
DICKENSON	RUSSELL	WISE

Only people who live in our service area can enroll with Optima Health Community Care. If you move outside of our service area, you cannot stay in this plan. If this happens, you will receive a letter from DMAS asking you to choose a new plan. You can also call the Managed Care Helpline

if you have any questions about your health plan enrollment. Contact the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608 or visit the website at cccplusva.com.

If You Have Medicare and Medicaid

If you have Medicare and Medicaid, some of your services will be covered by your Medicare plan and some will be covered by Optima Health Community Care. We are your CCC Plus Medicaid Plan.

Types of Services Under Medicare

- Inpatient Hospital Care (Medical and Psychiatric)
- Outpatient Care (Medical and Psychiatric)
- Physician and Specialists Services
- X-Ray, Lab Work and Diagnostic Tests
- Skilled Nursing Facility Care
- Home Healthcare
- Hospice Care
- Prescription Drugs
- Durable Medical Equipment
- *For more information, contact your Medicare Plan, visit Medicare.gov, or call Medicare at 1-800-633-4227.*

Types of Services Under CCC Plus (Medicaid)

- Medicare Copayments
- Hospital and Skilled Nursing when Medicare Benefits are Exhausted
- Long term nursing facility care (custodial)
- Home and Community Based Waiver Services like personal care and respite care, environmental modifications, and assistive technology services
- Community-based Behavioral Health Services
- Medicare non-covered services, like some over the counter medicines, medical equipment and supplies, and incontinence products.

You Can Choose the Same Health Plan for Medicare and Medicaid

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

- You receive better coordination of care through the same health plan.
- You have one health plan and one number to call for questions about all of your benefits.
- You work with the same Care Coordinator for Medicare and Medicaid. This person will work with you and your providers to make sure you get the care you need.

Extra or enhanced benefits offered for members that select Optima Health Community Care include the following. Additional information is provided in Section 10 in the handbook:

** These extra benefits are effective on January 1, 2023. For current extra benefits, call Member Services.

- Adult literacy program (HEAL Program sponsored by Optima Health Read, Learn, Grow)
- Adult vision services - members age 21 and up get one eye exam and $100 for frames yearly. The benefit is limited to in-network providers only.
- College application assistance – up to $75, sponsored by Optima Health Read, Learn, Grow (Restrictions apply. Authorization required.)
- ** Financial Wellness Program – tools and experts to help manage your spending and saving for major expenses, emergencies and retirement.
- Free smartphone
- GED Voucher Program - up to $275 for testing voucher and online prep program (Authorization required.)
- Healthy member incentives
- Healthy Moms: Welcoming Baby
- Home-delivered meals (Authorization required.)
- Memory alarms and devices – additional home security devices, such as door/window alarms and memory devices, bed alarms, chimes and "baby monitor" type. Care Coordinator will coordinate.
- Reading program for children - sponsored by Optima Health Read, Learn, Grow
- Transportation services (non-medical) –24 round-trip each year to community events, grocery store and more. Additional information is provided later in the handbook.
- Weight Management Wellness Program (online only)

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

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

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

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

CALL	1-800-552-3402 This call is free.
TTY	TTY users dial 711
WRITE	Virginia Insurance Counseling and Assistance Program 1610 Forest Avenue, Suite 100 Henrico, Virginia 23229
EMAIL	aging@dars.virginia.gov
WEBSITE	https://www.vda.virginia.gov/vicap.htm

3. How CCC Plus Works

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

What are the Advantages of CCC Plus

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

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

What are the Advantages of Choosing Optima Health Community Care

Optima Health is a local, Virginia-based company with over 30 years of experience in providing care to our members. Optima Health Community Care uses person-centered, comprehensive care coordination that addresses members' physical health, behavioral health, and long-term care needs. Through a personalized model of care, Optima Health coordinates a wide range of services from wellness and prevention, to home health and nursing care services to achieve the best outcomes. By creating an Individualized Care Plan for each member, considerations such as housing and members' preferences related to other needs will be incorporated.

Our Care Coordinators have a wide range of experience to meet the special needs of the population, including nursing, social work, and health and human services. Please see *Your Care Coordinator* in Section 4 of this handbook for additional information.

We also offer enhanced or extra benefits that are not covered by Medicaid. Please see Section 10 of this handbook.

Transition of Care Policy: Continuity of Care Period

The continuity of care period is 30 days. If Optima Health Community Care is new for you, you can keep seeing the doctors you go to now for the first 30 days. You can also keep getting your authorized services for the duration of the authorization or for 30 days after you first enroll, whichever is sooner. After 30 days in our plan, you will need to see doctors and other providers in the Optima Health Community Care network. A network provider is a provider who contracts and works with our health plan. You can call your Care Coordinator or Member Services for help finding a network provider. Your new provider can get a copy of your medical records from your previous provider, if needed.

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

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

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

If You Have Other Coverage

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

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

4. Your Care Coordinator

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

How Your Care Coordinator Can Help

Your Care Coordinator can:

- Answer questions about your healthcare
- Provide assistance with appointment scheduling
- Answer questions about getting any of the services you need. For example: behavioral health services, transportation, and long-term services and supports (LTSS)
    - Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and facilitate maximum independence. Examples include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as meal preparation, laundry, and shopping. LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities.

1. Help with arranging transportation to your appointments when necessary. If you need a ride to receive a Medicaid covered service and cannot get there, non-emergency transportation is covered. Just call 1-855-325-7558 (toll-free) or call your Care Coordinator for assistance.

- Answer questions you may have about your daily healthcare and living needs including these services:
    - Skilled nursing care
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Home healthcare

- Personal care services
- Mental health services
- Services to treat addiction
- Other services that you need

To help with your care, here are some things you can do to prepare for your meeting with your Care Coordinator:

1. Have a list of your current case management services ready
2. Have a list of your current doctors and other service providers
3. Have a list of family members and care givers who want to participate in your care plan, along with their contact information
4. Have a copy of your Advance Directive or living will
5. Have a list of current medications
6. Notify your Care Coordinator if English is your second language, so translation services can be provided

What is a Health Screening

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

Your answers will help Optima Health Community Care understand your needs, identify whether or not you have medically complex needs, and to determine when your Health Risk Assessment is required. Optima Health Community Care will use your answers to develop your Care Plan (for more information on your Care Plan, see below).

Please contact Optima Health Community Care if you need accommodations to participate in the health screening.

If you have questions about the health screening, please contact Member Services 1-800-881-2166, TTY 1-844-552-8148. This call is free.

What is a Health Risk Assessment

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

What is a Care Plan

A care plan includes the types of health services that are needed and how you will get them. It is based on your health risk assessment. After you and your Care Coordinator complete your health risk assessment, your care team will meet with you to talk about what health and/or long-term services and supports you need and want as well as your goals and preferences. Together, you and your care team will make a personalized care plan, specific to your needs. *(This is also referred to as a person-centered care plan.)* Your care team will work with you to update your care plan when the health services you need or choose change, and at least once per year.

How to Contact Your Care Coordinator

You can contact your Care Coordinator by calling the main phone number at 757-552-8398 or toll-free at 1-866-546-7924, or by calling your Care Coordinator on his or her direct line. You should receive a letter from your Care Coordinator, explaining how to contact him or her directly.

CALL	Phone number(s):_____ *Write in the phone number(s) once you receive your Care Coordinator contact information.* The phone number is local or toll-free. Individuals who are deaf or hard of hearing or who are speech-impaired, who want to speak to a Member Services representative, or who have a TTY or another assistive device, can dial 711 to reach a relay operator. They will help you reach our Member Services staff. Monday-Friday 8:00 a.m. to 5:00p.m. After 5:00 pm, please contact Member Services at the number at the bottom of this page. We have free interpreter services for people who do not speak English.

TTY	1-844-552-8148 This call is free. You can also call 711, the Telecommunications Relay service. Monday-Friday 8:00 a.m. to 5:00p.m. This number is for people who need hearing or speaking assistance. You must have special telephone equipment to call it.
FAX	*Write in fax number once you receive your Care Coordinator contact information.*
WRITE	PO Box 66189 Virginia Beach, VA 23466
EMAIL	*Write in email address once you receive your Care Coordinator contact information.*
WEBSITE	optimahealth.com/members

5. Help From Member Services

Our Member Services Staff are available to help you if you have any questions about your benefits, services or procedures or have a concern about Optima Health Community Care. Member Services is available for member questions from 8:00 to 8:00 p.m. ET, Monday – Friday, except for Commonwealth of Virginia holidays.

How to Contact Optima Health Community Care Member Services

CALL	1-800-881-2166 This call is free. Monday-Friday from 8:00 a.m. to 8:00 p.m. After Hours Nurse Advice Line is available 24 hours a day, 7 days a week to answer your questions at: 757-552-8899 or toll free at 1-844-387-9420. We have free interpreter services for people who do not speak English.
TTY	1-844-552-8148 This call is free. Monday-Friday 8:00 a.m. to 8:00 p.m. This number is for people who need hearing or speaking assistance. You must have special telephone equipment to call it.
WRITE	PO Box 66189 Virginia Beach, VA 23466
WEBSITE	optimahealth.com/members

How Member Services Can Help

Member Services can:

- Answer questions you have about Optima Health Community Care
- Answer questions you have about claims, billing or your Member ID Card
- Help you find a doctor or see if a doctor is in the Optima Health Community Care network
- Help you change your Primary Care Physician (PCP)
- Provide information on coverage decisions about your healthcare services (including medications)
    - A coverage decision about your healthcare is a decision about:
        - your benefits and covered services, or
        - the amount we will pay for your health services.

- Provide information on how you can submit an appeal about a coverage decision on your healthcare services (including medications). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake. (See *Your Right to Appeal* in Section 15 of this handbook).
- Grievances about your healthcare services (including medications). You can file a grievance about us or any provider (including a non-network or network provider). A network provider is a provider who contracts and works with the health plan. You can also file a grievance about the quality of the care you received to us or to the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608. (See *Your Right to File a Grievance* in Section 15 of this handbook, see *Important Words and Definitions Used In This Handbook* in Section 21 of this handbook).

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

If you are unable reach your Care Coordinator, you can reach a nurse or behavioral health professional 24 hours a day, 7 days a week to answer your questions toll-free at: 757-552-8899 or toll free at 1-844-387-9420.

When you call the After-Hours Nurse Advice Line, a registered nurse will ask you to describe your medical situation in as much detail as possible. Be sure to mention any other medical conditions you have, such as diabetes or hypertension.

Depending on the situation, you may be advised about appropriate home treatments, or advised to visit your plan doctor. If necessary, the nurse may direct you to an urgent care center or emergency department.

The nurses for our After-Hours Nurse Advice Line have training in emergency medicine, acute care, OB/GYN, and pediatric care. They are well prepared to answer your medical or behavioral health questions. However, since they are unable to access medical records, they cannot diagnose or medically treat conditions, order labs, write prescriptions, order home health services, or initiate hospital admissions or discharges.

CALL	757-552-8899or 1-844-387-9420 This call is free. Available 24 hours a day, 7 days a week Individuals who are deaf, hard of hearing, speech-impaired, or want to speak to a Member Services representative and have a TTY or other assistive device can dial 711 to reach a relay operator. They will help you reach our Member Services staff. We have free interpreter services for people who do not speak English.

TTY	TTY: 711 This call is free.

Behavioral Health Crisis Line Available 24 Hours a Day, 7 Days a Week

Our Behavioral Health Crisis Line is manned by professionals to evaluate and triage the urgency of needs, provide nurse advice and assist those in crisis. Contact Optima Health Community Care if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call 1-888-946-1168. If you have thoughts about harming yourself or someone else, you should:

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

CALL	757-552-7580 or 1-888-946-1168 This call is free. Available 24 hours a day, 7 days a week Individuals who are deaf, hard of hearing, speech-impaired, or want to speak to a Member Services representative and have a TTY or other assistive device can dial 711 to reach a relay operator. They will help you reach our Member Services staff. We have free interpreter services for people who do not speak English.
TTY	711 This call is free.

Addiction and Recovery Treatment Services (ARTS) Advice Line Available 24 Hours a Day, 7 Days a Week

If you are unable reach your Care Coordinator, you can reach an ARTS health professional 24 hours a day, 7 days a week to answer your questions at: 757-552-7580 or 1-888-946-1168. The call is free.

The ARTS Medical Advice Line is available to answer questions for members seeking help with substance abuse.

CALL	757-552-7580 or 1-888-946-1168 This call is free. Available 24 hours a day, 7 days a week Individuals who are deaf, hard of hearing or speech-impaired, or want to speak to a Member Services representative, and have a TTY or other assistive device can dial 711 to reach a relay operator. They will help you reach our Member Services staff. We have free interpreter services for people who do not speak English.

TTY	711 This call is free.

If You Do Not Speak English

We can provide you with translation services. Optima Health Community Care Member Services has employees who speak your language and we are able to access interpreter services. We also have written information in many languages for our members. Currently written materials are available in English and Spanish. If you need interpretation, please call Member Services (at no charge) at 1-855-687-6260 and request to speak to an interpreter or request written materials in your language.

If You Have a Disability and Need Assistance in Understanding Information or Working with Your Care Coordinator

We provide reasonable accommodations to people with disabilities in compliance with the Americans with Disabilities Act. This includes but is not limited to accessible communications (such as a qualified sign language interpreter), braille or large print materials, etc. If you need a reasonable accommodation please call Member Services (at no charge) at 1-800-881-2166 (TTY: 711)to ask for the help you need.

If You Have Questions About Your Medicaid Eligibility

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

6. How to Get Care and Services

How to Get Care from Your Primary Care Physician

Your Primary Care Physician

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

Choosing Your PCP

New members have the right to choose a PCP in our network soon after joining Optima Health Community Care by calling Member Services at 1-800-881-2166 (TTY: 711). If you do not already have a PCP you must request one prior to the 25th day of the month before your effective enrollment date, or else Optima Health Community Care may assign you a PCP. You have the right to change your PCP at any time by calling Member Services at the number listed at the bottom of this page.

If you do not have a PCP in our network, we can help you find a highly-qualified PCP in your community. For help locating a provider you can use our on-line provider directory at: optimahealth.com. The provider directory includes a list of all of the doctors, clinics, hospitals, labs, specialists, long term services and supports providers, and other providers who work with Optima Health Community Care. The directory also includes information on the accommodations each provider has for individuals who have disabilities or who do not speak English. We can also provide you with a paper copy of the provider directory. You can also call Member Services at the number on the bottom of this page or call your Care Coordinator for assistance.

You may want to find a doctor:

- Who knows you and understands your health condition,
- Who is taking new patients,

- Who can speak your language, or
- Who has appropriate accommodations for people with physical or other disabilities.

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

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

If You have Medicare, Tell us About Your PCP

If you have Medicare as primary, you do not have to choose a PCP in the Optima Health Community Care network. Simply call Member Services or your Care Coordinator to let us know the name and contact information for your PCP. We will coordinate your care with your Medicare assigned PCP.

If Your Current PCP is Not in Our Network

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

Changing Your PCP

You may call Member Services to change your PCP at any time to another PCP in our network. Also, it is possible that your PCP might leave our network. We will tell you within 15 days from when we know about this. We can help you find a new PCP.

You may also change your PCP at any time by signing in to your MyOptima account at optimahealth.com/members. If you do not have a MyOptima account, please visit optimahealth.com/members and select Register for Secure Access to create your account (please have your member ID card available).

Changes made online usually take 24 hours to process and can be changed once every 30 days.

Once registered and signed in:

- Select Change Primary Care Physician from the left menu.

- Select the member on your plan for whom you would like to assign a new PCP and then click Continue.
- In the Find a Doctor pop-up window, confirm your address is correct. If desired, narrow your search results with the search filters provided (distance from address, Specialty, Clinically Integrated Network, Doctor or Practice Name), then click Search.
- To select a new PCP from the search results, click the Make PCP button next to the doctor of your choice. Your selection will appear on your MyOptima account page.
- Choose a reason for changing your PCP from the drop-down menu on your MyOptima account page, then click Continue.
- Note your new PCP effective date and confirmation number, or select Print to print a copy for your records.

Getting an Appointment with Your PCP

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

Appointment Standards

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

- For an emergency - immediately.
- For urgent care and office visits with symptoms – within 24 hours of request.
- For routine primary care visit – within 30 calendar days.
- For behavioral health services – within 5 business days or as quickly as required by your condition
- For longer-term services and supports (LTSS) – within 5 business days or as quickly as required by your condition

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

- First trimester (first 3 months) - Within fourteen (14) calendar days of request.
- Second trimester (3 to 6 months) - Within seven (7) calendar days of request.

- Third trimester (6 to 9 months) - Within five (5) business days of request.
- High Risk Pregnancy - Within three (3) business days or immediately if an emergency exists.

If you are unable to receive an appointment within the times listed above, call Member Services at the number below and they will help you get the appointment.

How to Get Care From Network Providers

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

Travel Time and Distance Standards

Optima Health Community Care will provide you with the services you need within the travel time and distance standards described in the table below. These standards apply for services that you travel to in order to receive care from network providers. These standards do not apply to providers who provide services to you at home. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, in the Roanoke/Alleghany Region, or the Southwest Region, you should not have to travel more than 60 miles or 75 minutes to receive services.

Member Travel Time & Distance Standards		
Standard	**Distance**	**Time**
Urban		
• PCP	15 Miles	30 Minutes
• Specialists and other providers	30 Miles	45 Minutes
Rural		
• PCP	30 Miles	45 Minutes
• Specialists and other providers	60 Miles	75 Minutes
Roanoke/Alleghany & Southwest Regions		
Standard	**Distance**	**Time**
Urban and Rural		
• PCPs	30 Miles	45 Minutes

Member Travel Time & Distance Standards		
Standard	**Distance**	**Time**
• Specialists and other providers	60 Miles	75 Minutes

Accessibility

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

Telehealth Visits

Telehealth is a benefit that allows providers to deliver remote healthcare, either by phone or video. You can schedule remote appointments by using a mobile device or computer. Telehealth providers treat common health issues like a cold, fever, allergies and more. Visits are convenient, private and secure.

Telehealth is a good choice when your regular provider isn't available. It is also a good alternative to the emergency room and can help you avoid long waits at an urgent care center if you don't require emergency or urgent care.

Telehealth services are easy to use:
1. Go to www.optimahealth.com
2. Click Sign In/Register.
3. Click on Member.
4. Enter User name/New users must select "Register Now" to create an account.
5. Click on Virtual Visit.
6. Or you may call 1-877-552-7401 for assistance in registering.

For more information on pharmacy benefits and filling prescriptions, please see Section 9 How to Get Your Prescription Drugs of this handbook.

What are "Network Providers"

The Optima Health Community Care network providers include:

- Doctors, nurses, and other healthcare professionals that you can go to as a member of our plan;
- Clinics, hospitals, nursing facilities, and other places that provide health services in our plan;

- Early intervention providers, home health agencies and durable medical equipment suppliers;
- Long term services and supports (LTSS) providers including nursing facilities, hospice, adult day healthcare, personal care, respite care, and other LTSS providers.

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

What are "Network Pharmacies"

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

Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them. Call Member Services at the number at the bottom of the page for more information. Both Member Services and the Optima Health Community Care website (optimahealth.com/members) can give you the most up-to-date information about changes in our network pharmacies and providers.

What are Specialists

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

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

If you have a disabling condition or chronic illnesses you can ask us if your specialist can be your PCP.

You do not need a referral from your PCP for specialist care. If you and your PCP make the decision for you to see a plan specialist, your PCP will coordinate your care, and you can make your own appointment. Before you see a specialist, you should confirm that the plan specialist is in the Optima Health network. Visit optimahealth.com/members or contact Member Services at the number on the back of your Member ID card to make sure that your specialist is in the network.

To find out if a doctor or specialist is in our network, sign in to optimahealth.com/members, select Find Doctors, Drugs and Facilities from the top menu. Then select Search Your Network.

Upon signing in all relevant information, such as your health plan network and address, is pre-populated. Choose what type of doctor or facility you are looking for and populate any additional information. The results of your network will display.

If Your Provider Leaves Our Plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 15 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your healthcare needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a grievance or request a new provider. See Section 21 Important Words and Definitions Used in this Handbook
- If you find out one of your providers is leaving our plan, please contact your Care Coordinator so we can assist you in finding a new provider and managing your care.

How to Get Care from Out-of-Network Providers

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

- When Optima Health Community Care has approved a doctor out of its established network;
- When emergency and family planning services are rendered to you by an out of network provider or facility;
- When you receive emergency treatment by providers not in the network;
- When the needed medical services are not available in the Optima Health Community Care network;

- When Optima Health Community Care cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas;
- When the type of provider needed and available in the Optima Health Community Care network does not, because of moral or religious objections, furnish the service you need;
- Within the first 30 days of your enrollment, when your provider is not part of Optima Health Community Care network but has treated you in the past; and,
- If you are in a nursing facility when you enroll with Optima Health Community Care, and the nursing facility is not in the Optima Health Community Care network.

If your PCP or Optima Health Community Care refer you to a provider outside of our network, you are not responsible for any of the costs, except for your *patient pay* towards long term services and supports. See Section 13 of this handbook for information about what a *patient pay* is and how to know if you have one.

Care From Out-of-State Providers

Optima Health Community Care is not responsible for services you obtain outside Virginia except under the following circumstances:

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

Network Providers Cannot Bill You Directly

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

If You Receive a Bill for Covered Services

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

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

provider directly and take care of the bill for covered services.

If You Receive Care From Providers Outside of the United States

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

7. How to Get Care for Emergencies

What is an Emergency

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

What to do in an Emergency

Call 911 at once! You do not need to call Optima Health first. You do not need an authorization or a referral for emergency services.

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

Tell the hospital that you are an Optima Health Community Care member. Ask them to call Optima Health Community Care at the number on the back of your CCC Plus ID Card.

What is a Medical Emergency

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

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

What is a Behavioral Health Emergency

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

Examples of Non-Emergencies

Examples of non-emergencies are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. If you are not sure, call your PCP or the Optima Health Community Care 24/7 medical advice line at: 757-552-8899 or toll free at 1- 844-387-9420.

If You Have an Emergency When Away From Home

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

What is Covered if You Have an Emergency

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

Notifying Optima Health Community Care About Your Emergency

Notify your doctor and Optima Health Community Care as soon as possible about the emergency within 48 hours if you can. However, you will not have to pay for emergency services because of a delay in telling us. We need to follow up on your emergency care. Your Care Coordinator will assist you in getting the correct services in place before you are discharged to ensure that you get the best care possible. Please call Member Services at 1-800-881-2166 (TTY: 711). This number is also listed on the back of Optima Health Community Care Member ID Card.

After an Emergency

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

If You Are Hospitalized

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

If it Wasn't a Medical Emergency

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

8. How to Get Urgently Needed Care

What is Urgently Needed Care

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

You can find a list of urgent care centers we work with in our Provider and Pharmacy Directory, available on our website at optimahealth.com/members.

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

9. How to Get Your Prescription Drugs

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

Rules for Optima Health Community Care Outpatient Drug Coverage

Optima Health Community Care will usually cover your drugs as long as you follow the rules in this Section.

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

Getting Your Prescriptions Filled

In most cases, Optima Health Community Care will pay for prescriptions only if they are filled at Optima Health Community Care network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our members. You may go to any of our network pharmacies.

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

To fill your prescription, show your Member ID Card at your network pharmacy. If you have Medicare, show your Medicare Part D and Optima Health Community Care ID cards. The network pharmacy will bill Optima Health Community Care for the cost of your covered prescription drug.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call Optima Health Community Care to get the necessary information.

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

List of Covered Drugs

Optima Health Community Care has a List of Covered Drugs that are selected by Optima Health Community Care with the help of a team of doctors and pharmacists. The Optima Health Community Care List of Covered Drugs also includes all of the drugs on the DMAS Preferred Drug List (PDL). The List of Covered Drugs can be found at optimahealth.com/members. The List of Covered Drugs tells you which drugs are covered by Optima Health Community Care and also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get.

You can call Member Services to find out if your drugs are on the List of Covered Drugs or check on-line at optimahealth.com/members or we can mail you a paper copy of the List of Covered Drugs. The List of Covered Drugs may change during the year. To get the most up-to-date List of Covered Drugs, visit optimahealth.com/members or call Member Services daily between 8:00 am and 8:00 pm at the number on the bottom of this page.

To search for a drug on optimahealth.com/members, please sign in to your MyOptima account at optimahealth.com/members. If you do not have a MyOptima account, please visit optimahealth.com/members and select Register for Secure Access to create your account (please have your Member ID Card available).

In the left menu bar, click on Pharmacy Resources. Then click Access Pharmacy Resources. You will be sent to the Pharmacy Dashboard, where you can manage your prescriptions and pre-authorizations, as well as look up which drugs are covered and nearby pharmacies.

The List of Covered Drugs tells you which drugs are covered by Optima Health, and if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Changes to the formulary are posted on the website. If a drug you are taking is no longer offered on the formulary, Optima Health Community Care will notify you by letter at least 30 days before the change goes into effect.

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

Limits for Coverage of Some Drugs

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

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

If Optima Health Community Care is new for you, you can keep getting your authorized drugs for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. The continuity of care period is 30 days. Refer to *Transition of Care Policy: Continuity of Care Period* in Section 3 of this handbook.

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

Getting Approval in Advance

For some drugs, you or your doctor must get a service authorization approval from Optima Health Community Care before you fill your prescription. Please note that approved pharmacy services authorizations will not exceed one (1) year in duration. If you don't get approval, Optima Health Community Care may not cover the drug.

Trying a Different Drug First

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

Quantity Limits

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

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

Emergency Supply

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

Non Covered Drugs

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

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

Changing Pharmacies

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

If the pharmacy you use leaves the Optima Health Community Care network, you will have to find a new network pharmacy. To find a new network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services at the number at the bottom of the page or your Care Coordinator. Member Services can tell you if there is a network pharmacy nearby.

What if You Need a Specialized Pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialty drugs are used for treatment of complex diseases and when prescribed the medications required special handling or clinical care support prior to dispensing. Only a limited number of pharmacies are contracted by each MCO to provide these drugs. These medications will be shipped directly to the member's home or the prescriber office and cannot be picked up at all retail outlets. Also these drugs usually require a service authorization prior to dispensing. Be sure to check with the formulary of your plan regarding coverage of these specialty drugs and allow time for shipment deliveries.

Can You Use Mail-Order Services to Get Your Drugs

If your drug requires special handling, it may be mailed to you. You cannot use mail-order services to receive a long-term supply of a drug. If you have any questions, you can call Member Services at the number found at the bottom of this page.

Can You Get a Long-Term Supply of Drugs

Optima Health members may receive up to a thirty-four (34) day supply of a prescription drug at a retail or specialty pharmacy. Members may receive a ninety (90) day supply per prescription of select maintenance drugs identified on the "DMAS ninety (90) day Medication Maintenance List". After receiving two thirty-four (34) day or shorter duration fills. The list of covered dugs for DMAS ninety (90) day Medication list can be located at https://www.optimahealth.com/member/manage-plans/medicaid-prescription-drug-lists.

Optima Health will cover up to a 12-month supply of contraceptives including all oral tablets, patches, vaginal rings and injections that are used on a routine basis when dispensed from a pharmacy.

Can You Use a Pharmacy That is Not in the Optima Health Community Care Network

Most chain and independent pharmacies are in the Optima Health Community Care network. You can use a pharmacy outside of our network if the pharmacy agrees to our terms. You can call the Member Services number at the bottom of this page if you have questions about a pharmacy.

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

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

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works. The lock-in period is for 12 months. At the end of the lock in period, we'll check in with you to see if you should continue the program. If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to *Appeals, State Fair Hearings, and Grievances* in Section 15 of this handbook.

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

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

- A brief explanation of the PUMS program;
- A statement explaining the reason for placement in the PUMS program;
- Information on how to appeal to Optima Health Community Care if placed in the PUMS program;
- information regarding how request a State Fair Hearing after first exhausting the Optima Health Community Care appeals process;
- Information on any special rules to follow for obtaining services, including for emergency or after-hours services; and
- Information on how to choose a PUMS provider.

Contact Member Services at the number below or your Care Coordinator if you have any questions on PUMS.

10. How to Access Your CCC Plus Benefits

CCC Plus Benefits

As an Optima Health Community Care member, you have a variety of healthcare benefits and services available to you. You will receive most of your services through the Optima Health Community Care, but may receive some through DMAS or a DMAS Contractor.

- Services provided through Optima Health Community Care are described in this Section 10 of the handbook.
- Services covered by DMAS or a DMAS Contractor are described in Section 11 of this handbook.
- Services that are not covered through Optima Health Community Care or DMAS are described in Section 12 of this handbook.

Services you receive through Optima Health Community Care or through DMAS will not require you to pay any costs other than your "patient pay" towards long term services and supports. Section 13 of this handbook provides information on what a "patient pay" is and how you know if you have one.

General Coverage Rules

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

- Your services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means you need the service or supplies to prevent, diagnose, or treat a medical condition or its symptoms based on accepted standards of medical practice.
- In most cases, you must get your care from a network provider. A network provider is a provider who works with Optima Health Community Care. In most cases, Optima Health Community Care will not pay for care you get from an out- of-network provider unless the service is authorized by Optima Health Community Care. Section 6 has more information about using network and out-of-network providers, including *Services You Can Get Without First Getting Approval From Your PCP.*
- Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called a service authorization. Section 14 includes more information about service authorizations.
- If Optima Health Community Care is new for you, you can keep seeing the doctors you go to now during the 30-day continuity of care period. You can also keep getting your

authorized services for the duration of the authorization or during the continuity of care period after you first enroll, whichever is sooner. Also see Transition of Care Policy: *Continuity of Care Period* in Section 3 of this handbook.

Benefits Covered Through Optima Health Community Care

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

- **Abortion services**- coverage is only available in cases where there would be a substantial danger to the life of the mother.
- Addiction and Recovery Treatment Services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services, and case management. Services may require authorization. *Additional information about ARTS services is provided below in this section of the handbook.*
- Adult day healthcare services (see CCC Plus Waiver)
- Care Coordination services, including assistance connecting to CCC Plus covered services and to housing, food, and community resources. *See Section 4 of this handbook for more information about your Care Coordinator.*
- CCC Plus Home and Community Based Waiver services, (formerly known as the EDCD and Technology Assisted Waivers), including: adult day healthcare, assistive technology, environmental modifications, personal care services, personal emergency response systems (PERS), private duty nursing services, respite services, services facilitation, transition services. *Additional information about CCC Plus Waiver services is provided later in this Section. Section 11 of this handbook provides information about DD Waiver Services.*
- Clinic services, including renal dialysis.
- Colorectal cancer screening.
- Court ordered services.
- Doula services – a doula is 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.
- Durable Medical Equipment (DME) and supplies including medically necessary respiratory, oxygen, and ventilator equipment and supplies, wheelchairs and accessories, hospital

beds, diabetic equipment and supplies, incontinence products, assistive technology, communication devices, and rehabilitative equipment and devices and other necessary equipment and supplies.

- Early and Periodic Screening Diagnostic and Treatment services (EPSDT) for children under age 21. *Additional information about EPSDT services is provided later in this Section of the handbook.*
- Early Intervention services for children from birth to age 3. *Additional information about early intervention services is provided later in this Section of the handbook.*
- Electroconvulsive therapy (ECT).
- Emergency and post stabilization services. *Additional information about emergency and post stabilization services is provided in Section 7 of this handbook.*
- Emergency custody orders (ECO).
- Emergency services including emergency transportation services (ambulance, etc.).
- End Stage Renal Disease services.
- Eye examinations.
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of the Optima Health Community Care network. Optima Health Community Care does not require you to obtain a service authorization or a PCP referral for family planning services.
- Gender Dysphoria treatment services.
- Glucose test strips.
- Hearing (audiology) services. Covered through EPSDT.
- Home health services.
- Hospice services.
- Hospital care – inpatient/outpatient.
- Human Immunodeficiency Virus (HIV) testing and treatment counseling.
- Immunizations.
- Inpatient psychiatric hospital services.
- Laboratory, Radiology and Anesthesia Services.

- Lead investigations.
- Mammograms.
- Maternity care includes pregnancy care, doctors/certified nurse-midwife services. Additional information about maternity care is provided in Section 6 of this handbook.
- Mental health services, including, outpatient psychotherapy services, community-based, crisis and inpatient services. Community and facility based services include:
    - Mental Health Case Management
    - Therapeutic Day Treatment (TDT) for Children
    - Mental Health Skill-building Services (MHSS)
    - Intensive In-Home
    - Psychosocial Rehabilitation
    - Applied Behavior Analysis (ABA)
    - Mental Health Peer Recovery Supports Services
    - Mental Health Partial Hospitalization Program
    - Mental Health Intensive Outpatient
    - Assertive Community Treatment
    - Multisystemic Therapy (MST)
    - Functional Family Therapy (FFT)
    - Mobile Crisis Response
    - Community Crisis Stabilization
    - 23-Hour Crisis Stabilization
    - Residential Crisis Stabilization
- Nurse Midwife Services through a Certified Nurse Midwife provider.
- Nursing facility - includes skilled, specialized care, long stay hospital, and custodial care. *Additional information about nursing facility services is provided later in this Section of the handbook.*
- Organ transplants.
- Orthotics, including braces, splints and supports - for children under 21, or adults through an intensive rehabilitation program.
- Outpatient hospital services.
- Pap smears.
- Personal care or personal assistance services (through EPSDT or through the CCC Plus Waiver).
- Physical, occupational, and speech therapies.
- Physician's services or provider services, including doctor's office visits.

- Podiatry services (foot care).
- Prenatal and maternal services.
- Prescription drugs. *See Section 9 of this handbook for more information on Pharmacy Services.*
- Preventive care, including regular check-ups, screenings, and well-baby/child visits. *See Section 6 of this handbook for more information about PCP services.*
- Private duty nursing services (through EPSDT and through the CCC Plus HCBS Waiver).
- Prostate specific antigen (PSA) and digital rectal exams.
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses).
- Psychiatric or psychological services.
- Radiology services.
- Reconstructive breast surgery.
- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. *See Section 6 of this handbook for more information about PCP services.*
- Rehabilitation services – inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services).
- Renal (kidney) dialysis services.
- Second opinion services from a qualified healthcare provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.
- Surgery services when medically necessary and approved by Optima Health Community Care.
- Telemedicine services.
- Temporary detention orders (TDO) - when admitted to an acute care hospital or when a member less than 21 or older than 64 is admitted to a freestanding behavioral health facility.
- Tobacco Cessation Services education and pharmacotherapy for all members
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi

cabs). Optima Health Community Care will also provide transportation to/from most "carved-out" and enhanced services. *Transportation Services for DD Waiver services are covered through DMAS, as described in Section 11 of this handbook.*

- Vision services - one (1) exam annually
- Well Visits including annual PCP visits and associated health screenings

Extra Benefits We Provide That are not Covered by Medicaid

As a member of Optima Health Community Care you have access to services that are not generally covered through Medicaid fee-for-service. These are also known as "enhanced benefits." We provide the following extra benefits:

** These extra benefits are effective on January 1, 2023. For current extra benefits, call Member Services.

- Adult literacy program (HEAL Program)
- Adult vision services - Members age 21 and up get one (1) eye exam and $100 for frames yearly. The benefit is limited to in-network providers only.
- Baby Showers
- College application assistance - up to $75, sponsored by Optima Health Read, Learn, Grow (Restrictions apply. Authorization required.)
- **Diapers - Member will receive 400 diapers. Members receive one fulfillment of diapers per live birth, pending completion of prenatal and postpartum visits – both requirements must be met
- **Feminine Hygiene - members may purchase up to $20 per quarter
- **Financial Wellness - program to help achieve financial goals
- Free smartphone - eligible members receive 350 minutes, 1GB unlimited texts, and free monthly calls to the plan. ** Free unlimited wireless, texts, minutes and hotspot (1 per household). Members can check for eligibility.
- GED Prep & Testing Voucher – up to $275 for GED testing voucher and online prep program for eligible members. [(Authorization required.)] Member Outreach will coordinate service limits.
- HEAL Program: Health Literary Program
- Healthy member incentives for eligible members - prenatal & postpartum follow-up, HPV, baby, well-child and adolescent well-child checkup, childhood immunizations, diabetic eye exam, foster care, children PCP & dental visits, COVID-19

- Healthy Moms: Welcoming Baby
- **Healthy Savings Program – healthy food, discounts on over-the counter medications and products, baby items and cleaning products. Members can check for eligibility.
- Home-delivered meals (Authorization required.) - 14 meals delivered at home for eligible members post discharge from hospital stay, including OB or transitioning from a nursing home to the community. Must use the approved network. (Authorization required.)
- **Incontinence – eligible members may purchase up to $30 per quarter. (Authorization required.)
- **Mattress Cover/Pillowcase – All eligible members with asthma can receive one (1) free mattress cover/ protector and one (1) pillowcase every two (2) years, 2 set fulfillment maximum. All eligible members with asthma.
- Memory alarms and devices - additional home security devices, such as door/window alarms and memory devices, bed alarms, chimes and "baby monitor" type devices for eligible members diagnosed with dementia or Alzheimer's disease. Must use approved network. (Authorization required.)
- **Nutritious Food Program – pregnant women can receive healthy savings grocery card to purchase healthy food items, including fresh produce. Members will receive $75 per quarter. Dollars can roll over each quarter but will expire 12 months after live birth or miscarriage.
- **Online Community Resource Guide - online search tool to find food, housing, jobs, and more for eligible members
- **Pedometer - one (1) free pedometer for all eligible members over 5 years old.
- Reading program for children through Optima Health Read, Learn, Grow - ages 0 - 13 years old
- Sports Physicals - free sports physicals for all eligible members
- Transportation services (non-medical) - eligible members may use free 24 round trips each year for non-medical trips to grocery store, place of worship, community events, laundromat and more. Any unused trips do **not** carry over.
- Wellness Program: Weight Management (online only) – *Eating for Life* materials to assist eligible members improve current eating and exercise habits.
- **Wellness Program: Smoking Cessation for eligible members (online only)

**Wellness Rewards – up to $50 for wellness rewards for healthy behavior. Member Outreach will coordinate. (Restrictions apply.)

How to Access Early and Periodic Screening, Diagnostic, and Treatment Services

What is EPSDT

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

Getting EPSDT Services

Optima Health Community Care provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by Optima Health Community Care. For any services not covered by Optima Health Community Care, you can get these through the Medicaid fee-for-service program. Additional information about services provided through Medicaid fee-for-service is provided in Section 11 of this handbook.

Your provider of care should contact Optima Health Community Care to verify coverage and submit any service authorizations. Please see Section 14 of this handbook for information about *Service Authorization and Benefit Determination*.

Getting Early Intervention Services

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

The first step is meeting with the local *Infant and Toddler Connection* program in your community to see if your child is eligible. A child from birth to age three is eligible if he or she has (i) a 25% developmental delay in one or more areas of development; (ii) atypical development; or, (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

For more information, call your Care Coordinator. Your Care Coordinator can help. If your child is enrolled in Optima Health Community Care we provide coverage for early intervention services. Your Care Coordinator will work closely with you and the *Infant and Toddler Connection* program to help you access these services and any other services that your child may need. Information is also available at www.infantva.org or by calling 1-800-234-1448.

Behavioral Health Services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues. Substance use may also be a factor.

These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in your home or in the community, over a short or long timeframe. All services are performed by qualified individuals and organizations.

Optima Health provides most of the Medicaid EPSDT covered services, including Applied Behavior Analysis (ABA) services. Behavioral therapy services must be designed to enhance communication skills and decrease maladaptive patterns of behavior before there is a need for more restrictive level of care. ABA services:

- Are available to members under 21 years of age
- Include assessments (up to 5 hours per child, per provider)
- Should ensure the member's family or caregiver is trained to support the member in the home and community using the skills learned while actively participating in behavioral therapy
- Are only allowed after the service provider documents that lesser services such as Mental Health Services (MHS) are not the best option.

Please reach out to case management for assistance with accessing EPSDT services.

How to Access Behavioral Health Services

To access behavioral health services, you can call Optima Health Member Services 1-888-512-3171 TTY 1-844-552-8148, 8:00 am to 8:00 pm, Monday through Friday. The call is free and you can also be connected to your care coordinator during the call. You can also contact your Care Coordinator directly.

Behavioral Health Services Administrator (BHSA)

Some behavioral health services, such children's residential treatment and therapeutic foster care case management, are covered for you through Magellan of Virginia. Magellan of Virginia is

the behavioral health services administrator (BHSA) for the Department of Medical Assistance Services (DMAS). Optima Health's Member Services Department can help coordinate the services you need, including those that are provided through the BHSA.

Mental Health Services (MHS) and Trauma Informed Care

Optima Health provides coverage for traditional inpatient and partial psychiatric hospitalization. We also cover Mental Health Services (MHS) for Medicaid members. MHS services are also available for members who have experienced potentially traumatic events in their lifetime.

Trauma refers to intense and overwhelming experiences that involve serious loss, threat or harm to a person's physical and/or emotional well-being. These experiences may occur at any time in a person's life. They may involve a single traumatic event or may be repeated over many years. People often find a way of coping that may work in the short run, but can cause serious harm in the long run.

Optima Health's in-network providers deliver services to members through a trauma-informed care framework.

Optima Health Community Care follows the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements for service authorizations. For emergency services, please see *Behavioral Health Crisis Line* and *Addiction and Recovery Treatment Services (ARTS) Advice Line* in Section 5 of this handbook for more information. Please see Section 14 of this handbook for information about *Service Authorization and Benefit Determination*.

How to Access Non-Emergency Transportation Services
Transportation Services Covered by Optima Health

Rides may be provided if you have no other means of transportation and need to go to an appointment for a covered service. Call 1-855-325-7558 (TTY: 711), Monday – Friday 8:00 am – 5:00 pm to set up a ride. Trips need to be scheduled at least five (5) business days beforehand. Weekends and holidays do not count toward these days.

Access Addiction and Recovery Treatment Services (ARTS)

Optima Health Community Care offers a variety of services that help individuals who are struggling with substance abuse. This includes alcohol and drug use. Addiction is a medical illness, just like diabetes.

Many people face addiction, and can benefit from treatment. If you need treatment for addiction, we cover services that can help you.
Optima Health covers the following ARTS services:

- Inpatient acute detoxification hospitalization;
- Partial hospitalization;

- Group home / halfway house;
- Residential treatment facility services;
- Substance abuse intensive outpatient treatment;
- Outpatient (individual, family, and group) substance abuse treatment;
- Opioid treatment services (includes individual, group counseling; family therapy and medication administration); and
- Substance abuse peer specialist services.

Medication-assisted treatment options are also available for addiction involving prescription or non-prescription drugs. Peer services are provided by someone who has experienced similar issues and in recovery. Case management services are also available.

How to Access Addiction and Recovery Treatment Services (ARTS)

Talk to your Primary Care Provider (PCP) or call an Optima Healthcare Coordinator to determine the best option for you and how to get help in addiction and recovery treatment services.
To find an ARTS provider, you can do any of the following:

- look in the Provider and Pharmacy Directory
- visit our website at optimahealth.com
- call your Optima Healthcare Coordinator
- contact Member Services at 1-800-881-2166, TTY 1-844-552-8148, 8:00 am to 8:00 pm, Monday through Friday

If you have any questions or if you are interested in finding out more about ARTS, please do not hesitate to reach out to us. We hope you will take advantage of these services that are a benefit and are available at no cost to you.

Prior Authorizations for Behavioral Health and ARTS

Optima Health requires a prior service authorization for:

- all inpatient behavioral health and substance abuse admissions to hospitals
- partial hospitalization
- residential treatment
- substance abuse group home / halfway house treatment
- intensive outpatient substance abuse services

We also require a prior service authorization for the following Mental Health and Rehabilitation services (MHS) services:

- mental health case management
- therapeutic day treatment (TDT) for children
- mental health partial hospitalization program (MH-PHP)
- mobile Crisis Response
- community crisis stabilization
- 23-Hour crisis stabilization

- residential crisis stabilization
- assertive community treatment (ACT)
- mental health intensive outpatient program (MH-IOP)
- mental health skill-building services (MHSS)
- intensive in-home
- psychosocial rehab
- mental health peer support services (individual and group)

To find out more about how to request approval for these treatments or services, contact Member Services at 1-800-881-2166 TTY 1-844-552-8148, 8:00 am to 8:00 pm, Monday through Friday, or call your Care Coordinator.

Any person or child admitted to a Therapeutic Group Home (TGH) will not be excluded from the Medallion 4.0 program; however, the TGH per diem service is "carved out" of the Medallion 4.0 contracts and will be administered through Magellan of Virginia. Any professional medical services rendered to individuals in the TGH will be administered by Optima Health.

Optima Health Community Care follows the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements for service authorizations. For emergency services, please see *Behavioral Health Crisis Line* and *Addiction and Recovery Treatment Services (ARTS) Advice Line* in Section 5 of this handbook for more information. Please see Section 14 of this handbook for information about *Service Authorization and Benefit Determination*.

How to Access Long-Term Services and Supports (LTSS)

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

Commonwealth Coordinated Care Plus Waiver

Some members may qualify for home and community-based care waiver services through the Commonwealth Coordinated Care Plus Waiver (formerly known as the Elderly or Disabled with

Consumer Direction and Technology Assistance Waivers).

The Commonwealth Coordinated Care Plus (CCC Plus) Waiver is meant to allow a member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus Waiver services, you may choose how to receive personal assistance services. You have the option to receive services through an agency (known as agency directed) or you may choose to serve as the employer for a personal assistance attendant (known as self-directed.) Information on self-directed care is described in more detail below, in this Section of the handbook.

CC Plus Waiver Services may include:

- Private duty nursing services (agency directed)
- Personal care (agency or self-directed)
- Respite care (agency or self-directed)
- Adult day healthcare
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for members transitioning to the community from a nursing facility or long stay hospital
- Assistive technology (AT) - The maximum Medicaid-funded expenditure per individual for all AT-covered procedure codes combined shall be $5,000 per individual per State Fiscal Year (SFY) July 1 to June 30. Unexpended portions of the maximum amount shall not be carried over from one SFY to the next.
- Environmental modifications - available for a maximum Medicaid-funded amount of $5,000 per household per State Fiscal Year (SFY) July 1 through June 30.

Individuals enrolled in a DD Waiver should see *How to Get Services if you are in a DD Waiver* described later in this Section.

How to Self-Direct Your Care

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

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

Your Care Coordinator will also monitor your care as long as you are receiving CCC Plus Waiver services to make sure the care provided is meeting your daily needs.

If you need a service authorization for LTSS or a waiver, please contact your Care Coordinator. If you are unable reach your Care Coordinator, you can reach an ARTS health professional 24 hours a day, 7 days a week to answer your questions at: 757-552- 7580 or toll-free at 1-888-946-1168.

Nursing Facility Services

If you are determined to meet the coverage criteria for nursing facility care, and choose to receive your long-term services and supports in a nursing facility, Optima Health Community Care will provide coverage for nursing facility care. If you have Medicare, Optima Health Community Care will provide coverage for nursing facility care after you exhaust your Medicare covered days in the nursing facility, typically referred to as skilled nursing care.

If you are in a nursing facility, you may be able to move from your nursing facility to your own home and receive home and community-based services if you want to. If you are interested in moving out of the nursing facility into the community, talk with your Care Coordinator. Your Care Coordinator is available to work with you, your family, and the discharge planner at the nursing facility if you are interested in moving from the nursing facility to a home or community setting.

If you choose not to leave the nursing facility, you can remain in the nursing facility for as long as you are determined to meet the coverage criteria for nursing facility care.

Your doctor or other healthcare provider should submit your service authorization requests for most medical services. If you need a service authorization for LTSS, please contact your Care Coordinator.

Screening for Long Term Services and Supports

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

Freedom of Choice

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

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

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

How to Get Services if You are in a Developmental Disability Waiver

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

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

Optima Health Community Care will only provide coverage for your *non-waiver services*. Non-waiver services include all of the services listed in Section 10, *Benefits Covered through Optima Health Community Care. Exception:* If you are enrolled in one of the DD Waivers, you would not also be eligible to receive services through the CCC Plus Waiver.

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

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

The DD waivers have a wait list. Individuals who are on the DD waiver waiting list may qualify to be enrolled in the CCC Plus Waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in your community. For more information on the DD Waivers and the services that are covered under each DD Waiver, visit the Department of Behavioral Health and Developmental Services (DBHDS) website at: http://www.mylifemycommunityvirginia.org/ or call 1-844-603-9248. Your Care Coordinator will work closely with you and your DD or ID case manager to help you get all of your covered services. Contact your Care Coordinator if you have any questions or concerns.

How to Get Non-Emergency Transportation Services

Non-Emergency Transportation Services Covered by Optima Health Community Care

Non-Emergency transportation services are covered by Optima Health Community Care for covered services, carved out services, and enhanced benefits. Exception: If you are enrolled in a DD Waiver, Optima Health Community Care provides coverage for your transportation to/from your non-waiver services. (Refer to *Transportation to/from DD Waiver Services* below.)

Transportation may be provided if you have no other means of transportation and need to go to a physician or a healthcare facility for a covered service. For urgent or non-emergency medical appointments, call the reservation line at 1-855-325-7558. If you are having problems getting transportation to your appointments, call 1-855-325-7558 or Member Services at the number below. Member Services is here to help.

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

Transportation services are available. To schedule transportation to covered medical and behavioral health services, call toll-free 1-855-325-7558, Monday through Friday from 8:00 AM to 5:00 PM. Please call at least five (5) days in advance for routine appointments. You can call 24 hours a day, 7 days a week for urgent transportation needs. Bus tickets are also available at no cost to you (wheelchair bus service included). Please allow five (5) days for mailing of bus tickets.

Transportation will allow one additional person if needed to go with you to your appointment. Two children may go with their parent or guardian but only if space is available. To confirm your transportation vendor or check on a "late" ride, please call 1-855-325-7558.

Transportation To and From DD Waiver Services

If you are enrolled in a DD Waiver, Optima Health Community Care provides coverage for your transportation to and from your *non-waiver services.* (Call the number *in this section* for transportation to your ***non-waiver services***.)

Transportation to your DD Waiver services is covered by the DMAS Transportation Contractor. You can find out more about how to access transportation services through the DMAS Transportation Contractor on the website at: http://transportation.dmas.virginia.gov/or by calling the Transportation Contractor. Transportation for routine appointments are taken Monday through Friday between the hours of 6:00 AM to 8:00 PM. The DMAS Transportation Contractor is available 24 hours a day, 7 days a week to schedule urgent reservations, at: 1-866-386-8331 or TTY 1-866-288-3133 or 711 to reach a relay operator.

If you have problems getting transportation to your DD waiver services, you may call your DD or

ID Waiver case manager or the DMAS Transportation Contractor at the number above. You can also call your Care Coordinator. Your Care Coordinator will work closely with you and your DD or ID Waiver case manager to help get the services that you need. Member Services is also available to help at the number below.

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

Carved-Out Services

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

Your Care Coordinator can also help you to access these services if you need them.

- Dental Services are provided through the DMAS Dental Benefits Administrator. DMAS has contracted with a Dental Benefits Administrator to coordinate the delivery of all Medicaid dental services. The dental program provides coverage for the following populations and services:

  If you have any questions about your dental coverage through ***the DMAS Dental Benefits Administrator***, you can reach DentaQuest Member Services at 1-888-912-3456, Monday through Friday, 8:00 AM - 6:00 PM EST. The TTY/TDD number is 1-800-466-7566. Additional information is provided at: https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/

  Optima Health Community Care provides coverage for non-emergency transportation for any dental services covered through the DMAS Dental Benefits Administrator, as described above. Contact Member Services at the number below if you need assistance.

- Optima Health Community Care provides coverage for oral services such as hospitalizations, surgeries or services billed by a medical doctor not a dentist.

- Developmental Disability (DD) Waiver Services, including Case Management for DD Waiver Services, are covered through DBHDS. The carve-out includes any DD Waiver services that are covered through EPSDT for DD waiver enrolled individuals and transportation to/from DD Waiver services. Also see *How to Get Services if you are in a Developmental Disability Waiver* in Section 10 of this handbook.

- School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's *Individualized Education Program (IEP).* While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid,

school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.

- Treatment Foster Care Case Management is managed by Magellan of Virginia and more information is available at: http://www.magellanofvirginia.com or by calling: 1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711. You can also call your Care Coordinator for assistance.
- Therapeutic Group Home Services for children and adolescents younger than the age of 21. This is a place where children and adolescents live while they get treatment. Children under this level of care have serious mental health concerns. These services provide supervision and behavioral healthcare toward therapeutic goals. These services also help the member and their family work towards discharge to the member's home. Additional information about Therapeutic Group Home Services is available on the Magellan website at: http://www.magellanofvirginia.com or by calling: 1-800-424-4046, TDD: 1-800-424-4048 or TTY: 711. You can also call your Care Coordinator for assistance.
- For members age twenty-one (21) through sixty-four (64), where the member goes into private freestanding Institution for Mental Disease (IMD) or a State freestanding IMD for a Temporary Detention Order (TDO), the state TDO program will pay for the service.

Services That Will End Your CCC Plus Enrollment

If you receive any of the services below, your enrollment with Optima Health Community Care will end. You will receive these services through DMAS or a DMAS Contractor.

- PACE (Program of All Inclusive Care for the Elderly). *For more information about PACE, talk to your Care Coordinator or visit:* http://www.pace4you.org/
- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).
- You are receiving care in a Psychiatric Residential Treatment Facility (children under 21). Additional information about Psychiatric Residential Treatment Facility Services is available on the Magellan website at: http://www.magellanofvirginia.com or by calling: 1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711. You can also call your Care Coordinator for assistance.
- You reside in a Veteran's Nursing Facility.
- You reside in one of these State long-term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.

12. Services Not Covered by CCC Plus

The following services are not covered by Medicaid or Optima Health Community Care. If you receive any of the following non-covered services, you will be responsible for the cost of these services.

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Assisted suicide
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Christian Science nurses
- Cosmetic treatment or surgery
- Daycare, including companion services for the elderly (except in some home- and community-based service waivers)
- Drugs prescribed to treat hair loss or to bleach skin
- Elective abortions
- Erectile Dysfunction drugs
- Eyeglasses or their repair for members age 21 or older are not covered by Medicaid. (Discounts on eyeglasses are covered by Optima Health Community Care as an extra benefit.)
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by Optima Health Community Care)
- Medical care other than emergency services, urgent services, or family planning services, received from providers outside of the network unless authorized by Optima Health Community Care
- Personal care services (except through some home and community-based service waivers or under EPSDT)
- Prescription drugs covered under Medicare Part D, including the Medicare copayment.
- Private duty nursing (except through some home and community-based service waivers or under EPSDT)

- Services rendered while incarcerated
- Weight loss clinic programs unless authorized
- Care outside of the United States

If You Receive Non-Covered Services

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

- Services are medically necessary and authorized, and
- Services are listed as *Benefits Covered Through* Optima Health Community Care in Section 10 of this handbook, and
- You receive services by following plan rules.

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

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

13. Member Cost Sharing

There are no copayments for services covered through the CCC Plus Program. This includes services that are covered through Optima Health Community Care or services that are carved-out of the CCC Plus contract. The services provided through Optima Health Community Care or through DMAS will not require you to pay any costs other than your patient pay towards long term services and supports. See the *Member Patient Pay* Section below.

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

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

Member Patient Pay Towards Long Term Services and Supports

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

Medicare Members and Part D Drugs

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

14. Service Authorization and Benefit Determination

Service Authorization

There are some treatments, services, and drugs that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called a service authorization. You, your doctor, or someone you trust can ask for a service authorization. Service authorizations, including Pharmacy, will not exceed one (1) year in duration.

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

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

We look at standards of care based on:

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

Optima Health Community Care does not reward employees, consultants, or other providers to:

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

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

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

- All acute rehabilitation
- All inpatient hospitalizations
- All intensive outpatient programs
- All out-of-area services except emergency care

- All outpatient surgeries/short stays/observations
- All partial hospitalizations
- All rehabilitation programs (cardiac, pulmonary and vascular rehabilitation)
- All services by non-participating providers
- Any surgical or diagnostic procedure in which Anesthesiology or conscious sedation is billed
- Applied Behavior Analysis
- Augmentative Speech Devices
- Durable Medical Equipment (single items over the $1,200 and all rentals)
- Genetic testing
- Hyperbaric Therapy
- Injectable drugs, including but not limited to, Synvisc/Hyalgan, Synagis, Remicade, IVIG
- Long-Term Services and Support (LTSS)
- Oral surgery and related services
- Orthotics/Prosthetics (single items over the $1,200 and all rentals, repairs and duplicates)
- Outpatient Advanced Imaging Services (CT, CTA, MRI, MRA, MRS or PET scans)
- Oxygen (rental)
- Plastic surgery
- Skilled-Nursing Services
- Transplants
- Waiver Services
- Wheelchairs and seating

To find out more about how to request approval for these treatments or services you can contact Member Services at the number below or call your Care Coordinator.

Service Authorizations and Continuity of Care

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

How to Submit a Service Authorization Request

Your doctor or other healthcare provider should submit your service authorization requests for most medical services. If you need a service authorization for LTSS or a waiver, please contact your Care Coordinator.

What Happens After We Get Your Service Authorization Request

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

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

Timeframes for Service Authorization Review

Optima Health Community Care follows National Committee for Quality Assurance service authorization standards and timeframes. Optima Health Community Care is responsible for deciding how quickly the authorization is needed depending on the urgency and type of service requested. For standard authorization decisions, Optima Health Community Care will provide written notice as quickly as needed, and within fourteen (14) calendar days. For urgent decisions, Optima Health Community Care will provide written notice within three (3) calendar days or 72 hours.

Urgent requests include requests for medical or behavioral healthcare or services where waiting fourteen (14) days could seriously harm your health or ability to function in the future. Care or services to help with transitions from inpatient hospital or institutional setting to home are also urgent requests. You or your doctor can ask for an urgent request if you believe that a delay will cause serious harm to your health. For standard or urgent decisions, if Optima Health Community Care, you or your provider request an extension, or more information is needed, an extension of up to fourteen (14) additional calendar days is allowed.

For pharmacy services, we must provide decisions by telephone or other telecommunication

device within 24 hours.

There may be an instance where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit an authorization request for the prescribed medication. Please note that approved pharmacy service authorization will not exceed one (1) year in duration.

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

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

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

Optima Health
Appeals and Grievances
PO Box 6253
Glen Allen, VA 23058
Phone: 1-844-434-2916 (TTY: 711)
Fax: 1-866-472-3920

Email: memberappeals@sentara.com

You or someone you trust can file a grievance with Optima Health Community Care if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a grievance about the way Optima Health Community Care handled your service authorization request to the State through the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608. Also see *Your Right to File a Grievance*, in Section 15 of this handbook.

Benefit Determination

We will notify you with our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service

authorization request. If you disagree with our decision, you have the right to file an appeal with us. Also see *Your Right to Appeal*, in Section 15 in this handbook.

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

Advance Notice

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

Post Payment Review

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

15. Appeals, State Fair Hearings, and Grievances

Your Right to Appeal

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

For example, you can appeal if Optima Health Community Care denies:

- A request for a healthcare service, supply, item or drug that you think you should be able to get, or
- A request for payment of a healthcare service, supply, item, or drug that Optima Health Community Care denied.

You can also appeal if Optima Health Community Care stops providing or paying for all or a part of a service or drug you receive through CCC Plus that you think you still need.

Authorized Representative

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

Adverse Benefit Determination

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

How to Submit Your Appeal

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

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

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

Send your Appeal request to:

Optima Health
Appeals and Grievances
PO Box 6253
Glen Allen, VA 23058
Phone: 1-844-434-2916 (TTY: 711)
Fax: 1-866-472-3920
Email: memberappeals@sentara.com

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

Continuation of Benefits

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

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

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

What Happens After We Get Your Appeal

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

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

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to make a decision

on your case. This information is available at no cost to you.

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

Optima Health
Appeals and Grievances
PO Box 6253
Glen Allen, VA 23058
Phone: 1-844-434-2916 (TTY: 711)
Fax: 1-866-472-3920
Email: memberappeals@sentara.com

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

Timeframes for Appeals

Standard Appeals

If we have all the information we need we will tell you our decision within thirty (30) days of when we receive your appeal request. We will tell you within two (2) calendar days after receiving your appeal if we need more information. A written notice of our decision will be sent within two (2) calendar days from when we make the decision.

Expedited Appeals

If we have all the information we need, expedited appeal decisions will be made within 72 hours of receipt of your appeal. We will tell you within two (2) calendar days after receiving your appeal if we need more information. We will tell you our decision by phone and send a written notice within two (2) calendar days from when we make the decision.

If We Need More Information

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

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

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

Optima Health
Appeals and Grievances
PO Box 6253
Glen Allen, VA 23058
Phone: 1-844-434-2916 (TTY: 711)
Fax: 1-866-472-3920
Email: memberappeals@sentara.com

You or someone you trust can file a grievance with Optima Health Community Care if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a grievance about the way Optima Health Community Care handled your appeal to the State through the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608.

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

Written Notice of Appeal Decision

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

Your Right to a State Fair Hearing

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

State Fair Hearings can be requested for an adverse benefit decision related to Medicaid covered services. You cannot appeal to DMAS for an adverse benefit decision related to extra benefits we provide that are not covered by Medicaid (see Section 10 for a list of extra benefits).

Standard or Expedited Review Requests

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

Authorized Representative

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

Where to Send the State Fair Hearing Request

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

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

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

After You File Your State Fair Hearing Appeal

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

State Fair Hearing Timeframes

Expedited Appeal

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

Standard Appeal

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

Continuation of Benefits

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

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

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. **You may, however, have to repay Optima Health Community Care for any services you receive during the continued coverage period if the Optima Health Community Care adverse benefit determination is upheld and the services were provided solely because of the requirements described in this Section.**

If the State Fair Hearing Reverses the Denial

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

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

If services were provided while the State Fair Hearing was pending

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

If You Disagree with the State Fair Hearing Decision

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

Your Right to File a Grievance

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

Timeframe for Grievances

You can file a grievance with us at any time.

What Kinds of Problems Should be Grievances

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

<u>Grievances about quality</u>

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

<u>Grievances about privacy</u>

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

<u>Grievances about poor customer service</u>

- A healthcare provider or staff was rude or disrespectful to you.
- Optima Health Community Care staff treated you poorly.
- Optima Health Community Care is not responding to your questions.
- You are not happy with the assistance you are getting from your Care Coordinator.

Grievances about accessibility

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

Grievances about communication access

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

Grievances about waiting times

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

Grievances about cleanliness

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

Grievances about communications from us

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

There Are Different Types of Grievances

You can make an internal grievance and/or an external grievance. An internal grievance is filed with and reviewed by Optima Health Community Care. An external grievance is filed with and reviewed by an organization that is not affiliated with Optima Health Community Care.

Internal Grievances

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

Optima Health
Appeals and Grievances
PO Box 6253
Glen Allen, VA 23058

Phone: 1-844-434-2916 (TTY: 711)
Fax: 1-866-472-3920
Email: complaints@sentara.com

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

We will notify you of the outcome of your grievance within a reasonable time, but no later than 90 calendar days after we receive your grievance.

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

External Grievances

You Can File a Grievance with the Managed Care Helpline

You can make a Grievance about Optima Health Community Care to the Managed Care Helpline. Contact the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608.

You Can File a Complaint with the Office for Civil Rights

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

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

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

You Can File a Grievance with the Office of the State Long-Term Care Ombudsman

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

The State's Long-Term Care Ombudsman program offers assistance to persons receiving long term care services, whether the care is provided in a nursing facility or assisted living facility, or through community-based services to assist persons still living at home. A Long-Term Care Ombudsman does not work for the facility, the State, or Optima Health Community Care. This helps them to be fair and objective in resolving problems and concerns.

The program also represents the interests of long-term care consumers before state and federal government agencies and the General Assembly.

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

Office of the State Long-Term Care Ombudsman

1-800-552-5019 This call is free.

This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

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

16. Member Rights

Your Rights

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

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

- Be informed of where, when and how to obtain the services you need from Optima Health Community Care, including how you can receive benefits from out-of-network providers if the services are not available in the Optima Health Community Care network.
- Complain about Optima Health Community Care to the State. You can call the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608 to make a grievance about us.
- Appoint someone to speak for you about your care and treatment and to represent you in an Appeal;
- Make advance directives and plans about your care in the instance that you are not able to make your own healthcare decisions. See Section 17 of this handbook for information about Advance Directives.
- Change your CCC Plus health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference Section 2 of this handbook or call the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608 or visit the website at cccplusva.com for more information.
- Appeal any adverse benefit determination (decision) by Optima Health Community Care that you disagree with that relates to coverage or payment of services. See *Your Right to Appeal* in this Section 15 of the handbook.
- File a grievance about any concerns you have with our customer service, the services you have received, or the care and treatment you have received from one of our network providers. See *Your Right to File a Grievance* in Section 15 of this handbook.
- To receive information from us about our plan, your covered services, providers in our network, and about your rights and responsibilities.
- To make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this Section of the handbook.)
- Exercise your rights and to know that you will not have any retaliation against you by [Health Plan], any of our doctors/providers or state agencies

Your Right to be Safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If you, or someone you know, is being abused, physically, is being neglected, or is being taken advantage of financially by a family member

or someone else, you should call your local Department of Social Services or the Virginia Department of Social Services' 24-hour, toll-free hotline at: 1-888 832-3858. You can make this call anonymously; you do not have to provide your name. The call is free.

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

Your Right to Confidentiality

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

Optima Health Community Care staff will ask questions to confirm your identity before we discuss or provide any information regarding your health information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Optima Health Community Care protect the confidentiality of your health information. We will not use or further release your health information except as necessary for treatment, payment, and health plan operations, as permitted or required by law, or as authorized by you. Optima Health Community Care is required by law to maintain the confidentiality and security of your health information. We will only use or share your health information as needed to provide you with the care you need or as allowed by law unless you give us written permission to share it with others.

If you are receiving care or have a diagnosis for substance use disorder and/or addiction, recovery, and treatment services, you must provide us written permission to share your information unless the information is being shared with a company who is working for Optima Health Community Care in its efforts to provide you care and insurance benefits.

A complete description of your rights under HIPAA can be found in the Sentara Healthcare Notice of Privacy Practices. A copy of the notice is included in this handbook. You can also go to optimahealth.com/members to see a copy of our Privacy Notice.

Your Right to Privacy

We understand that medical information about you and your health is personal and we are committed to protecting it. We use information about you to administer your benefits, process your claims, provide education and clinical care, coordinate your benefits with other insurance carriers, and other activities related to providing you with healthcare coverage.

The Commonwealth of Virginia also has laws in place to protect the privacy of your insurance information. Optima Health Community Care requires an Authorization of Designated Agent form whenever anyone other than you needs to obtain and/or change health information. You can download a copy of the form at optimahealth.com/members under Manage My Plan, Member Forms, or by calling Member Services at the number on the back on your Member ID Card.

You have the legal right to see and receive a copy of your health information including your claims records. You also have the right to correct your health information, request confidential communications, ask us to limit the information we share, and get a copy of the Sentara Healthcare Notice of Privacy Practices.

You also have the right to request a list of who we have released your information to for certain circumstances. This is called an Accounting of Disclosures and may be obtained by calling the Member Services number on your Member ID Card.

You may file a grievance with Optima Health Community Care or with the Secretary of the U.S. Department of Health and Human Services, if you believe your privacy rights have been violated. To file a grievance with Optima Health Community Care, please call the Member Services number on your Member ID Card.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

References to "Sentara," "we," "us," and "our" means the members of the Sentara Healthcare ACE, which is an affiliated covered entity. An affiliated covered entity is a group of organizations under common ownership or control who designate themselves as a single affiliated covered entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Sentara Healthcare ACE, and its employees and workforce members who are involved in providing and coordinating your health care, are all bound to follow the terms of this Notice. The members of the Sentara Healthcare ACE will share federally protected health information (i.e., your medical information) with each other for treatment, payment, and health care operations as permitted by HIPAA and this Notice. A complete list of the members of the Sentara Healthcare ACE is provided at the end of this Notice.

Our Pledge Regarding Your Protected Health Information

Sentara is committed to safeguarding protected health information about you. We create a record of certain health information related to your health benefit plan administered by certain Sentara entities. We need this information to provide you with quality services and to comply with certain legal requirements.

This Notice applies to all the health information records related to your health benefit plan administered by certain Sentara Health Plans.

We are required by law to:

• _Maintain the privacy of your medical information;

• _Provide you this Notice describing our legal duties and privacy practices with respect to your medical information;

• _Notify you following a breach of your unsecured medical information; and

• _Follow the terms of this Notice.

How We May Use and Disclose Protected Health Information About You Without Your Authorization (Permission)

The following sections describe different ways that we may use and disclose your protected health information without your authorization (permission). For each category of uses or disclosures, we will describe them and give some examples. Some medical information, such as certain genetic information, certain drug and alcohol information, HIV information, and mental health information, may be entitled to special restrictions by state and federal laws. We abide by all applicable state and federal laws related to the protection of such medical information. Not every use or disclosure will be listed, but all of the ways we are permitted to use and disclose protected health information about you will fall within one of the following categories.

Treatment: We may use or disclose medical information about you to provide you with medical treatment and/or coordinate with health care providers on treatment for you.

Payment: We may use and disclose your protected health information to make coverage determinations, to coordinate benefits, and to help pay your medical bills submitted to us for payment. For example, we may use your medical information from a surgery you received at a hospital so that the hospital can be paid.

Health Care Operations: We may use and disclose protected health information about you for our health care operations and for certain health care operations of other providers who furnish care to you. These uses and disclosures are necessary to operate our health plans and to make sure that all of our members receive quality services. We may use and disclose protected health information to provide customer services. For example, we may use protected health information about you to review our services, to evaluate the performance of our staff, and to survey you on your satisfaction with our services. We may review and/or aggregate member information to decide what additional services or benefits our health plans should offer, what services are not needed, and whether certain new services are effective. We may combine the protected health information we have about you with other members' protected health information to compare how we are doing and see where we can make improvements in the services we offer.

Business Associates: We may share your protected health information with certain third parties referred to as "business associates." Business associates provide various services to or for Sentara. Examples include billing services, transcription services, and legal services. We require our business associates to sign an agreement requiring them to protect your protected health information and to

use and disclose your protected health information only for the purposes for which we have contracted for their services.

Individuals Involved in Your Care or Payment for Your Care: Unless you tell us not to, we may release protected health information about you to individuals involved in your medical care such as a friend, a family member, or any individual you identify. We also may give your protected health information to someone who helps pay for your care. Additionally, we may disclose protected health information about you to your legal representative, meaning generally, a person who has the authority by law to make healthcare decisions for you. Sentara typically will treat your legal representative the same way as we would treat you with respect to your medical information.

Communications with You: We, or our Business Associates, may contact you via telephone, email, or text message about your treatment, care, or payment related activities. As an example, we may remind you that you have an appointment for medical care and provide information about treatment. We or our Business Associate may also use your protected health information to communicate with you about health-related benefits or services that may be of interest to you, such as available immunizations.

If you provide us with your email address and/or phone number, you acknowledge that we, or our Business Associates, may exchange protected health information with you by email, text, or phone call. These messages may be sent using automated dialing and/or pre-recorded messages. You agree we can communicate with you through these methods via phone calls, emails, text messages, or other means based on the contact information you have on file with us. You also understand and agree that communication via email and text or are inherently unsecure and that there is no assurance of confidentiality of information communicated in this manner. You agree that you are the user and/or subscriber of the e-mail address and/or phone number provided to us, and you accept full responsibility for e-mails, phone calls, and/or text messages made or sent to or from this e-mail address or phone number. If you prefer not to exchange protected health information via email, text or over the phone, you can choose not to communicate with us via those means by notifying the Privacy Officer (see contact information at the end of this Notice).

As Required or Permitted by Law: We will disclose medical information about you when required to do so by federal and/or state law. This includes sharing information with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Legal Proceedings, Lawsuits and Other Legal Actions: We may disclose protected health information about you to courts, attorneys, court employees, and others when we receive a court order, subpoena, discovery request, warrant, summons, or other lawful instructions. We also may disclose protected health information about you to those working on Sentara's behalf in a lawsuit or action involving Sentara. We may also disclose information for law enforcement purposes as required by law or in response to a valid subpoena, summons, court order, or similar process.

Incidental Disclosures: There are certain disclosures of protected health information that may occur while we are providing service to you or conducting our business. We will make reasonable efforts to limit these incidental disclosures.

Additional Uses and Disclosures of Your Protected Health Information Without Your Authorization (Permission)

We may use and disclose your protected health information in the following special situations:

• _**Disaster-Relief Efforts**: We may disclose protected health information about you to an organization assisting in a disaster-relief effort so that your family can be notified about your condition, status, and location. If you do not want us to disclose your protected health information for this purpose, you must tell your caregivers so that we do not disclose this information unless we must do so to respond to the emergency.

• _**To Avert a Serious Threat to Health or Safety**: We may use and disclose protected health information about you to help prevent a serious and imminent threat to your health and safety or the health and safety of the public or another person.

• _**Military**: If you are a member of the armed forces, domestic (United States) or foreign, we may release protected health information about you to the military authorities as permitted or required by law.

• _**Workers' Compensation**: We may disclose protected health information about you for workers' compensation or similar programs as permitted or required by law.

• _**Coroners, Medical Examiners and Funeral Directors**: We may disclose protected health information about you to a coroner, medical examiner, or funeral director as necessary for them to carry out their duties.

• _**National Security and Intelligence Activities**: We may disclose protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities as permitted or required by law.

• _**Protective Services for the President of the United States and Others**: We may disclose protected health information about you to authorized federal officials so they may conduct special investigations or provide protection to the President of the United States, other authorized persons, or foreign heads of state as permitted or required by law.

• _**Inmates**: If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release protected health information about you to the correctional institution or law enforcement officials as permitted or required by law.

How We May Use and Disclose Protected Health Information About You Upon Your Written Authorization (Permission)

Marketing: We must obtain your written permission to use or disclose your protected health information for marketing purposes except in certain circumstances. For example, written permission is not required for face-to-face encounters involving marketing, or where we are providing a gift of nominal value (for example, a coffee mug), or a communication about our own services or products (for example, we may send you a postcard announcing the arrival of a new surgeon or x-ray machine).

Sale of Protected Health Information: We must obtain your written permission to disclose your protected health information in exchange for remuneration (payment).

Other Uses and Disclosures of Your Protected Health Information Without Your Authorization (Permission): Other uses and disclosures of your protected health information not covered by the categories included in this Notice or applicable laws, rules, or regulations will be made only with your written permission. If you provide us with such written permission, you may revoke it at any time. We are not able to take back any uses or disclosures that we already made in reliance on your written permission.

Your Rights Regarding Protected Health Information About You

You have the following rights regarding your protected health information:

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and/or receive a copy of the protected health information that is used by us to make decisions about your benefits. The exceptions to this are any psychotherapy notes, information collected for certain legal proceedings, and any protected health information restricted by law.

To inspect and/or receive a copy of your medical information, we require that you submit your request in writing to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plans Privacy Officer (contact information below). If you request a copy of your medical information, we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. Your request will be fulfilled in a timely manner not to exceed 30 days.

Under certain circumstances, we may deny your request to inspect or copy your protected health information, such as if we believe it may endanger you or someone else. If you are denied access to your protected health information, you may request that another licensed health care professional review the denial. We will comply with the outcome of the review.

Right to Request Confidential Communications: You have the right to request that we use a certain method to communicate with you about Sentara Health Plan matters or that we send Sentara Health Plan information to you at a certain location if the communication could endanger you. For example, you may ask that we send your information by a specific means, such as by U.S. mail only, or to a specified address. If you want us to communicate with you in a certain way, you will need to give us specific details about how you want to be contacted including a valid alternative address. We will not ask you the reason for the request, and we will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have. We require that you submit your request in writing to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plan Privacy Officer (contact information below).

Right to Request an Amendment: If you feel that the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the protected health information. To request an amendment, we require that you submit your request in writing and that you provide the reason for the request. You should direct your request to the Health Plan's Members Services. If you are unsure where to submit your request, please contact the Sentara Health Plans Privacy Officer (contact information below). If we agree to your request, we will amend your record(s) and notify you of such. In certain circumstances, we cannot remove what was in the record(s), but we may add supplemental information to clarify. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to an Accounting of Disclosures: You have a right to make a written request to receive a list of the disclosures we have made of your protected health information in the six years prior to your request. The accounting of disclosures you receive will not include disclosures made for treatment, payment, or healthcare operations activities of Sentara Health Plans. Additionally, it will not include disclosures made to you. To request an accounting of disclosures, we require that you submit your request in writing to the Sentara Health Plans Privacy Officer (contact information below). You must state the time period for which you want to receive the accounting, which may not be longer than six years and which may not date back more than six years from the date of your request. You must indicate whether you wish to receive the list of disclosures electronically or on paper.

The first accounting of disclosures you receive in a 12-month period will be free. We may charge you for responding to additional requests in that same period. We will inform you of the costs involved before any costs are incurred. You may choose to withdraw or modify your request at that time.

Right to Request Restrictions: You have the right to request a restriction, or limitation, on the protected health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request. If we agree to your request, we will comply with your request unless the protected health information is needed to provide you with emergency treatment, or we are required by law to not disclose it.

To request a restriction, you must make your request in writing to the Sentara Health Plans Privacy Officer (contact information provided below) and tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limits to apply (for example, disclosures to your spouse). We are allowed to end the restriction by providing you notice. If we end the restriction, it will only affect the medical information that was created or received after we notify you.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you have previously agreed to receive this Notice electronically. Copies of this Notice are available by contacting the Sentara Health Plans Privacy Officer (contact information below). This notice is posted on our website and can be downloaded at: www.optimahealth.com.

Right to Receive Notification of a Breach: You have the right to receive written notification of any breach of your unsecured protected health information.

Changes to This Notice: We reserve the right to change this Notice from time to time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any medical information we receive about you in the future. We will post a copy of the current notice on the Sentara Health Plans website at www.optimahealth.com and provide the revised notice, or information about the material change and how to obtain the revised notice in our next annual mailing to members then covered by the plan. Please review the Notice from time to time to ensure you are familiar with our HIPAA privacy practices.

Questions, Requests, or Complaints: If you have questions or believe that your privacy rights have been violated, you may file a complaint with Sentara Health Plans or with the Secretary of the Department of Health and Human Services. To file a complaint with Sentara Health Plans, contact the Sentara Health Plans Privacy Officer. ***You will not be penalized or retaliated against for filing a complaint.***

Sentara Health Plans
Attn: Privacy Officer
PO Box 66189
Virginia Beach, VA 23466
757-552-7485

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

This Notice is effective 01/01/2022 and replaces all earlier versions.

This Notice of Privacy Practices covers an Affiliated Covered Entity or "ACE". When this Notice refers to the Sentara Healthcare ACE, it is referring to Sentara Healthcare and each of the following subsidiaries and affiliates:
Optima Health Insurance Company Optima Health Plan
Sentara Health Plans, Inc.

Optima Behavioral Health Services, Inc.

Spanish

Optima Health Community Care cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Korean

Optima Health Community Care은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Vietnamese

Optima Health Community Care 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

Optima Health Community Care 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

Optima Health Community Care أويلتزم اللون أو العرق أساس على يميز ولا بها المعمول الفدرالية المدنية الحقوق بقوانين

الجنس أو الإعاقة أو السن أو الوطني الأصل.

Tagalog

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

Farsi

Optima Health Community Care 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

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

Urdu

Optima Health Community Care ہے کرتا تعمیل کی قوانین کے حقوق شہری وفاقی اطلاق ل ِ قاب

کرتا۔ نہیں امتیاز پر بنیاد کی جنس یا معذوری ،عمر ،قومیت ، رنگ ،نسل کہ یہ اور

French

Optima Health Community Care 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

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

Hindi

Optima Health Community Care लागूहोने यो संघीय नागरक िअधकार क़ाननू का पालन करता ह और जात, रंग, राय मूल, आयु, वकलांगता, या लग केआधार पर भेदभाव नह करता ह।

German

Optima Health Community Care erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Bengali

Optima Health Community Care যাজয্ ফডারল নাগিরক িঅধকার আইন েমন েচল এবং জাত, রঙ, জাতীয় উৎপ, বয়স, অমতা, বা েলর িভে◌ত বষময্ েকর না।

Bassa

Optima Health Community Care Nyɔ ɓěɛ̀ kpɔ̃ nyɔ̌n-dyù gbo-gmɔ̀ -gmà ɓěɔ̀ dyi ké wa ní ge nyɔ̌n-dyù mú dyììn ɖé ɓóɖó-dù nyɔɔ̀ sɔ̀ kɔ̃ ɛ mú, mɔɔ kà nyɔɔ̀ dyɔɔ̀ -kù nyu nìɛ̀ kɛ mú, mɔɔ ɓóɖó ɓɛ́ nyɔɔ̀ sɔ̀ kɔ̃ ɛ mú, mɔɔ zɔ̃ĭ̃ kà nyɔɔ̀ ɖẵ nyuɛ mú, mɔɔ nyɔɔ̀ mɛ kɔ́ dyíɛ mú, mɔɔ nyɔɔ̀ mɛ mɔ̀ gàa, mɔɔ nyɔɔ̀ mɛ mɔ̀ màa kɛɛ mú.

17. Member Responsibilities

Your Responsibilities

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

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

- If you get care in an out-of-area or out-of-network hospital or emergency room.
- If your caregiver or anyone responsible for you changes.
- If you are part of a clinical research study.

Advance Directives

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

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

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

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

Where to Get the Advance Directives Form

You can get the Virginia Advance Directives form at:
http://www.virginiaadvancedirectives.org/the-virginia-hospital---healthcares-association--vhha--form.html

You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicaid may also have advance directive forms. You can get help with completing an Advance Care Plan (ACP) in Virginia from:

- As You Wish Organization; Part of the Advance Care Planning Coalition of
- Virginia: asyouwishvirginia.org/ or 757-325-9400,
- Sentara Healthcare(https://www.sentara.com/hampton-roads- virginia/patientguide/advance-care-planning.aspx),
- Five Wishes (https://www.agingwithdignity.org/),
- http://www.vdh.virginia.gov/OLC/documents/2011/pdfs/2011-VA-AMD-Simple.pdf may also have advance directive forms.
- http://www.virginiaadvancedirectives.org/the-virginia-hospital---healthcares-association--vhha--form.html

Completing the Advance Directives Form

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

Share the Information with People You Want to Know About It

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

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

We Can Help You Get or Understand Advance Directives Documents

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

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

Other Resources

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

You can store your advance directive at the Virginia Department of Health Advance Healthcare Directive Registry: https://connectvirginia.org/adr/

If Your Advance Directives Are Not Followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the following organizations.

For complaints about doctors and other providers, contact the Enforcement Division at the Virginia Department of Health Professions:

CALL	Virginia Department of Health Professions: Toll-Free Phone: 1-800-533-1560 Local Phone: 804-367-4691
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
FAX	804-527-4424
EMAIL	enfcomplaints@dhp.virginia.gov
WEBSITE	http://www.dhp.virginia.gov/Enforcement/complaints.htm

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

CALL	Toll-Free Phone: 1-800-955-1819 Local Phone: 804-367-2106
WRITE	Office of Licensure and Certification Virginia Department of Health 9960 Mayland Drive, Suite 401 Richmond, Virginia 23233-1463
FAX	804-527-4503
EMAIL	mchip@vdh.virginia.gov
WEBSITE	https://www.vdh.virginia.gov/licensure-and-certification/

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements Discrimination is Against the Law

Optima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Optima Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Optima Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

Optima Health Member Services
PO Box 66189
Virginia Beach, VA 23466
757-552-7401 or toll free 1-877-552-7401
TTY Relay 1-800-828-1140 or 711

If you believe that Optima Health has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Optima Health
PO Box 66189
Virginia Beach, VA 23466
757-552-7485 (TTY: 711)

You can file a grievance in person or by mail. If you need help filing a grievance, please contact the 1557 Coordinator at the information listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available 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, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you are visually impaired and need large print or other assistance to view this document, please contact us at 1-855-687-6260 (TTY: 711).

Rev. 05/01/2023

18. Fraud, Waste, and Abuse

What is Fraud, Waste, and Abuse

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

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

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

Common types of healthcare fraud, waste, and abuse include:

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

How Do I Report Fraud, Waste, or Abuse

Fraud increases the cost of healthcare for everyone. Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number or other personal information over the telephone or email it to people you do not know, except for your healthcare providers or Optima Health representatives.
- Do not go to a doctor who says that an item or service is not usually covered, but they know how to bill the health plan to get it paid. Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
  Optima Health provides its members a way to report situations or actions they think may be potentially illegal, unethical, or improper. If you want to report fraudulent or abusive practices, you can call the Fraud and Abuse Hotline at the number below. You can also send an email or forward your information to the address below. All referrals may remain

anonymous. Please be sure to leave your name and number if you wish to be contacted for follow up. If appropriate, the necessary governmental agency (e.g., DMAS, CMS, OIG, BOI, etc.) will be notified as required by law.

Optima Health Fraud and Abuse Hotline

Phone: 1-866-826-5277
Email: compliancealert@sentara.com
Mail: Optima Health, c/o Special Investigations Unit
PO Box 66189, Virginia Beach, VA 23466

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

Department of Medical Assistance Services Fraud Hotline

Phone: 1-800-371-0824 or 1-866-486-1971 or (804) 786-1066

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

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

Virginia Office of the State Inspector General

Fraud, Waste, and Abuse Hotline

Phone: 1-800-723-1615

Fax: 804-371-0165

Email: covhotline@osig.virginia.gov

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

19. Other Important Resources

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

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

(804) 662-9502 (Voice / TTY)
1-800-552-7917 (Voice / TTY)
(804) 662-9718 (Fax)
1602 Rolling Hills Drive, Suite 203
Richmond, VA 23229-5012

http://www.vddhh.org

Agency Name	Areas Served
Mountain Empire Older Citizens, Inc. P.O. Box 888 Big Stone Gap, VA 24219-0888 Michael Wampler, Executive Director Phone: 276-523-4202 or 1-800-252-6362 FAX: 276-523-4208 Email: mwampler@meoc.org	Counties of Lee, Wise, and Scott. City of Norton.
Appalachian Agency For Senior Citizens, Inc. P.O. Box 765 Cedar Bluff, VA 24609-0765 Regina Sayers, Executive Director Phone: 276-964-4915 or 1-800-656-2272 FAX: 276-963-0130 Email: aasc@aasc.org	Counties of Dickenson, Buchanan, Tazewell, and Russell.
District Three Governmental Cooperative 4453 Lee Highway Marion, VA 24354-4270 Mike Guy, Executive Director Phone: 276-783-8150 or 1-800-541-0933 FAX: 276-783-3003 Email: district-three@smyth.net	Counties of Washington, Smyth, Wythe, Bland, Grayson, and Carroll. Cities of Galax and Bristol.

Agency Name	Areas Served
New River Valley Agency on Aging 141 East Main Street, Suite 500 Pulaski, VA 24301 Tina King, Executive Director Phone: 540-980-7720 FAX: 540-980-7724 Email: nrvaoa@nrvaoa.org	Counties of Giles, Floyd, Pulaski andMontgomery. City of Radford.
Local Office on Aging, Inc. P.O. Box 14205 Roanoke, Virginia 24038-4205 RonBoyd, CEO Phone: 540-345-0451 / Fax: 540-981-1487 Email: ronboyd@loaa.org	Counties of Roanoke, Craig, Botetourt, and Alleghany. Cities of Salem, Roanoke, Clifton Forge,andCovington.
Fairfax Area Agency on Aging 12011 Government Center Parkway, Suite 720 Fairfax, VA 22035 Sharon Lynn, Director Phone: 703-324-5411 FAX: 703-449-9552 Email: Sharon.Lynn@fairfaxcounty.gov	County of Fairfax. Cities of Fairfax and Falls Church.
Loudoun County Area Agency on Aging 20145 Ashbrook Place, Suite 170 Ashburn, VA 20147 Lynn A. Reid, Administrator Phone: 703-777-0257 FAX: 703-771-5161 Email: lynn.reid@loudoun.gov	County of Loudoun.
Prince William Area Agency on Aging 5 County Complex, Suite 240 Woodbridge, VA 22192 Sarah R. Henry, Director Phone: 703-792-6400 FAX: 703-792-4734 Email: SHenry@pwcgov.org	County of Prince William. Cities of Manassas, Manassas Park, and Woodbridge.

Agency Name	Areas Served
Rappahannock-Rapidan Community Services Board P.O. Box 1568 Culpeper, VA 22701 Ray Parks, Director of Community Support Services Phone: 540-825-3100 FAX: 540-825-6245 TTY: 540-825-7391 Email: rparks@rrcsb.org	Counties of Orange, Madison, Culpeper, Rappahannock, and Fauquier.
Jefferson Area Board for Aging 674 Hillsdale Drive, Suite 9 Charlottesville, VA 22901 Marta Keane, CEO Phone: 434-817-5222 FAX: 434-817-5230 Email: mkeane@jabacares.org	Counties of Nelson, Albemarle, Louisa, Fluvanna, and Greene. City of Charlottesville.
Central Virginia Alliance for Community Living, Inc. (PSA 11) 501 12th Street, Suite A Lynchburg, VA 24504 Deborah Silverman, Director Phone: 434-385-9070 FAX: 434-385-9209 Email: cvacl@cvcl.org	Counties of Bedford, Amherst, Campbell, and Appomattox. Cities of Bedford and Lynchburg.
Southern Area Agency on Aging 204 Cleveland Avenue Martinsville, VA 24112-4228 Teresa Fontaine, Executive Director Phone: 276-632-6442 FAX: 276-632-6252 Email: saaa@southernaaa.org	Counties of Patrick Henry, Franklin, and Pittsylvania. Cities of Martinsville and Danville.
Lake Country Area Agency on Aging 1105 West Danville St South Hill, Virginia 23970-3501 Gwen Hinzman, President/CEO Phone: 434-447-7661 FAX: 434-447-4074 Email: lakecaaa@lcaaa.org	Counties of Halifax, Mecklenburg, and Brunswick. City of South Boston.

Agency Name	Areas Served
Piedmont Senior Resources Area Agency on Aging, Inc. P.O. Box 398 Burkeville, Virginia 23922-0398 Justine Young, Executive Director Phone: 434-767-5588 or 800-995-6918 FAX: 434-767-2529 Email: JYoung@PiedmontSeniorResources.com	Counties of Nottoway, Prince Edward, Charlotte, Lunenburg, Cumberland, Buckingham, and Amelia.
Senior Connections- Capital Area Agency on Aging, Inc. 24 East Cary Street Richmond, VA 23219 Thelma Bland Watson, Executive Director Phone: 804-343-3000 or 800-995-6918 FAX: 804-649-2258 Email: gstevens@youraaa.org	Counties of Charles City, Henrico, Goochland, Powhatan, Chesterfield, Hanover, and New Kent. City of Richmond.
Rappahannock Area Agency on Aging, Inc. 460 Lendall Lane Fredericksburg, VA 22405 Leigh Wade, Executive Director Phone: 540-371-3375 or 800-262-4012 FAX: 540-371-3384 Email: lwade@raaa16.org	Counties of Caroline, Spotsylvania, Stafford, and King George. City of Fredericksburg.
Bay Aging P.O. Box 610 Urbanna, VA 23175 Kathy Vesley, President Phone: 804-758-2386 FAX: 804-758-5773 Email: kvesley@bayaging.org	Counties of Westmoreland, Northumberland, Richmond, Lancaster, Essex, Middlesex, Mathews, King and Queen, King William, and Gloucester.
Crater District Area Agency On Aging 23 Seyler Drive Petersburg, VA 23805 Gladys Mason, Acting Executive Director Phone: 804-732-7020 FAX: 804-732-7232 Email: gmason@cdaaa.org	Counties of Dinwiddie, Sussex, Greensville, Surry, and Prince George. Cities of Petersburg, Hopewell, Emporia, and Colonial Heights.

Agency Name	Areas Served
Senior Services of Southeastern Virginia 5 Interstate Corporate Center 6350 Center Drive, Suite 101 Norfolk, Virginia 23502 John Skirven, Executive Director Phone: 757-461-9481 FAX: 757-461-1068 Email: services@sseva.org	Counties of Southampton and Isle of Wight. Cities of Franklin, Suffolk, Portsmouth, Chesapeake, Virginia Beach, and Norfolk.
Peninsula Agency on Aging, Inc. 739 Thimble Shoals Boulevard Building 1000, Suite 1006 Newport News, VA 23606 William Massey, CEO Phone: 757-873-0541 FAX: 757-872-1437 Email: ceo@paainc.org	Counties of James City and York. Cities of Williamsburg Newport News, Hampton, and Poquoson.
Eastern Shore Area Agency on Aging- Community Action Agency, Inc. P.O. Box 415 Belle Haven, Virginia 23306 Diane Musso, CEO Phone: 757-442-9652 or 800-452-5977 FAX: 757-442-9303 Email: ESAAA12@gmail.com	Counties of Accomack and Northampton

20. Information for Medicaid Expansion Members

What Makes You Eligible to be a Medicaid Expansion Member

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

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

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at 1-833-5CALLVA or TDD: 1-888-221-1590 about any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia at http://www.coverva.org.

Enrollment for a Medicaid Expansion Member

Within three (3) months after you enroll with Optima Health Community Care, a health plan representative will contact you or your authorized representative via telephone, mail or in person to ask you some questions about your health and social needs.

If you do not meet the medically complex criteria, you may transfer from CCC Plus to the Medicaid Managed Care Medallion 4.0 program. If Optima Health Community Care is unable to contact you, or you refuse to participate in the entire health screening, you may be transferred to the Medallion program. You will stay with Optima Health no matter which program you are in. If you prefer to change health plans, you can change within the first 90 days of enrolling into the Medallion 4.0 program. For more information on the Health Screening, see section 4.

If you do not meet medically complex criteria and do not agree, you have a right to submit a grievance to Optima Health Community Care. See the Your Right to File a Grievance section for details.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between November 1 and December 31 coverage begin date. You will get a letter from DMAS during open enrollment with more information.

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

1. You move out of the health plan’s service area,
2. You need multiple services provided at the same time but cannot access them within the health plan’s network,

3. Your residency or employment would be disrupted as a result of your residential, institutional, or employment supports provider changing from an in-network to an out-of-network provider, and
4. Other reasons determined by DMAS, including poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care.
5. You do not meet medically complex criteria and transfer to the Medallion 4.0 Medicaid Managed Care program.

The Managed Care Helpline handles "good cause" requests and can answer any questions you may have. Contact the Managed Care Helpline at 1-800-643-2273 or TDD 1-800-817-6608, or visit the website at cccplusva.com.

Medicaid Expansion Benefits and Services

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

1. Services provided through Optima Health Community Care are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 10.
2. Services covered by DMAS or a DMAS Contractor are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 11.
3. Services that are not covered through Optima Health Community Care or DMAS are described in the Commonwealth Coordinated Care Plus Program Member Handbook, Section 12.

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

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

Optima Health Community Care will also encourage you to take an active role in your health. If you frequently visit the emergency room, Optima Health Community Care will reach out to you to help you address your needs. There may be opportunities to address your needs outside of the emergency room, like in physician offices and clinics.

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

21. Important Words and Definitions Used in This Handbook

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

Also see the definition for patient pay.

- **Coverage decision**: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services.
- **Covered drugs**: The term we use to mean all of the prescription drugs covered by Optima Health Community Care.
- **Covered services**: The general term we use to mean all of the healthcare, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by Optima Health Community Care.
- **Durable medical equipment**: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.
- **Emergency medical condition**: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.
- **Emergency medical transportation**: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.
- **Emergency room care**: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.
- **Emergency services**: Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.
- **Excluded services**: Services that are not covered under the Medicaid benefit.
- **Fair hearing**: See State Fair Hearing. The process where you appeal to the State on a decision made by us that you believe is wrong.
- **Fee-for-service**: The general term used to describe Medicaid services covered by the Department of Medical Assistance Services (DMAS).
- **Generic drug**: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.
- **Grievance**: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.
- **Habilitation services and devices**: Services and devices that help you keep, learn, or improve skills and functioning for daily living.
- **Health insurance**: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.
- **Health plan**: An organization made up of doctors, hospitals, pharmacies, providers of

long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

- **Health Risk Assessment**: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.
- **Home health aide**: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.
- **Home healthcare**: Healthcare services a person receives in the home including nursing care, home health aide services and other services.
- **Hospice services**: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- **Hospitalization**: The act of placing a person in a hospital as a patient.
- **Hospital outpatient care**: Care or treatment that does not require an overnight stay in a hospital.
- **List of Covered Drugs (Drug List)**: A list of prescription drugs covered by Optima Health Community Care. Optima Health Community Care chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."
- **Long-term services and supports (LTSS)**: A variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and maintain maximum independence. Examples include assistance with bathing, dressing, toileting, eating, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital.
- **Managed Care Plan or Managed Care Organization (MCO)**: An organization which offers managed care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, which means an arrangement for the delivery of healthcare in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of healthcare services for a covered person on a prepaid or insured basis which (i) contains one or more

incentive arrangements, including any credentialing requirements intended to influence the cost or level of healthcare services between the health carrier and one or more providers with respect to the delivery of healthcare services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Additionally, for the purposes of this Contract, and in accordance with 42 CFR § 438.2, an entity that has qualified to provide the services covered under this Contract to qualifying members must be as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other individuals within the area served, and meets the solvency standards of 42 CFR § 438.116.

- **Medically Necessary**: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.
- **Medicaid (or Medical Assistance)**: A program run by the federal and the state government that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Most healthcare costs are covered if you qualify for both Medicare and Medicaid.
- **Medicare**: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").
- **Medicare-covered services**: Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and Part B.
- **Medicare-Medicaid enrollee**: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."
- **Medicare Part A**: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.
- **Medicare Part B**: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.
- **Medicare Part C**: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

- **Medicare Part D**: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid.
- **Member Services**: A department within Optima Health Community Care responsible for answering your questions about your membership, benefits, grievances, and appeals.
- **Model of care**: A way of providing high-quality care. The CCC Plus model of care includes care coordination and a team of qualified providers working together with you to improve your health and quality of life.
- **Network**: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your healthcare services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide healthcare services. We call them "network providers" when they agree to work with the Optima Health Community Care and accept our payment and not charge our members an extra amount. While you are a member of Optima Health Community Care, you must use network providers to get covered services. Network providers are also called "plan providers."
- **Network pharmacy**: A pharmacy (drug store) that has agreed to fill prescriptions for Optima Health Community Care members. We call them "network pharmacies" because they have agreed to work with Optima Health Community Care. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- **Non-participating provider**: A provider or facility that is not employed, owned, or operated by Optima Health Community Care and is not under contract to provide covered services to members of Optima Health Community Care.
- **Nursing facility**: A medical care facility that provides care for people who cannot get their care at home but who do not need to be in the hospital. Specific criteria must be met to live in a nursing facility.
- **Ombudsman**: An office in your state that helps you if you are having problems with Optima Health Community Care or with your services. The ombudsman's services are free.
- **Out-of-network provider or Out-of-network facility**: A provider or facility that is not employed, owned, or operated by Optima Health Community Care and is not under contract to provide covered services to members of Optima Health Community Care.
- **Participating provider**: Providers, hospitals, home health agencies, clinics, and other places that provide your healthcare services, medical equipment, and long-term services and supports that are contracted with Optima Health Community Care. Participating providers are also "in-network providers" or "plan providers."

- **Patient Pay**: The amount you may have to pay for long term care services based on your income. The Department of Social Services (DSS) must calculate your patient pay amount if you live in a nursing facility or receive CCC Plus Waiver services and have an obligation to pay a portion of your care. DSS will notify you and Optima Health Community Care if you have a patient pay, including the patient pay amount (if any).
- **Physician services**: Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.
- **Plan**: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.
- **Prescription drug coverage**: Prescription drugs or medications covered (paid) by your Optima Health Community Care. Some over-the-counter medications are covered.
- **Prescription drugs**: A drug or medication that, by law, can be obtained only by means of a physician's prescription.
- **Primary Care Physician (PCP)**: Your primary care physician (also referred to as your primary care provider) is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your healthcare. Often they are the first person you should contact if you need healthcare. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.
- **Prosthetics and Orthotics**: These are medical devices ordered by your doctor or other healthcare provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.
- **Provider**: A person who is authorized to provide your healthcare or services. Many kinds of providers participate with Optima Health Community Care, including doctors, nurses, behavioral health providers and specialists.
- **Premium**: A monthly payment a health plan receives to provide you with healthcare coverage.
- **Private duty nursing services**: skilled in-home nursing services provided by a licensed RN, or by an LPN under the supervision of an RN, to waiver members who have serious medical conditions or complex healthcare needs.
- **Referral**: In most cases you PCP must give you approval before you can use other providers in the Optima Health Community Care network. This is called a referral.

- **Rehabilitation services and devices**: Treatment you get to help you recover from an illness, accident, injury, or major operation.
- **Service area**: A geographic area where an Optima Health Community Care is allowed to operate. It is also generally the area where you can get routine (non-emergency) services.
- **Service authorization**: Also known as preauthorization. Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from Optima Health Community Care.
- **Skilled nursing care**: care or treatment that can only be done by licensed nurses. Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings or rapidly changing health status.
- **Skilled Nursing Facility (SNF)**: A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.
- **Specialist**: A doctor who provides healthcare for a specific disease, disability, or part of the body.
- **Urgently needed care (urgent care)**: Care you get for a non-life threatening sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Optima Health Community Care Member Services

CALL	1-800-881-2166Calls to this number are free. Member Services is available 8:00 a.m. to 8 p.m. ET Monday-Friday, except Commonwealth of Virginia holidays. Individuals who are deaf, hard of hearing, speech-impaired, or want to speak to a Member Services representative and have a TTY or other assistive device can dial 711 to reach a relay operator. They will help you reach our Member Services staff. Member Services also has free language interpreter services available for non-English speakers.
TTY	1-844-552-8148 This number is for people who need hearing or speaking assistance. You must have special telephone equipment to call it. Calls to this number are free. Member Services is available 8:00 a.m. to 8 p.m. ET Monday-Friday, except Commonwealth of Virginia holidays.
WRITE	PO Box 66189 Virginia Beach, VA 23466
WEB SITE	optimahealth.com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