Welcome

Aetna Better Health® of Virginia

Cardinal Care 2025 Member Handbook

AetnaBetterHealth.com/Virginia

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VA-25-04-02

aetna® | CardinalCare Virginia's Medicaid Program

Helpful Information

Our website
AetnaBetterHealth.com/Virginia

Mailing address
Aetna Better Health of Virginia
PO Box 818044
Cleveland, OH 44184-8044

Member Services
1-800-279-1878 24 hours a day, 7 days a week

Services for the Hearing and Speech Impaired
711

Language Translation/Interpretation Services **1-800-279-1878**

Behavioral Health and Substance Use Services and 24-Hour Helpline
1-800-279-1878

Care Management
1-800-279-1878

24-Hour Nurse Line
1-877-878-8940

Dental (Smiles for Children)
1-888-912-3456

Transportation
1-800-734-0430

Personal Information

My member ID number

My PCP's phone number

My Primary Care provider (PCP)

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

Cardinal Care Model Member Handbook

(Effective July 1, 2025)

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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 the Aetna Better Health of Virginia Member Services toll-free number at **1-800-279-1878 (TTY: 711)**, available 24 hours a day, 7 days a week, visit our website at **AetnaBetterHealth.com/Virginia**, 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 Member Services at **1-800-279-1878 (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 **AetnaBetterHealth.com/Virginia** or **dmas.virginia.gov**.

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-385-4104 (TTY: 711).

Aetna Better Health of Virginia 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 1-800-385-4104 (TTY: 711).

Aetna Better Health 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. 1-800-385-4104 (TTY: 711) 번으로 전화해 주십시오.

Aetna Better Health은(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 1-800-385-4104 (TTY: 711).

Aetna Better Health 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 1-800-385-4104 (TTY: 711)

Aetna Better Health 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 باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو على الرقم **1-800-385-4104** (للصم والبكم: **711**)

Amharic
ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ፣ የቋንቋ እርዳታ አገልግሎቶች፣ በነጻ፣ ተዘጋጀተውልዎታል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-385-4104 (መስማት ለተሳናቸው: TTY: 711)

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

Urdu
پر کال کریں۔ (TTY: 711) 1-800-385-4104 توجہ فرمائیں :اگر آپ اردو بولتے ہیں تو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔

Aetna Better Health 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 1-800-385-4104 (TTY: 711).

Sumusunod ang Aetna Better Health 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 بھ زبان فارسی گفتگو می کنید، تسھیلات زبانی بصورت رایگان برای شما. با شماره 1-800-385-4104 تماس بگیرید (TTY: 711).

Aetna Better Health از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و ھیچگونه 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 1-800-385-4104 (ATS : 711).

Aetna Better Health 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। 1-800-385-4104 (TTY: 711) নম্বরে কল করুন।

Aetna Better Health 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. 1-800-385-4104 (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। 1-800-385-4104 (TTY: 711) पर कॉल करें।

Aetna Better Health 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। 1-800-385-4104 (TTY: 711) मा कल गर्नुहोस्।

Aetna Better Health 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 1-800-385-4104 (TTY: 711).

Aetna Better Health соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.
1-800-385-4104 (TTY: 711)

Notice of Nondiscrimination

Aetna Better Health does not discriminate (or treat you differently) based on race, color, national origin, age, disability, or sex. Aetna Better Health of Virginia complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, health status, or need for health care services.

Aetna Better Health provides:

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

If you need these services, contact Member Services at **1-800-385-4104 (TTY: 711)**. This call is free.

If you think Aetna Better Health 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:

Address: Attn: Civil Rights Coordinator
PO Box 818001
Cleveland, OH 44181-8001
Telephone: **1-888-234-7358 (TTY: 711)**
Email: MedicaidCRCoordinator@aetna.com

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If you are visually impaired and need large print or other assistance to access this document, please contact us at **1-800-385-4104 (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 **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 **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 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
Member Services	**1-800-279-1878 (TTY: 711)** **AetnaBetterHealth.com/Virginia** 7 days 24 hours Aetna Mobile App and Member Web Portal Members can call their care manager directly or request a care manager by calling Member Services. Members can also use the Aetna Mobile App or the Member Web Portal.
Aetna Better Health's Medical Advice Line	**1-800-279-1878 (TTY: 711)** 24 hours a day, seven days a week
Aetna Better Health's Behavioral Health Crisis Line	**1-800-279-1878 (TTY: 711)** 24 hours a day, seven days a week
Addiction and Recovery Treatment Services (ARTS) Medical Advice Line	**1-800-279-1878 (TTY: 711)** 24 hours a day, seven days a week
Department of Behavioral Health and Developmental Services (DBHDS) for DD Waiver Services	My Life My Community Helpline **1-844-603-9248** TTY: **804-371-8977** Monday through Friday, 9 a.m. to 4:30 p.m. **www.mylifemycommunityvirginia.org**
Cardinal Care Dental Benefits Administrator	**1-888-912-3456** **TTY: 1-800-466-7566** **dentaquest.com/state-plans/regions/virginia** Monday through Friday, 8:00 a.m. to 6:00 p.m.
Aetna Better Health's Vision Services	VSP – Vision Service Plan **1-800-877-7195**

Entity Name	Contact Information
the Aetna Better Health Transportation Services	Reservations Phone Number: **1-800-734-0430, option 1** Ride Assist Phone Number: **1- 800-734-0430, option 2** TTY: **711** Reservations Days and Hours of Operation: Monday through Friday 7 AM – 8 PM EST Urgent and Same Day Hours of Operation: 24 hours a day, 7 days per week, 365 days a year Or, book your ride online at **member.modivcare.com/login**
Cardinal Care Transportation for Developmental Disability Waiver Services	**1-866-386-8331** **TTY: 1-866-288-3133** Dial **711** to reach a TRS operator 24 hours a day, seven days a week
Cardinal Care Managed Care Enrollment Helpline	**1-800-643-2273** **TTY: 1-800-817-6608** Monday through Friday, 8:30 a.m. to 6:00 p.m.
Department of Health and Human Services' Office for Civil Rights	**1-800-368-1019** **TTY: 1-800-537-7697** **hhs.gov/ocr**
Office of the State Long-Term Care Ombudsman	**1-800-552-5019** **TTY: 1-800-464-9950** **elderrightsva.org**

Staying Connected

Have you moved, changed phone numbers, or gotten a new email address? It is important to let us know so that you keep getting high quality health insurance. The Department and Aetna Better Health 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 Aetna Better Health of Virginia. Aetna Better Health 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.

This handbook will help you understand your covered benefits and how to get help from Aetna Better Health. Use it to jump start a healthier you. The first steps you should take include:

- Choose a PCP (make sure you call Member Services to let us know who you choose).
- Review the list of covered and non-covered services Review how to get prescription medicines
- Review the added benefits you get for being an Aetna Better Health member
- Complete any health screenings requested by Aetna Better Health

Aetna Better Health Member Services is available to help if you have any questions or concerns. Call **1-800-279-1878 (TTY: 711)** 24 hours/7 days a week or visit us at **AetnaBetterHealth.com/Virginia/contact-us**.

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 Aetna Better Health 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 Aetna Better Health 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 Aetna Better Health 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 6:00 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

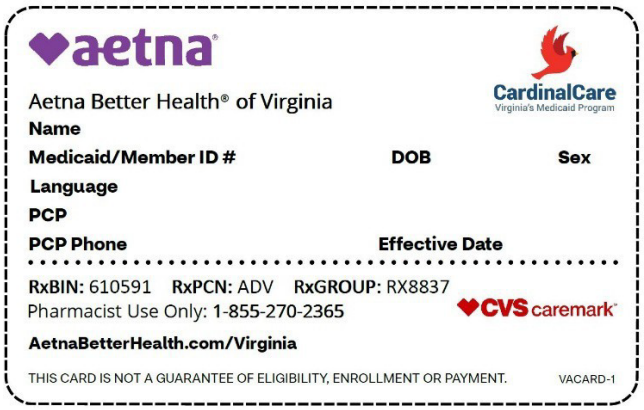
You should have received a welcome packet that includes your Member ID Card, information on the Aetna Better Health Provider Directory, and the Preferred Drug List. If you did not receive your welcome packet, call Member Services at **1-800-279-1878**. Members can access resources via the mobile app and the Member Web Portal.

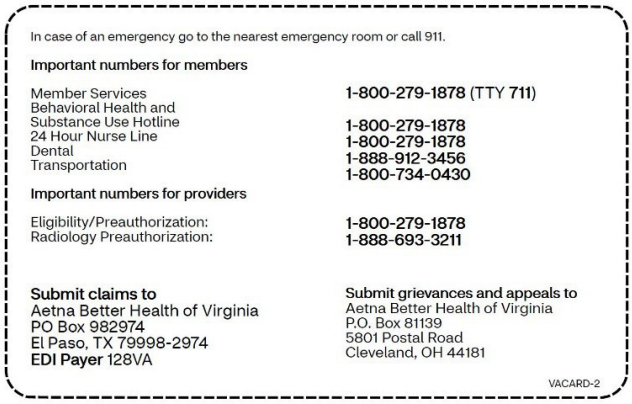
Aetna Better Health Member ID Card

You must show your Aetna Better Health Member ID card to get services or prescription drugs covered by Aetna Better Health (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 Member Services right away to get a new one.

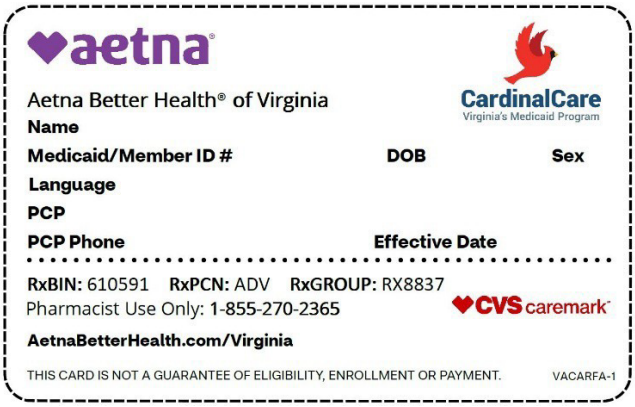
Below are samples of your Aetna Better Health Member ID card:

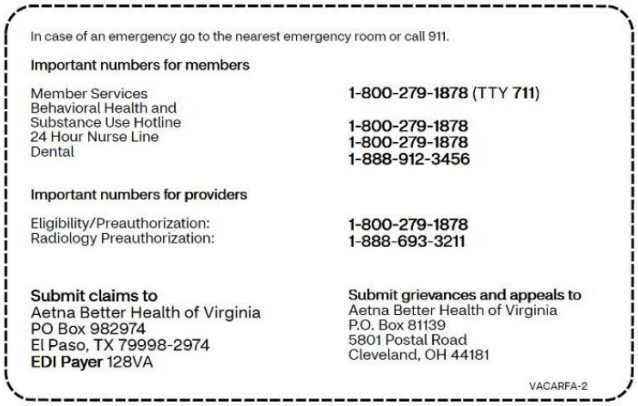
All members except FAMIS members


aetna
Aetna Better Health® of Virginia
CardinalCare
Virginia's Medicaid Program
Name
Medicaid/Member ID #
DOB
Sex
Language
PCP
PCP Phone
Effective Date
RxBIN: 610591 RxPCN: ADV RxGROUP: RX8837
Pharmacist Use Only: 1-855-270-2365
CVS caremark
AetnaBetterHealth.com/Virginia
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.
VACARD-1


In case of an emergency go to the nearest emergency room or call 911.
Important numbers for members
Member Services
Behavioral Health and Substance Use Hotline
24 Hour Nurse Line
Dental
Transportation
1-800-279-1878 (TTY 711)
1-800-279-1878
1-800-279-1878
1-888-912-3456
1-800-734-0430
Important numbers for providers
Eligibility/Preauthorization:
Radiology Preauthorization:
1-800-279-1878
1-888-693-3211
Submit claims to
Aetna Better Health of Virginia
PO Box 982974
El Paso, TX 79998-2974
EDI Payer 128VA
Submit grievances and appeals to
Aetna Better Health of Virginia
P.O. Box 81139
5801 Postal Road
Cleveland, OH 44181
VACARD-2

FAMIS members only:





You may have more than one health insurance card. In addition to your Aetna Better Health 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 Aetna Better Health 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 Aetna Better Health Member ID Card when you receive services.

The Aetna Better Health Provider Directory

The provider directory lists providers and pharmacies that participate in the Aetna Better Health network of contracted providers. It also includes information on the accommodations each provider has for members with disabilities or who do not speak English. **The directory includes the providers:**

- Name
- Gender
- Specialty
- Address and locations
- Phone number
- Hospital and medical group affiliations
- Whether the provider is accepting new patients
- Board certification (including a link to the most current board certification status)
- Languages spoken by provider and clinical staff
- Accommodations for members with disabilities

You can access our provider directory online. Visit **AetnaBetterHealth.com/Virginia**. Then select "Find a Provider" to access our provider search tool. You can also download a printable version of our full directory by visiting **AetnaBetterHealth.com/Virginia**. If you need additional assistance, call Aetna Better Health of Virginia's Member Services at **1-800-279-1878 (TTY: 711).**

Preferred Drug List
This list tells you which prescription drugs are covered by Aetna Better Health 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 Member Services to find out if your drugs are on the list or check online at **AetnaBetterHealth.com/Virginia**. Aetna Better Health can also mail you a paper copy at your request.

Other Insurance

If you have more than one health insurance plan, then Medicaid pays for services after your other insurance plans have paid your provider. This means that if you have other insurance, are in a car accident, or if you are injured at work, then your other insurance or workers compensation must pay for your services first. Let Member Services know if you have other insurance so that Aetna Better Health 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

The Aetna Better Health Provider Network

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

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

Aetna Better Health 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 Member Services at **1-800-279-1878 (TTY: 711)** or visit us at **AetnaBetterHealth.com/Virginia**.

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

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

- Care from your primary care provider (PCP).
- Family planning services and supplies.
- Routine women’s health care services like breast exams, screening mammograms, pap tests, and pelvic exams, as long as you get them from a network provider.
- Emergency or urgently needed services.

- Routine dental services.
- Services from Indian health providers, if you are eligible.
- Other services for members with special health care needs as determined by Aetna Better Health

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. Member Services or your care manager can help.

Choosing Your PCP

You have the right to choose a PCP that is in the Aetna Better Health network. Review your Provider Directory to find a PCP in your community who can best meet your health care needs. You can also call 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, Aetna Better Health will assign you a PCP. Aetna Better Health 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 Aetna Better Health network, you can continue seeing them for up to 30 days after enrolling in Aetna Better Health. 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 Aetna Better Health network after the 30-day or 60-day period, Aetna Better Health will assign you a PCP. If you have a Medicare assigned PCP, you do not have to choose a PCP in the Aetna Better Health network. Call 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 Member Services to choose another PCP in the Aetna Better Health network. Once you have selected your new PCP, you will receive a new ID card with that PCP listed. Please make sure you present this card at your next appointment. Your new PCP will be effective on the first day of the month.

Specialists

If you need care that your PCP cannot provide, Aetna Better Health 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.

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

When a Provider Leaves the Network

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

- Ask that medically necessary treatment you get is not interrupted and Aetna Better Health 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 Aetna Better Health has not replaced your previous provider with a qualified provider or that your care is not being appropriately managed.

Getting Care Outside of the Aetna Better Health network

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

- If Aetna Better Health 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 Aetna Better Health approves an out-of-network provider.
- If you are in a nursing facility when you enroll with Aetna Better Health, 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 Aetna Better Health network. This care is free.

If your PCP or Aetna Better Health refers you to a provider outside of our network, you are not responsible for any of the costs. However, the services may need to be preauthorized. Your doctor can request preauthorized services on your behalf.

If you were previously enrolled in Virginia's Medicaid program but are new to Aetna Better Health, 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 Aetna Better Health network unless Aetna Better Health extends this timeframe for you. You can call 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 Aetna Better Health, 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 Member Services. If you need a ride to your appointment, call ModivCare at **1-800-734-0430 (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 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 3 business days and seven calendar days of your request, depending on the stage and risk of the pregnancy. Remember to tell Aetna Better Health when you plan to be out of town so Aetna Better Health 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 what type of care you need, call your PCP or the Aetna Better Health Medical Advice Line at **1-800-279-1878 (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 for when you get sick or injured and preventive care that keeps you healthy	Contact your PCP's office or Aetna Better Health 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 **AetnaBetterHealth.com/Virginia** 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 Aetna Better Health network if you can.
Emergency care (or care for an emergency medical condition) is care you get when an illness or injury is so	Call 911 and go to the nearest hospital. You have the right to get emergency care 24 hours a day, seven days a week from any hospital or other setting, even if you are in another city or state. Aetna Better Health 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	No. You can get emergency care from network providers or out-of-network providers. You do not need a referral or

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

Getting Care After Hours

If you need non-emergency care after normal business hours, call **1-800-279-1878**.
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.
- Answer specific questions or give you advice on what to do when you need health care, such as calling your PCP, making an appointment, or going immediately to the emergency room

Transportation to Care

Non-Emergency Medical Transportation

If you need transportation to receive covered benefits such as medical, behavioral, dental, vision and pharmacy services, call the Aetna Better Health Transportation Reservation line. Aetna Better Health covers non-emergency transportation for covered services. If you have trouble getting an appointment, call the Aetna Better Health Transportation Where's My Ride/Ride Assist, Member Services or your care manager. If you have your own ride to your appointment, your driver may be paid back at a set rate per mile (limits apply). Members, family, friends and caregivers are eligible for mileage reimbursement through Aetna Better

Health. You must call **1-800-734-0430** before your appointment to be eligible for reimbursement.

If you have your own ride to your appointment, your driver may be paid back at a set rate per mile (limits apply). Members, family, friends and caregivers are eligible for mileage reimbursement through Aetna Better Health's Transportation Provider, ModivCare. You must call ModivCare before your appointment to obtain a Trip Number and be eligible for reimbursement. Visit **www.mymodivcare.com/members/va** and go to *Forms* to review the Mileage Reimbursement Program Instructions, Mileage Reimbursement Trip Log Instructions, and download a Mileage Reimbursement Trip Log.

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

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

Emergency Medical Transportation
If you are experiencing an emergency medical condition and need transportation to the hospital, call **911** for an ambulance. Aetna Better Health 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 Aetna Better Health's Member Services. Members can log onto the Member Portal from the website or app **AetnaBetterHealth.com/Virginia** You can also call **1-800-279-1878 (TTY: 711)** 24 hours a day, seven days a week to talk to an on-call nurse or other licensed health professional.

What is Care Management?

If you have significant health care needs, you will receive care management. Care management helps to improve the coordination between your different providers and the services you receive. If you get care management, Aetna Better Health will assign you a care manager. Your care manager is someone from Aetna Better Health 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, Aetna Better Health Aetna Better Health 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 Aetna Better Health Aetna Better Health understand your needs and decide whether to assign you to a care manager. If you are not assigned a care manager, you can ask Aetna Better Health Aetna Better Health 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 **1-800-279-1878 (TTY: 711)**. This call is free.

How Your Care Manager Can Help You

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

How to Contact Your Care Manager
You can call Member Services or log into the Member Web Portal to see who your assigned Care Manager is or request a new care manager. Free interpreter services are available in all languages for people who do not speak English.

Contact Method	Contact Information
Call	**1-800-279-1878 (TTY: 711)** 24 hours per day/7 days per week
Fax	**1-866-207-8901**
Write	Aetna Better Health of Virginia PO Box 818044 Cleveland, OH 44184-8044
Email	Visit the contact page on our website at **AetnaBetterHealth.com/Virginia – Contact us** to send us a secure message. You may also send an email directly to **VAMedicaidMemberServices@Aetna.com**
Website	**AetnaBetterHealth.com/Virginia**

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 Aetna Better Health conducts the Health Screening and assigns you a care manager, Aetna Better Health will contact you to conduct a more in-depth Health Risk Assessment. During the Health Risk Assessment, your care manager or another health care professional will ask you more questions about your physical health, behavioral health, social needs, and your goals and preferences. The Health Risk Assessment helps your care manager to understand your needs and get you the right care. You can choose to do the Health Risk Assessment in-person, over the phone, or by video conference. 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, Aetna Better Health is responsible for coordinating your Cardinal Care benefits with your Medicare health plan and any other health plan(s) you have. Call Aetna Better Health's Member Services or your care manager if you have questions about how your different health plans work together and make sure your services are paid for correctly.

Transitioning Care between Health Plans

If you change Medicaid health plans, as your new health plan, Aetna Better Health, 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, Aetna Better Health, to ensure continuity of care and services. For more information and details regarding your specific transition, call Aetna Better Health's 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 a home health, personal care, or respite services.
- Have a substance use disorder.
- Use a ventilator.
- Are homeless.

If you need a care manager, call Aetna Better Health's Member Services for assistance.

5. Your Benefits

Overview of Covered Benefits

Covered benefits are services provided by Aetna Better Health, 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 Aetna Better Health 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: AetnaBetterHealth.com/Virginia. Call Member Services at 1-800-279-1878 (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 the Aetna Better Health network. In some cases, you may need to get approval (a "service authorization") from Aetna Better Health 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.

Aetna Better Health does not exclude benefits, including counseling or referral services, due to moral or religious objections. If an Aetna Better Health provider is not able to provide the services you need due to moral or religious objections, Aetna Better Health will help you get the services you need with an out-of-network provider.

Benefits for All Members

Physical Health Services

Aetna Better Health 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, including routine checkups and annual exams

As soon as you get your ID Card, even if you are not sick, call and schedule an appointment with your PCP for a well visit. Your PCP will look for any problems you may have because of your age, weight, and habits. Your PCP will also find ways to be healthier. Children should also see their PCP for checkups, shots, and screenings as soon as possible. For checkups, shots, and screenings, try to call your child's PCP two or three weeks ahead to ask for an appointment. To obtain information on service authorization requirements for physical health services, you may call Member Services at **1-800-279-1878 (TTY: 711)** or your Care Manager.

Remember, services marked with an asterisk (*) may require service authorization. Providers must notify Aetna Better Health within 24 hours of an elective/emergent/urgent admission. To support inpatient concurrent review decisions, Aetna Better Health uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system.

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. Aetna Better Health 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

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

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

Mental Health Services
• 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

Aetna Better Health complies with the Mental Health Parity and Addiction Equity Act (MHPAEA). Limits on behavioral health services including mental health benefits or addiction recovery, and treatment benefits are no more restrictive than similar physical health benefits.

For questions about addiction and recovery services, call the ARTS Medical Advice Line at **1-800-279-1878 (TTY: 711)** 24 hours a day, seven days a week. If you do not know how to get services during a crisis, we will help find a crisis provider for you. If you have thoughts about harming yourself or someone else, you should:

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

If you are thinking of harming yourself or someone else, call the Behavioral Health Crisis Line **1-800-279-1878 (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)

Aetna Better Health and the Department cover LTSS such as private duty nursing, personal care, and adult-day health care services to help people meet their daily needs and maintain independence living in the community or a facility. Before receiving LTSS, a community-based or hospital team will conduct a screening to see if you meet "level of care" criteria – in other words, whether you qualify for and need LTSS. Contact your care manager to learn about the screening process to receive LTSS. 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 Aetna Better Health, 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, Aetna Better Health will cover nursing facility care after you have used all of the skilled nursing care that was available to you. To obtain information on service authorization requirements for LTSS, you may call Member Services 24 hours a day, 7 days a week at **1-800-279-1878 (TTY: 711)** or you can call your care manager Monday through Friday,

9 AM – 5 PM EST. If you have LTSS, you may need to pay for part of your care. Please see Section 9, Cost Sharing for more information.

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 Aetna Better Health 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

To obtain information on service authorization requirements for waiver services, you may call Member Services 24 hours a day, 7 days a week at **1-800-279-1878 (TTY: 711)** or you can call your Care Manager Monday through Friday, 9 AM – 5 PM EST.

Benefits for Children/Youth Under Age 21

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

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

- Screenings/well-child visits and immunizations
- Periodic screening services (vision, hearing and dental)
- COVID-19 counseling visits
- Developmental services
- Eyeglasses (including a replacement for glasses that are lost, broken, or stolen) and other vision services
- Orthotics (braces, 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 Aetna Better Health's Member Services or your care manager. EPSDT treatment services may require prior authorization. For more information see Section 5, Your Benefits and Section 7, Getting Approval for Your Services, Treatments, and Drugs.

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 Aetna Better Health. There is no cost to you for EI services. Contact Aetna Better Health's Member Services for a list of EI providers, specialists, and case managers. Your care manager can connect you to your local Infant and Toddler Connection program to help you access these services. You can also call the Infant and Toddler Connection program directly at **1-800-234-1448. (TTY: 711)** or visit **itcva.online**.

School Health Services
The Department covers the cost of some health care or health-related services provided to Cardinal Care-enrolled children at their school. School health services can include certain medical, behavioral health, hearing, personal care, or rehabilitation therapy services, such as occupational therapy, speech therapy, and physical therapy services, 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 Prental enrollees are eligible for 60 days of postpartum coverage.)
Aetna Better Health 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 (see below)
- 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)

Maternity Matters Program
All Pregnant members will receive the Let's Go Baby Book in the mail.

All pregnant members are outreached, assigned to a level of care management, and contacted each trimester, at minimum. The program interventions are evidenced-based on American College of Obstetricians and Gynecologists (ACOG), MCG, and March of Dimes. Member responses to questionnaires and assessments generate interventions. Unique aspects of the program include but are not limited to:

- Promotion of low dose aspirin to prevent preeclampsia in high-risk members.
- Use of pharmacy claims for prenatal vitamins to identify members for preeclampsia initiative and care management engagement.
- Offer of free over-the-counter pregnancy tests and use that data to identify members who may be or think they may be pregnant.
- Coverage and promotion of long-acting reversible contraception.
- Coverage and member and provider incentives for two dental visits during pregnancy.
- Postpartum care management to continue for members for six months post-delivery and for one year for members with opioid use disorder or substance use disorder.
- Edinburgh screening for depression by health plan care management staff at discharge from delivery, at six weeks, six months, 12 months and/or 18 months with referral to treatment if positive screen.
- Maternity Next Best Action messaging campaign.
- Member incentives (My Maternity Matters™) for keeping prenatal and postpartum appointments.
- Child care/respite benefit for high-risk members.
- Leveraging community health workers (CHWs) to facilitate access to care and services.

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 Aetna Better Health network. To obtain information on service authorization requirements for maternity benefits, you may call Member Services 24 hours a day, 7 days a week at **1-800-279-1878 (TTY: 711)** or you can call your Care Manager Monday through Friday, 9 AM – 5 PM EST.

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 Aetna Better Health Members

Aetna Better Health provides some added benefits for members. These include:

- One eye exam per year, plus $125 toward eyewear, including glasses and contact lenses through Vision Service Plan
- One hearing exam, $1,500 toward hearing aids, plus 60 batteries each year, plus unlimited visits for hearing aid fittings
- Free rides to local resources or services — up to 15 round trips or 30 one-way trips each year
- Home-delivered meals after hospital discharge for seven days
- Diabetes management, appointment and medication reminders, and exercise/weight goal setting and tracking through MyActiveHealth
- Eligible members can access CampusEd, an online resource that can help members earn their GED and start a new career. We'll also pay for your GED test (up to $120)
- Members aged 18 years and older who have a high school diploma or GED can get $500 to apply toward supplies to support next steps in life, like higher education, military, or trade school (For 2024 graduates and beyond)
- Eligible members who are aged 18 or older, are prescribed opioids, and have children in the home can receive a lockbox to secure their medications.
- Members aged 18 and older can receive $250 toward English as a Second Language (ESL) classes.
- Members aged 16 and older can receive $150 to use for the removal of human trafficking or gang-related tattoos.
- Members aged 18 and older who are tenants can receive $300 for legal services and education for housing support.
- $20 per month for members with periods to spend on essential period products, like pads, tampons, cleansing cloths, and more
- $25 per month for new moms who engage with Care Management to purchase essential products for both mom and baby each month.
- 300 free size 1 baby diapers for new moms, delivered to their home
- Annual sports participation physical for members 7 to 18 years old
- Water safety and swimming lessons for members ages 6 months to 6 years old

- Go Get Active: Eligible members aged 5 to 18 who receive a well-child visit can receive up to $200 to engage in healthy programs and activities (e.g., after-school programs, sports programs, and zoo or state park admissions).
- $50 refillable debit card for eligible members to purchase healthy foods at specific retailers or online for home delivery
- Breastfeeding support with 24/7 nurse line through Pacify
- Members with asthma can get one set of hypoallergenic bedding and up to $400, depending on area of service, to use towards one deep carpet cleaning annually.
- Eligible members with anxiety or depression or elderly members in nursing facilities can receive a curated box with therapeutic resources.
- Eligible members with memory care issues or an intellectual disability can receive one electronic companion pet for comfort and emotional support.

6. Your Prescription Drugs

Understanding Your Prescription Drug Coverage

Prescription drugs are medicines your provider orders ("prescribes") for you. Usually, Aetna Better Health 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 Aetna Better Health, 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 Aetna Better Health and the Department, see the Preferred Drug List at AetnaBetterHealth.com/Virginia. The Preferred Drug List is the list of medications covered by Aetna Better Health as part of your benefits. The Preferred Drug List can change during the year, but Aetna Better Health will always have the most up-to-date information.

The List of Covered Drugs can be found at AetnaBetterHealth.com/Virginia. The List of Covered Drugs tells you which drugs are covered by Aetna Better Health and also tells you if there are any rules or restrictions on any drugs. You can call Member Services to find out if your drugs are on the List of Covered Drugs or request a paper copy of the List of Covered Drugs. To get the most up-to-date List of Covered Drugs, visit **AetnaBetterHealth.com/Virginia** or call **1-800-279-1878 (TTY: 711)**.

If the Preferred Drug List changes during the year and the change impacts a drug you are taking, Aetna Better Health will notify you and your doctor at least 30 days before the change takes effect. This will allow time to determine if a different covered drug is acceptable or whether a service authorization should be submitted.

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.

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 Aetna Better Health before you can get your prescription filled (see *Section 7, Getting Approval for Your Services, Treatments, and Drugs*). If you do not get approval, Aetna Better Health may not cover the drug. To find out if the drug you need has a special rule, check the Preferred Drug List. If Aetna Better Health 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, Aetna Better Health may require "step therapy". This is when you try a drug (usually one that is less expensive) before Aetna Better Health 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 Aetna Better Health approval. You can get Aetna Better Health approval if a pharmacist believes that your health would be at-risk without the benefit of the drug. When this happens, Aetna Better Health may authorize a 72-hour emergency supply. All that needs to happen is the pharmacist would fill the 72-hour supply or call the CVS Caremark pharmacy help desk if needed.

Long-Term Supply of Drugs
You can get a long-term supply of certain drugs on Aetna Better Health's Drug List. These drugs are used on a regular basis to treat chronic or long-term medical condition. The 90-day supply drug list can be found at **AetnaBetterHealth.com/Virginia** and must meet specific requirements prior to getting a 90-day supply. To become eligible, you must have received two 30- to 34-day medication fills in the past 120 days. Some network pharmacies allow you to get a long-term supply of certain drugs. You can also use mail-order services to get a long-term supply of certain drugs. See Getting Your Drugs Mailed to Your Home or call Member Services for more information.

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 Aetna Better Health members. To find a network pharmacy, use your Provider Directory available at **AetnaBetterHealth.com/Virginia.**. You can use any of the Aetna Better Health 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 the Aetna Better Health network, you can find a new pharmacy in the Provider Directory or by calling Member Services at **1-800-279-1878 (TTY: 711)**.

When you go to the network pharmacy to drop off a prescription or pick up your drugs, show your Aetna Better Health Member ID Card. If you have Medicare, show both your Medicare Card and Aetna Better Health Member ID Card. Call 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. Use the pharmacy search tool at **AetnaBetterHealth.com/Virginia** to find a pharmacy to meet your needs. CVS Caremark may also be an option for you.

To get order forms and information about filling your prescriptions by mail, call Member Services 24 hours a day, 7 days a week at **1-800-279-1878 (TTY: 711)**. Or, you can call your Care Manager Monday through Friday, 9 AM – 5 PM EST. You may request a mail order form, or you can register online with CVS Caremark at **www.caremark.com**.

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.

Aetna Better Health 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, Aetna Better Health 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 Aetna Better Health 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 Aetna Better Health 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. Aetna Better Health has a group of health care providers and health specialists that review new and existing drugs, medical procedures, behavioral health procedures and devices. The group recommends what will and will not be covered. This is done by a review of research and clinical guidelines. It's also done by looking at what other doctors are doing.

If you are new to Aetna Better Health, Aetna Better Health 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

Aetna Better Health 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
Aetna Better Health's Member Services or your Care Manager can answer your questions and share more about how to request a service authorization. If you want to request a specific service that requires a service authorization, your care manager can help you find the right provider who can help figure out if you need the service.

For assistance with obtaining a service authorization, you may call Member Services 24 hours a day, 7 days a week at **1-800-279-1878 (TTY: 711)** or you can call your Care Manager Monday through Friday, 9 AM – 5 PM EST.

Timeframe for Service Authorization Review
After receiving your service authorization request, Aetna Better Health will make a decision whether to approve or deny a request. Normally, Aetna Better Health 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, Aetna Better Health will decide more quickly. Aetna Better Health will instead give written notice within three calendar days. Post service authorization requests are reviewed in 30 calendar days. After receiving your service authorization, if not enough information was received from the requesting provider to make a medical necessity decision, Aetna Better Health may request additional information to make the decision with a possible 14 calendar day extension.

Aetna Better Health will make any decisions about pharmacy services within 24 hours. On weekends or a holiday, Aetna Better Health 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.

Aetna Better Health will contact your provider if Aetna Better Health 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 Aetna Better Health taking more time to review your request or if you do not like the way Aetna Better Health 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 Aetna Better Health to help decide your case, then you, or your provider can ask Aetna Better Health to take more time to make a decision in order to include the additional information.

Adverse Benefit Determinations

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

- 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 Aetna Better Health makes an adverse benefit determination, Aetna Better Health 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 Aetna Better Health, contact Aetna Better Health Member Services or the provider who would be providing you the service to follow up. When Aetna Better Health tells you the decision in writing, Aetna Better Health 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 Aetna Better Health

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 Aetna Better Health makes about your health coverage or covered services. You must appeal within 60 calendar days after hearing Aetna Better Health's decision about your service authorization request. You can allow an authorized representative (provider, family member, etc.) or your attorney act on your behalf. If you choose to let someone file the appeal on your behalf, you must call Member Services at **1-800-279-1878 (TTY: 711)** to let Aetna Better Health 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, Aetna Better Health 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 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 Aetna Better Health

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

Phone Requests	**1-800-279-1878** TTY: 711
Written Requests	Mail: PO Box 81139 5801 Postal Road Cleveland, OH 44181 Fax: **866-669-2459**

Timeframe for Appeal to Aetna Better Health
When you file an appeal, be sure to let Aetna Better Health know of any new or additional information that you want to be used in making the appeal decision. You can file oral or written within 60 calendar days from Notice of Action letter (NOA). You can also call Member Services if you need help. Within three business days, Aetna Better Health will send you a letter to let you know that Aetna Better Health received your appeal.

If Aetna Better Health needs more information to help make an appeal decision, Aetna Better Health 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), Aetna Better Health will also call you right away. If Aetna Better Health needs more information, the decision about your standard or expedited appeal could be delayed by up to 14 days from the respective timeframes.

If Aetna Better Health has all the information needed from you:

- Within 72 hours of receiving your *expedited* appeal request, Aetna Better Health 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, Aetna Better Health will send you a written notice to tell you the decision.

If You Are Unhappy with Aetna Better Health's Appeal Decision
Aetna Better Health 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 Aetna Better Health if:

- You disagree with the final appeal decision you receive from Aetna Better Health.

OR

- Aetna Better Health does not respond to your appeal in a timely manner.

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

How to Submit Your State Fair Hearing Appeal
You (or your authorized representative) must appeal to the state within 120 calendar days from when Aetna Better Health 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 Aetna Better Health's appeal decision and any documents you want the Department

to review. If you have chosen an authorized representative, you must provide documents that show that 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 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: **appeals-registration.dmas.virginia.gov/client** AIMS Portal to submit appeals: **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 Aetna Better Health. The 90-day timeframe does not include the number of days between Aetna Better Health's decision on your appeal and the date you sent your State Fair Hearing request to the Department. You will have the chance to participate in a hearing and present your position.

State Fair Hearing Outcome
If the State Fair Hearing reverses Aetna Better Health's appeal decision, Aetna Better Health 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 Aetna Better Health. If you continued to get services while you waited for a decision on your State Fair Hearing appeal, Aetna Better Health 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 Aetna Better Health's final appeal decision. Please mail external review requests to:

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

Please include: your name, your child's name (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.

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 Aetna Better Health or an outside organization if you are unhappy. You can make complaints about:

- Accessibility: For example, if you cannot physically access your provider's office/facilities or you need language assistance and did not get it.

- Quality: For example, if you are unhappy with the quality of care you got in the hospital.
- Customer Services: For example, if your provider or health care staff was rude to you.
- Wait Times: For example, if you have trouble getting an appointment or have to wait a long time to see your provider.
- Wait Times for a Decision: For example, if you are unhappy about the extension of time proposed by Aetna Better Health 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 Aetna Better Health
To file a complaint with Aetna Better Health, call Member Services at **1-800-279-1878 (TTY: 711)** or file a complaint in writing by mailing it to PO Box 81139, 5801 Postal Road Cleveland, OH 44181 or fax it to **866-669-2459**. 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 Aetna Better Health can help.

If you need assistance with a complaint, you may talk to your care manager. In handling complaints, Aetna Better Health 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.

Aetna Better Health 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), Aetna Better Health 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 Aetna Better Health, 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 Aetna Better Health or the Department. Most Aetna Better Health 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 Member Services for help at **1-800-279-1878 (TTY: 711)**. Remember, if you get services that are not covered through Aetna Better Health 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 Aetna Better Health a monthly premium for your coverage. If you are enrolled in Aetna Better Health but do not actually qualify for coverage because information you provided to the Department or to Aetna Better Health 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:

- A right to receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities
- A right to be treated with respect and recognition of their dignity and their right to privacy
- A right to participate with practitioners in making decisions about their health care
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- A right to voice complaints or appeals about the organization or the care it provides
- A right to make recommendations regarding Aetna Better Health's member rights and responsibilities policy
- A right to exercise his or her rights, and that the exercise of those rights does not adversely affect the way Aetna Better Health and its network providers or the State treat the member
- A right to information regarding applicable copays or other costs for which the member is responsible
- A right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- A right to treatment that is nondiscriminatory based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment
- A right to receive information and treatment that is considerate of members' cultural or ethnic backgrounds; that takes into account members' language limitations/reading needs and limitations, and visual or auditory limitations.
- A right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- A right to free interpreter services for members with limited English proficiency or with hearing impairments
- A right to receive information about advance directives and to formulate or nullify advance directives
- A right (of the member or member's authorized representative) to access member records in accordance with applicable federal and state law, including Health Insurance Portability and Accountability Act (HIPAA)
- A right for members or members' authorized representatives to request amendments and/or corrections to the member's record in accordance with law

- A right to choose a PCP from the Aetna Better Health network
- A right to a second opinion from an appropriately qualified participating health care professional at no cost to the member. If a Aetna Better Health practitioner is not available, Aetna Better Health arranges for a second opinion out of network at no more cost to the member than if the service was obtained in-network.
- A right to obtain emergency care without prior approval from Aetna Better Health or the member's PCP regardless of whether the emergency care facility is in the Aetna Better Health network
- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status, or disability.
- Be treated with respect and consideration for your privacy and dignity.
- Get information (including through this handbook) about your health plan, provider, coverage, and benefits.
- Get information in a way you can easily understand. Remember: interpretation, written translation, and auxiliary aids are available free of charge.
- Access health care and services in a timely, coordinated, and culturally competent way.
- Get information from your provider and health plan about treatment choices.
- Participate in all decisions about your health care, including the right to say "no" to any treatment offered.
- Ask your health plan for help if your provider does not offer a service because of moral or religious reasons.
- Get a copy of your medical records and ask that they be changed or corrected in accordance with State and Federal Law.
- Have your medical records and treatment be confidential and private. Aetna Better Health 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.
- 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, Aetna Better Health, or the Department.
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- File appeals and complaints and ask for a State Fair Hearing (see *Section 8, Appeals and Complaints*).
- Exercise any other rights guaranteed by federal or state laws (the Americans with Disabilities Act, for example).

Advance Directives

Advance directives are written instructions to those caring for you that tell them what to do if you are unable to make health care decisions for yourself. Your advance directive lists the type of care you do or do not want if you become so ill or injured that you cannot speak for yourself. It is your right and choice about whether to fill out an advance directive. Aetna Better Health is responsible for providing you with written information about advance directives and your right to create an advance directive under Virginia law. Aetna Better Health must also help you understand why Aetna Better Health 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.
- 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 Aetna Better Health has not provided you with the information you need about advance directives, or you are concerned that Aetna Better Health 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 Aetna Better Health can better serve you. Aetna Better Health invites you to join the Aetna Better Health Member Advisory Committee. As a member of the committee, you can participate in educational meetings that happen once every three months. You can attend 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 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 **www.dmas.virginia.gov/about-us/boards-and-public-meetings/member-advisory-committee**.

11. Your Responsibilities

General Responsibilities

Aetna Better Health members, their families or guardians have the responsibility to:

- Supply information (to the extent possible) that Aetna Better Health and its practitioners and providers need in order to provide care
- Follow plans and instructions for care that have been agreed to with their practitioners/providers
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

In addition, members have the following responsibilities:

- Read the member handbook and other plan documents that convey information pertinent to utilizing services and working with Aetna Better Health
- Follow the Aetna Better Health rules explained in the member handbook and other plan documents
- Know the name of their assigned PCP and care manager
- Show their ID card to each practitioner, provider and pharmacy before obtaining services.
- Protect their member ID card and report lost or stolen ID card to Aetna Better Health
- Use the emergency room (ER) for true emergencies only
- Schedule and keep appointments with providers and practitioners, allowing for 24-hour notice when the appointment must be changed or canceled
- Treat the providers, practitioners and other staff with respect.
- Inform Aetna Better Health and DMAS when the member's address or phone number changes
- Reporting family changes that might affect eligibility or enrollment to DMAS
  - This includes changes in family size, employment, and moving out of state
- Report other health insurance coverage, including Medicare, to Aetna Better Health
- Provide the treating practitioner/provider with a copy of the member's living will and/or advance directive
- Follow this handbook, understand your rights, and ask questions when you do not understand or want to learn more.
- Treat your providers, Aetna Better Health 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 Aetna Better Health when you need to change your care plan.
- Get covered services from the Aetna Better Health network when possible (see *Section 3, Providers and Getting Care*).
- Get approval from Aetna Better Health 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 Aetna Better Health or the Department.
- Report suspected fraud, waste, and abuse (see below).

Call Member Services at 1-800-279-1878 (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:

Reporting Fraud, Waste and Abuse to Aetna Better Health of Virginia

Phone	**1-844-317-5825** **TTY: 711**
Email	reportfraudabuseva@aetna.com
Website	**AetnaBetterHealth.com/Virginia/medicaid-fraud-abuse-form.html**

The Department's Fraud and Abuse Hotline

Phone	**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	**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.

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