COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

Sentara Community Plan Member Handbook

(Effective July 1, 2025)

Table of Contents

1. Let's Get Started

Welcome to Cardinal Care

This Member Handbook explains benefits and how to access services for Cardinal Care, Virginia's Medicaid/FAMIS program. Medicaid and the Family Access to Medical Insurance Security (FAMIS) Plan are health insurance programs funded by the state and the federal government. They are run by the Virginia Department of Medical Assistance Services (DMAS or "the Department"). For more information, visit dmas.virginia.gov and dmas.virginia.gov/for-members/cardinal-care. Monthly income limits for eligibility vary by program. For more information on eligibility, visit Cover Virginia at coverva.org or Virginia's insurance marketplace at marketplace.virginia.gov. Both Medicaid and FAMIS have full benefits as described below. For questions, call Sentara Health Plans Member Services toll-free number at 1-800-881-2166 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m., visit our website at sentarahealthplans.com, or call your care manager.

Other Languages and Formats

If you need this handbook in large print, in other formats or languages, read aloud, or if you need a paper copy, call Sentara Health Plans Member Services at 1-800-881-2166 (TTY: 711). You can get what you need for free. Members with alternative hearing or speech communication needs can dial 711 to reach a Telecommunications Relay Services (TRS) operator who can help you. Auxiliary aids and services are available upon request at no cost. Visit us online anytime at sentarahealthplans.com or dmas.virginia.gov.

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260 (TTY: 711).

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

Spanish
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-687-6260 (TTY: 711).

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

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260 (TTY: 711)번으로 전화해 주십시오.

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

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-687-6260 (TTY: 711).

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

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-687-6260（TTY：711）

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

Arabic
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يُرجى الاتصال بالرقم 1-XXX-XXX-1-855-687-6260 (الهاتف النصي: 711).

تلتزم الخطة بقوانين الحقوق المدنية الفيدرالية المعمول بها ولا تميّز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

Amharic
ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ፣ የቋንቋ እርዳታ አገልግሎቶች፣ በነጻ፣ ተዘጋጀተውልዎታል። ወደ ሚከተለው ቁጥር ይደውሉ 1-855-687-6260 (መስማት ለተሳናቸው: 711).

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

Urdu
توجہ فرمائیں :اگر آپ اردو بولتے ہیں تو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ 1-855-687-6260 (TTY: 711) پر کال کریں۔

Sentara Health Plans قابل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور نسل، رنگ، قومی اصل، عمر معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

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: 711).

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

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما. با شماره 1-855-687-6260تماس بگیرید (TTY: 711).

Sentara Health Plans 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.

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-687-6260 (ATS : 711).

Sentara Health Plans 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.

Bengali
মনোযোগ দিন: যদি আপনি বাংলা বলতে পারেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। 1-855-687-6260 (TTY: 711) নম্বরে কল করুন।

Sentara Health Plans প্রযোজ্য ফেডারেল নাগরিক অধিকার আইন মেনে চলে এবং জাতি, বর্ণ, জাতীয় উৎপত্তি, বয়স, অক্ষমতা বা লিঙ্গের ভিত্তিতে বৈষম্য করে না।

Telugu
శ్రద్ధ: మీరు మాట్లాడితే భాషను చొప్పించండి, భాషా సహాయ సేవలు మీకు ఉచితంగా లభిస్తాయి. 1-855-687-6260 (TTY: 711) కు కాల్ చేయండి.

ప్రణాళిక వర్తించే సమాఖ్య పౌరహక్కుల చట్టాలకు అనుగుణంగా ఉంటుంది మరియు జాతి, రంగు, జాతీయ మూలం, వయస్సు, వైకల్యం లేదా లింగం ఆధారంగా వివక్ష చూపదు.

Hindi
ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए मुफ्त में भाषा सहायता सेवाएँ उपलब्ध हैं। 1-855-687-6260 (TTY: 711) पर कॉल करें।

Sentara Health Plans लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राय, मूल, आयु, विकलांगता या लिंग के आधार पर भेदभाव नहीं करता है।

Nepali
ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। 1-855-687-6260 (TTY: 711) मा कल गर्नुहोस्।

Sentara Health Plans लागू हुने संघीय नागरिक अधिकार कानुनहरूको पालना गर्छ र जाति, रंग, राष्ट्रिय उत्पत्ति, उमेर, अपाङ्गता वा लिङ्गको आधारमा भेदभाव गर्दैन।

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-687-6260 (телетайп: 711).

Sentara Health Plans соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.
1-855-687-6260

Notice of Nondiscrimination

Sentara Health Plans does not discriminate (or treat you differently) based on race, color, national origin, age, disability, or sex. Sentara Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes) expected length of life, degree of medical dependency, quality of life, or other health conditions.

Sentara Health Plans provides:

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

If you need these services, contact Sentara Health Plans Member Services at 1-800-881-2166 (TTY: 711). This call is free.

If you think Sentara Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at:
Sentara Health Plans
1557 Coordinator/Compliance
PO Box 66189, Virginia Beach, VA 23466
757-552-7485
shpprivacy@sentara.com

***

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

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH

Building, Washington, D.C. 20201; 1-800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://hhs.gov/ocr/office/file/index.html.

Important Contact Information

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

Entity Name	Contact Information
Sentara Health Plans Member Services	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. sentarahealthplans.com Download the mobile app by searching Sentara Health Plans in the App Store or Google Play. 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.
Sentara Health Plans 24/7 Nurse Advice Line	1-833-933-0487 TTY: 711 24 hours a day, seven days a week
Sentara Community Care	Call 757-388-1830 for information regarding scheduling and services or visit sentara.com/communitycare. Services will vary by location.
Sentara Health Plans Behavioral Health Crisis Line	1-833-686-1595 TTY: 711 24 hours a day, seven days a week
Addiction and Recovery Treatment Services (ARTS) Medical Advice Line	1-800-881-2166 TTY: 711 Monday through Friday, 8 a.m. to 5 p.m.

Entity Name	Contact Information
Department of Behavioral Health and Developmental Services (DBHDS) for DD Waiver Services	My Life My Community Helpline 1-844-603-9248 TTY: 804-371-8977 Monday through Friday, 9 a.m. to 4:30 p.m. https://www.mylifemycommunityvirginia.org/
Cardinal Care Dental Benefits Administrator	1-888-912-3456 TTY: 1-800-466-7566 https://dentaquest.com/state-plans/regions/virginia/ Monday through Friday, 8 a.m. to 6 p.m.
Sentara Health Plans Vision Services	1-844-453-3378 TTY: 711 vsp.com/choice
Sentara Health Plans Transportation Services	1-877-892-3986 TTY: 711 Monday through Friday, 6 a.m. to 6 p.m.
Cardinal Care Transportation for Developmental Disability Waiver Services	1-866-386-8331 TTY: 1-866-288-3133 Dial 711 to reach a TRS operator 24 hours a day, 7 days a week
Cardinal Care Managed Care Enrollment Helpline	1-800-643-2273 TTY: 1-800-817-6608 Monday through Friday, 8:30 a.m. to 6 p.m.
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019 TTY: 1-800-537-7697 hhs.gov/ocr
Office of the State Long-Term Care Ombudsman	1-800-552-5019 TTY: 1-800-464-9950 elderrightsva.org

Staying Connected

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

You can update your contact information today:

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

2. Cardinal Care Managed Care Overview

Health Plan Enrollment

You are successfully enrolled in Sentara Health Plans. Sentara Health Plans is a Cardinal Care Medicaid/FAMIS managed care plan (a "health plan") that covers your health care and provides care management. A health plan is an organization that contracts with doctors, hospitals, and other providers to work together to get you the health care you (the member) need. In Virginia, there are five Cardinal Care health plans that operate statewide. You can learn more about these health plans at www.VirginiaManagedCare.com.

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

After enrollment, it is important for members to choose a primary care provider (PCP), schedule an Annual Wellness Visit, and complete their medical health screening.

Sentara Health Plans Member Services is available to help if you have any questions or concerns. Call 1-800-881-2166 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m., or visit us at sentarahealthplans.com.

You can change your health plan:

- For any reason during the first 90 calendar days of enrollment.
- For any reason once a year during your open enrollment period. DMAS and Plan will notify you of your open enrollment period.
- If you lose Medicaid coverage temporarily and it causes you to miss your open enrollment period.
- When you need a specific service or type of service that Plan does not cover, including for moral or religious reasons.
- If losing a Long Term Services and Supports provider would cause a change in important services you receive, such as employment or residential services.
- For "good cause" reasons determined by the Department. Examples include poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care. This includes obstetric (OB) care. If you are pregnant and your OB provider does not participate with Sentara Health Plans but does participate with Medicaid fee-for-service (FFS), you can ask to get coverage through Medicaid FFS until after the delivery of your baby.

- Note: Members in Foster Care, Former Foster Care, and receiving Adoption Assistance are automatically assigned to Anthem's Foster Care Specialty Plan unless they elect to opt out. If you are a Former Foster Care or Adoption Assistance member, you may select a different health plan if you opt out but will not have access to the extra benefits offered by the Foster Care Specialty Plan.

Call the Cardinal Care Managed Care Enrollment Helpline at 1-800-643-2273 (TTY: 1-800-817-6608), Monday through Friday, 8:30 a.m. to 6 p.m., or visit the website at virginiamanagedcare.com. You can also download the app. To get the app, search for Virginia Cardinal Care on Google Play or the App Store for information about your open enrollment period, or "good cause," or to help you choose or change your health plan. Cardinal Care Managed Care Enrollment Helpline services are free. Effective 7/1/25, FAMIS members should contact the Managed Care Helpline.

Welcome Packet

You should have received a welcome packet that includes your member ID card, information on Sentara Health Plans Provider Directory, and the Preferred Drug List. If you did not receive your welcome packet, call Sentara Health Plans Member Services at 1-800-881-2166 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. You can also access important health plan information and resources through the Sentara Health Plans mobile app or the secure member portal at sentarahealthplans.com/signin.

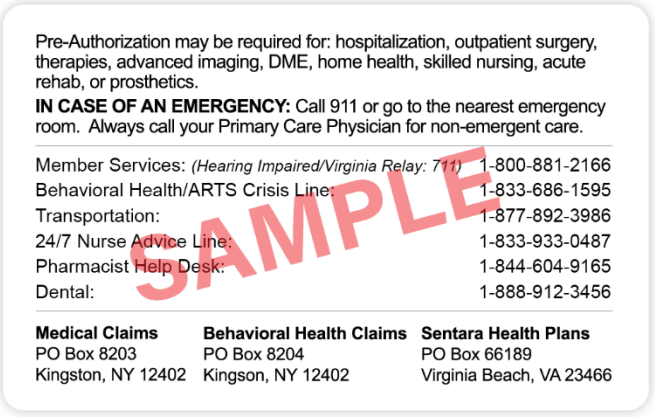
Sentara Health Plans Member ID Card

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

Sentara Community Plan Member ID Card

Group Number: OCC

Non-FAMIS



FAMIS

You may have more than one health insurance card. In addition to your Sentara Health Plans member ID card, you should also have your Commonwealth of Virginia Medicaid/FAMIS ID card. Keep this card to access services that are covered by the Department under Medicaid/FAMIS. If you have Medicare and Medicaid, show your Medicare card and Sentara Health Plans member ID card when you receive services.

If you have coverage with a private (non-Medicaid) insurance company, show your private insurance ID card and your Sentara Health Plans member ID card when you receive services.

Sentara Health Plans Provider Directory
The provider directory lists behavioral health, medical, long-term services and supports (LTSS) providers and pharmacies that participate in Sentara Health Plans network of contracted providers. It also includes information on the accommodations each provider has for members with disabilities or who do not speak English. You may request a paper copy of the directory by calling Sentara Health Plans Member Services and ask that a hard copy be mailed to you within five (5) business days at no charge. You can also view or download the Provider Directory at sentaramedicaid.com/documents

The directory will include the following information for all in-network providers as data is available*:

- Name, address, telephone number.
- Office hours and after-hours provider sites.
- Hospital affiliations.
- Medical Group affiliations.
- Licensing information number and/or national provider identifier.
- Any accommodations for people with physical disabilities or special needs.
- Whether the provider is accepting new patients.
- Website URL.
- Whether the provider is on a public transportation route.
- Any cultural and/or linguistic capabilities including access to languages or interpreter services of the provider and provider's staff.
- Behavioral health providers: Training/experience treating trauma and areas of specialty, including substance use.
- Restrictions on member's freedom of choice among network providers.
- Name, address, and telephone number of current network pharmacies and member instructions on contacting Member Services to find a pharmacy.
- As applicable, whether the health care professional or non-facility-based network provider has completed cultural competence training.

**Information available in the directory is based on provider-supplied data.*

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

Other Insurance

If you have more than one health insurance plan, then Medicaid pays for services after your other insurance plans have paid your provider. This means that if you have other insurance, are in a car accident, or are injured at work, then your other insurance or workers compensation must pay for your services first. Let Sentara Health Plans Member Services know if you have other insurance so that Sentara Health Plans can coordinate your benefits. (FAMIS members cannot have other creditable coverage.)

If you receive or are eligible for Medicare and have questions about how Medicare and Medicaid work together, the Virginia Insurance Counseling and Assistance Program (VICAP) provides free and confidential health insurance counseling to people on Medicare. Call 1-800-552-3402 (TTY: 711). This call is free.

3. Providers and Getting Care

Sentara Health Plans Provider Network

We use the term “providers” to refer to doctors, hospitals, pharmacies, and other health care that provide the services you need. All the providers we contract with are referred to as our “provider network.”

We refer to providers as “in-network” when Sentara Health Plans contracts with them to serve our members, and “out of network” if Sentara Health Plans does not contract with them. It is important that the providers you choose accept Cardinal Care members and participate in Sentara Health Plans network (they are “in-network providers”). Sentara Health Plans network includes access to care 24 hours a day, seven days a week.

Sentara Health Plans provides you with a choice of providers that are located near you. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, you should not have to travel more than 60 miles or 75 minutes to receive services. To find providers, such as primary care providers (PCPs), specialists, and hospitals, you can:

- Search for providers in the Provider Directory (see *Section 2, Cardinal Care Managed Care Overview*).
- Call Sentara Health Plans Member Services at 1-800-881-2166 (TTY: 711) or visit us at sentarahealthplans.com.

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

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

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

Primary Care Providers (PCPs)

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

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

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

Choosing Your PCP

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

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

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

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

Changing Your PCP
You can change your PCP at any time. Call Sentara Health Plans Member Services to choose another PCP in the Sentara Health Plans network. You can also change your PCP by signing in to the secure member portal at sentarahealthplans.com/signin.

The PCP change takes effect immediately. You will receive a new member ID card within 7–10 business days.

Specialists

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

Out-Of-State Providers

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

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

Sentara Health Plans may need to give you authorization to see a provider who is out-of-state. Sentara Health Plans does not cover any health care services outside of the United States.

*With Sentara Health Plans, Medicaid and FAMIS moms will not be held responsible for any charges for post-stabilization care services furnished by Sentara Health Plans network or out-of-network providers. Sentara Health Plans ensures that FAMIS Children are not held responsible for any charges for post-stabilization care services furnished by Sentara Health Plans network or out-of-network providers.

When a Provider Leaves the Network

If your PCP leaves Sentara Health Plans network, Sentara Health Plans will let you know and help you find a new PCP. If one of your other providers is leaving the

Sentara Health Plans network, contact Sentara Health Plans Member Services or your care manager for help finding a new provider and managing your care. You have the right to:

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

Getting Care Outside of Sentara Health Plans Network

You can get the care you need from a provider outside of Sentara Health Plans network in any of the following circumstances:

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

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

Choices for Nursing Facility Members

If you are in a nursing facility at the time you enroll in Sentara Health Plans, you may choose to:

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

Making Appointments with Providers

Call your provider's office to make an appointment. For help with making an appointment, call Sentara Health Plans Member Services. If you need a ride to your appointment, call 1-877-892-3986 (TTY: 711). If you call after hours, leave a message explaining how to reach you. Your PCP or other provider will call you back as quickly as possible. If you have difficulty getting an appointment with a provider, contact Sentara Health Plans Member Services.

Timeliness of Appointments

We require your provider to make routine primary care service appointments within 30 days of your request. These appointments do not include routine physical exams, routine specialty services (such as dermatology, for example), or regularly-scheduled visits to monitor a chronic condition that does not require visits every 30 days.

If you are pregnant, prenatal care appointments must be made available to you between three business days and seven calendar days of your request, depending on the stage and risk of the pregnancy. Remember to tell Sentara Health Plans when you plan to be out of town so Sentara Health Plans can help you arrange your services.

Telehealth

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

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

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

Getting Care from the Right Place When You Need It Quickly

It is important to choose the right place to get care based on your health needs, especially when you need care quickly or unexpectedly. Below is a guide to help you decide whether your usual care team, like your PCP, can help you or whether you should go to an urgent care center or the emergency room. If you are not sure of what type of care you need, call your PCP or Sentara Health Plans Medical Advice Line at 1-833-933-0487 (TTY: 711), 24 hours a day, seven days a week. This call is free.

Type of Care	How to Get Care	Examples of When to Get This Type of Care	Need a Referral?
PCPs can provide care when you get sick or injured and preventive care that keeps you healthy.	Contact your PCP's office or Sentara Health Plans to schedule an appointment.	• Minor illness/injury • Flu/fever • Vomiting/diarrhea • Sore throat, earache, or eye infection • Sprains/strains • Possible broken bones	No
Urgent care is care you get for a sickness or an injury that needs medical care quickly and could turn into an emergency.	Check the Provider Directory at sentarahealthplans.com to find an urgent care clinic.	Urgent care can manage similar things as your PCP, but is available when other offices are unavailable.	No, but make sure to go to an urgent care clinic that is in the Sentara Health Plans network if you can.
Emergency care (or care for an emergency medical condition) is care you get when an illness or injury is so serious that your (or, as applicable,	Call 911 and go to the nearest hospital. You have the right to get emergency care 24 hours a day, 7 days a week from any hospital or other setting, even if you are in another city or state. Sentara Health Plans will provide follow-up care after the emergency	• Unconsciousness • Difficulty breathing • Serious head, neck, or back injury • Chest pain/pressure • Sudden severe headaches • Trouble speaking, numbness in face, arm, or leg • Severe bleeding	No. You can get emergency care from network providers or out-of-network providers. You do not need a referral or service authorization.

Type of Care	How to Get Care	Examples of When to Get This Type of Care	Need a Referral?
your unborn baby's) health, bodily functions, body organs or body parts may be in danger if you do not get medical care right away.		• Severe burns • Convulsions/seizures • Broken bones • Fear you might hurt yourself or someone else ("behavioral health emergency") • Sexual assault	

Getting Care After Hours

If you need non-emergency care after normal business hours, call 1-833-933-0487 (TTY: 711).

A nurse or behavioral health professional can:

- Answer medical questions and give you advice for free.
- Help you decide if you should see a provider right away.
- Help with medical conditions.

Transportation to Care

Transportation, Meals, and Lodging Support

Sentara Health Plans ensures you can get medically-necessary care by covering transportation, and in some cases, meals and lodging, under Virginia Medicaid (DMAS) guidelines. We provide non-emergency transportation (like buses, taxis, or wheelchair vans) to medical, behavioral health, dental, and long-term care appointments through our partner, ModivCare. Call 1-877-892-3986 (TTY: 711) to schedule a ride. Trips over 75 miles or out-of-state (beyond 50 miles, except to Duke University, Children's National Hospital, or Children's Hospital of Philadelphia) require a signed medical necessity form from your doctor and approval by Sentara Health Plans leadership. Urgent trips do not require advance notice, while routine trips need five (5) business days' notice. If you live more than 75 miles from your healthcare provider, have a signed medical necessity form, and need an overnight stay, we may cover lodging and up to $50 a day per person for meals (for you and one attendant, or the parent of a FAMIS member), booked through Sentara Health Plans Travel Services with receipts required for reimbursement. Call Member Services at 1-800-881-2166 (TTY: 711) for help or to request approval.

If you have trouble getting an appointment, call Sentara Health Plans Transportation Where's My Ride/Ride Assist, Member Services, or your care manager. FAMIS members are not eligible for Non-Emergency Medical Transportation.

If you need transportation to developmental disability waiver services, contact the Cardinal Care Transportation for Developmental Disability Waiver Services Contractor at 1-866-386-8331 (TTY: 711) or visit transportation.dmas.virginia.gov. If you have problems getting transportation to your developmental disability waiver services, call Where's My Ride at 1-866-246-9979 or your developmental disability waiver Case Manager.

What Happens if a Request Is Denied

If we do not approve your request for transportation, lodging, or meals, we'll let you know why based on our policy rules. These decisions follow Virginia Medicaid guidelines and are handled by our team quickly. If we deny your request, you'll get a letter explaining the reason and how to appeal if you disagree.

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

4. Care Coordination and Care Management

Care Coordination

All members can get help finding the right health care or community resources by calling Sentara Health Plans Member Services. You can also call 1-833-933-0487 (TTY: 711) 24 hours a day, 7 days a week to talk to an on-call nurse or other licensed health professional.

What is Care Management?

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

How to Get a Care Manager

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

If you have questions or need help with the Health Screening, contact Member Services at 1-800-881-2166 (TTY: 711). This call is free.

How Your Care Manager Can Help You

Your care manager is someone from Sentara Health Plans with special health care expertise who can help you manage your health and social needs. Your care manager can:

- Assess your health and social needs.
- Answer questions about your benefits, like physical health services, behavioral health services, and long-term services and supports (LTSS) (see *Section 5, Your Benefits*).
- Help connect you to community resources (for example, programs that can support your housing and food needs).
- Support you in making informed decisions about your care and what you prefer.
- Assist you with scheduling appointments when needed and find available providers in the Sentara Health Plans network, and make referrals to other providers, as needed.
- Help you get transportation to your appointments (see *Section 3, Providers and Getting Care*).
- Make sure you get your prescription drugs and help if you feel side effects.
- Share your test results and other health care information with your providers so your care team knows your health status.
- Help with moving between health care settings (like from a hospital or nursing facility to home or another facility).
- Make sure your needs are met once you leave a hospital or nursing facility and on an ongoing basis.

How to Contact Your Care Manager
You will receive a letter from your care manager explaining how to contact them directly. Free interpreter services are available in all languages for people who do not speak English.

Contact Method	Contact Information
Call	1-866-546-7924 (TTY: 711) Monday through Friday, 8 a.m. to 5 p.m.
Fax	See the letter from your care manager for their fax number.
Write	PO Box 66189, Virginia Beach, VA 23466
Email	See the letter from your care manager for their email.
Website	sentarahealthplans.com

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

Health Risk Assessment

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

Your Care Plan

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

Your Care Team

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

Coordination with Medicare or Other Health Plans

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

Transitioning Care between Health Plans

If you change Medicaid health plans, as your new health plan, Sentara Health Plans, is responsible for coordinating your Cardinal Care benefits with your previous health plan. The previous Medicaid health plan is responsible for transferring service authorizations and other pertinent information to your new health plan, Sentara Health Plans, to ensure continuity of care and services. For more information and details regarding your specific transition, call Sentara Health Plans Member Services or your care manager if you have questions about how your new and previous health plans work together and make sure your services are transitioned.

Additional Care Management Services

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

- Are in foster care, were in foster care, or receive adoption assistance.
- Are pregnant and are at higher risk for complications during and after pregnancy.
- Receive services in your home or the community, such as home health, personal care, or respite services.
- Have a substance use disorder.
- Use a ventilator.
- Are homeless.

If you need a care manager, call Sentara Health Plans Member Services for assistance.

5. Your Benefits

Overview of Covered Benefits

Covered benefits are services provided by Sentara Health Plans, the Department, or its contractor. In order to get covered benefits, the service must be medically necessary. A medically necessary service is a service you need to prevent, diagnose, or treat a medical condition or its symptoms. Your health care provider will give Sentara Health Plans your medical records and other information to show that the service is medically necessary.

You can also access the full list of your covered benefits at: sentarahealthplans.com/benefits. Call Sentara Health Plans Member Services at 1-800-881-2166 (TTY: 711) or your care manager, if you have one, for more information about your services and how to get them.

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

For services not covered under your benefits, please contact Member Services or your care manager, to help you find the resources that can support your current needs and ongoing wellness.

Benefits for All Members

Physical Health Services

Sentara Health Plans and the Department cover physical health services (including dental and vision) for Cardinal Care members:

- Adult Day Health Care
- Cancer screenings and services (colorectal cancer screening, mammograms, pap smears, prostate specific antigen, and digital rectal exams, reconstructive breast surgery)
- Care management and care coordination services (see *Section 4, Care Coordination and Care Management*)
- Clinic services

- Clinical trials (routine patient costs related to participation in a qualifying trial)
- Court-ordered services, emergency custody orders (ECO), and temporary detention orders (TDO)
- Dental services (more on this below)
- Durable Medical Equipment (DME) (respiratory, oxygen, and ventilator equipment and supplies; wheelchairs and accessories; hospital beds; diabetic equipment and supplies; incontinence products; assistive technology; communication devices; rehabilitative equipment and devices)
- Early and Periodic Screening Diagnostic and Treatment (EPSDT) (more on this below)
- Early Intervention (EI) services (more on this below)
- Emergency and post-stabilization services
- Gender dysphoria treatment services
- Glucose test strips
- Hearing services
- Home and community-based waiver services (more on this below)
- Home health
- Hospice
- Hospital care (inpatient and outpatient)
- Human Immunodeficiency Virus (HIV) services (testing and treatment counseling)
- Immunizations (adult and child)
- Laboratory, radiology, and anesthesia services
- Lead Investigations
- Oral services (hospitalizations, surgeries, services billed by a medical provider)
- Organ transplants (for all children and for adults who are in intensive rehabilitation)
- Orthotics (children under age 21)
- Nutritional counseling for chronic disease
- Podiatry services (foot care)
- Prenatal and maternal services (pregnancy/postpartum care) (more on this below)
- Prescription drugs (see *Section 6, Your Prescription Drugs*)
- Preventive care (regular check-ups, screenings, well-baby/child visits)
- Prosthetics (arms/legs and supportive attachments, breasts, and eye prostheses)
- Regular medical care (PCP office visits, referrals to specialists, exams)
- Radiology services
- Rehabilitation services (inpatient and outpatient, including physical/ occupational therapy and speech pathology/audiology services)
- Renal services (dialysis, End Stage Renal Disease services)
- School health services (more on this below)
- Surgery services
- Telehealth services (more on this below)
- Tobacco cessation services

- Transportation services (see *Section 3, Providers and Getting Care*)
- Tribal clinical provider type services
- Vision services (eye exams/treatment/ glasses to replace those lost, damaged, or stolen for children under age 21 (under EPSDT))
- Well visits (Plan to describe specific services)

Remember, services marked with an asterisk (*) may require service authorization. If you and your doctor decide to plan a procedure for a specific day, that is called a pre-service request. Sentara Health Plans will review the request before the date of the procedure and provide a determination. If the procedure is an emergency, your doctor can notify Sentara Health Plans and the review will be completed faster. If you get sick unexpectedly and need to go to the emergency room or your doctor decides that you need to go directly to the hospital, Sentara Health Plans does not need to be notified before you go. If you are admitted to the hospital from the doctor's office or the emergency room, the hospital will work with Sentara Health Plans to get a service authorization. While you are in the hospital, Sentara Health Plans will continue to check on you during your stay by working with the case manager at the hospital to make sure you have what you need when you are discharged.

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

Dental Service	Children/Youth Under Age 21	Pregnant/ Postpartum People	Adults Age 21 and Older
Braces	Covered	Not Covered	Not Covered
Cleanings	Covered (including fluoride)	Covered	Covered
Crowns	Covered	Covered	Limited Coverage
Dentures	Covered (including partials)	Covered (including partials)	Covered
Exams	Covered (including regular check-ups)	Covered	Covered

Dental Service	Children/Youth Under Age 21	Pregnant/ Postpartum People	Adults Age 21 and Older
Extractions and Oral Surgeries	Covered	Covered	Covered
Fillings	Covered	Covered	Covered
Gum Treatment	Covered	Covered	Covered
Root Canals	Covered (including treatment)	Covered	Covered
Sealants	Covered	Not Covered	Not Covered
Space Maintainers	Covered	Not Covered	Not Covered
X-Rays	Covered	Covered	Covered

Behavioral Health Services

Sentara Health Plans, the Department or its contractor covers the behavioral health treatment services in the table below for Sentara Health Plans members. Behavioral health refers to mental health and addiction services. In Virginia, treatment for addiction is called “Addiction and Recovery Treatment Services” (ARTS). Sentara Health Plans Member Services, your PCP, and your care manager can help you get the behavioral health services you need.

Mental Health Services
• 23-hour observation • Applied behavior analysis • Assertive community treatment • Community stabilization • Functional family therapy • Intensive in-home • Mental health case management • Mental health intensive outpatient • Mental health partial hospitalization program • Mental health peer recovery support services • Mental health skill-building services • Mobile crisis • Multisystemic therapy • Psychiatric residential treatment facility • Psychosocial rehabilitation • Residential crisis stabilization

Mental Health Services

- Therapeutic day treatment
- Therapeutic group home
- Inpatient psychiatric services
- Outpatient psychiatric services

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

Addiction and Recovery Treatment Services (ARTS)

- Screening, Brief Intervention, and Referral to Treatment
- Substance Use Case Management Services
- Outpatient Services
- Intensive Outpatient Services
- Partial Hospitalization
- Substance Use Residential Treatment
    -
- Medication Assisted Treatment
- Peer Recovery Support Services
- Opioid Treatment Services
  Office Based Addiction Treatment

Certain Mental Health and ARTS services may require an authorization or registration request to be submitted by your provider prior to you starting services. Your provider should work with Sentara Health Plans to ensure any authorization/registration requirements are met prior to initiating services. We work with providers to ensure you are getting the appropriate care for your needs. Sentara Health Plans provides the same level of benefits for substance use and behavioral health treatment services as we do medical and surgical care, in line with the Mental Health Parity and Addiction Equity Act (MHPAEA). For questions about addiction and recovery services, call 1-800-881-2166 (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m., and ask for the ARTS care coordinator. This call is free.

If you are thinking of harming yourself or someone else, call the Behavioral Health Crisis Line 1-833-686-1595 (TTY: 711) 24 hours a day, seven days a week. This call is free. Remember, if you need help right away, call 911. or the 988 Suicide and Crisis Lifeline

Long-Term Services and Supports (LTSS)
Sentara Health Plans and the Department cover LTSS such as private duty nursing, personal care, and adult-day health care services to help people meet their daily needs and maintain independent living in the community or a facility. Before receiving LTSS, a community-based or hospital team will conduct a screening to see if you meet "level of care" criteria – in other words, whether you qualify for and need LTSS. Contact your care manager to learn about the screening process to receive LTSS. FAMIS members are not eligible for LTSS services.

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

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

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

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

Some members may qualify for HCBS waiver services (see table below). To learn more or to find out if you are eligible, contact Sentara Health Plans or your care manager. Developmental Disability waiver services are managed through the Department of Behavioral Health and Developmental Services (DBHDS). You can also find more information about Developmental Disability waiver services on the DBHDS website mylifemycommunityvirginia.org or by calling 1-844-603-9248. FAMIS enrollees are not eligible for HCBS.

Waiver	Description	Examples of Covered Benefits
Commonwealth Coordinated Care (CCC) Plus Waiver	Provides care in your home and community instead of a nursing facility. You can choose to receive agency-directed or consumer-directed services, or both.	• Adult Day Health Care • Assistive technology • Environmental modifications • Personal care • Personal Emergency Response System • Private duty nursing • Respite • Transition services
Developmental Disability Waivers: Building Independence (BI) Community Living (CL) Family and Individual Supports (FIS)	Provides supports and services to members with developmental disabilities to help with successful living, learning, physical and behavioral health, employment, recreation, and community inclusion. Waivers may have a waiting list. You should put your name on the waiting list if you need to so that when space opens up you can start receiving these services.	• Assistive technology • Benefits planning services • Electronic home-based services • Employment and day support • Environmental modifications • Personal emergency response system • Crisis supports • Residential options

LTSS services may be consumer-directed (allows the member or authorized representative to act as the employer for personal care or respite services) or agency-directed. For both consumer-directed or agency-directed services, a member must have a responsible back-up plan in case their nurse or attendant cannot work. Sentara Health Plans will not be able to approve services without a back-up plan in place.

Many LTSS services will require a service authorization before the services can be provided. The provider will have to send in clinical notes and required DMAS forms that show that you meet the level of care for the service requested. The staff looking at your authorization request will work closely with your care manager to ensure you get the appropriate service. Some LTSS services have limits, meaning that you can only have a certain amount of that service for an established time period.

Benefits for Children/Youth Under Age 21

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

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

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

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

FAMIS children are eligible for well-child visits and immunizations, but not all EPSDT services. For more information on accessing EPSDT services, contact Sentara Health Plans Member Services or your care manager.

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

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

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

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

Benefits for Family Planning and Pregnant/Postpartum People

You can get free health care services to help you have a healthy pregnancy and a healthy baby. This includes health care services for up to 12 months after you give birth. (FAMIS prenatal enrollees are eligible for 60 days of postpartum coverage.)
Sentara Health Plans and the Department cover the following services:

- Labor and delivery services
- Doula services
- Family planning (services, devices, drugs – including long-acting reversible contraception – and supplies for the delay or prevention of pregnancy)
- Lactation consultation and breast pumps
- Nurse midwife/provider services
- Pregnancy-related services
- Prenatal/infant services and programs
    - Baby showers
    - Referrals to programs such as CHIP and Urban Baby Beginnings
    - Maternal health education workshops
    - The HEAL Program® (Health Education and Literacy)
    - Prenatal care member incentive
    - Nutritious food grocery card for pregnant members
- Postpartum services (including postpartum depression screening)
- Services to treat any medical condition that could complicate pregnancy
- Smoking cessation services
- Substance Use Treatment Services
- Abortion services (only if a doctor certifies in writing that there is a substantial danger to the mother's life)

Remember, you do not need a service authorization or a referral for family planning services. You can get family planning services from any provider, even if they are not in Sentara Health Plans network.

Newborn Coverage

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

Added Benefits for Sentara Health Plans Members

Sentara Health Plans provides some added benefits for members*. These include:

- Adult incontinence products – purchase up to $30 in products every three months.
- Adult vision exams for members 21 and up and $100 for frames each year.
- Baby showers for pregnant members.

- College application assistance – up to $75 toward applying for college (restrictions apply).
- Diabetes prevention program.
- Diapers – receive up to 400 per live birth for qualifying members.
- Feminine hygiene products – order up to $20 of products every three months.
- Financial wellness program.
- GED coaching and testing – may receive up to $275 for testing voucher and online prep program.
- The HEAL Program® (health education and literacy).
- Healthy member incentives – earn up to $50 in gift cards per year.
- Home-delivered meals after hospital discharge, including delivery – up to 56 meals.
- iPad cover or tablet cover (does not include the iPad or tablet) – up to $25 for a durable iPad cover or tablet to protect an electronic device.
- Mattress cover and pillowcase for qualifying members with asthma or chronic obstructive pulmonary disease (COPD) (restrictions apply).
- Memory alarms and devices.
- Mobile app for quick access to plan and benefit information, member ID cards, forms, and more.
- Online member portal to access your account, member ID card, plan details, virtual appointments, and more.
- Online resource guide to find food, housing, jobs, and more.
- Pedometer.
- Pregnant members – $75 per quarter to purchase healthy foods.
- Safe Sleep – new mothers receive a baby monitor, sleep sack, or pack-n-play to encourage safe sleeping practices.
- Sports physicals.
- Transportation (non-medical) – members get rides to places like community events, grocery stores, and more (24 round trips per year).
- Transportation services for LTSS caregivers (non-medical) – 24 round trips each year of non-emergency transportation trips for caregivers of LTSS members, including free rides to grocery stores, pharmacy, and the member's home – no more than 50 miles.
- Welcoming Baby℠ incentive-based program supports members during pregnancy and after giving birth.
- Hearing Aid.

* Restrictions and limitations may apply to some benefits.

Call Sentara Health Plans Member Outreach at 1-833-261-2367, Monday through Friday, 8 a.m. to 5:30 p.m., to find out more about your Added Benefits or go to sentaramedicaid.com/benefits for more details. For more information on healthy member incentives, go to sentaramedicaid.com/giftcard.

Chronic Disease Management

Sentara Health Plans offers a Chronic Disease Management Program to help you understand and manage your health conditions. It also outlines anything that can have an impact on your health.

The program is voluntary and offers the following services for members with COPD, diabetes, hypertension, congestive heart failure, asthma, or HIV/AIDS:

- Educational materials to help you self-manage your condition
- 24/7 Free Nurse Advice Line
- Support from our nurses and other care staff
- Community education classes
- Communication with you on your plan of care

Participation in the program is free and will not change your benefits with Sentara Health Plans. You may stop participating in this program at any time.

If you would like to participate in this program or have any questions, please call 1-866-243-0937 (TTY: 711). We are available Monday through Friday, 8 a.m. to 5 p.m., except holidays.

6. Your Prescription Drugs

Understanding Your Prescription Drug Coverage

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

To know which prescriptions are covered by Sentara Health Plans and the Department, see the Preferred Drug List at sentaramedicaid.com/drugs. This is the list of medications covered by Sentara Health Plans as part of your benefits. You can also search our drug list online by going to sentarahealthplans.com/findadoc and selecting the "Drug and Pharmacy Search" button. The Preferred Drug List can change during the year, but Sentara Health Plans will always have the most up-to-date information. Changes to the Preferred Drug List are posted on the website. If a drug you are taking is no longer offered on the Preferred Drug List, Sentara Health Plans will notify you by letter at least 30 days before the change goes into effect. We will generally cover a drug on the Sentara Community Plan Preferred Drug List 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 get a service authorization from us for you to receive certain drugs.

By law there are some drugs that cannot be covered. Drugs that cannot be covered include experimental drugs, drugs for weight gain (drugs for weight loss are covered for members who meet the medical criteria), drugs used to promote fertility or for the treatment of sexual or erectile dysfunction, and drugs used for cosmetic purposes. Contact Member Services with questions about your prescription coverage.

Prescription Drugs for FAMIS Members

Generic outpatient prescription drugs are covered for FAMIS members. If you choose a brand drug you are responsible for 100% of the difference between the allowable charge of the generic drug and the brand drug. Weight loss drugs are not covered for FAMIS members.

Drugs that Require You or Your Provider to Take Extra Steps

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

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

Emergency Supply of Drugs

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

Long-Term Supply of Drugs

Sentara Health Plans members may receive up to a 34-day supply of a prescription drug at a retail or specialty pharmacy. Members may receive a 90-day supply per prescription of select maintenance drugs identified on the DMAS 90-day Medication Maintenance List after receiving two, 34-day or shorter duration fills. The list of covered drugs for DMAS 90-day Medication Maintenance Management List can be viewed at sentaramedicaid.com/drugs. Sentara Health Plans 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.

Getting Your Drugs from a Network Pharmacy

Once your provider orders a prescription for you, you will need to get your prescription drugs filled at a network pharmacy (except during an emergency). A network pharmacy is a drug store that agrees to fill drugs for Sentara Health Plans members. To find a network pharmacy, use your Provider Directory available at sentarahealthplans.com/findadoc and select the “Drug and

Pharmacy Search" button. You can use any of Sentara Health Plans network pharmacies.

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

When you go to the network pharmacy to drop off a prescription or pick up your drugs, show your Sentara Health Plans Member ID Card. Call Sentara Health Plans Member Services or your care manager if you have questions or need help getting a prescription filled or finding a network pharmacy.

Getting Your Drugs Mailed to Your Home

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

Mail-order benefits are only available for FAMIS members. If you have trouble getting to the pharmacy or have questions about mail-order options, please contact Member Services.

Patient Utilization Management and Safety Program

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

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

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

Second Opinions

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

Service Authorization

There are some services, treatments, and drugs that require service authorization before you receive them or continue receiving them. A service authorization helps to figure out if certain services are medically necessary and if Sentara Health Plans can cover them for you. After assessing your needs and making a care recommendation, your provider must submit a request for a service authorization to Sentara Health Plans with information that explains why you need the service. This helps make sure that they can be paid for the services they provide to you. Sentara Health Plans has a committee that reviews all new technology and literature that make sure we use the most up-to-date criteria when making decisions about your health care. Once the literature is approved by the committee, Sentara Health Plans will use it to help make decisions about medical necessity when your doctor requests new services, treatment, or drugs.

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

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

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

Sentara Health Plans does not reward employees, consultants, or other providers to:

- Deny care or services that you need.
- Support decisions that approve less than what you need.

- Say you do not have coverage.

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

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

How to Get a Service Authorization
Service authorizations are usually requested by your doctor or the facility providing your care. The facility or physician may request by phone, fax, or they can put the request in using the Sentara Health Plans portal and the request will be routed to the appropriate team. Sentara Health Plans Member Services or your care manager can answer your questions and share more about how to request a service authorization. If you want to request a specific service that requires a service authorization, your care manager can help you find the right provider who can help figure out if you need the service.

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

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

Sentara Health Plans will contact your provider if Sentara Health Plans needs more information or time to make a decision about your service authorization. You will be informed of the communication to your requesting provider. If you disagree with Sentara Health Plans taking more time to review your request or if

you do not like the way Sentara Health Plans handled your request, see *Section 8, Appeals and Complaints,* on how to file a complaint. You can talk to your care manager about your concerns, or you may call the Cardinal Care Managed Care Enrollment Helpline at 1-800-643-2273 (TTY: 1-800-817-6608). If you have more information to share with Sentara Health Plans to help decide your case, then you, or your provider can ask Sentara Health Plans to take more time to make a decision in order to include the additional information.

Adverse Benefit Determinations

If Sentara Health Plans denies a service authorization request, this is called an "adverse benefit determination." An adverse benefit determination can also occur when Sentara Health Plans approves only part of the care request or a service amount that is less than what your provider requested. 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 with expertise in the care or service you requested to. include Long Term Services and Support. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity. Examples of adverse benefit determinations include when Sentara Health Plans:

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

If Sentara Health Plans makes an adverse benefit determination, Sentara Health Plans will usually notify your provider and you in writing at least 10 days before making changes to your service. But, if you do not hear from Sentara Health Plans, contact Sentara Health Plans Member Services or the provider who would be providing you the service to follow up. When Sentara Health Plans tells you the decision in writing, Sentara Health Plans will tell you what the decision was, why the decision was made, and how to appeal if you disagree. You should share a copy of the decision with your provider. If you disagree with the decision,

you can request an appeal. See *Section 8, Appeals and Complaints*, for more information on the appeal process.

8. Appeals and Complaints

Appeals

When to File an Appeal with Sentara Health Plans

You have the right to file an appeal if you disagree with an adverse benefit determination (see *Section 7, Getting Approval for Your Services, Treatments, and Drugs*) that Sentara Health Plans makes about your health coverage or covered services. You must appeal within 60 calendar days after hearing Sentara Health Plans decision about your service authorization request. You can allow an authorized representative (provider, family member, etc.) or your attorney to act on your behalf. If you choose to let someone file the appeal on your behalf, they must have your written consent, and you must call Sentara Health Plans Member Services at 1-800-881-2166 (TTY: 711) to let Sentara Health Plans know. See *Section 7, Getting Approval for Your Services, Treatments, and Drugs,* for more information on service authorizations and adverse benefit determinations.

If you need assistance with an appeal, you may talk to your care manager. In handling appeals, Sentara Health Plans will give you any reasonable assistance in completing forms and taking other procedural steps related to an appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

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

How to Submit Your Appeal to Sentara Health Plans

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

Phone Requests	1-844-434-2916 TTY: 711
Written Requests	Mail: Sentara Health Plans

	Attn: Appeals Department PO Box 62876 Virginia Beach, VA 23466 Fax: 1-866-472-3920

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

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

If Sentara Health Plans has all the information needed from you:
- Within 72 hours of receiving your *expedited* appeal request, Sentara Health Plans will send you a written notice and try to provide verbal notice to tell you the decision.
- Within 30 days of receiving your *standard* appeal request, Sentara Health Plans will send you a written notice to tell you the decision.

If You Are Unhappy with Sentara Health Plans Appeal Decision
Sentara Health Plans has one level of appeal for you to request. After that, you can file an appeal to the Department through what is called the State Fair Hearing process after filing an appeal with Sentara Health Plans if:
- You disagree with the final appeal decision you receive from Sentara Health Plans.

OR
- Sentara Health Plans does not respond to your appeal in a timely manner.

Like Sentara Health Plans appeals process, you may be able to keep getting services that were denied while you wait for a decision on your State Fair

Hearing appeal (but may ultimately have to pay for these services if your State Fair Hearing appeal is denied).

How to Submit Your State Fair Hearing Appeal
You (or your authorized representative) must appeal to the state within 120 calendar days from when Sentara Health Plans issues its final appeal decision. You can appeal by phone, in writing, or electronically. If you appeal in writing, you can write your own letter or use the Department's appeal request form. Be sure to include a full copy of the final written notice showing Sentara Health Plans appeal decision and any documents you want the Department to review. If you have chosen an authorized representative, you must provide documents that show that the individual can act on your behalf. You can also file an appeal online at the Department's website using the Appeals Information Management System (AIMS) portal. More information on filing an appeal through AIMS can be found on the Department's Appeals website at https://dmas.virginia.gov/appeals/.

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

Phone Requests	1-804-371-8488 TTY: 1-800-828-1120
Written Requests	Mail: Appeals Division, DMAS, 600 E. Broad Street, Richmond, VA 23219 Fax: 804-452-5454
Electronic Requests	Website: dmas.virginia.gov/appeals Email: appeals@dmas.virginia.gov DMAS Appeals Information Management System (AIMS) Website to register for AIMS: https://appeals-registration.dmas.virginia.gov/client AIMS Portal to submit appeals: https://login.vamedicaid.dmas.virginia.gov/

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

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

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

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

How FAMIS members ask for an External Review
FAMIS members can request an external review instead of, or in addition to, a State Fair Hearing. You or your authorized representative must submit a written request for external review within 30 calendar days of receipt of the Sentara Health Plans final appeal decision. Please mail external review requests to:

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

Please include: your name, your child's name (or your name, if for services you yourself received) and Medicaid ID number, your phone number with area code, and copies of any relevant notices or information.

Complaints

When to File a Complaint

You have the right to file a complaint (a “grievance”) at any time. You will not lose your coverage for filing a complaint. A complaint or grievance is defined as an expression of dissatisfaction about any matter other than an adverse action or an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member’s rights. Grievance includes a member's right to dispute an extension of time proposed by the Managed Care Organization (MCO) to make an authorization decision.

You can complain about anything except a decision about your health coverage or covered services. (For those types of issues, you will need to submit an appeal – see above). You can file a complaint to either Sentara Health Plans or an outside organization if you are unhappy. You may file a complaint with the MCO at any time. You can make complaints about:

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

How to File a Complaint with Sentara Health Plans

To file a complaint with Sentara Health Plans, call Sentara Health Plans Member Services at phone number (TTY: phone number) or file a complaint in writing by mailing it to Plan address or faxing it to Plan fax number. With the exception of an attorney, a provider or an authorized representative may file a grievance on your behalf with your written consent. Be sure to include details on what the complaint is about so that Sentara Health Plans can help. With the exception of

an attorney, a provider or an authorized representative may file a complaint on your behalf, but they must have your written consent.

If you need assistance with a complaint, you may talk to your care manager. In handling complaints, Sentara Health Plans will give you any reasonable assistance in completing forms and taking other procedural steps related to a complaint. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

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

How to File a Complaint with an Outside Organization

To file a complaint with an outside organization that is not affiliated with Sentara Health Plans, you can:

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

- Written Requests: Virginia Department of Health, Office of Licensure and Certification, 9960 Maryland Drive, Suite 401, Richmond, Virginia 23233-1463; or email: mchip@vdh.virginia.gov.

9. Cost Sharing

Copayments

Copayments are when you pay a fixed amount for certain services covered by Sentara Health Plans or the Department. Most Sentara Health Plans members will not owe copayments for covered services. However, there are some exceptions (see below). If you receive a bill for a covered service, contact Sentara Health Plans Member Services for help at 1-800-881-2166 (TTY: 711). Remember, if you get services that are not covered through Sentara Health Plans or the Department, you must pay the full cost yourself.

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

Patient Pay

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

Premiums

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

10. Your Rights

General Rights

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

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

- Voice a complaint or file an appeal about the organization or the care it provides.
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example).
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Ask about the Physician Incentive Plans.

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

Sentara Health Plans 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.

Sentara Health Plans 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 Sentara Health Plans 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.

Sentara Health Plans 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 Sentara Health Plans 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.

Your Right to Privacy
You have the legal right to see and receive a copy of your health information including your claims records. You 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 Member Services.

You may file a complaint with Sentara Health Plans or with the Secretary of the U.S. Department of Health and Human Services, if you believe your privacy rights have been violated. Call Member Services to file a complaint with Sentara Health Plans.

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 Health 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 Health 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 Health 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 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: sentarahealthplans.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 sentarahealthplan.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 01/01/2025 and replaces all earlier versions.

APPENDIX A

AFFILIATES

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

Sentara Health Administration, Inc.

Sentara Health Insurance Company

Sentara Health Plans

Sentara Behavioral Health Services, Inc.

AvMed, Inc.

Advance Directives

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

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

- Virginiaadvancedirectives.org.
- Your care manager, if you have one.
- Your provider, a lawyer, a legal services agency, a social worker, the hospital.
- Sentara Health Plans Member Services, if applicable.

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

- 1-800-533-1560 (TTY: 711).
- Email enfcomplaints@dhp.virginia.gov.

- Write Virginia Department of Health Professions, Enforcement Division, 9960 Maryland Drive, Suite 300, Henrico, Virginia 23233-146.

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

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

Member Advisory Committee

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

You can also apply to join the DMAS Member Advisory Committee (MAC). The Department established the MAC to provide a formal method for enrollees' voices to be included in the DMAS decision-making process and to inform DMAS change management strategies. The committee is made up entirely of Medicaid-enrolled individuals or an authorized representative of an enrollee. If you are interested in learning more about the MAC, visit the Department's MAC website at https://www.dmas.virginia.gov/about-us/boards-and-public-meetings/member-advisory-committee/.

11. Your Responsibilities

General Responsibilities

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

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

Call Sentara Health Plans Member Services at 1-800-881-2166 (TTY: 711) to let them know if:

- Your name, address, phone number, or email have changed (*see Section 1, Let's Get Started*).

- Your health insurance changes in any way (from your employer or workers' compensation, for example) or you have liability claims, like from a car accident.
- Your Member ID Card is damaged, lost, or stolen.
- You have problems with health care providers or staff.
- You are admitted to a nursing facility or the hospital.
- Your caregiver or anyone responsible for your changes.
- You join a clinical trial or research study.

Reporting Fraud, Waste, and Abuse

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

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

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

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

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

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

The Department's Fraud and Abuse Hotline

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

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

Phone	**1-804-371-0779** **Toll free: 1-800-371-0824** **TTY: 711**
Fax	804-786-3509
Email	MFCU_mail@oag.state.va.us
Mail	Office of the Attorney General, Medicaid Fraud Control Unit 202 North Ninth Street Richmond, VA 23219

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

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

12. Key Words and Definitions in This Handbook

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

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

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

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

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

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

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

- **Care Coordination:** Help that the health plan provides to members so that members understand what services are available and how to get the health care or social services that they need. Care coordination is available to all members,

including those who are not assigned a care manager and do not need or want care management.

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

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

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

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

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

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

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

- **Cover Virginia:** Virginia's statewide support center. Individuals can call 1-833-5CALLVA (TTY: 1-888-221-1590) for free or visit coverva.org/en to learn about and

apply for health insurance, renew their coverage, update information, and ask questions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and provider visits) and supplies (like wheelchairs and walkers) that are

medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This page intentionally blank.

PO Box 66189

Virginia Beach, VA 23466

sentarahealthplans.com

1-800-881-2166 (TTY: 711)

Monday–Friday, 8 a.m.–8 p.m.

SHP_MD_MEM_BKT_250002_0525