

Optima Health Community Care



MEMBER HANDBOOK



optimahealth.com/community-care

Effective January 1, 2020

Where To Find Information

Help in Other Languages or Alternate Formats	10
<i>Help in Other Languages.....</i>	<i>10</i>
1. Commonwealth Coordinated Care Plus (CCC Plus)	13
<i>Welcome to Optima Health Community Care.....</i>	<i>13</i>
<i>How to Use This Handbook.....</i>	<i>13</i>
<i>Other Information We Will Send to You</i>	<i>13</i>
Optima Health Community Care Member ID Card	14
Provider and Pharmacy Directory.....	14
<i>Important Phone Numbers.....</i>	<i>16</i>
2. What is Commonwealth Coordinated Care Plus.....	18
<i>What Makes You Eligible to be a CCC Plus Member.....</i>	<i>18</i>
CCC Plus Enrollment.....	18
Reasons You Would Not be Eligible to Participate in CCC Plus	18
What if I Am Pregnant	19
Coverage for Newborns Born to Moms Covered Under CCC Plus	19
Medicaid Eligibility	20
<i>Choosing or Changing Your Health Plan.....</i>	<i>20</i>
Health Plan Assignment.....	20
You Can Change Your Health Plan Through the CCC Plus Helpline	20
Automatic Re-Enrollment.....	21
What is Optima Health Community Care Service Area.....	21
<i>If You Have Medicare and Medicaid.....</i>	<i>22</i>
You Can Choose the Same Health Plan for Medicare and Medicaid.....	23
<i>How to Contact the Medicare State Health Insurance Assistance Program (SHIP).....</i>	<i>24</i>
3. How CCC Plus Works.....	25
<i>What are the Advantages of CCC Plus</i>	<i>25</i>
<i>What are the Advantages of Choosing Optima Health Community Care.....</i>	<i>26</i>
<i>Transition of Care Policy: Continuity of Care Period.....</i>	<i>26</i>
<i>If You Have Other Coverage.....</i>	<i>27</i>
4. Your Care Coordinator.....	28
<i>How Your Care Coordinator Can Help.....</i>	<i>28</i>
<i>What is a Health Risk Assessment.....</i>	<i>30</i>
<i>What is a Care Plan.....</i>	<i>30</i>
<i>How to Contact Your Care Coordinator.....</i>	<i>30</i>
5. Help From Member Services	32
<i>How to Contact Optima Health Community Care Member Services.....</i>	<i>32</i>
<i>How Member Services Can Help.....</i>	<i>32</i>
<i>Medical Advice Line Available 24 Hours a Day, 7 Days a Week.....</i>	<i>33</i>

<i>Behavioral Health Crisis Line Available 24 Hours a Day, 7 Days a Week</i>	34
<i>Addiction and Recovery Treatment Services (ARTS) Advice Line Available 24 Hours a Day, 7 Days a Week</i>	34
<i>If You Do Not Speak English</i>	35
<i>If You Have a Disability and Need Assistance in Understanding Information or Working with Your Care Coordinator</i>	35
<i>If You Have Questions About Your Medicaid Eligibility</i>	35
6. How to Get Care and Services	36
<i>How to Get Care from Your Primary Care Physician</i>	36
Your Primary Care Physician.....	36
Choosing Your PCP	36
If You have Medicare, Tell us About Your PCP.....	37
If Your Current PCP is not in Our Network.....	37
Changing Your PCP	37
Getting an Appointment with Your PCP.....	38
Appointment Standards	38
<i>How to Get Care From Network Providers</i>	39
Travel Time and Distance Standards	39
Accessibility.....	39
What are “Network Providers”	40
What are “Network Pharmacies”	40
What are Specialists	40
If Your Provider Leaves Our Plan.....	41
<i>How to Get Care from Out-of-Network Providers</i>	41
Care From Out-of-State Providers	42
Network Providers Cannot Bill You Directly	42
If You Receive a Bill for Covered Services	43
<i>If You Receive Care From Providers Outside of the United States</i>	43
7. How to Get Care for Emergencies.....	44
<i>What is an Emergency</i>	44
<i>What to do in an Emergency</i>	44
<i>What is a Medical Emergency</i>	44
<i>What is a Behavioral Health Emergency</i>	44
<i>Examples of Non-Emergencies</i>	45
<i>If You Have an Emergency When Away From Home</i>	45
<i>What is Covered if You Have an Emergency</i>	45
<i>Notifying Optima Health Community Care About Your Emergency</i>	45
<i>After an Emergency</i>	45
<i>If You Are Hospitalized</i>	45
<i>If it Wasn’t a Medical Emergency</i>	46
8. How to Get Urgently Needed Care.....	47
<i>What is Urgently Needed Care</i>	47
9. How to Get Your Prescription Drugs.....	48

<i>Rules for Optima Health Community Care Outpatient Drug Coverage</i>	<i>48</i>
<i>Getting Your Prescriptions Filled.....</i>	<i>48</i>
<i>List of Covered Drugs.....</i>	<i>49</i>
<i>Limits for Coverage of Some Drugs.....</i>	<i>49</i>
<i>Getting Approval in Advance</i>	<i>50</i>
<i>Trying a Different Drug First.....</i>	<i>50</i>
<i>Quantity Limits</i>	<i>50</i>
<i>Emergency Supply</i>	<i>50</i>
<i>Non Covered Drugs</i>	<i>51</i>
<i>Changing Pharmacies.....</i>	<i>51</i>
<i>What if You Need a Specialized Pharmacy.....</i>	<i>52</i>
<i>Can You Use Mail-Order Services to Get Your Drugs</i>	<i>52</i>
<i>Can You Get a Long-Term Supply of Drugs</i>	<i>52</i>
<i>Can You Use a Pharmacy That is Not in the Optima Health Community Care Network.....</i>	<i>52</i>
<i>What is the Patient Utilization Management and Safety (PUMS) Program</i>	<i>52</i>
10. How to Access Your CCC Plus Benefits	54
<i>CCC Plus Benefits</i>	<i>54</i>
<i>General Coverage Rules.....</i>	<i>54</i>
<i>Benefits Covered Through Optima Health Community Care</i>	<i>55</i>
<i>Extra Benefits We Provide That are not Covered by Medicaid</i>	<i>58</i>
<i>How to Access Early and Periodic Screening, Diagnostic, and Treatment Services.....</i>	<i>59</i>
<i>What is EPSDT</i>	<i>59</i>
<i>Getting EPSDT Services.....</i>	<i>60</i>
<i>Getting Early Intervention Services</i>	<i>60</i>
<i>How to Access Behavioral Health Services.....</i>	<i>60</i>
<i>How to Access Addiction and Recovery Treatment Services (ARTS).....</i>	<i>61</i>
<i>How to Access Long-Term Services and Supports (LTSS).....</i>	<i>61</i>
<i>Commonwealth Coordinated Care Plus Waiver</i>	<i>62</i>
<i>How to Self-Direct Your Care</i>	<i>63</i>
<i>Nursing Facility Services</i>	<i>63</i>
<i>Screening for Long Term Services and Supports.....</i>	<i>63</i>
<i>Freedom of Choice.....</i>	<i>64</i>
<i>How to Get Services if You are in a Developmental Disability Waiver.....</i>	<i>64</i>
<i>How to Get Non-Emergency Transportation Services.....</i>	<i>65</i>
<i>Non-Emergency Transportation Services Covered by Optima Health Community Care</i>	<i>65</i>
<i>Transportation To and From DD Waiver Services.....</i>	<i>65</i>
11. Services Covered Through the DMAS Medicaid Fee-For-Service Program	67
<i>Carved-Out Services.....</i>	<i>67</i>
<i>Services That Will End Your CCC Plus Enrollment</i>	<i>68</i>
12. Services Not Covered by CCC Plus.....	70
<i>If You Receive Non-Covered Services.....</i>	<i>71</i>

13. Member Cost Sharing.....	72
<i>Member Patient Pay Towards Long Term Services and Supports.....</i>	<i>72</i>
<i>Medicare Members and Part D Drugs</i>	<i>72</i>
14. Service Authorization and Benefit Determination	73
<i>Service Authorization.....</i>	<i>73</i>
<i>Service Authorizations and Continuity of Care</i>	<i>74</i>
<i>How to Submit a Service Authorization Request.....</i>	<i>74</i>
<i>What Happens After We Get Your Service Authorization Request</i>	<i>74</i>
<i>Timeframes for Service Authorization Review.....</i>	<i>75</i>
15. Appeals, State Fair Hearings, and Grievances.....	78
<i>Your Right to Appeal.....</i>	<i>78</i>
Authorized Representative	78
Adverse Benefit Determination.....	78
How to Submit Your Appeal.....	78
Continuation of Benefits	79
What Happens After We Get Your Appeal.....	79
Timeframes for Appeals.....	80
Written Notice of Appeal Decision	81
<i>Your Right to a State Fair Hearing.....</i>	<i>81</i>
Standard or Expedited Review Requests	81
Authorized Representative	81
Where to Send the State Fair Hearing Request	81
After You File Your State Fair Hearing Appeal	82
State Fair Hearing Timeframes	82
Continuation of Benefits	82
If the State Fair Hearing Reverses the Denial	83
If You Disagree with the State Fair Hearing Decision.....	83
<i>Your Right to File a Grievance.....</i>	<i>83</i>
Timeframe for Grievances	83
What Kinds of Problems Should be Grievances	83
There Are Different Types of Grievances.....	85
Internal Grievances	85
External Grievances	85
16. Member Rights.....	87
<i>Your Rights</i>	<i>87</i>
<i>Your Right to be Safe</i>	<i>88</i>
<i>Your Right to Confidentiality.....</i>	<i>89</i>
<i>Your Right to Privacy</i>	<i>89</i>
Your Rights Regarding Medical Information	95
We Maintain About You.....	95
<i>How to Join the Member Advisory Committee</i>	<i>99</i>
<i>We Follow Non-Discrimination Policies</i>	<i>99</i>
17. Member Responsibilities	103
<i>Your Responsibilities</i>	<i>103</i>

<i>Advance Directives</i>	104
Where to Get the Advance Directives Form	104
Completing the Advance Directives Form.....	105
Share the Information with People You Want to Know About It	105
We Can Help You Get or Understand Advance Directives Documents	105
Other Resources	105
If Your Advance Directives Are Not Followed	105
Notice Informing INDIVIDUALS ABOUT Nondiscrimination and Accessibility Requirements	106
18. Fraud, Waste, and Abuse	108
<i>What is Fraud, Waste, and Abuse</i>	108
<i>How Do I Report Fraud, Waste, or Abuse</i>	108
19. Other Important Resources	111
20. Information for Medicaid Expansion Members	117
<i>What Makes You Eligible to be a Medicaid Expansion Member</i>	117
<i>Enrollment for a Medicaid Expansion Member</i>	117
<i>Medicaid Expansion Benefits and Services</i>	118
21. Important Words and Definitions Used in this Handbook	120

Help in Other Languages or Alternate Formats

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

If you have any problems reading or understanding this information, please contact our Member Services staff at 1-888-512-3171 (TTY 1-844-552-8148 for help at no cost to you.

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

Help in Other Languages

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

Spanish

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

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260 (TTY: 1-844-552-8148). 번으로 전화해 주십시오.

Vietnamese

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

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-687-6260 (TTY: 1-844-552-8148)。

Arabic

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

Tagalog

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

Farsi

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

Amharic

**ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት
ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-xxx-xxx-xxxx (መስማት ለተሳናቸው: 1-xxx-xxx-xxxx).**

Urdu

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

French

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

Russian

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

Hindi

ध्यान दः यद आप हदी बोलते ह तो आपके ि लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-855-687-6260 (TTY: 1-844-552-8148) पर कॉल कर।

German

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

Bengali

লক্ষ্য করনঃ যিদি আযিন বাংলা, কথা বললত িল রন, তালেল য নঃখরচায় ভাষা সোয়তা যিলরষবা
ডিল আআছ। আ ফান করন ১-855-687-6260 (TTY: ১-844-552-8148)।

Bassa

Dè dε nìà kε dyédé gbo: ɔ jǔ ké m̃ [Bàsó ò -wùdù-po-nyò] jǔ ní, nǐ, à wuɖu kà kò dò po-poò bé ìn m̃ gbo kpáa. Ɖá 1-855-687-6260 (TTY:1-844-552-8148)

1. Commonwealth Coordinated Care Plus (CCC Plus)

Welcome to Optima Health Community Care

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

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

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

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

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

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

How to Use This Handbook

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

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




Other Information We Will Send to You

You should have already received your Optima Health Community Care Member ID Card, and

information on how to access a Provider and Pharmacy Directory, and a List of Covered Drugs. You can also access this information at optimahealth.com/members or by calling Optima Health Community Care Member Services at 1-888-512-3171. The name and contact information for your Optima Health Community Care Coordinator will arrive in a separate letter.

Optima Health Community Care Member ID Card

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

 <p>OPTIMA HEALTH COMMUNITY CARE</p> <p>Member Name: JOHN DOE Member Number: 9999999*99 Group Number: 999999 Member Effective Date: 99-99-99 PCP Name: 999999999999999999999999 PCP Phone: 999-999-9999</p> <p>Medicaid #: 999999999999 DOB: 99-99-9999</p> <p>Detailed benefit information is available at optimahealth.com and our mobile app</p>	 <p>OPTIMA HEALTH COMMUNITY CARE MEDICAID XP</p> <p>Member Name: JOHN DOE Member Number: 9999999*99 Group Number: OHCC Member Effective Date: 99-99-99 PCP Name: 999999999999999999999999 PCP Phone: 999-999-9999</p> <p>OV: \$0 ER: \$0 RX: \$0</p> <p>Medicaid #: 999999999999 DOB: 99-99-9999</p>  <p>Detailed information at optimahealth.com and our mobile app</p>																																				
<p>Pre Authorization may be required for: hospitalization, outpatient surgery and therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics. IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.</p> <p>FOR PHARMACIST USE ONLY: BIN# 610011 OptumRx Pharmacist Help Desk: 9-999-999-9999</p> <table border="1"> <tr> <td>Member Services: (Translation Services Available)</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>Pharmacy Member Services:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>TTY Virginia Relay Service: (Hearing Impaired)</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>24-Hour Nurse Advice Line:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>Smiles for Children (Under age 21):</td> <td>9-999-999-9999</td> </tr> <tr> <td>Transportation:</td> <td>9-999-999-9999</td> </tr> <tr> <td>Behavioral Health/ARTS Crisis Line:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>Provider Relations:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>Medical/Pharmacy Pre Authorization:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> </table> <p>MEDICAL CLAIMS P.O. Box 5028 Troy, MI 48007-5028</p> <p>BEHAVIORAL HEALTH CLAIMS P.O. Box 1440 Troy, MI 48099-1440</p> <p>Offered by Optima Health Plan</p>	Member Services: (Translation Services Available)	999-999-9999 OR 9-999-999-9999	Pharmacy Member Services:	999-999-9999 OR 9-999-999-9999	TTY Virginia Relay Service: (Hearing Impaired)	999-999-9999 OR 9-999-999-9999	24-Hour Nurse Advice Line:	999-999-9999 OR 9-999-999-9999	Smiles for Children (Under age 21):	9-999-999-9999	Transportation:	9-999-999-9999	Behavioral Health/ARTS Crisis Line:	999-999-9999 OR 9-999-999-9999	Provider Relations:	999-999-9999 OR 9-999-999-9999	Medical/Pharmacy Pre Authorization:	999-999-9999 OR 9-999-999-9999	<p>Pre Authorization may be required for: hospitalization, outpatient surgery and therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics. IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.</p> <p>FOR PHARMACIST USE ONLY: BIN# 610011 OptumRx Pharmacist Help Desk: 9-999-999-9999</p> <table border="1"> <tr> <td>Member Services: (Translation Services Available)</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>Pharmacy Member Services:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>TTY Virginia Relay Service: (Hearing Impaired)</td> <td>999 OR 9-999-999-9999</td> </tr> <tr> <td>24-Hour Nurse Advice Line:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>Smiles for Children (Under age 21):</td> <td>9-999-999-9999</td> </tr> <tr> <td>Transportation:</td> <td>9-999-999-9999</td> </tr> <tr> <td>Behavioral Health/ARTS Crisis Line:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>Provider Relations:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> <tr> <td>Medical/Pharmacy Pre Authorization:</td> <td>999-999-9999 OR 9-999-999-9999</td> </tr> </table> <p>MEDICAL CLAIMS P.O. Box 5028 Troy, MI 48007-5028</p> <p>BEHAVIORAL HEALTH CLAIMS P.O. Box 1440 Troy, MI 48099-1440</p> <p>Offered by Optima Health Plan</p>	Member Services: (Translation Services Available)	999-999-9999 OR 9-999-999-9999	Pharmacy Member Services:	999-999-9999 OR 9-999-999-9999	TTY Virginia Relay Service: (Hearing Impaired)	999 OR 9-999-999-9999	24-Hour Nurse Advice Line:	999-999-9999 OR 9-999-999-9999	Smiles for Children (Under age 21):	9-999-999-9999	Transportation:	9-999-999-9999	Behavioral Health/ARTS Crisis Line:	999-999-9999 OR 9-999-999-9999	Provider Relations:	999-999-9999 OR 9-999-999-9999	Medical/Pharmacy Pre Authorization:	999-999-9999 OR 9-999-999-9999
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Medical/Pharmacy Pre Authorization:	999-999-9999 OR 9-999-999-9999																																				

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

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

Provider and Pharmacy Directory

You can find the most up-to-date Provider and Pharmacy Directories at optimahealth.com/communitycare. You can also ask for an annual Provider and Pharmacy

Directory by calling Member Services at the number at the bottom of this page.

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

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

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

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

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

*Information available is based on provider-supplied data.

Important Phone Numbers

<p>Your Care Coordinator</p> <p><i>Add contact information when you receive your letter.</i></p>	
<p>Optima Health Community Care Member Services</p>	<p>757-552-8360 OR 1-888-512-3171</p> <p>TTY: 1-844-552-8148</p>
<p>Optima Health Community Care 24/7 Medical /Behavioral Health Advice Line</p>	<p>757-552-8899 OR 1-844-387-9420</p>
<p>Optima Health Community Care 24/7 Behavioral Health Crisis Line</p>	<p>757-552-7580 OR 1-888-946-1168</p>
<p>Optima Health Community Care Adult Dental <i>(if offered)</i></p>	<p>Contact DentaQuest at 844-824-2016 or https://www.dentaquest.com/</p>
<p>Smiles for Children through DentaQuest, DMAS Dental Benefits Administrator</p>	<p>For questions or to find a dentist in your area, call <i>Smiles For Children</i> at 1-888-912-3456. Information is also available on the DMAS website at: http://www.dmas.virginia.gov/#/dentalservices or the DentaQuest website at: http://www.dentaquestgov.com/</p>
<p>Optima Health Community Care Transportation</p>	<p>Contact Southeastrans at 1-855-325-7558</p>
<p>DMAS Transportation Contractor for transportation to and from DD Waiver Services</p>	<p>1-866-386-8331</p> <p>TTY 1-866-288-3133</p> <p>Or dial 711 to reach a relay operator</p>
<p>CCC Plus Helpline</p>	<p>1-844-374-9159</p> <p>TDD: 1-800-817-6608</p> <p>or visit the website at cccplusva.com.</p>

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

2. What is Commonwealth Coordinated Care Plus

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

What Makes You Eligible to be a CCC Plus Member

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

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

CCC Plus Enrollment

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

Reasons You Would Not be Eligible to Participate in CCC Plus

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

- You lose/lost Medicaid eligibility.
- You do not meet one of the eligible categories listed above.
- You are enrolled in hospice under the regular fee-for-service Medicaid program prior to any CCC Plus benefit assignment.
- You enroll in the Medicaid Health Insurance Premium Payment (HIPP) program.
- You enroll in PACE (Program of All-Inclusive Care for the Elderly). *For more information about PACE, talk to your Care Coordinator or visit: <http://www.pace4you.org/>*

- You reside in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).
- You are receiving care in a Psychiatric Residential Treatment Facility (children under age 21).
- You reside in a Veteran's Nursing Facility.
- You reside in one of these State long term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.
- You live on Tangier Island.

What if I Am Pregnant

If you are within your first ninety (90) days of initial enrollment, and in your third (3rd) trimester of pregnancy, and your provider is not participating with Optima Health Community Care, you may request to move to another MCO where your provider participates. If your provider does not participate with any of the CCC Plus health plans, you may request to receive coverage through fee-for-service Medicaid until after delivery of your baby. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD: 1-800-817-6608 to make this request.

Coverage for Newborns Born to Moms Covered Under CCC Plus

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

- Calling the Cover Virginia Call Center at 1 (855) 242-8282 to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child.

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

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

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

Medicaid Eligibility

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

Choosing or Changing Your Health Plan

Health Plan Assignment

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

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

You Can Change Your Health Plan Through the CCC Plus Helpline

The CCC Plus Helpline can help you choose the health plan that is best for you. For assistance, call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at cccplusva.com. The CCC Plus Helpline is available Monday through Friday (except on State Holidays) from 8:30 am to 6:00 pm. The CCC Plus Helpline can help you understand your health plan choices and answer your questions about which doctors and other providers participate with each health plan. The CCC Plus Helpline services are free and are not connected to any CCC Plus health plan.

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between October and December with a January 1st coverage begin date. You will get a letter from DMAS during open enrollment with more information. You may also ask to change your health plan at any time for “good cause,” which can include:

- You move out of the health plan’s service area,
- You need multiple services provided at the same time but cannot access them within the health plan’s network,
- Your residency or employment would be disrupted as a result of your residential,

institutional, or employment supports provider changing from an in-network to an out-of-network provider, and

- Other reasons determined by DMAS, including poor quality of care and lack of access to appropriate providers, services, and supports, including specialty care.

The CCC Plus Helpline handles “good cause” requests and can answer any questions you may have. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at cccplusva.com.

Automatic Re-Enrollment

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

What is Optima Health Community Care Service Area

CENTRAL REGION		
AMELIA	HANOVER	PETERSBURG
BRUNSWICK	HENRICO	POWHATAN
CAROLINE	HOPEWELL	PRINCE EDWARD
CHARLES CITY	KING AND QUEEN	PRINCE GEORGE
CHESTERFIELD	KING GEORGE	RICHMOND CITY
COLONIAL HEIGHTS	KING WILLIAM	RICHMOND CO.
CUMBERLAND	LANCASTER	SOUTHAMPTON
DINWIDDIE	LUNENBURG	SPOTSYLVANIA
EMPORIA	MATHEWS	STAFFORD
ESSEX	MECKLENBURG	SURRY
FRANKLIN CITY	MIDDLESEX	SUSSEX
FREDERICKSBURG	NEW KENT	WESTMORELAND
GOOCHLAND	NORTHUMBERLAND	
GREENSVILLE	NOTTOWAY	
TIDEWATER REGION		
ACCOMACK	JAMES CITY CO.	PORTSMOUTH
CHESAPEAKE	NEWPORT NEWS	SUFFOLK
GLOUCESTER	NORFOLK	VIRGINIA BEACH
HAMPTON	NORTHAMPTON	WILLIAMSBURG
ISLE OF WIGHT	POQUOSON	YORK
NORTHERN & WINCHESTER REGION		
ALEXANDRIA	FALLS CHURCH	PAGE
ARLINGTON	FAUQUIER	PRINCE WILLIAM
CLARKE	FREDERICK	RAPPAHANNOCK
CULPEPER	LOUDOUN	SHENANDOAH
FAIRFAX CITY	MANASSAS CITY	WARREN
FAIRFAX CO.	MANASSAS PARK	WINCHESTER
CHARLOTTESVILLE WESTERN REGION		

ALBEMARLE	DANVILLE	NELSON
AMHERST	FLUVANNA	ORANGE
APPOMATTOX	GREENE	PITTSYLVANIA
AUGUSTA	HALIFAX	ROCKINGHAM
BUCKINGHAM	HARRISONBURG	STAUNTON
CAMPBELL	LOUISA	WAYNESBORO
CHARLOTTE	LYNCHBURG	
CHARLOTTESVILLE	MADISON	
ROANOKE/ALLEGHANY REGION		
ALLEGHANY	FRANKLIN CO.	PULASKI
BATH	GILES	RADFORD
BEDFORD CO.	HENRY	ROANOKE CITY
BOTETOURT	HIGHLAND	ROANOKE CO.
BUENA VISTA	LEXINGTON	ROCKBRIDGE
COVINGTON	MARTINSVILLE	SALEM
CRAIG	MONTGOMERY	WYTHE
FLOYD	PATRICK	
SOUTHWEST REGION		
BLAND	GALAX	SCOTT
BRISTOL	GRAYSON	SMYTH
BUCHANAN	LEE	TAZEWELL
CARROLL	NORTON	WASHINGTON
DICKENSON	RUSSELL	WISE

Only people who live in our service area can enroll with Optima Health Community Care. If you move outside of our service area, you cannot stay in this plan. If this happens, you will receive a letter from DMAS asking you to choose a new plan. You can also call the CCC Plus Helpline if you have any questions about your health plan enrollment. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 or visit the website at cccplusva.com.

If You Have Medicare and Medicaid

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

Types of Services Under Medicare

- Inpatient Hospital Care (Medical and Psychiatric)
- Outpatient Care (Medical and Psychiatric)
- Physician and Specialists Services
- X-Ray, Lab Work and Diagnostic Tests
- Skilled Nursing Facility Care

Types of Services Under CCC Plus (Medicaid)

- Medicare Copayments
- Hospital and Skilled Nursing when Medicare Benefits are Exhausted
- Long term nursing facility care (custodial)
- Home and Community Based Waiver Services like personal care and respite

- Home Health Care
- Hospice Care
- Prescription Drugs
- Durable Medical Equipment
- *For more information, contact your Medicare Plan, visit Medicare.gov, or call Medicare at 1-800-633-4227.*
- care, environmental modifications, and assistive technology services
- Community Behavioral Health Services
- Medicare non-covered services, like some over the counter medicines, medical equipment and supplies, and incontinence products.

You Can Choose the Same Health Plan for Medicare and Medicaid

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

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

Enhanced benefits offered for members that select Optima Health Community Care include:

- Adult dental services for members age 21 and older through DentaQuest in- network providers only:
 - One annual oral exam,
 - One annual cleaning, and
 - One annual set of x-rays
- Adult literacy program (HEAL Program)
- Assistive devices (Authorization required.)
- Diabetic foot care (Authorization required.)
- Discounts on eyeglasses
- Free cell phones
- GED voucher and online prep
- Healthy member incentives
- Healthy Moms: Partners in Pregnancy
- Home-delivered meals (Authorization required.)

- Memory alarms and devices (Authorization required.)
- Reading program for children (Read, Learn, Grow)
- Smoking cessation Wellness Program
- Telehealth services through MDLIVE
- Transportation services (non-medical) – up to three (3) round trip rides every 3 months to community events, grocery store and more. Additional information is provided later in the handbook.
- Weight Management Wellness Program

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

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

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

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

3. How CCC Plus Works

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

What are the Advantages of CCC Plus

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

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

What are the Advantages of Choosing Optima Health Community Care

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

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

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

Transition of Care Policy: Continuity of Care Period

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

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

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

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

If You Have Other Coverage

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

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

4. Your Care Coordinator

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

How Your Care Coordinator Can Help

Your Care Coordinator can:

- Answer questions about your health care
- Provide assistance with appointment scheduling
- Answer questions about getting any of the services you need. For example: behavioral health services, transportation, and long-term services and supports (LTSS)
 - Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and facilitate maximum independence. Examples include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as meal preparation, laundry, and shopping. LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities.
- Help with arranging transportation to your appointments when necessary. If you need a ride to receive a Medicaid covered service and cannot get there, non-emergency transportation is covered. Just call 1-855-325-7558 (toll-free) or call your Care Coordinator for assistance.
- Answer questions you may have about your daily health care and living needs including these services:
 - Skilled nursing care
 - Physical therapy
 - Occupational therapy
 - Speech therapy
 - Home health care

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

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

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

What is a Health Screening

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

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

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

If you have questions about the health screening, please contact Member Services 1-888-512-3171, TTY 1-844-552-8148 . This call is free.

What is a Health Risk Assessment

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

What is a Care Plan

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

How to Contact Your Care Coordinator

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

CALL

Phone number(s): _____

Write in the phone number(s) once you receive your Care Coordinator contact information. The phone number is local or toll-free.

Individuals who are deaf or hard of hearing or who are speech-impaired, who want to speak to a Member Services representative, or who have a TTY or another assistive device, can dial 711 to reach a relay operator. They will help you reach our Member Services staff.

Monday-Friday 8:00 a.m. to 5:00p.m. After 5:00 pm, please contact Member Services at the number at the bottom of this page.

We have free interpreter services for people who do not speak English.

TTY	<p>1-844-552-8148 This call is free.</p> <p>You can also call 711, the Telecommunications Relay service.</p> <p>Monday-Friday 8:00 a.m. to 5:00p.m.</p> <p>This number is for people who need hearing or speaking assistance. You must have special telephone equipment to call it.</p>
FAX	<i>Write in fax number once you receive your Care Coordinator contact information.</i>
WRITE	<p>4417 Corporation Lane</p> <p>Virginia Beach, VA 23462</p>
EMAIL	<i>Write in email address once you receive your Care Coordinator contact information.</i>
WEBSITE	optimahealth.com/members

5. Help From Member Services

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

How to Contact Optima Health Community Care Member Services

CALL	1-888-512-3171 This call is free. Monday-Friday from 8:00 a.m. to 8:00 p.m. After Hours Nurse Advice Line is available 24 hours a day, 7 days a week to answer your questions at: 757-552-8899 or toll free at 1-844-387-9420. We have free interpreter services for people who do not speak English.
TTY	1-844-552-8148 This call is free. Monday-Friday 8:00 a.m. to 8:00 p.m. This number is for people who need hearing or speaking assistance. You must have special telephone equipment to call it.
WRITE	4417 Corporation Lane Virginia Beach, VA 23462
WEBSITE	optimahealth.com/members

How Member Services Can Help

Member Services can:

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

- Provide information on how you can submit an appeal about a coverage decision on your health care services (including medications). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake. (See *Your Right to Appeal* in Section 15 of this handbook).
- Grievances about your health care services (including medications). You can file a grievance about us or any provider (including a non-network or network provider). A network provider is a provider who contracts and works with the health plan. You can also file a grievance about the quality of the care you received to us or to the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608. (See *Your Right to File a Grievance* in Section 15 of this handbook).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If You Do Not Speak English

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

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

We provide reasonable accommodations to people with disabilities in compliance with the Americans with Disabilities Act. This includes but is not limited to accessible communications (such as a qualified sign language interpreter), braille or large print materials, etc. If you need a reasonable accommodation please call Member Services (at no charge) at 1-888-512-3171 to ask for the help you need.

If You Have Questions About Your Medicaid Eligibility

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

6. How to Get Care and Services

How to Get Care from Your Primary Care Physician

Your Primary Care Physician

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

Choosing Your PCP

New members have the right to choose a PCP in our network soon after joining Optima Health Community Care by calling Member Services at 1-888-512-3171. If you do not already have a PCP you must request one prior to the 25th day of the month before your effective enrollment date, or else Optima Health Community Care may assign you a PCP. You have the right to change your PCP at any time by calling Member Services at the number listed at the bottom of this page.

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

You may want to find a doctor:

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

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

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

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

If You have Medicare, Tell us About Your PCP

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

If Your Current PCP is not in Our Network

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

Changing Your PCP

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

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

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

Once registered and signed in:

- Select Change Primary Care Physician from the left menu.

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

Getting an Appointment with Your PCP

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

Appointment Standards

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

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

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

- First trimester (first 3 months) - Within fourteen (14) calendar days of request.
- Second trimester (3 to 6 months) - Within seven (7) calendar days of request.
- Third trimester (6 to 9 months) - Within five (5) business days of request.
- High Risk Pregnancy - Within three (3) business days or immediately if an emergency exists.

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

How to Get Care From Network Providers

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

Travel Time and Distance Standards

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

Member Travel Time & Distance Standards		
Standard	Distance	Time
Urban <ul style="list-style-type: none">• PCP• Specialists and other providers	15 Miles 30 Miles	30 Minutes 45 Minutes
Rural <ul style="list-style-type: none">• PCP• Specialists and other providers	30 Miles 60 Miles	45 Minutes 75 Minutes
Roanoke/Alleghany & Southwest Regions		
Standard	Distance	Time
Urban and Rural <ul style="list-style-type: none">• PCPs• Specialists and other providers	30 Miles 60 Miles	45 Minutes 75 Minutes

Accessibility

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

What are “Network Providers”

The Optima Health Community Care network providers include:

- Doctors, nurses, and other health care professionals that you can go to as a member of our plan;
- Clinics, hospitals, nursing facilities, and other places that provide health services in our plan;
- Early intervention providers, home health agencies and durable medical equipment suppliers;
- Long term services and supports (LTSS) providers including nursing facilities, hospice, adult day health care, personal care, respite care, and other LTSS providers.

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

What are “Network Pharmacies”

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

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

What are Specialists

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

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

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

You do not need a referral from your PCP for specialist care. If you and your PCP make the

decision for you to see a plan specialist, your PCP will coordinate your care, and you can make your own appointment. Before you see a specialist, you should confirm that the plan specialist is in the Optima Health network. Visit optimahealth.com/members or contact Member Services at the number on the back of your Member ID card to make sure that your specialist is in the network.

To find out if a doctor or specialist is in our network, sign in to optimahealth.com/members, select Find Doctors, Drugs and Facilities from the top menu. Then select Search Your Network. Upon signing in all relevant information, such as your health plan network and address, is pre-populated. Choose what type of doctor or facility you are looking for and populate any additional information. The results of your network will display.

If Your Provider Leaves Our Plan

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

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

How to Get Care from Out-of-Network Providers

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

- When Optima Health Community Care has approved a doctor out of its established network;

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

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

Care From Out-of-State Providers

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

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

Network Providers Cannot Bill You Directly

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

If You Receive a Bill for Covered Services

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

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

If You Receive Care From Providers Outside of the United States

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

7. How to Get Care for Emergencies

What is an Emergency

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

What to do in an Emergency

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

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

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

What is a Medical Emergency

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

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

What is a Behavioral Health Emergency

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

Examples of Non-Emergencies

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

If You Have an Emergency When Away From Home

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

What is Covered if You Have an Emergency

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

Notifying Optima Health Community Care About Your Emergency

Notify your doctor and Optima Health Community Care as soon as possible about the emergency within 48 hours if you can. However, you will not have to pay for emergency services because of a delay in telling us. We need to follow up on your emergency care. Your Care Coordinator will assist you in getting the correct services in place before you are discharged to ensure that you get the best care possible. Please call MemberServices at 1-888-512-3171. This number is also listed on the back of Optima Health Community Care Member ID Card.

After an Emergency

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

If You Are Hospitalized

If you are hospitalized, a family member or a friend should contact Optima Health Community Care as soon as possible. By keeping Optima Health Community Care informed, your Care

Coordinator can work with the hospital team to organize the right care and services for you before you are discharged. Your Care Coordinator will also keep your medical team including your home care services providers informed of your hospital and discharge plans.

If it Wasn't a Medical Emergency

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

8. How to Get Urgently Needed Care

What is Urgently Needed Care

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

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

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

9. How to Get Your Prescription Drugs

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

Rules for Optima Health Community Care Outpatient Drug Coverage

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

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

Getting Your Prescriptions Filled

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

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

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

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

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

List of Covered Drugs

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

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

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

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

Changes to the formulary are posted on the website. If a drug you are taking is no longer offered on the formulary, Optima Health Community Care will notify you by letter at least 30 days before the change goes into effect.

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

Limits for Coverage of Some Drugs

For certain prescription drugs, special rules limit how and when we cover them. In general, our

rules encourage you to get a drug that works for your medical condition and that is safe and effective, and cost effective.

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

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

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

Getting Approval in Advance

For some drugs, you or your doctor must get a service authorization approval from Optima Health Community Care before you fill your prescription. If you don't get approval, Optima Health Community Care may not cover the drug.

Trying a Different Drug First

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

Quantity Limits

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

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

Emergency Supply

There may be an instance where your medication requires a service authorization, and your

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

Non Covered Drugs

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

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

Changing Pharmacies

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

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

What if You Need a Specialized Pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include pharmacies that supply drugs for home infusion therapy or residents of a long-term care facility, such as a nursing facility.

Usually, nursing facilities have their own pharmacies. If you are a resident of a nursing facility, we must make sure you can get the drugs you need at the nursing facility's pharmacy. If you have any problems getting your drug benefits in a nursing facility, please contact your Care Coordinator or Member Services at the number at the bottom of the page.

Can You Use Mail-Order Services to Get Your Drugs

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

Can You Get a Long-Term Supply of Drugs

You can receive up to a one-month supply (31 days) of a drug.

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

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

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

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

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works. The lock-in period is for 12 months. At the end of the lock in period, we'll check in with you to see if you should continue the program. If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days

of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to *Appeals, State Fair Hearings, and Grievances* in Section 15 of this handbook.

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

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

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

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

10. How to Access Your CCC Plus Benefits

CCC Plus Benefits

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

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

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

General Coverage Rules

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

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

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

Benefits Covered Through Optima Health Community Care

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

- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. *See Section 6 of this handbook for more information about PCP services.*
- Preventive care, including regular check-ups, screenings, and well-baby/child visits. *See Section 6 of this handbook for more information about PCP services.*
- Addiction and Recovery Treatment Services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services, and case management. Services may require authorization. *Additional information about ARTS services is provided below in this Section of the handbook.*
- Adult day health care services (see CCC Plus Waiver)
- Behavioral health services, including, inpatient and outpatient individual, family, and group psychotherapy services, Community Mental Health Rehabilitation Services including:
 - Mental Health Case Management
 - Therapeutic Day Treatment (TDT) for Children
 - Day Treatment/ Partial Hospitalization for Adults
 - Crisis Intervention and Stabilization
 - Intensive Community Treatment
 - Mental Health Skill-building Services (MHSS)
 - Intensive In-Home
 - Psychosocial Rehabilitation
 - Behavioral Therapy
 - Mental Health Peer Supports
- Care coordination services, including assistance connecting to CCC Plus covered services and to housing, food, and community resources. *See Section 4 of this handbook for more information about your Care Coordinator.*
- Clinic services, including renal dialysis.
- CCC Plus Home and Community Based Waiver services, (formerly known as the EDCD and

Technology Assisted Waivers), including: adult day health care, assistive technology, environmental modifications, personal care services, personal emergency response systems (PERS), private duty nursing services, respite services, services facilitation, transition services. *Additional information about CCC Plus Waiver services is provided later in this Section. Section 11 of this handbook provides information about DD Waiver Services.*

- Colorectal cancer screening.
- Court ordered services.
- Durable medical equipment (DME) and supplies including medically necessary respiratory, oxygen, and ventilator equipment and supplies, wheelchairs and accessories, hospital beds, diabetic equipment and supplies, incontinence products, assistive technology, communication devices, and rehabilitative equipment and devices and other necessary equipment and supplies.
- Early and Periodic Screening Diagnostic and Treatment services (EPSDT) for children under age 21. *Additional information about EPSDT services is provided later in this Section of the handbook.*
- Early Intervention services for children from birth to age 3. *Additional information about early intervention services is provided later in this Section of the handbook.*
- Electroconvulsive therapy (ECT).
- Emergency custody orders (ECO).
- Emergency services including emergency transportation services (ambulance, etc.).
- Emergency and post stabilization services. *Additional information about emergency and post stabilization services is provided in Section 7 of this handbook.*
- End stage renal disease services.
- Eye examinations.
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of the Optima Health Community Care network. Optima Health Community Care does not require you to obtain a service authorization or a PCP referral for family planning services.
- Glucose test strips.
- Hearing (audiology) services. Covered through EPSDT.

- Home health services.
- Hospice services.
- Hospital care – inpatient/outpatient.
- Human Immunodeficiency Virus (HIV) testing and treatment counseling.
- Immunizations.
- Inpatient psychiatric hospital services.
- Laboratory, Radiology and Anesthesia Services.
- Lead investigations.
- Mammograms.
- Maternity care - includes: pregnancy care, doctors/certified nurse-midwife services.
Additional information about maternity care is provided in Section 6 of this handbook.
- Nursing facility - includes skilled, specialized care, long stay hospital, and custodial care.
Additional information about nursing facility services is provided later in this Section of the handbook.
- Nurse Midwife Services through a Certified Nurse Midwife provider.
- Organ transplants.
- Orthotics, including braces, splints and supports - for children under 21, or adults through an intensive rehabilitation program.
- Outpatient hospital services.
- Pap smears.
- Personal care or personal assistance services (through EPSDT or through the CCC Plus Waiver).
- Physician's services or provider services, including doctor's office visits.
- Physical, occupational, and speech therapies.
- Podiatry services (foot care).
- Prenatal and maternal services.
- Prescription drugs. *See Section 9 of this handbook for more information on Pharmacy Services.*
- Private duty nursing services (through EPSDT and through the CCC Plus HCBS Waiver).
- Prostate specific antigen (PSA) and digital rectal exams.

- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses).
- Psychiatric or psychological services.
- Radiology services.
- Reconstructive breast surgery.
- Renal (kidney) dialysis services.
- Rehabilitation services – inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services).
- Second opinion services from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.
- Surgery services when medically necessary and approved by Optima Health Community Care.
- Telemedicine services.
- Temporary detention orders (TDO).
- Tobacco Cessation Services for pregnant women, children, and adolescents under age 21.
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). Optima Health Community Care will also provide transportation to/from most “carved-out” and enhanced services. *Transportation Services for DD Waiver services are covered through DMAS, as described in Section 11 of this handbook.*
- Vision services.
- Well Visits including annual PCP visits and associated health screenings.
- Abortion services- coverage is only available in cases where there would be a substantial danger to the life of the mother.

Extra Benefits We Provide That are not Covered by Medicaid

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

- Adult dental services for members age 21 and older through DentaQuest in-network

providers only:

- One annual oral exam,
 - One annual cleaning, and
 - One annual set of x-rays
- Adult literacy program (HEAL Program)
 - Assistive devices (Authorization required.)
 - Diabetic foot care (Authorization required.)
 - Discounts on eyeglasses
 - Free cell phones
 - GED voucher and online prep
 - Healthy member incentives
 - Healthy Moms: Partners in Pregnancy
 - Home-delivered meals (Authorization required.)
 - Memory alarms and devices (Authorization required.)
 - Reading program for children (Read, Learn, Grow)
 - Smoking cessation Wellness Program
 - Telehealth Services through MDLIVE
 - Transportation services (non-medical) - Effective January 1, 2020, you may use up to three trips in a quarter for non-medical trips. Trips are limited to 50 miles one way and may include an out-of-state location if it is within 50 miles of the pick-up address. Any unused trips **do not** carry over to the next quarter.
 - Weight Management Wellness Program

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

What is EPSDT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a federally mandated Medicaid benefit that provides comprehensive and preventive health care services for children under age 21. If you have a child that is under age 21, EPSDT provides appropriate preventive, dental, behavioral health, developmental, and specialty services. It includes coverage

for immunizations, well child visits, lead investigations, private duty nursing, personal care, and other services and therapies that treat or make a condition better. It will also cover services that keep your child's condition from getting worse. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid.

Getting EPSDT Services

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

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

Getting Early Intervention Services

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

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

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

How to Access Behavioral Health Services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues as well as using substances at some time in

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

Contact your Care Coordinator if you are having trouble coping with thoughts and feelings. Your Care Coordinator will help you make an appointment to speak with a behavioral healthcare professional.

Some Behavioral Health services are covered for you through Magellan, the DMAS Behavioral Health Services Administrator (BHSA). Your Care Coordinator will work closely with the BHSA to coordinate the services you need, including those that are provided through the BHSA.

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

How to Access Addiction and Recovery Treatment Services (ARTS)

Optima Health Community Care offers a variety of services that help individuals who are struggling with using substances, including drugs and alcohol. Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment no matter how bad the problem may seem. If you need treatment for addiction, we provide coverage for services that can help you. These services include settings in inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options are also available if you are dealing with using prescription or non-prescription drugs. Other options that are helpful include peer services (someone who has experience similar issues and in recovery), as well as case management services. Talk to your PCP or call your Care Coordinator to determine the best option for you and how to get help in addiction and recovery treatment services. To find an ARTS provider, you can look in the Provider and Pharmacy Directory, visit our website, call your Care Coordinator, or contact Member Services at one of the numbers below.

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

Optima Health Community Care provides coverage for long-term services and supports (LTSS) including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. LTSS can provide

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

Commonwealth Coordinated Care Plus Waiver

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

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

CCC Plus Waiver Services may include:

- Private duty nursing services (agency directed)
- Personal care (agency or self-directed)
- Respite care (agency or self-directed)
- Adult day health care
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for members transitioning to the community from a nursing facility or long stay hospital
- Assistive technology
- Environmental modifications

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

How to Self-Direct Your Care

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

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

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

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

Nursing Facility Services

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

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

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

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

Screening for Long Term Services and Supports

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

screening process in order to receive LTSS.

Freedom of Choice

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

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

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

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

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

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

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

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

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

included in your person-centered individualized service plan.

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

How to Get Non-Emergency Transportation Services

Non-Emergency Transportation Services Covered by Optima Health Community Care

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

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

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

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

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

Transportation To and From DD Waiver Services

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

transportation to your **non-waiver services**.)

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

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

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

Carved-Out Services

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

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

- Dental Services are provided through the *Smiles For Children* program. DMAS has contracted with DentaQuest to coordinate the delivery of all Medicaid dental services. *Smiles for Children* provides coverage for the following populations and services:
 - For children under age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services.
 - For pregnant women: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, bridges, partials, and dentures, tooth extractions and other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. The dental coverage ends 60 days after the baby is born.
 - For adults age 21 and over, coverage is only available for limited medically necessary oral surgery services. Routine dental services are not covered for adults other than as described above for pregnant women.

If you have any questions about your dental coverage through *Smiles for Children*, you can reach DentaQuest Member Services at 1-888-912-3456, Monday through Friday, 8:00 AM - 6:00 PM EST. The TTY/TDD number is 1-800-466-7566. Additional information is provided at: <http://www.dmas.virginia.gov/#/dentalservices>

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

The following adult dental services for members age 21 and older are covered by Optima Health Community Care through DentaQuest in-network providers as an enhanced benefit:

- One annual oral exam,
- One annual cleaning, and
- One annual set of x-rays

- Developmental Disability (DD) Waiver Services, including Case Management for DD Waiver Services, are covered through DBHDS. The carve-out includes any DD Waiver services that are covered through EPSDT for DD waiver enrolled individuals and transportation to/from DD Waiver services. Also see *How to Get Services if you are in a Developmental Disability Waiver* in Section 10 of this handbook.
- School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's *Individualized Education Program (IEP)*. While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.
- Treatment Foster Care Case Management is managed by Magellan of Virginia and more information is available at: <http://www.magellanofvirginia.com> or by calling: 1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711. You can also call your Care Coordinator for assistance.
- Therapeutic Group Home Services for children and adolescents younger than the age of 21. This is a place where children and adolescents live while they get treatment. Children under this level of care have serious mental health concerns. These services provide supervision and behavioral health care toward therapeutic goals. These services also help the member and their family work towards discharge to the member's home. Additional information about Therapeutic Group Home Services is available on the Magellan website at: <http://www.magellanofvirginia.com> or by calling: 1-800-424-4046, TDD: 1-800-424-4048 or TTY: 711. You can also call your Care Coordinator for assistance.
- For members age twenty-one (21) through sixty-four (64), where the member goes into private freestanding Institution for Mental Disease (IMD) or a State freestanding IMD for a Temporary Detention Order (TDO), the state TDO program will pay for the service.

Services That Will End Your CCC Plus Enrollment

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

- PACE (Program of All Inclusive Care for the Elderly). *For more information about PACE, talk to your Care Coordinator or visit:* <http://www.pace4you.org/>

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

12. Services Not Covered by CCC Plus

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

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

- Prescription drugs covered under Medicare Part D, including the Medicare copayment.
- Private duty nursing (except through some home and community-based service waivers or under EPSDT)
- Routine dental care if you are age 21 or older (This is covered as an enhanced benefit under Adult Dental Services.)
- Services rendered while incarcerated
- Weight loss clinic programs unless authorized
- Care outside of the United States

If You Receive Non-Covered Services

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

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

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

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

13. Member Cost Sharing

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

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

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

Member Patient Pay Towards Long Term Services and Supports

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

Medicare Members and Part D Drugs

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

14. Service Authorization and Benefit Determination

Service Authorization

There are some treatments, services, and drugs that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called a service authorization. You, your doctor, or someone you trust can ask for a service authorization.

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

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

We look at standards of care based on:

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

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

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

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

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

- All acute rehabilitation
- All inpatient hospitalizations
- All intensive outpatient programs
- All out-of-area services **except emergency care**
- All outpatient surgeries/short stays/observations
- All partial hospitalizations
- All rehabilitation programs (cardiac, pulmonary and vascular rehabilitation)
- All services by non-participating providers

- Any surgical or diagnostic procedure in which Anesthesiology or conscious sedation is billed
- Applied Behavioral Analysis
- Augmentative Speech Devices
- Durable Medical Equipment (single items over the \$1,200 and all rentals)
- Genetic testing
- Hyperbaric Therapy
- Injectable drugs, including but not limited to, Synvisc/Hyalgen, Synagis,
- Rabies, Remicaid, IVIG
- Long-Term Services and Support (LTSS)
- Oral surgery and related services
- Orthotics/Prosthetics (single items over the \$1,200 and all rentals, repairs and duplicates)
- Outpatient Advanced Imaging Services (CT, CTA, MRI, MRA, MRS or PET scans)
- Oxygen (rental)
- Plastic surgery
- Skilled-Nursing Services
- Transplants
- Waiver Services
- Wheelchairs and seating

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

Service Authorizations and Continuity of Care

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

How to Submit a Service Authorization Request

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

What Happens After We Get Your Service Authorization Request

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

used by DMAS.

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

Timeframes for Service Authorization Review

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

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

For pharmacy services, we must provide decisions by telephone or other telecommunication device within 24 hours.

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

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give Optima Health Community Care to help decide your case. This can be done by calling 757- 552-7560 or toll-free at 1-888-946-1167 or writing to Optima Health Community Care, 4417 Corporation Lane, Virginia Beach, VA 23462.

You or someone you trust can file a grievance with Optima Health Community Care if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a grievance about the way Optima Health Community Care handled your service authorization request to the State through the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608. Also see *Your Right to File a Grievance*, in Section 15 of this handbook.

Benefit Determination

We will notify you with our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you disagree with our decision, you have the right to file an appeal with us. Also see *Your Right to Appeal*, in Section 15 in this handbook.

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

Advance Notice

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

Post Payment Review

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

15. Appeals, State Fair Hearings, and Grievances

Your Right to Appeal

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

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

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

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

Authorized Representative

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

Adverse Benefit Determination

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

How to Submit Your Appeal

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

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

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

Send your Appeal request to: Optima Health Community Care Appeals, P.O. Box 62876, Virginia Beach, VA 23466-2876, toll free fax: 1-866-472-3920. If you send your standard appeal by phone, it must be followed up in writing. Expedited process appeals submitted by phone do not require you to submit a written request.

Continuation of Benefits

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

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

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

What Happens After We Get Your Appeal

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

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

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

You can also provide information that you want to be used in making the appeal decision in person or in writing: Optima Health Community Care Appeals, P.O. Box 62876, Virginia Beach, VA 23466-2876, Toll-free phone number: 1-844-434-2916 or toll-free fax: 1-866-472-3920.

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

Timeframes for Appeals

Standard Appeals

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

Expedited Appeals

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

If We Need More Information

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give Optima Health Community Care to help decide your case. This can be done by calling or writing to: Optima Health Community Care Appeals, P.O. Box 62876, Virginia Beach, VA 23466-2876, Toll-free phone number: 1-844-434-2916 or toll-free fax: 1-866-472-3920.

You or someone you trust can file a grievance with Optima Health Community Care if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a grievance about the way Optima Health Community Care handled your appeal to the State through the CCC Plus Help Line at 1-844-374-9159 or TDD 1-800-817-6608.

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

Written Notice of Appeal Decision

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

Your Right to a State Fair Hearing

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

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

Standard or Expedited Review Requests

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

Authorized Representative

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

Where to Send the State Fair Hearing Request

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

circumstances with permission from DMAS.

You may write a letter or complete a Virginia Medicaid Appeal Request Form. The form is available at your local Department of Social Services or on the DMAS website at <http://www.dmas.virginia.gov/#/appealsresources>. You should also send DMAS a copy of the letter we sent to you in response to your Appeal.

You must sign the appeal request and send it to:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street

Richmond, Virginia 23219

Fax: (804) 452-5454

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

After You File Your State Fair Hearing Appeal

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

State Fair Hearing Timeframes

Expedited Appeal

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

Standard Appeal

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

Continuation of Benefits

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

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

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor.

You may, however, have to repay Optima Health Community Care for any services you receive during the continued coverage period if the Optima Health Community Care adverse benefit determination is upheld and the services were provided solely because of the requirements described in this Section.

If the State Fair Hearing Reverses the Denial

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

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

If services were provided while the State Fair Hearing was pending

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

If You Disagree with the State Fair Hearing Decision

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

Your Right to File a Grievance

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

Timeframe for Grievances

You can file a grievance with us at any time.

What Kinds of Problems Should be Grievances

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

Community Care grievance process.

Grievances about quality

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

Grievances about privacy

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

Grievances about poor customer service

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

Grievances about accessibility

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

Grievances about communication access

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

Grievances about waiting times

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

Grievances about cleanliness

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

Grievances about communications from us

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

There Are Different Types of Grievances

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

Internal Grievances

To make an internal grievance, call Member Services at the number below. You can also write your grievance and send it to us. If you put your grievance in writing, we will respond to your grievance in writing. You can file a grievance in writing, by mailing or faxing it to us at Optima Health Community Care Grievances, P.O. Box 62876, Virginia Beach, VA 23466-2876, Fax: 757-687-6232, Toll-free fax: 1-866-472-3920. Hearing impaired members may call the TTY number 1-844-552-8148 or 711.

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

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

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

External Grievances

You Can File a Grievance with the CCC Plus Helpline

You can make a Grievance about Optima Health Community Care to the CCC Plus Helpline. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608.

You Can File a Complaint with the Office for Civil Rights

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

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

Office of Civil Rights- Region III

Department of Health and Human Services

150 S Independence Mall West Suite 372

Public Ledger Building
Philadelphia, PA 19106
1-800-368-1019
Fax: 215-861-4431
TDD: 1-800-537-7697

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

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

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

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

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

Office of the State Long-Term Care Ombudsman

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

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

Virginia Office of the State Long-Term Care Ombudsman

Virginia Department for Aging and Rehabilitative Services

8004 Franklin Farms Drive

Henrico, Virginia 23229

804-662-9140

<http://www.ElderRightsVA.org>

16. Member Rights

Your Rights

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

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

Health Community Care, including how you can receive benefits from out-of-network providers if the services are not available in the Optima Health Community Care network.

- Complain about Optima Health Community Care to the State. You can call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 to make a grievance about us.
- Appoint someone to speak for you about your care and treatment and to represent you in an Appeal;
- Make advance directives and plans about your care in the instance that you are not able to make your own health care decisions. See Section 17 of this handbook for information about Advance Directives.
- Change your CCC Plus health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference Section 2 of this handbook or call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 or visit the website at cccplusva.com for more information.
- Appeal any adverse benefit determination (decision) by Optima Health Community Care that you disagree with that relates to coverage or payment of services. See *Your Right to Appeal* in this Section 15 of the handbook.
- File a grievance about any concerns you have with our customer service, the services you have received, or the care and treatment you have received from one of our network providers. See *Your Right to File a Grievance* in Section 15 of this handbook.
- To receive information from us about our plan, your covered services, providers in our network, and about your rights and responsibilities.
- To make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this Section of the handbook.)

Your Right to be Safe

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

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

Your Right to Confidentiality

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

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

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

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

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

Your Right to Privacy

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

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

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

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

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

Sentara Healthcare Notice of Privacy Practice

Effective Date: June 2, 2005 Revised: October 18, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE APPLIES TO SENTARA HEALTHCARE AND ITS AFFILIATED COVERED ENTITY HEALTHCARE PROVIDERS.* THIS NOTICE WILL BE UPDATED WITH ANY CHANGES TO THE SENTARA HEALTHCARE AFFILIATED COVERED ENTITIES.

If you have any questions about this notice, please contact the office of the Sentara Privacy Contact Person.

Sentara HIPAA Privacy Contact Person
PO Box 2200
Norfolk, VA 23501
1-800-981-6667

Who Will Follow This Notice

This notice describes Sentara Healthcare's privacy practices including:

- All divisions, affiliates, facilities, medical groups, departments and units of Sentara Healthcare;
- Any member of a volunteer group we allow to help you while you are in a Sentara Healthcare facility;
- All employees, staff and other Sentara Healthcare personnel; and
- Sentara hospital-based residents, medical students, physicians and physician groups with regard to services provided and medical records kept at a Sentara facility (all together "Sentara" or "we").

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

We create a medical record of the care and services you receive at Sentara care sites. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice applies to all of the Sentara Healthcare medical records of your care generated by a Sentara entity, whether made by Sentara personnel or your personal provider. Your personal provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice tells you about the ways in which we may use and disclose your medical information. It also describes your rights and certain obligations we have regarding use and disclosure of information.

We Are Required By Law to:

- Make sure that all of your medical information and that which identifies you is kept private;
- Give you this notice of our legal duties and privacy practices; and
- Follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and give examples. Not every use or disclosure in a category will be listed, however all of the ways we are permitted to use and disclose information fall within one of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Sentara personnel and care providers who are involved in your care. Among those caring for you are medical, nursing and other health care personnel in training who, unless you request otherwise, may be present during your care as part of their education. We may use still or motion pictures and closed circuit television monitoring of your care. We may also share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, X-rays and emergency medical transportation, as well as with family members or others providing services that are part of your care.
- **For Payment** - Sentara may use and disclose your medical information so that it or other entities involved in your care may obtain payment from you, an insurance company or a third party for treatment and services you receive. We and your physician(s) may disclose your medical information to any person, Social Security Administration, insurance or benefit payor, health care service plan or workers' compensation carrier which is, or may be, responsible for part or all of your bill. For example, we may give your insurer information about surgery you received at a Sentara hospital so they will pay us or reimburse you. We may also tell your insurer about a treatment you are going to receive to obtain prior approval, to determine whether your plan will cover the treatment, or to resolve an appeal or grievance. Information on members of Sentara managed care plans may be used and disclosed to

determine if services requested or received are covered benefits under its insurance, and to underwrite your group's health plan. Sentara is required to agree, if you request, to restrict disclosure of PHI to a health plan for any healthcare item or service which you have paid in full out of pocket.

- **For Health Care Operations** - We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to run Sentara and make sure that all of our patients and members receive quality services. For example, we may use medical information to review our treatment and services, to evaluate the performance of our staff, and to survey you on your satisfaction with our treatment and/or services. We may combine medical information to decide what additional services or health benefits Sentara should offer, what services are not needed, and whether certain new treatments are effective. We may disclose information to doctors, nurses, technicians, students training with Sentara, and other Sentara personnel for review and learning purposes. We may combine the medical information we have with medical information from other health care entities to compare how we are doing and see where we can make improvements in the care and services we offer. Sentara may also disclose information to private accreditation organizations, including, but not limited to, the Joint Commission on Accreditation of Healthcare Organizations and the National Committee, Det Norske Veritas (DNV) Hospital Accreditation Program, Quality Assurance, or other accreditation entities, in order to obtain accreditation from these organizations. We may use your information to credential providers in our health plan network and to grant hospital privileges to providers. We may also provide to others de-identified information that does not identify you, to be used in healthcare studies.
- **Appointment Reminders** - We may use and disclose your information to remind you of an appointment at a Sentara location.
- **Treatment Alternatives** - We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services** - We may use and disclose your information to tell you about health related benefits or services.
- **Fundraising Activities** - We may use and disclose medical information about you so that we or a foundation related to Sentara may contact you in an effort to raise money for Sentara. We only release information such as your name, address and phone number and the dates you received treatment or services. You have the right to be removed from any fundraising listing so that you will not be contacted. Opting out of fundraising activities will in no way affect any access or level of care to any patient. Once a patient opts-out of the fundraising listing, Sentara Healthcare will avoid contacting you unless the patient at a later time decides to opt-in for fundraising contact. Opting out or in for fundraising can be done by phone or email.
- **Hospital Directory** - We may include your name, location in the hospital, and your general condition (e.g., fair, stable, etc.) in the hospital directory while you are a patient at a Sentara hospital. The directory information may be released to people who ask for you by name so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

You may ask to restrict some or all of the information contained in the directory.

- **Research** - Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, must be reviewed and approved by either an institutional review board (IRB) or privacy board. In limited situations, your medical information may be reviewed by a researcher preparing to conduct a research study.
- **As Required By Law** - We will disclose medical information about you when required to do so by federal, state or local law. This includes, but is not limited to, disclosures to mandated patient registries.
- **To Avert a Serious Threat to Health or Safety** - We may use and disclose medical information about you to a person able to help prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **To Sponsors of Group Health Plans** - We may disclose your medical information to the sponsor of a self-funded group health plan, as defined under ERISA. We may also give your employer information on whether you are enrolled in or have dis-enrolled from a health plan offered by the employer.
- **Marketing** - We must obtain your prior written authorization to use your protected health information for marketing purposes except for a face-to-face encounter or a communication involving a promotional gift of nominal value. We are prohibited from selling lists of patients and enrollees to third parties or from disclosing protected health information to a third party for the marketing activities of the third party without your authorization. We may communicate with you about treatment options or our own health-related products and services. For example, our health care plans may inform patients of additional health plan coverage and value-added items and services, such as special discounts.
- **Activities Requiring Authorization** - Sentara requires specific patient authorization for disclosure of Protected Health information in the event of 1) disclosures that constitute a sale of PHI, 2) disclosure of PHI for Marketing Purposes and, 3) disclosures of psychotherapy notes. You may revoke an authorization at any time.

Special Situations

- **Organ and Tissue Donation** - We may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation; or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans** - We may release medical information about members of the domestic or foreign armed forces as required by the appropriate military command authorities.
- **Workers' Compensation** - We may release medical information about you for workers' compensation or similar programs.
- **Public Health Activities** - We may disclose medical information about you for public health activities. These activities include the following:
 - to prevent or control disease, injury or disability;
 - to report births and deaths;
 - to report child abuse or neglect;

- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence where you agree or when required or authorized by law.
- **Health Oversight Activities** - We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, but are not limited to, audits, investigations, examinations, inspections, and licensure.
- **Lawsuits and Disputes** - If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or reasonable efforts have been made by the party seeking the information to secure a qualified protective order. We also may disclose your information to Sentara's attorneys and, in accordance with applicable state law, to attorneys working on Sentara's behalf.
- **Law Enforcement** - We may release medical information if asked to do so by a law enforcement official:
 - In response to a court order, subpoena, warrant, summons or similar process;
 - To identify or locate a suspect, fugitive, material witness, or missing person;
 - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
 - About a death we believe may be the result of criminal conduct;
 - About criminal conduct at the location of a Sentara entity; and
 - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of person(s) who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors** - We may release medical information to a coroner, medical examiner or funeral director as necessary for them to carry out their duties.
- **National Security and Intelligence Activities** - We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities.
- **Protective Services for the President and Others** - We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.
- **Inmates** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the

safety and security of the correctional institution.

- *Uses and Disclosures Regarding Food and Drug Administration (FDA) -*
Regulated Products and Activities - We may disclose protected health information, without your authorization, to a person subject to the jurisdiction of the FDA for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products.
- **Genetic Information** - Consistent with the Genetic Information Nondiscrimination Act (GINA), your health plan is prohibited from using or disclosing genetic information for underwriting purposes.
- **School Immunization Admission Requirements** - You do not need to provide an authorization for schools to receive immunization information.
- **All Other Uses & Disclosures of PHI** - Any other use and/or disclosure of your PHI not specified in this notice will require a signed authorization prior to use.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

WE MAINTAIN ABOUT YOU.

You have the following rights regarding your medical information:

- **Right to Inspect and Copy** - You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing on a form provided by Sentara to the Health Information Management (HIM) department. You have a right to obtain a paper or electronic copy. Your request should indicate in what form you want the information. You may also request where the information is to be sent. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Sentara will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend** - If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for a Sentara entity. To request an amendment, your request must be made in writing on a form provided by Sentara and submitted to the Health Information Management (HIM) department. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the medical information kept by or for a Sentara entity;
 - Is not part of the information which you would be permitted to inspect and copy; or
 - Is accurate and complete.
- **Right to an Accounting of Disclosures** - You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. It does not include disclosures made for treatment, payment, health care operations, disclosures you authorize or other disclosures for which an accounting is not required under HIPAA. To request this list or accounting of disclosures, you must submit your request in writing on a form provided by Sentara to the Health Information Management (HIM) department. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically.) The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
 - **Right to Request Restrictions** - You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing on a form provided by Sentara to the Health Information Management (HIM) department. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, i.e. disclosures to your spouse.
 - **Right to Request Confidential Communications** - You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work or by mail. To request confidential communications, you may make your request in writing to the Health Information Management (HIM) department. You may also telephone the office of the Privacy Contact Person, however in order to protect your privacy we may not be able to accommodate requests made by telephone. We will not ask you the reason for your request, and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
 - **Right to a Paper Copy of This Notice** - You have the right to a paper copy of this notice at any time, even if you have previously agreed to receive this notice electronically. To obtain a paper copy of this notice, please write or call the Health Information Management (HIM) department.
 - **Right to Breach Notification** - In the event that unsecured protected health information is

inappropriately disclosed, an investigation of the event will be conducted. If it is determined to be a breach of your information, you will receive notification of the breach by first class mail.

- **Underwriting** - Sentara will not use patient's genetic information in an adverse manner for underwriting purposes.
- **Rights of the Deceased** - PHI of an individual that has been deceased for 50 years or more is NOT covered by HIPAA. Covered Entities are permitted to disclose a deceased person's PHI to family members and others who were involved in the care or payment for care if not contrary to prior expressed preference.

Change to this Notice

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice with the effective date at Sentara health care treatment facilities. We will post a current updated copy of this notice on our website, www.sentara.com. In addition, each time you have an appointment at, register at, or are admitted to a Sentara hospital or other Sentara treatment location for treatment or health care services, we will offer you a copy of the current notice. If you are a member of a Sentara health plan, your Evidence of Coverage or Certificate of Insurance will contain the version of the notice in effect as of the printing of those documents, plus any amendment to the notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Sentara or with the Secretary of the Department of Health and Human Services. To file a complaint with Sentara, contact the Privacy Contact Person. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

Other Uses of Medical Information

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

Additional Notices

If you have insurance through Optima Health Plan, Optima Health Group, or Optima Health Insurance Company, please refer to your Evidence of Coverage or Certificate of Insurance for the Notice of Insurance Information Practices and notice of Financial Information Practices required by Virginia law.

State Laws

Sentara will also comply with relevant state laws that may govern the privacy of your information.

Sentara HIPAA Privacy Contact Person

PO Box 2200

Norfolk, VA 23501

1-800-981-6667

*The Sentara Healthcare affiliated covered entities are:

SENTARA HEALTHCARE

SENTARA MEDICAL GROUP

SENTARA HOSPITALS

SENTARA LIFECORPORATION

HALIFAX REGIONAL HEALTHCARE

HOSPITAL, INC.

SENTARA ENTERPRISES

POTOMAC HOSPITAL CORPORATION OF PRINCE WILLIAM

SENTARA HEALTHCARE CAROLINA

MARTHA JEFFERSON HOSPITAL

OPTIMA HEALTH OF NORTH CAROLINA, L.L.C.

OPTIMA BEHAVIORAL HEALTH SERVICES, INC.

OPTIMA FAMILY CARE OF NORTH CAROLINA, INC.

OPTIMA HEALTH GROUP

OPTIMA HEALTH INSURANCE COMPANY

SENTARA QUALITY CARE NETWORKS

MARTHA JEFFERSON MEDICAL GROUP, LLC

MEDICAL TRANSPORT, LLC

SENTARA RMH MEDICAL CENTER

RMH MEDICAL GROUP, LLC

SENTARA ALBEMARLE REGIONAL MEDICAL CENTER, LLC

SENTARA BLUE RIDGE, LLC

SENTARA DOMINION HEALTH GROUP, LLC

SENTARA ENTERPRISES

SENTARA HALIFAX PROFESSIONAL SERVICES, LLC

SENTARA SOUTHSIDE HEALTH SERVICES, INC.

SENTARA HEALTH PLANS OF OHIO, INC

SENTARA HEALTH PLANS OF NORTH CAROLINAS, INC.

SENTARA HEALTH PLANS, INC.

SENTARA PRINCESS ANNE HOSPITAL

SENTARA VENTURES

HALIFAX REGIONAL LONG TERM CARE, INC.

SENTARA SOUTHSIDE HEALTH SERVICES, INC.

SENTARA DOMINION HEALTH GROUP, LLC

SENTARA HALIFAX PROFESSIONAL SERVICES, LLC

DOMINION HEALTH MEDICAL ASSOCIATES, LTD

SMG ANESTHESIA SPECIALISTS, LLC
HOSPITAL FOR EXTENDED RECOVERY
VALLEY WELLNESS CENTER
MARTHA JEFFERSON MEDICAL ENTERPRISES, INC.
ALBEMARLE PHYSICIAN SERVICES – SENTARA
PROPRIUM, LLC
SARMC ANESTHESIA SPECIALISTS, LLC

How to Join the Member Advisory Committee

Optima Health Community Care would like you to help us improve our health plan. We invite you to join our Member Advisory Committee. On the committee, you can let us know how we can better serve you. Going to these meetings will give you and your caregiver or family member the chance to help plan meetings and meet other members in the community. These educational meetings are held once every three months. If you would like to attend or would like more information, please contact Optima Health Community Care Member Services using one of the numbers below.

We Follow Non-Discrimination Policies

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

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

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

Spanish

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

Korean

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

Vietnamese

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

Chinese

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

Arabic

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

.الجنس أو الإعاقة أو السن أو الوطني الأصل

Tagalog

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

Farsi

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

Amharic

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

Urdu

Optima Health Community Care ہے کرتا تعمیل کی قوانین کے حقوق شہری وفاقی اطلاق ل ِ قاب کرتا۔ نہیں امتیاز پر بنیاد کی جنس یا معذوری، عمر، قومیت، رنگ، نسل کہ یہ اور

French

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

Russian

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

Hindi

Optima Health Community Care लागूहोने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता ह और जात, रंग, राय मूल, आयु, वकलांगता, या लग के आधार पर भेदभाव नह करता ह।

German

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

Bengali

Optima Health Community Care যাজ্ ফডারল নাগিরক অধিকার আইন মেন চেল এবং জাত, রঙ, জাতীয় উৎপত্তি, বয়স, অমতা, বা লের ভিত্তে বষমষ্ কের না।

Bassa

Optima Health Community Care Nyo běě kpĩ nyoũn-dyù gbo-gmò -gmà běě dyi ké wa ní ge nyoũn-dyù mú dyiìn dé bódó-dù nyoò sò kɔ̃ ɛ mú, mɔɔ kà nyoò dyòò -kù nyu niè kɛ mú, mɔɔ bódó bɛ nyoò sò kɔ̃ ɛ mú, mɔɔ zǝjǝ kà nyoò dǎ nyue mú, mɔɔ nyoò me kó dyíe mú, mɔɔ nyoò me mò gàa, mɔɔ nyoò me mò màa kɛɛ mú.

17. Member Responsibilities

Your Responsibilities

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

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

- If your caregiver or anyone responsible for you changes.
- If you are part of a clinical research study.

Advance Directives

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

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

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

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

Where to Get the Advance Directives Form

You can get the Virginia Advance Directives form at:

<http://www.virginiaadvancedirectives.org/the-virginia-hospital---healthcares-association--vhha-form.html>

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

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

Completing the Advance Directives Form

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

Share the Information with People You Want to Know About It

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

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

We Can Help You Get or Understand Advance Directives Documents

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

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

Other Resources

You may also find information about advance directives in Virginia at:

www.virginiaadvancedirectives.org.

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

If Your Advance Directives Are Not Followed

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

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

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

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

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

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Discrimination is Against the Law

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

Optima Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact:

Optima Health
4417 Corporation Lane, Virginia Beach, VA 23462
1-855-687-6260, 757-552-7116 (Fax)

languagehelp@sentara.com

If you believe that Optima 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 with:

Sharon Dajon, Section 1557 Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
1-844-801-3779, 757-552-7116 (Fax)

languagehelp@sentara.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator (above) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).

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

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

18. Fraud, Waste, and Abuse

What is Fraud, Waste, and Abuse

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

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

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

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

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

How Do I Report Fraud, Waste, or Abuse

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

- Do not give your plan identification (ID) number or other personal information over the telephone or email it to people you do not know, except for your healthcare providers or Optima Health representatives.
- Do not go to a doctor who says that an item or service is not usually covered, but they know how to bill the health plan to get it paid. Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

Optima Health provides its members a way to report situations or actions they think may be potentially illegal, unethical, or improper. If you want to report fraudulent or abusive practices, you can call the Fraud and Abuse Hotline at the number below. You can also send

an email or forward your information to the address below. All referrals may remain anonymous. Please be sure to leave your name and number if you wish to be contacted for follow up. If appropriate, the necessary governmental agency (e.g., DMAS, CMS, OIG, BOI, etc.) will be notified as required by law.

Optima Health Fraud and Abuse Hotline

Phone: 1-866-826-5277

Email: compliancealert@sentara.com

Mail: Optima Health, c/o Special Investigations Unit, 4417 Corporation Lane,
Virginia Beach, VA 23462

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

Department of Medical Assistance Services Fraud Hotline

Phone: 1-800-371-0824 or

1-866-486-1971 or

(804) 786-1066

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

Email: MFCU_mail@oag.state.va.us

Fax: 804-786-3509

Mail: Office of the Attorney General

Medicaid Fraud Control Unit

202 North Ninth Street

Richmond, VA 23219

Virginia Office of the State Inspector General

Fraud, Waste, and Abuse Hotline

Phone: 1-800-723-1615

Fax: 804-371-0165

Email: covhotline@osig.virginia.gov

Mail: State FWA Hotline

101 N. 14th Street

The James Monroe Building 7th Floor

Richmond, VA 23219

Optima Health Community Care Member Services 1-888-512-3171; TTY 1-844-552-8148, 109
Daily 8:00 am to 8:00 pm. The call is free.

19. Other Important Resources

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

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

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

<http://www.vddhh.org>

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

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

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

Agency Name	Areas Served
<p><u>Lake Country Area Agency on Aging</u> 1105 West Danville St South Hill, Virginia 23970-3501 Gwen Hinzman, President/CEO Phone: 434-447-7661 FAX: 434-447-4074 Email: lakecaaa@lcaaa.org</p>	<p>Counties of Halifax, Mecklenburg, and Brunswick. City of South Boston.</p>
<p><u>Piedmont Senior Resources Area Agency on Aging, Inc.</u> P.O. Box 398 Burkeville, Virginia 23922-0398 Justine Young, Executive Director Phone: 434-767-5588 or 800-995-6918 FAX: 434-767-2529 Email: JYoung@PiedmontSeniorResources.com</p>	<p>Counties of Nottoway, Prince Edward, Charlotte, Lunenburg, Cumberland, Buckingham, and Amelia.</p>
<p><u>Senior Connections- Capital Area Agency on Aging, Inc.</u> 24 East Cary Street Richmond, VA 23219 Thelma Bland Watson, Executive Director Phone: 804-343-3000 or 800-995-6918 FAX: 804-649-2258 Email: gstevens@youraaa.org</p>	<p>Counties of Charles City, Henrico, Goochland, Powhatan, Chesterfield, Hanover, and New Kent. City of Richmond.</p>
<p><u>Rappahannock Area Agency on Aging, Inc.</u> 460 Lendall Lane Fredericksburg, VA 22405 Leigh Wade, Executive Director Phone: 540-371-3375 or 800-262-4012 FAX: 540-371-3384 Email: lwade@raaa16.org</p>	<p>Counties of Caroline, Spotsylvania, Stafford, and King George. City of Fredericksburg.</p>

Agency Name	Areas Served
<u>Bay Aging</u> P.O. Box 610 Urbanna, VA 23175 Kathy Vesley, President Phone: 804-758-2386 FAX: 804-758-5773 Email: kvesley@bayaging.org	Counties of Westmoreland, Northumberland, Richmond, Lancaster, Essex, Middlesex, Mathews, King and Queen, King William, and Gloucester.
<u>Crater District Area Agency On Aging</u> 23 Seyler Drive Petersburg, VA 23805 Gladys Mason, Acting Executive Director Phone: 804-732-7020 FAX: 804-732-7232 Email: gmason@cdaaa.org	Counties of Dinwiddie, Sussex, Greenville, Surry, and Prince George. Cities of Petersburg, Hopewell, Emporia, and Colonial Heights.
<u>Senior Services of Southeastern Virginia</u> 5 Interstate Corporate Center 6350 Center Drive, Suite 101 Norfolk, Virginia 23502 John Skirven, Executive Director Phone: 757-461-9481 FAX: 757-461-1068 Email: services@sseva.org	Counties of Southampton and Isle of Wight. Cities of Franklin, Suffolk, Portsmouth, Chesapeake, Virginia Beach, and Norfolk.
<u>Peninsula Agency on Aging, Inc.</u> 739 Thimble Shoals Boulevard Building 1000, Suite 1006 Newport News, VA 23606 William Massey, CEO Phone: 757-873-0541 FAX: 757-872-1437 Email: ceo@paainc.org	Counties of James City and York. Cities of Williamsburg Newport News, Hampton, and Poquoson.
<u>Eastern Shore Area Agency on Aging- Community Action Agency, Inc.</u> P.O. Box 415 Belle Haven, Virginia 23306 Diane Musso, CEO Phone: 757-442-9652 or 800-452-5977 FAX: 757-442-9303	Counties of Accomack and Northampton

Agency Name	Areas Served
Email: ESAAA12@gmail.com	

20. Information for Medicaid Expansion Members

What Makes You Eligible to be a Medicaid Expansion Member

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

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

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

Enrollment for a Medicaid Expansion Member

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

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

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

You can change your health plan during the first 90 days of your CCC Plus program enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. Open enrollment occurs each year between November 1st and December 18th with a January 1st coverage begin date. You will get a letter from DMAS during open enrollment with more information.

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

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

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

The CCC Plus Helpline handles “good cause” requests and can answer any questions you may have. Contact the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, or visit the website at cccplusva.com.

Medicaid Expansion Benefits and Services

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

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

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

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

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

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

21. Important Words and Definitions Used in this Handbook

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

similar charges. Also see the definition for patient pay.

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

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

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

supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

- **Medicaid (or Medical Assistance):** A program run by the federal and the state government that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Most health care costs are covered if you qualify for both Medicare and Medicaid.
- **Medicare:** The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see “Health plan”).
- **Medicare-covered services:** Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and Part B.
- **Medicare-Medicaid enrollee:** A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dual eligible beneficiary.”
- **Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.
- **Medicare Part B:** The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.
- **Medicare Part C:** The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.
- **Medicare Part D:** The Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid.
- **Member Services:** A department within Optima Health Community Care responsible for answering your questions about your membership, benefits, grievances, and appeals.
- **Model of care:** A way of providing high-quality care. The CCC Plus model of care includes care coordination and a team of qualified providers working together with you to improve your health and quality of life.
- **Network:** “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies,

clinics, and other places that provide your health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them “network providers” when they agree to work with the Optima Health Community Care and accept our payment and not charge our members an extra amount. While you are a member of Optima Health Community Care, you must use network providers to get covered services. Network providers are also called “plan providers.”

- **Network pharmacy:** A pharmacy (drug store) that has agreed to fill prescriptions for Optima Health Community Care members. We call them “network pharmacies” because they have agreed to work with Optima Health Community Care. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- **Non-participating provider:** A provider or facility that is not employed, owned, or operated by Optima Health Community Care and is not under contract to provide covered services to members of Optima Health Community Care.
- **Nursing facility:** A medical care facility that provides care for people who cannot get their care at home but who do not need to be in the hospital. Specific criteria must be met to live in a nursing facility.
- **Ombudsman:** An office in your state that helps you if you are having problems with Optima Health Community Care or with your services. The ombudsman’s services are free.
- **Out-of-network provider or Out-of-network facility:** A provider or facility that is not employed, owned, or operated by Optima Health Community Care and is not under contract to provide covered services to members of Optima Health Community Care.
- **Participating provider:** Providers, hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports that are contracted with Optima Health Community Care. Participating providers are also “in-network providers” or “plan providers.”
- **Patient Pay:** The amount you may have to pay for long term care services based on your income. The Department of Social Services (DSS) must calculate your patient pay amount if you live in a nursing facility or receive CCC Plus Waiver services and have an obligation to pay a portion of your care. DSS will notify you and Optima Health Community Care if you have a patient pay, including the patient pay amount (if any).
- **Physician services:** Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.
- **Plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your

providers and services. They all work together to provide the care you need.

- Prescription drug coverage: Prescription drugs or medications covered (paid) by your Optima Health Community Care. Some over-the-counter medications are covered.
- Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.
- Primary Care Physician (PCP): Your primary care physician (also referred to as your primary care provider) is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.
- Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.
- Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with Optima Health Community Care, including doctors, nurses, behavioral health providers and specialists.
- Premium: A monthly payment a health plan receives to provide you with health care coverage.
- Private duty nursing services: skilled in-home nursing services provided by a licensed RN, or by an LPN under the supervision of an RN, to waiver members who have serious medical conditions or complex health care needs.
- Referral: In most cases you PCP must give you approval before you can use other providers in the Optima Health Community Care network. This is called a referral.
- Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, injury, or major operation.
- Service area: A geographic area where an Optima Health Community Care is allowed to operate. It is also generally the area where you can get routine (non-emergency) services.
- Service authorization: Also known as preauthorization. Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from Optima Health Community Care.
- Skilled nursing care: care or treatment that can only be done by licensed nurses.

Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings or rapidly changing health status.

- Skilled Nursing Facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.
- Specialist: A doctor who provides health care for a specific disease, disability, or part of the body.
- Urgently needed care (urgent care): Care you get for a non-life threatening sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Optima Health Community Care Member Services

CALL	<p>1-888-512-3171 Calls to this number are free.</p> <p>Member Services is available 8:00 a.m. to 8 p.m. ET Monday-Friday, except Commonwealth of Virginia holidays.</p> <p>Individuals who are deaf, hard of hearing, speech-impaired, or want to speak to a Member Services representative and have a TTY or other assistive device can dial 711 to reach a relay operator. They will help you reach our Member Services staff.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>1-844-552-8148</p> <p>This number is for people who need hearing or speaking assistance. You must have special telephone equipment to call it.</p> <p>Calls to this number are free. Member Services is available 8:00 a.m. to 8 p.m. ET Monday-Friday, except Commonwealth of Virginia holidays.</p>
WRITE	<p>4417 Corporation Lane</p> <p>Virginia Beach, VA 23462</p>
WEB SITE	<p>optimahealth.com</p>