MCCofVA.com

Molina Complete Care

Member Handbook

MEDALLION 4.0 PROGRAM

Virginia Department of Medical Assistance Services (DMAS)

Effective December 1, 2021

MOLINA® HEALTHCARE | Molina Complete Care

MEDALLION 4.0 Growing Strong

Table of Contents

Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including on-line, large print, braille or audio CD. To request this handbook in an alternate format and/or language ***please call us at 1-800-424-4518 (TTY 711)*** and we will provide an alternate format within 5 business days.

If you are having difficulty understanding this information, please contact our Member Services staff at **1-800-424-4518 (TTY 711)** for help at no cost to you.

Additionally, Members with alternative hearing or speech communication needs can dial 711 to reach a Telecommunications Relay Services (TRS) operator who will help you reach MCC's Member Services staff. Voice and TRS users can make a 711 call from any telephone anywhere in the United States free of charge.

If you do not speak English, call us at 1-800-424-4518 (TTY 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language free of charge.

Spanish: Si no habla inglés, llámenos a 1-800-424-4518 (TTY 711). Tenemos acceso a servicios de intérprete y podemos ayudar a responder sus preguntas en su idioma de forma gratuita. También podemos ayudarle a encontrar un proveedor de atención médica que pueda comunicarse con usted en su idioma.

Korean: 영어로 말할 수 없다면1-800-424-4518 (TTY 711). 로 전화하십시오. 저희는 통역 서비스를 이용할 수 있으며 귀하의 언어로 된 질문에 무료로 답변 할 수 있습니다. 우리는 또한 귀하의 언어로 의사 소통 할 수있는 의료 서비스 제공자를 찾도록 도울 수 있습니다.

Vietnamese: Nếu bạn không nói được tiếng Anh, hãy gọi cho chúng tôi tại 1-800-424-4518 (TTY 711). Chúng tôi có quyền truy cập vào các dịch vụ phiên dịch và có thể giúp trả lời câu hỏi của bạn trong ngôn ngữ của bạn miễn phí. Chúng tôi cũng có thể giúp bạn tìm thấy một nhà cung cấp chăm sóc sức khỏe người có thể giao tiếp với bạn bằng ngôn ngữ của bạn.

Chinese: 如果您不会说英语，请致电1-800-424-4518 (TTY 711)。 我们可以使用翻译服务，并可以用您的语言免费回答您的问题。 我们还可以帮助您找到一个能用您的语言与您沟通的医疗保健提供者。

Arabic:

إذا كنت لا يتكلمون الإنكليزية، اتصل بنا على 1-800-424-4518 (TTY 711)
الحصول على خدمات مترجم شفوي، ويمكن أن تساعد في الإجابة على أسئلتك باللغة الخاصة بك .يمكننا
.أيضا مساعدتك العثور على موفر الرعاية الصحية الذين يمكن التواصل معك باللغة الخاصة بك

Tagalog: kung ikaw ay hindi nagsasalita ng ingles , mo sa amin & lt ; 1-800-424-4518 (TTY 711) & gt ; . kami ay ng interpreter paglilingkod at makakatulong ang sagot sa tanong na ang wika ng katungkulan . at kami ay tulungan ka ng ng pangangalaga sa kalusugan nagkakaloob na ang pamamahagi sa inyo sa inyong mga wika.

Farsi:

اگر انگلیسی صحبت با ما تماس بگیرید د< 1-800-424-4518 (TTY 711) . ما دسترسی به خدمات مترجم شفاهی و سئوالات
زبان شما می تواند کمک کند. ما همچنین می توانید کمک ارائه دهنده مراقبت های بهداشتی است که می تواند ارتباط با شما زبان
خود را پیدا کنید.

Amharic: እንግሊዝኛ መናገር የማይችሉ ከሆነ, 1-800-424-4518 (TTY 711)ይደውሉልን. እኛ የአስተርጓሚ አገልግሎቶች መዳረሻ ያላቸው እና ከክፍያ ነጻ በራስዎ ቋንቋ ውስጥ የእርስዎን ጥያቄዎች መልስ ለማግኘት ይችላሉ. እኛ ደግሞ እንደ እናንተ የእርስዎን ቋንቋ ከአንተ ጋር መገናኘት የሚችል የጤና እንክብካቤ አቅራቢ እንዲያገኙ ሊረዱዎት ይችላሉ.

Urdu:

اگر آپ انگریزی نہیں بولتے، تو 1-800-424-4518 (TTY 711) پر ہمیں کال کریں. ہم مترجم کی
خدمات تک رسائی حاصل ہے اور مفت کے انچارج اپنی زبان میں آپ کے سوالات کا جواب دینے میں مدد کر
سکتے .ہم نے بھی آپ جو آپ کی زبان میں آپ کے ساتھ بات چیت کر سکتے ایک صحت کی دیکھ بھال فراہم کی
.تلاش میں مدد کر سکتے ہیں

French: Si vous ne parlez pas anglais, appelez-nous à 1-800-424-4518 (TTY 711). Nous avons accès à des services d'interprètes et pouvons vous aider à répondre à vos questions dans votre langue gratuitement. Nous pouvons également vous aider à trouver un fournisseur de soins de santé qui peut communiquer avec vous dans votre langue.

Russian: Если вы не говорите по-английски, позвоните нам по телефону 1-800-424-4518 (TTY 711). Мы имеем доступ к услугам переводчика и может помочь ответить на ваши вопросы на вашем языке бесплатно. Мы также можем помочь вам найти поставщика медицинских услуг, которые могут общаться с вами на вашем языке.

Hindi: आप अंग्रेजी नहीं बोलते हैं, तो 1-800-424-4518 (TTY 711) पर कॉल करें। हम दुभाषिया सेवाओं के लिए उपयोग किया है और नि:शुल्क अपनी भाषा में आपके सवालों के जवाब कर सकते हैं। हम यह भी मदद कर सकता है आप एक स्वास्थ्य देखभाल प्रदाता जो आपकी भाषा में आप के साथ संवाद कर सकते हैं।

German: Wenn Sie kein Englisch sprechen, rufen Sie uns unter 1-800-424-4518 (TTY 711) an. Wir haben Zugang zu Dolmetscherdiensten und können Ihnen helfen, Ihre Fragen in Ihrer Sprache kostenlos zu beantworten. Wir können Ihnen auch helfen, einen Arzt zu finden, der mit Ihnen in Ihrer Sprache kommunizieren kann.

Bengali: আপনি ইংরজেি বলতে পারি না, তাহলে 1-800-424-4518 (TTY 711) আমাদরে সঙ্গে যে োগাযে োগ করুন. আমরা দে ভাষীর পরষিবোগুলতিে অ্যাক্সসে আছে এবং নখিরচা আপনার ভাষায় আপনার প্রশ্নরে উত্তর সাহায্য করতে পারনে. আমরা সাহায্য করতে পারনে একটি স্বাস্থ্যরে যত্ন প্রদানকারী যারা আপনার ভাষায় আপনার সাথে যে োগাযে োগ করতে পারনে.

Portuguese: Se você não fala inglês, ligue para 1-800-424-4518 (TTY 711). Temos acesso a serviços de intérprete e podemos ajudar a responder às suas perguntas no seu idioma gratuitamente. Também podemos ajudá-lo a encontrar um profissional de saúde que possa se comunicar com você em seu idioma.

1. Medicaid Managed Care Plan

Welcome to MCC

Thank you for choosing Molina Complete Care (MCC) as your preferred Medicaid Managed Care 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 may have or get help making appointments. If you need to speak with us right away or before we contact you, call MCC Member Services at 1-800-424-4518 (TTY 711), visit our website at www.mccofva.com, or call the Virginia Medicaid Managed Care Helpline at 1-800-643-2273 (TTY 1-800-817-6608) from 8:30 a.m. to 6 p.m. local time, Monday through Friday for help. This handbook is also available on the MCC website located at www.mccofva.com.

MCC is a health plan that is committed to helping you live a vibrant and healthy life. As a member of MCC, you and your needs come first in everything we do. Our approach is based on our exclusive Integrated Health NeighborhoodSM model. Through this model, you are at the center of your own "neighborhood" as we connect you to local services and resources specifically chosen to benefit you the most. Nationally, Molina has more than 20 years of experience managing specialty health programs for Medicaid-eligible members and other individuals, including low-income individuals, such as children and women eligible for temporary financial assistance; older adults or those living with blindness or disabilities; foster children, and individuals living with behavioral health challenges. Our person-centered culture and dedication to offering choices to our members sets us apart from other health plans.

How to Use This Handbook

This handbook will help you understand your benefits and how you can get help from MCC. This handbook is a health care and MCC member guide that explains health care services, behavioral health coverage, prescription drug coverage, and other services and supports covered under the program. This guide will help you take the best steps to make our 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 or need guidance, please check this handbook, call MCC Member Services at 1-800-424-4518 (TTY 711), visit our website at www.mccofva.com, or call Virginia Medicaid Managed Care Helpline free of charge at 1-800-643-2273 (TTY 1-800-817-6608) from 8:30 a.m. to 6 p.m. local time, Monday

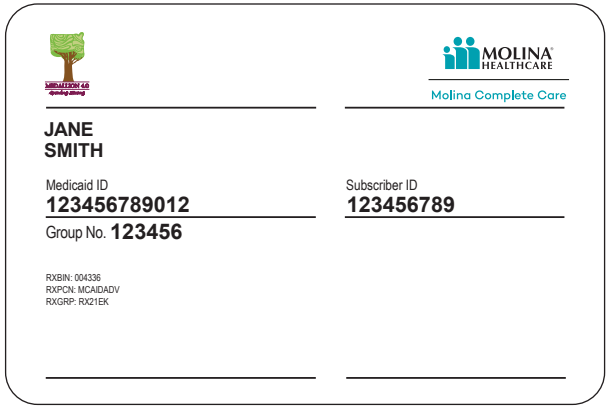
through Friday. Members and providers can access this information using their Android or Apple device after downloading the Medallion app. To get the app, search for Virginia Managed Care on Google Play or the App Store.

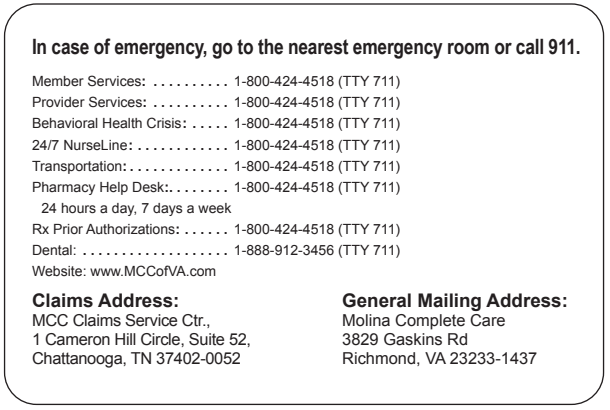
You can also get the latest information related to COVID-19 from Member Services, your Care Coordinator, and www.mccofva.com.

Your Welcome Packet

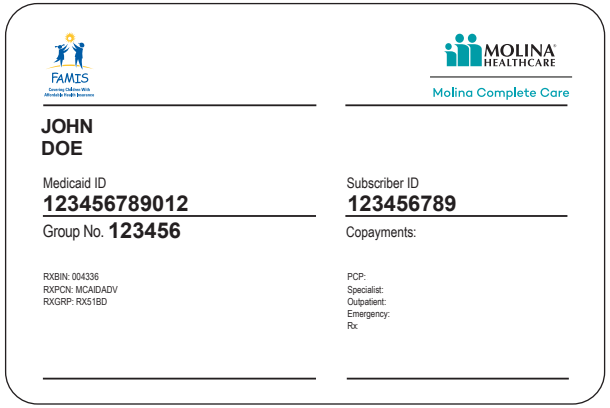
Member ID Card

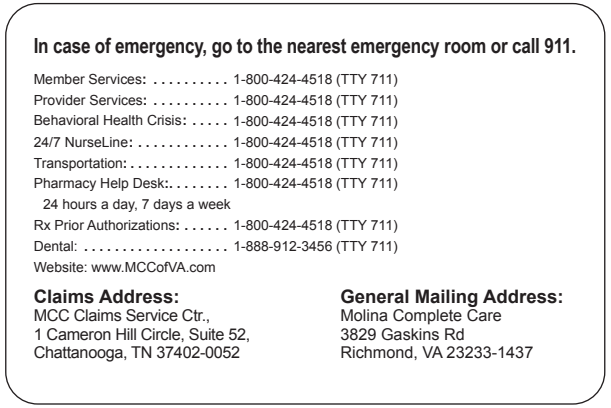
You should have received a welcome packet that included your MCC Member ID Card. Your MCC ID card is used to access Medicaid managed care program health care services and supports at doctor visits and when you pick up prescriptions. You must show this card to get services or prescriptions. Below is a sample card to show you what yours will look like:





FAMIS Member ID card:





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

Keep your Commonwealth of Virginia Medicaid ID card to access services that are covered through the State, under the Medicaid fee-for-service program. These services are described in Services Covered through Medicaid Fee-For-Service, in section 10 of this handbook.

Provider and Pharmacy Directories

You should have received information about the MCC Provider and Pharmacy Directories. These directories list the providers and pharmacies that participate in MCC's network. While you are a member of our plan, and in most cases, you must use one of our network providers to get covered services.

You may ask for a paper copy of the Provider and Pharmacy Directory by calling Member Services at the number at the bottom of the page. You can also see or download the Provider and Pharmacy Directory at www.mccofva.com. Your Provider Directory lists doctors, hospitals, pharmacies and other services and supports that are part of our network. You can find provider names, addresses, phone numbers, and other important information about our network providers in this directory.

What Is MCC's Service Area?

MCC covers the entire Commonwealth of Virginia. Only people who live in our service area can enroll with MCC. If you move outside of our service area, you cannot stay in this plan. If this happens, you will receive a letter from Department of Medical Assistance Services (DMAS) asking you to choose a new plan. You can also call the Managed Care Helpline if you have any questions about your health plan enrollment. Contact the Managed Care Helpline at 1-800-643-2273 or visit the website at virginiamanagedcare.com. Members and Providers can access this information using their Android or Apple device after downloading the Medallion app. To get the app, search for Virginia Managed Care on Google Play or the App Store.

List of Covered Drugs

You can access or download the Provider and Pharmacy Directory at www.mccofva.com or receive a printed copy by calling 1-800-424-4518 (TTY 711). A Preferred Drug List is a list of drugs that we cover that are safe and helpful for you to receive quality care. We will generally cover the drugs listed in our Preferred Drug List as long as the drug is medically necessary, the drug is filled at a participating pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions and details on quantity limits, prior approval requirements, and age limits, please visit www.mccofva.com.

List of Covered and Non-Covered Services

As an MCC member, you have a variety of health care benefits and services available to you. See section 8 of this handbook. Or you can access or download MCC's Covered Services at www.mccofva.com or receive a printed copy by calling 1-800-424-4518 (TTY 711).

The Provider 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 MCC network. While you are a member of our plan, you generally must use one of our network providers and/or pharmacies to get covered services. See *Transition of Care Period* in section 2 of this handbook.

Information About Eligibility

If you have questions about your Medicaid eligibility, contact your case 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 MCC,

please call the Member Services number listed at the bottom of this page. You may also visit Cover Virginia at www.coverva.org, or call 833-5CALLVA (TDD: 1-888-221-1590). **These calls are free**.

Getting Help Right Away

MCC's 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 MCC.

How To Contact MCC Member Services

CALL	1-800-424-4518 **This call is free**. 8 a.m. – 8 p.m. local time, Monday - Friday We have free interpreter services for people who do not speak English.
TTY	TTY 711 **This call is free**.
FAX	1-855-472-8574
WRITE	3829 Gaskins Road, Richmond VA 23233
EMAIL	MCCVA@molinahealthcare.com
WEBSITE	www.mccofva.com

How MCC's Member Services Representatives Can Help You

- Answer questions about MCC
- Answer questions about claims and how to submit them, billing or Member ID Cards
- Assistance finding or checking to see if a doctor is in MCC's network
- Assistance with changing your Primary Care Provider (PCP)
- Help you understand your benefits and covered services including the amount that we will pay so that you can make the best decisions about your health care.
- Appeals about your health care services (including drugs). 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.
- Complaints about your health care services (including prescriptions). You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you received to us or to the Managed Care Helpline at 1-800-643-2273.

How To Contact a MCC Care Manager/Coordinator (if you have been assigned a Care Coordinator)

Your Care Coordinator is a health care professional who can answer questions about your health care, provide assistance with appointment scheduling, help you find providers or services needed and help you understand your benefits. If you are assigned a Care Coordinator, he or she will be contacting you to complete a health risk assessment and develop a plan to help you get the care you need to stay healthy. If you need to request a care coordinator change, you may contact Member Services.

CALL	1-800-424-4518 **This call is free**. 8 a.m. – 8 p.m. local time, Monday – Friday We have free interpreter services for people who do not speak English.
TTY	TTY 711 **This call is free**.
FAX	1-804-452-5454
WRITE	3829 Gaskins Road, Richmond VA 23233
WEBSITE	www.mccofva.com

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

You can reach a nurse or behavioral health professional 24 hours a day, 7 days a week to answer your health questions toll-free at: 1-800-424-4518 (TTY 711). When you call the Medical Advice Line you will be able to get help with questions you may have about when to get care, what type of care may be best for your illness or health concern, information about access to care, when to seek emergency or urgent care and education on an illness or health concern. This is not a substitute for medical attention from a provider, but it can be a helpful consultation.

CALL	1-800-424-4518 **This call is free**. Available 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	TTY 711 **This call is free**. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Behavioral Health Crisis Line

The crisis line is similar to the Medical Advice line—it is there to assist you in the event of a behavioral health crisis.

Contact MCC if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call 1-800-424-4518 (TTY 711). If your symptoms include 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	1-800-424-4518 This call is free. Available 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	TTY 711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Other Important Numbers

DMAS Dental Benefits Administrator	For questions or to find a dentist in your area, call the DMAS Dental Benefits Administrator at 1-888-912-3456. Information is also available on the DMAS website at: https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/ or the DentaQuest website at: http://www.dentaquestgov.com/

MCC Transportation*	1-800-424-4518 (TTY 711) *Not applicable to FAMIS.
DMAS Transportation Contractor for transportation to and from DD Waiver Services	1-866-386-8331 TTY 1-866-288-3133 Or dial 711 to reach a relay operator
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019 or visit the website at www.hhs.gov/ocr

2. How Managed Care Works

The program is a mandatory managed care program for members of Virginia Medicaid (12VAC30-120-370). The Department of Medical Assistance Services (DMAS) contracts with managed care organizations (MCOs) to provide most Medicaid covered services across the state. MCC is approved by DMAS to provide person-centered care coordination and health care services. Through this person-centered program, our goal is to help you improve your quality of care and quality of life

What Makes You Eligible to be a Member?

When you apply for Medical Assistance, you are screened for all possible programs based on your age, income, and other information. To be eligible for a Medical Assistance Program, you must meet the financial and non-financial eligibility conditions for that program. Please visit the Virginia Department of Social Services' (VDSS) Medicaid Assistant Program page for eligibility details and/or VDSS Medicaid Forms and Applications page for application and other Medicaid form details.

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

- Children under age 21
- Foster Care and Adoption Assistance Child under age 26
- Pregnant women including two months post delivery
- Parent Caretakers

Medicaid eligible persons who do not meet certain exclusion criteria must participate in the program. Enrollment in is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. For more information about exclusionary criteria and participation, please refer to 12VAC30-120-370.

What Makes You NOT Eligible To Be A Member?

- You would not be able to participate if any of the following apply to you:
- You lose Medicaid eligibility.

- You do not meet one of the eligible categories above
- You meet exclusionary criteria 12VAC30-120-370
- You are hospitalized at the time of enrollment
- You are enrolled in a Home and Community Based (HCBS) waiver
- You are admitted to a free-standing psychiatric hospital
- You are receiving care in a Psychiatric Residential Treatment Level C Facility (children under 21)
- You meet the criteria for another Virginia Medicaid program
- Hospice
- Virginia Birth-Related Neurological Injury Compensation Act

Third Party Liability

Comprehensive Health Coverage

- Members enrolled in Medicaid, determined by DMAS as having comprehensive health coverage, other than Medicare, will be eligible for enrollment in Medallion 4.0, as long as no other exclusion applies.
- Members who obtain other comprehensive health coverage after enrollment in Medallion 4.0 remain enrolled in the program.
- Members who obtain Medicare after Medallion 4.0 enrollment will be disenrolled and subsequently enrolled into the Commonwealth Coordinated Care Plus (CCC+) program.
- MCOs are responsible for coordinating all benefits with other insurance carriers (as applicable) and follow Medicaid "payer of last resort" rules.
- MCOs cover the member's deductibles and coinsurance up to the maximum allowable reimbursement amount that would have been paid in the absence of other primary insurance coverage.
- When the TPL payor is a commercial MCO/HMO organization, the MCO is responsible for the full member copayment amount.

MCOs ensure that members are NOT held accountable for payments and copayments for any Medicaid covered service.

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:

1. Those services federally required to be provided at public expense as is the case for
   a. assessment/EI evaluation,
   b. development or review of the Individual Family Service Plan (IFSP); and,
   c. targeted case management/service coordination;
2. Developmental services; and,
3. Any covered early intervention services where the family has declined access to their private health/ medical insurance.

Enrollment

Enrollment in the program is required for eligible individuals. DMAS and the Managed Care Helpline manage the enrollment for the program. To participate, you must be eligible for Medicaid. The program allows for a process which speeds up member access to care coordination, disease management, 24-hour nurse call lines, and access to specialty care. This is especially important for members with chronic care needs, pregnant women, and foster care children who quickly need access to care.

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 instance, you may have been enrolled with us before through Medicaid. You may also have been assigned to us if certain providers you see are in our network.

Changing Your Health Plan

Assistance through the Managed Care Helpline can help you choose the health plan that is best for you. For assistance, call the Managed Care Helpline at 1-800-643-2273 or visit the website at virginiamanagedcare.com. The Managed Care Helpline is available Monday through Friday (except on State holidays) from 8:30 a.m. to 6 p.m. Operators can help you understand your health plan choices and/or answer

questions about which doctors and other providers participate with each health plan, among many helpful items. The helpline services are free and are not connected to any health plan.

Members and Providers can access this information using their Android or Apple device after downloading the Medallion app. To get the app, search for "Virginia Managed Care" on Google Play or the App Store.

You can change your health plan during the **first 90 days** of your enrollment for any reason. You can also change your health plan once a year during **open enrollment** for any reason. You will get a letter from DMAS during open enrollment with more information. You may also ask to change your health plan for "good cause" at any time. The Helpline handles good cause requests and can answer any questions you have. Contact the Helpline at 1-800-643-2273 or visit the website at virginiamanagedcare.com.

Automatic Re-Enrollment

If your enrollment ends with us and you regain eligibility for the program within 30 days or less, you will automatically be reenrolled with MCC. You will be sent a re-enrollment letter from the Department of Medical Assistance Services.

What Are the Advantages of Choosing MCC?

Some of the advantages of include:

- Access to MCC Care Managers. MCC's Care Manager works with you and with your providers to make sure you get the care you need
- The ability to take control over your care with help from MCC's care team and Care Managers
- A Care Team and Care Managers who are available to work with you to come up with a care plan specifically designed to meet your health needs
- 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 1-800-424-4518 (TTY 711) at any time
- MCC is the health plan that is all about YOU. We put your needs first in everything that we do to make sure you have the best experience possible as a member of our health plan. Through our exclusive Integrated Health NeighborhoodSM model, we'll connect you to local services and resources specifically chosen to benefit you the most

- We'll also help you stay healthy and active. Our support teams will work with you to identify potential health risks and help you address them through diet, exercise, or other means that work best for you
- We also regularly assess new technology, which includes medical and behavioral health procedures, medications, and devices, to add as benefits and services

We also offer a wide range of added benefits to help you live a vibrant and healthy life:

Benefit	**Details**
Vision	Up to $100 for glasses or contacts every two years for adults 21 and over
Mother-Baby Connections	Text messages with important health information to help: • Understand what is happening with your body • Recognize warning signs • Know what to expect during your delivery You'll also get: • Infant sleep sacks and diapers • An invitation to baby showers hosted by MCC (hosted quarterly per region) • "Baby Basics" book • Rides to WIC appointments, Lamaze and parenting classes
Sports physicals	Annual sports physicals from a primary care physician (PCP) for children ages 10-18
Adult physicals	Routine physicals from a PCP for adults 21 and over
Bicycle helmets	One bicycle helmet per year for children under 18

Benefit	Details
Transitions of Care for foster children	Backpack with supplies (personal hygiene items, community resource guides, area maps) for foster children leaving foster care
Transitions of Care for adults	Backpack with supplies (personal hygiene items, community resource guides, area maps, pill boxes) for adults with frequent or avoidable emergency room visits
Smart phone	Get a free smart phone with: • 350 free minutes each month • 4.5 GB of data each month • Unlimited text messaging
Complete Care Counts incentives	Get up to $50 in gift cards each year when you do things that help your health, like: • Quit smoking • Get your annual physical • Go to all your doctor visits when pregnant • Seeing your doctor within a week after hospital discharge
Community Connections	Online search tool to help you find important services in your area, like housing, food, job training and more
Post-discharge meals	After you get out of the hospital, you and one family member get three meals delivered each day for up to five days
SaveAround coupon book	Discount coupon book or various retailers.

What is a Health Risk Assessment?

Within the first few weeks after you enroll with MCC, a Care Manager will reach out to you to ask you some questions about your needs and choices. They 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 very complete assessment of your medical, psychosocial, cognitive, and functional status. The HRA is generally completed by a Care Manager **within the first 30 to 60 days** of your enrollment with MCC depending upon the type of services that you require. This health risk assessment will enable your Care Manager to help you get the care that you need.

Transition of Care Period

If MCC is new for you, you can keep previously authorized and/or scheduled doctor's appointments and prescriptions for the **first 30 days**. If your provider is not currently in MCC's network, then you may be asked to select a new provider that is in MCC's provider network. If your doctor leaves MCC's network, we will notify you **within 15 days** so that you have time to select another provider.

What If I 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 for covered Medicaid services when Medicaid is not the first payer. Let Member Services know if you have other insurance so that we can best coordinate your benefits. MCC's Care Managers will also work with you and your other health plan to coordinate your services.

3. How to Get Regular Care and Services

"Regular care" means exams, regular check-ups, shots or other treatments to keep you well, getting medical advice when you need it, and referring you to the hospital or specialists when needed. Be sure to call your PCP whenever you have a medical question or concern. If you call after hours or on weekends, leave a message with where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

- Your care must be **medically necessary**.
- The services you get must be needed:
  - To prevent, or diagnose and correct what could cause more suffering, or
  - To deal with a danger to your life, or
  - To deal with a problem that could cause illness, or
  - To deal with something that could limit your normal activities.

How to Get Care From A Primary Care Provider (PCP)

A 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 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 with any questions about referrals or prior authorizations.

Provider Directory

The provider directory includes a list of all of the doctors, specialty physicians, hospitals, clinics, pharmacies, laboratories, affiliations, accommodations for persons with physical disabilities, and behavioral health providers. The provider directory also includes provider qualifications, specialties, provider addresses, phone

numbers, web site URLs (if available), board certification status (if applicable), and new patient acceptance (open or closed panels) who work with MCC. We can also provide you with a paper copy of the provider directory. You can also call MCC Member Services at the number on the bottom of this page for assistance or to learn more details about our network providers, such as which medical school they attended and residency completion information.

Choosing Your PCP

If you do not have a PCP, we can help you find a highly qualified PCP in in your community. For help locating a provider you can use our on-line provider directory at: www.mccofva.com.

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 accommodations that you require.

If you have a disabling condition or chronic illnesses you can ask us if your specialist can be your PCP. We also contract with Federally Qualified Health Centers (FQHC). FQHCs 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 includes 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 do not select a PCP by the 25th of the month before the effective date of your coverage, MCC will auto-enroll you with a PCP. MCC will notify you in writing of the assigned PCP. You will need to call the Member Services number at the bottom of the page to select a new PCP.

If Your Current PCP Is Not in MCC's Network

You can continue to see your current PCP for up to 30 days even if they are not in the MCC network. During the first 30 days of your enrollment with MCC your Care Coordinator can help you find a PCP in MCC's network. At the end of the 30-day period, if you do not choose a PCP in the MCC network, MCC will assign a PCP to you.

How to Get Care From Other 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. MCC 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.

Changing Your PCP

You may call or visit MCC's Member Services to change your PCP at any time to another PCP in our network. Please understand that it is possible your PCP will leave the MCC network. We will tell you within 30 days of the provider's intent to leave our network. We are happy to help you find a new PCP. The web address for our Member Services program is www.mccofva.com.

Getting an Appointment with Your PCP

Your PCP will take care of most of your health care needs. Call your PCP or visit your PCP's website 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 office visits with symptoms—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 seven (7) calendar days of request
- Second trimester (3 to 6 months)—Within seven (7) calendar days of request

- Third trimester (6 to 9 months)—Within three (3) 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

Travel Time and Distance Standards

MCC 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 receive 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 you should not have to travel more than 60 miles or 75 minutes to receive services.

Member Travel Time & Distance Standards		
Standard	**Distance**	**Time**
Urban PCP Specialists	15 miles 30 miles	30 minutes 45 minutes
Rural PCP Specialists	30 miles 60 miles	45 minutes 75 minutes

Accessibility

MCC 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 to a provider or accessing services because of a disability, contact Member Services at the telephone numbers below for assistance.

Telehealth Visits

MCC supports the use of telehealth visits. A telehealth visit is when you see your doctor over phone or video chat instead of going into their office. Please ask your doctor if they do telehealth visits and what you can do to schedule one. Call Member Services if you need help making an appointment.

Your regular doctor may be able to prescribe certain medications via telehealth visit. Check with your doctor to see if your medications can be prescribed this way.

What If A Provider Leaves MCC's Network?

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 30 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 an appeal of our decision
- If you find out one of your providers is leaving our plan, please contact your Case Manager so we can assist you in finding a new provider and managing your care

What Types of People and Places Are Network Providers?

MCC's 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
- Providers for children with special health care needs
- Behavioral Health and Substance Abuse practitioners, therapists, and counselors

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 MCC's website can give you the most up-to-date information about changes in our network pharmacies and providers.

Services You Can Get Without A Referral or Prior Authorization

In some cases, you will need an approval from your PCP before seeing other providers. This approval is called a **referral**. MCC does not require referrals to see Specialist providers. However, some Specialists that are in the network do require a referral from your PCP. The only time MCC would require a service to be prior authorized would be if the PCP/Provider is referring them to a non-par provider. You can get services like the ones listed below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers
- Urgently needed care from network providers
- Family Planning Services and Supplies
- Routine women's health care services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral

4. How to Get Specialty Care and Services

What are Specialists?

If you need care that your PCP cannot provide, your PCP may send you to see a specialist. Most of the specialists are in MCC's 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.

How Do I Access A Network Specialist?

If you need care that your PCP cannot provide, your PCP may send you to a specialist when needed or appropriate based on your medical needs. Most of the specialists are in MCC's network. A specialist is a doctor who provides health care for a specific disease.

Call us at 1-800-424-4518 (TTY 711) if you need more information about how to find a specialist in our network.

How to Get Care From Out-Of-Network Providers

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

- When MCC 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 MCC's network
- When MCC 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 MCC's network does not, because of moral or religious objections, furnish the service you need
- Within the first 30 calendar days of your enrollment, where your provider is not part of MCC's network but he has treated you in the past
- If you are in a nursing home when you enroll with MCC, and the nursing home is not in MCC's network

If your PCP or MCC 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 14 of this handbook for information about what a patient pay is and how to know if you have one.

How To Get Care From Out of State Providers

MCC 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.

5. How to Get Emergency Care and Services

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 MCC first. 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, please remain calm.

Tell the hospital that you are an MCC member. Ask them to call MCC at the number on the back of your 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.
  - 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 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 MCC's 24/7 medical advice line at 1-800-424-4518 (TTY 711).

If You Have an Emergency When You are 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 MCC card. Tell them you are in MCC's program.

What is Covered If You Have An Emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. Prior authorization is not required for emergency services. If you need an ambulance to get to the emergency room, our plan covers that. 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 MCC About Your Emergency

Notify your doctor and MCC 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 1-800-424-4518 (TTY 711). This number is also listed on the back of MCC's member card.

After An Emergency

MCC will provide necessary follow-up care, including through out-of-network providers, 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 MCC as soon as possible. By keeping MCC 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.

What If It Wasn't A Medical Emergency After All?

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 go to a network provider, or
- the additional care you get is considered "urgently needed care" and you follow the rules for getting urgently needed care. (See Urgently Needed Care in section 6 of this handbook.)

6. How to Get Urgently Needed Care

What is Urgently Needed Care?

Urgently needed care is care you get for a 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. In most situations, we will cover urgently needed care only if you get this care from a 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 www.mccofva.com.

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.

7. How to Get 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 MCC's Outpatient Drug Coverage

MCC will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care. Prescriptions for controlled substances must be written by an in-network doctor or provider.
2. You generally must use a network pharmacy to fill your prescription
3. Your prescribed drug must be on MCC's List of Covered Drugs. If it is not on the Drug List, we may be able to cover it by giving you an authorization. To find the list of covered drugs, you can look in the Member Portal, visit our website, or contact Member Services at the number at the bottom of the page
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 reference books

Getting Your Prescriptions Filled

In most cases, MCC will pay for prescriptions only if they are filled at MCC's 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 (www.mccofva.com), or contact Member Services at the number at the bottom of the page.

To fill your prescription, show your Member ID Card at your network pharmacy. The network pharmacy will bill MCC 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 MCC 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.

List of Covered Drugs

MCC has a List of Covered Drugs that are selected by MCC with the help of a team of doctors and pharmacists. The MCC 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 www.mccofva.com. The List of Covered Drugs tells you which drugs are covered by MCC 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 www.mccofva.com, 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 www.mccofva.com or call 1-800-424-4518 (TTY 711). Member Services is available from 8 a.m. to 8 p.m. local time, Monday through Friday. If you would like a paper copy of the List of Covered Drugs, please call Member Services and we can arrange to mail you a paper copy.

If you are on a drug that is impacted by a change to the List of Covered Drugs, you and your provider will be notified in writing 30 days prior to the change taking effect. We will generally cover a drug on MCC's 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 Transition of Care in section 12 of this handbook.

If MCC is new for you, you can keep getting your authorized drugs for the duration of the authorization or for 90 days after you first enroll, whichever is sooner. Refer to Transition of Care Period in section 11 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 12 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 MCC before you fill your prescription. If you don't get approval, MCC 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 visit our website at www.mccofva.com.

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

What if You Need a Specialized Pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialty drugs are used for treatment of complex diseases and when prescribed the medications required special handling or clinical care support prior to dispensing. Only a limited number of pharmacies are contracted by each MCO to provide these drugs.

These medications will be shipped directly to the member's home or the prescriber office and cannot be picked up at all retail outlets. Also, these drugs usually require a service authorization prior to dispensing. Be sure to check with the formulary of your plan regarding coverage of these specialty drugs and allow time for shipment deliveries.

CVS Caremark Specialty is our preferred specialty pharmacy. We would like you to get your specialty medicine sent through the mail from CVS Caremark Specialty. CVS Caremark Specialty will work closely with you and your provider to give you what you need to effectively manage your condition. MCC limits the days supply on specialty prescriptions to 31 days.

CVS Caremark Specialty pharmacy makes it easy for you to get your specialty medicine with services to help you including:

- Coaching programs to help manage your condition
- Free delivery to your home or another address within two days of ordering
- Supplies at no cost, such as syringes and needles
- Highly trained pharmacists and nurses available to answer any questions
- Insurance specialists to help you get the most out of your benefits
- Online member portal where you can request refills and learn more

If you have a new prescription or if you are requesting a refill from another pharmacy, please call CVS Caremark Specialty Pharmacy to get your medicine delivered to you at no cost. If you do not want to use CVS Caremark Specialty Pharmacy, tell the pharmacy team member at the time of the call and they will make a change that will allow you to continue to get your specialty medicine at your current pharmacy. For questions about our Specialty Pharmacy program, please call 1-800-237-2767.

Can You Use Mail-Order Services To Get Your Prescriptions?

MCC understands that picking up your medications can be challenging at times. If you are having trouble getting your medications from your local pharmacy, we can help by providing them through a mail-order service. Most medications can be mailed to you quickly and securely. For questions about our pharmacy mail-order service, please call 1-844-285-8668.

Can You Get a Long-Term Supply of Drugs?

MCC does not usually allow long-term supplies (for example, 90 days or longer) of medications. But we do provide the option to obtain a long-term supply of medications in some cases. Contact Member Services if you think this is something you may need.

Can You Use a Pharmacy that is not in MCC's Network?

In most cases, we will expect you to use a network pharmacy to get your prescription drugs. This is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies. Please visit our website to locate a pharmacy near you and search for a pharmacy through our Provider Directory. Or call Member Services at 1-800-424-4518 (TTY 711). If you choose to fill your prescriptions at a pharmacy that is not in the MCC network, you may be responsible for the full cost of the medication.

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 inclusion 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 Complaints (Grievances) in section 13 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 MCC 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 MCC if placed in the PUMS program
- Information regarding how request a State Fair Hearing after first exhausting MCC's appeals process
- Information on any special rules to follow for obtaining services, including for emergency or after-hours services
- 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.

8. Benefits

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 services to prevent, diagnose, or treat a medical condition or prevent a condition from getting worse
2. In most cases, you must get your care from a network provider. A network provider is a provider who works with MCC. In most cases, MCC will not pay for care you get from an out-of-network provider unless the service is authorized by MCC. Section 3 has information about Services You Can Get Without First Getting Approval From Your PCP. Section 4 has more information about using network and out-of-network providers
3. Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called service authorization. Section 12 includes more information about service authorizations.
4. If MCC 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. Also see Transition of Care Period in section 12.

Benefits Covered Through MCC

MCC covers all of the following services for you when they are medically necessary.

- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc. See section 3 of this handbook for more information about PCP services
- Preventive care, including regular check-ups, well baby/child care. See section 3 of this handbook for more information about PCP services
- Addiction, recovery, and 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 later in this section of the handbook

- Chiropractic services
  - For EPSDT and FAMIS members only
- Clinic services
- Colorectal cancer screening
- Mental Health and Rehabilitative Services
- Court ordered services
- Durable medical equipment and supplies (DME)
- 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 designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third birthday. 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 5 and 6 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 MCC's network. MCC does not require you to obtain service authorization or PCP referrals on family planning services
- Gender Dysphoria treatment services
- Glucose test strips

- Head Start Program assistance
- Hearing (audiology) services
- 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 testing and environmental investigations working with the local health department
- Mammograms
- Maternity care—includes pregnancy care, doctors/certified nurse-midwife services. Additional information about maternity care is provided in section 6 of this handbook
- Mental health services, including, outpatient psychotherapy services, community-based, crisis and inpatient services. Community and facility-based services include:
  - Mental Health Case Management
  - Therapeutic Day Treatment (TDT) for Children
  - Mental Health Skill-building Services (MHSS)
  - Intensive In-Home
  - Psychosocial Rehabilitation
  - Applied Behavior Analysis
  - Mental Health Peer Recovery Supports Services
  - Mental Health Partial Hospitalization Program
  - Mental Health Intensive Outpatient

  - Assertive Community Treatment
  - Multisystemic Therapy (MST)
  - Functional Family Therapy (FFT)
  - Mobile Crisis
  - Community Stabilization
  - 23-Hour Observation
  - Residential Crisis Stabilization
- 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
- 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 7 of this handbook for more information on pharmacy services.
- Private duty nursing services (through EPSDT) under age 21
- 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 MCC
- Telemedicine services
- Temporary detention orders (TDO)
- Tobacco Cessation Services, education and pharmacotherapy for all members
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs. MCC will also provide transportation to/from most carved-out services. Additional information about transportation services is provided later in this section of the handbook. (Note: Transportation services are not applicable to AMIS)
- Vision services
- Well Visits
- Abortion services—coverage is only available in cases where there would be a substantial danger to life of the mother

* Please refer to the FAMIS addendum for FAMIS benefits.

Extra Benefits We Provide That are not Covered by Medicaid

As a member of MCC 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:

Benefit	Details
Vision	Up to $100 for glasses or contacts every two years for adults 21 and over
Mother-Baby Connections	Text messages with important health information to help: • Understand what is happening with your body • Recognize warning signs • Know what to expect during your delivery You'll also get: • Infant sleep sacks and diapers • An invitation to baby showers hosted by MCC (hosted quarterly per region) • "Baby Basics" book • Rides to WIC appointments, Lamaze and parenting classes
Sports physicals	Annual sports physicals from a primary care physician (PCP) for children ages 10-18
Adult physicals	Routine physicals from a PCP for adults 21 and over
Bicycle helmets	One bicycle helmet per year for children under 18
Transitions of Care for foster children	Backpack with supplies (personal hygiene items, community resource guides, area maps) for foster children leaving foster care

Transitions of Care for adults	Backpack with supplies (personal hygiene items, community resource guides, area maps, pill boxes) for adults with frequent or avoidable emergency room visits
Smart phone	Get a free smart phone with: • 350 free minutes each month • 4.5 GB of data each month • Unlimited text messaging
Complete Care Counts incentives	Get up to $50 in gift cards each year when you do things that help your health, like: • Quit smoking • Get your annual physical • Go to all your doctor visits when pregnant • Seeing your doctor within a week after hospital discharge
Community Connections	Online search tool to help you find important services in your area, like housing, food, job training and more
Post-discharge meals	After you get out of the hospital, you and one family member get three meals delivered each day for up to five days
SaveAround coupon book	Discount coupon book or various retailers.

What is Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly.

EPSDT promotes the early and universal assessment of children's health care needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. EPSDT screenings are conducted by physicians or certified nurse practitioners and can occur during the following:

- Screening/well child check-ups (EPSDT/Periodic screenings)—Checkups that occur at regular intervals.
- Important routine lab tests, such as testing for lead levels in children—this should be done on all children at 12 and 24 months, or at 24 and 72 months for children not previously tested.
- Sick visits (EPSDT/Inter-periodic Screenings)—unscheduled check-ups or problem focused assessments that can happen at any time because of child's illness or a change in condition.

We also cover any and all services identified as necessary to correct, or ameliorate any identified defects or conditions. Coverage is available under EPSDT for services even if the service is not available under the State's Medicaid Plan to the rest of the Medicaid population. All treatment services require service authorization (before the service is rendered by the provider).

How to Access EPSDT Service Coverage

MCC provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by MCC. For any services not covered by MCC, you can get these through the Medicaid fee-for-service program. Additional information is provided in section 11 of this handbook. You can also contact your Care Coordinator by calling MCC Member Services at 1-800-424-4518 (TTY 711).

How to Access Early Intervention Service Coverage

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 services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development. The services include speech therapy, physical therapy, and occupational therapy. The first step is meeting with the local Infant and Toddler Connection program in your community to see if your child is eligible. Children from birth to age three are eligible if they have (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 MCC we provide coverage for early intervention services. If the family requests assistance with transportation and scheduling to receive Early Intervention services, we provide this assistance.

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 https://itcva.online or by calling 1-800-234-1448.

Foster Care and Adoption Assistance

MCC can provide individuals who are in foster care or are receiving adoption assistance with assistance in referrals to providers, transition planning (for youth about to leave the foster care system) and care coordination. In fact, MCC has a case management team that specializes in these services and in working with local Departments of Social Services to help navigate medical and/or behavioral health care and other resources. For more information about these resources, please call Member Services at 1-800-424-4518 (TTY 711), 8 a.m. to 8 p.m. local time, Monday through Friday.

How to Access Maternal and Child Health Services

With your Medicaid or FAMIS MOMS health care coverage, you can get free services to help you have a healthy pregnancy and a healthy baby. Medicaid and FAMIS MOMS pay for your prenatal care and the delivery of your baby. Getting medical care early in your pregnancy is very important.

MCC has programs for pregnant women that include:

- Pregnancy-related and post-partum services
- Prenatal and infant programs
- Services to treat any medical condition that may complicate pregnancy
- Lactation consultation and breast pumps
- Smoking cessation
- Postpartum depression screening

MCC's Mother-Baby Connections program offers you comprehensive ongoing education and support from preconception through the first year of your newborn's life. The Mother-Baby Connections program

empowers you with actionable health information and tools that inform, enable, influence, and incentivize your engagement in self-management promoting healthy behaviors and controlling modifiable risk factors during pregnancy.

Mother-Baby Connections benefits:

- Case management for women and newborns at high risk
- 24/7 Nurse Line and Crisis Line support
- Connection to community-based programs
- Mobile member engagement including
- Text4Baby
- Breastfeeding support
- Preterm labor prevention education
- Substance use program
- Smoking cessation program
- CenteringPregnancy support
- Home visitation programs
- Postpartum care and services including access to Long Acting Reversible Contraceptive (LARC)

Call us at 1-800-424-4518 (TTY 711) if you have any questions or would like more information about our programs.

Enrollment for Newborns

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

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

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

- Name
- Date of Birth
- Race
- Sex
- The infant's mother's name and Medicaid ID number

How to Access Family Planning Services

Family planning services include 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 MCC network.

How to Access Population Health Programs

MCC has programs to help you improve your health and wellness. The Population Health Management (PHM) programs are designed to help keep you healthy, improve your safety and manage multiple chronic illnesses. The programs include:

- Diabetes self-management
- Appropriate emergency department usage
- Smoking cessation
- Wellness program for adults, children, pregnant members and infants

To find out more about these educational and interactive programs, please speak with your assigned care coordinator or call Member Services.

How to Access Complex Case Management

If you have more than one medical condition you are trying to take care of or have recently had a hospitalization or a change in your current health, MCC is here to help. MCC offers a no-cost Complex Case Management program to help you get the medical care and services you need. If you would like help managing your health, you can call Member Services to refer yourself to the Complex Case Management program.

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.

Some Behavioral Health services are covered for you through Molina, the DMAS Behavioral Health Services Administrator (BHSA). MCC's Member Services can help coordinate the services you need, including those that are provided through the BHSA.

We are here to help you make sure that you get the care you need to feel better. We can help make sure you see your provider quickly. Please call if you need help. You can get help in finding a behavioral health or substance abuse provider by calling 1-800-424-4518 (TTY 711). Through our NurseLine, someone is available to help you 24 hours a day and seven days a week.

You can also look in our provider directory. It is available on our website at www.mccofva.com. We will give you the names of providers in your local area if you call. You can choose to call one of these providers for an appointment. You do not need to call your PCP for a referral for substance abuse appointments. Some services do require an approval from us. Your provider will ask for an approval when it is needed.

The services you can get include inpatient and outpatient hospital services and psychiatric services. You can also get a range of behavioral health services. Sometimes you can get these services in your community. Sometimes you can get them in your home or in schools. Some of the behavioral health services you may need for you or a family member include:

- Individual, family and group therapy
- Day treatment for adults and children
- Individual and family assessments
- Evaluations

- Treatment planning
- Psychosocial rehabilitation
- Targeted case management
- Therapeutic behavioral on-site services for children and adolescents

We also offer peer support services such as recovery navigation. This is a service provided by trained peers who use their lived mental health and substance abuse recovery to help others gain hope and move forward with their own recovery.

How to Access Addiction and Recovery Treatment Services (ARTS)

MCC 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, counseling services and behavioral therapy 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 experienced 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.

Our ARTS Care Coordinators have a lot of experience with helping people. They manage substance use benefits, coordinate ARTS services and assess all requests for residential and inpatient treatment. The ARTS Care Coordinators work with providers and MCC staff to complete service requests and authorizations. These authorizations are communicated to providers in a timely way and are documented in our clinical system.

Some members may live in areas that are hard to get to. The Care Coordinators might recommend telehealth services in these cases. They may also schedule assessments in members' homes if telehealth or other services are not possible.

We also offer peer support services such as recovery navigation. This is a service provided by trained peers who use their lived mental health and substance abuse recovery to help others gain hope and move forward with their own recovery.

How to Access Non-Emergency Transportation Services

Transportation Services Covered by MCC

Non-Emergency transportation services are covered by MCC for covered services, carved out services, and enhanced benefits.

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 1-833-273-7416. If you are having problems getting transportation to your appointments, call 1-833-273-7416 or MCC Member Services at the number below. We require 72 hours advanced notice for transportation requests for routine appointments.

In case of a life-threatening emergency, call 911. Refer to How to Get Care for Emergencies in chapter 5 of this handbook.

*Transportation benefits are not applicable to FAMIS.

9. Services Not Covered by MCC

The following services are not covered by Medicaid or MCC. 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
- Christian Science nurses
- Cosmetic treatment or surgery
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers)
- Drugs prescribed to treat hair loss or to bleach skin
- Elective Abortions
- Erectile Dysfunction Drugs
- Experimental or Investigational Procedures
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by MCC)
- Medical care other than emergency services, urgent services, urgent care services, or family planning services, received from providers outside of the network unless authorized by MCC
- 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
- Services are listed as Benefits Covered Through MCC in section 8 of this handbook, and
- You receive services by following plan rules.

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. Section 13 provides instructions for how to appeal MCC's coverage decisions. You may also call Member Services to learn more about your appeal rights or to obtain assistance in filing an appeal.

10. Services Covered Through Medicaid Fee-For-Service

DMAS will provide you with coverage for any of the services listed below. These services are known as "carved-out services." You stay in MCC when receiving these services. Your provider bills fee-for-service Medicaid (or its Contractor) for these services.

Carved Out services

- Dental Services are provided through the DMAS Dental Benefits Administrator. The state has contracted with its DMAS Dental Benefits Administrator to coordinate the delivery of all Medicaid dental services. The dental program 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, 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 will include cleanings, x-rays, exams, fillings, dentures, root canals, gum-related treatment, oral surgery and more

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

  MCC provides coverage for non-emergency transportation for any dental services covered through the DMAS Dental Benefits Administrator, as described above. Contact MCC Member Services at the number below if you need assistance. MCC provides coverage for oral services such as hospitalizations, surgeries or services billed by a medical doctor not a dentist.

- 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.

Services That Will End Your Enrollment

If you receive any of the services below, your enrollment with MCC will close and you will be served by the Medicaid Fee-For-Service program so long as you remain eligible for Medicaid.

- You are receiving care in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- You are receiving care in a Psychiatric Residential Treatment Level C Facility (children under 21)
- You are receiving care in a nursing facility
- You are receiving care in a long-term care facility

11. Member Cost Sharing

There are no copayments for services covered through the Medallion 4.0 program. This includes services that are covered through MCC or services that are carved-out of the Medallion 4.0 contract. The services provided through MCC or through DMAS will not require you to pay any costs other than your patient pay toward long term services and supports. See the *Member Patient Pay* Section below.

Medallion 4.0 does not allow providers to charge you for covered services. MCC 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 9 of this handbook for a list of non-covered services.

Member Patient Pay Toward Services

You may have a patient pay responsibility toward the cost health care services. A patient pay may be calculated for certain members for certain services. When your income exceeds a certain amount, you may be required to contribute toward the cost of certain services. 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 MCC if you are required to pay toward the cost of any services. 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 Medallion 4.0 program. Medallion 4.0 does not pay the copayment for the medicines that Medicare Part D covers.

12. Service Authorization Procedure

Service Authorizations Explained

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. Your doctor makes requests for service authorizations.

If the services you require are covered through Medicare then a service authorization from MCC 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 MCC 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

MCC 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.

To find out more about how to request approval for services or to obtain an authorization you can contact Member Services at 1-800-424-4518 (TTY 711).

Service Authorizations and Transition of Care

If you are new to MCC we will honor any service authorization approvals made by the Department of Medical Assistance Services (DMAS) or issued by another plan for up to 30 days (or until the authorization ends if that is sooner than 30 days).

How to Submit a Service Authorization Request

Members are not required to submit a service authorization. This process will be handled by your provider. If you have questions about the process, please contact Member Services at 1-800-424-4518 (TTY 711).

The following is a list of services that require authorization from your provider. Your provider is required to contact MCC to obtain the authorization. (This list is subject to change and there may be additional services that require authorization).

Benefit	Details
Addiction and Recovery Treatment Services	Yes
Behavioral Health Services	Yes—Inpatient Services
Cardiac (Heart) and Pulmonary (Breathing) Rehab	Yes

Chiropractic Services	Yes—coverage only for those under 21 years old and for FAMIS members
Community Mental Health Rehabilitation Services	Yes—some services require a PA and some services require a notification
Durable Medical Supplies	Yes—some services require a PA
Hearing Aids	Yes, and for FAMIS members
High Tech Radiology (MRI, MRA, PET Scan)	Yes
Home Health	Yes
Inpatient Services	Yes
Laboratory Services	Yes—Genetic Labs
Occupational Therapy	Yes
Orthotics and Prosthetics	Yes

Out of Network Services	Yes
Outpatient Services	Yes—some services require a PA
Pain Management Services	Yes
Physical Therapy	Yes
Prescription Medications and Injections	Yes
Second Opinions	Yes—If the provider is not participating with MCC
Sleep Studies	Yes
Speech Therapy	Yes
Transplants	Yes
Transportation	Yes—some services require a PA

What Happens After Submitting A Service Authorization Request?

MCC has a review team to be sure you receive medically necessary services. Doctors and nurses 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.

After we get your request, we will review it under a standard or expedited (fast) review process. You or your doctor can ask for an expedited review if you believe that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your case will be handled under the standard review process.

Timeframes for Service Authorization Review

In all cases, we will review your request as quickly as your medical condition requires us to do so but no later than mentioned below.

Physical Health Services	Service Authorization Review Timeframes
Inpatient Hospital Services (Standard Review Process)	Within 14 calendar days or as quickly as your condition requires.
Inpatient Hospital Services (Expedited Review Process)	Within 72 hours from receipt of your request; or, as quickly as your condition requires.

Outpatient Services (Standard Review Process)	Within 14 calendar days or as quickly as your condition requires.
Outpatient Services (Expedited Review Process)	Within 72 hours from receipt of your request; or, as quickly as your condition requires.

Behavioral Health Services	**Service Authorization Review Timeframes**
Outpatient (Standard Review Process)	Within 14 calendar days or as quickly as your condition requires.
Inpatient (Standard Review)	Within 14 calendar days or as quickly as your condition requires.

Pharmacy Services	**Service Authorization Review Timeframes**
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 either a standard or expedited decision about your service request we will:

- Write and tell you and your provider what information is needed. If your request is in an expedited review, 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 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 MCC to help decide your case. This can be done by calling 1-800-424-4518 (TTY 711).

You or someone you trust can file a complaint with MCC 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 complaint about the way MCC handled your service authorization request to the State through the Managed Care Helpline at 1-800-643-2273. Also see Your Right to File a Complaint in section 13 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 13 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 name 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 13 of this Handbook.

Continuation of Care

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.

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 MCC even if we later deny payment to the provider.

13. Appeals, State Fair Hearings, and Complaints (Grievances)

Your Right To Appeal

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

For example, you can appeal if MCC denies:

- A request for a health care service, supply, item or drug that you think you should be able to get,
- Services have been decreased or stopped, or
- A request for payment of a health care service, supply, item, or drug that MCC denied.

You can also appeal if MCC stops providing or paying for all or a part of a service or drug you receive 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 MCC 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 and giving them permission to act on your behalf.

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 12 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 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 another 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:

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

or you can call 1-800-424-4518 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday through Friday.

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 5 calendar 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 writing to:
Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

In person to
Appeals and Grievance
Molina Healthcare, Inc.
3829 Gaskins Road
Richmond, VA 23233

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 30 days of when we receive your appeal request. We will tell you within 2 calendar days after receiving your appeal if we need more information. A written notice of our decision will be sent within 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 and we will send a written notice and attempt to provide oral notice within this timeframe. If there is a need for additional documentation or if a delay in rendering a decision is in your interest the timeframe for an expedited appeal decision, the timeframe may be increased up to an additional 14 days.

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 MCC to help decide your case. This can be done by calling or writing to:

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

or you can call 1-800-424-4518 (TTY 711) from 8:00 a.m. to 8:00 p.m., Monday through Friday.

You or someone you trust can file a complaint with MCC 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 complaint about the way MCC handled your appeal to the State through the Help Line at 1-800-643-2273.

Written Notice of Appeal Decision

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.

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 name 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) MCC's 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.

Standard or Expedited Review Requests

For appeals that will be heard by DMAS you will have an answer generally within 90 days from the date you filed your appeal with MCC. The 90 day timeframe does not include the number of days between our decision on your appeal and the date you sent your State fair hearing request to DMAS. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited appeal within 72 hours of receiving the letter from your doctor.

Authorized Representative

You can give someone like your PCP, provider, friend, 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

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

1. **Electronically.** Online at www.dmas.virginia.gov/#/appealsresources or email to appeals@dmas.virginia.gov
2. **By fax.** Fax your appeal request to DMAS at (804) 452-5454

3. **By mail or in person.** Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219

4. **By phone.** Call DMAS at (804) 371-8488 (TTY: 1-800-828-1120)

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

After You File Your State Fair Hearing Appeal

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

State Fair Hearing Timeframes

Expedited Appeal

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

Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will give you an answer within 90 days from the date you filed your appeal with MCC. The 90-day timeframe does not include the number of days between our decision on your appeal and the date you sent your State Fair Hearing request to DMAS. 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 MCC for any services you receive during the continued coverage period if MCC's 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, MCC must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date MCC 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, MCC 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 Complaint

MCC 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 complaint or as an appeal.

What Kinds of Problems Should be Complaints

The complaint 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 MCC's complaint process.

Complaints about quality

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

Complaints about privacy

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

Complaints about poor customer service

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

Complaints 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

Complaints 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

Complaints 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 MCC staff

Complaints about cleanliness

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

Complaints 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 Complaints

You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by MCC. An external complaint is filed with and reviewed by an organization that is not affiliated with MCC.

Internal Complaints

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

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030
Phone: 1-800-424-4518 (TTY 711)

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

We will notify you of the outcome of your complaint within a reasonable time, but **no later than 30 calendar days after we receive your complaint.**

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

External Complaints

You Can File a Complaint with the Managed Care Helpline

You can make a complaint about MCC to the Managed Care Helpline at 1-800-643-2273 (TTY 1-800-817-6608) 8:30 a.m. to 6 p.m. local time, Monday through Friday.

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.

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

14. Member Rights

Your Rights

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

- Receive timely access to care and services in accordance with MCC contracts and federal and state regulations
- Receive a prompt response to questions and requests
- Know who is providing your medical services and care
- Know what services are available to you. This includes if you need an interpreter because you don't speak English
- Participate with practitioners in making decisions about your health care, including the right to refuse treatment
- Choose to receive long term services and supports in your home or community or in a nursing facility
- Have confidentiality and privacy about your medical records and when you get treatment
- Receive information on available treatment options and alternatives presented in a manner appropriate to your condition and ability to understand
- Have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit
- Receive treatment for any emergency medical condition that will deteriorate from failure to rovide treatment
- Know if medical treatment is for the purpose of experimental research. If it is, the member can refuse or accept the services
- 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 recognition for your dignity and right to privacy
- Request and receive a copy of your medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion
- Get care in a culturally competent manner without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status, religion, handicap or source of payment
- Be informed of where, when and how to obtain the services you need from MCC, including how you can receive benefits from out-of-network providers if the services are not available in MCC's network
- Receive full information and counseling on the availability of known financial resources for your care
- Know whether a health care provider or facility accepts the MCC contract rates
- Receive in writing from the provider, before receiving any non-covered services, notice:
  - of the non-covered service(s) to be rendered
  - that said services are not covered under the member benefits
  - that you will be liable for the cost of the service(s)
  - the cost of the service(s)

  If requested, please provide a copy of such writing to MCC. If the member does not agree to pay for such non-covered services in writing, neither the member nor MCC is liable for the cost
- Freely exercise your rights in a way that does not adversely affect the way the provider treats you
- Voice complaints or file appeals to the State about MCC or the care it provides. You can call the Helpline at 1-800-643-2273 to make a complaint 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 14 of this handbook for information about Advance Directives
- Change your health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference section 2 of this handbook or call the Managed Care Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) or visit the website at www.virginiamanagedcare.com for more information
- Appeal any adverse benefit determination (decision) by MCC that you disagree with that relates to coverage or payment of services. See Your Right to Appeal in this section 12 of the handbook
- File a complaint 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 Complaint in section 12 of this handbook
- Receive information about MCC, its services, its practitioners and providers and member rights and responsibilities
- Make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this section of the handbook)
- Exercise your rights and to know that you will not have any retaliation against you by MCC, or any of our doctors/providers or state agencies

Your Right to be Safe

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

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

Your Right to Confidentiality

MCC 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.

MCC staff will ask questions to confirm your identity before we discuss or provide any information regarding your health information.

Information about your medical conditions and services is kept very safe. All applicable confidentiality laws and regulations are followed by MCC, including those special rules related to substance use disorder and addiction, recovery and treatment services. We only share this information with others when you tell us it is okay to do so. If, for example, you would like for us to share this information with your family or other providers, we will ask you to sign a release form.

Your Right to Privacy

MCC believes in protecting the privacy of your health information. We may only use or disclose your Protected Health Information (PHI) for very specific reasons, and will not release your health information to unauthorized individuals without your permission. PHI is any information related to a person's health that identifies an individual. This information can be electronic or in any other format. Different types of uses and disclosures are listed and explained in further detail in our Notice of Privacy Practices, which can be found on our website. This notice also lists in detail your rights to privacy as an MCC member.

MCC follows all Commonwealth and federal laws and regulations relating to privacy. This includes the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have rules that protect your health information in all forms—oral, written, and electronic. We protect the following information:

- Member name
- Member ID number
- Member address
- Member telephone number
- Social security number
- Date of birth

- Health status
- Names of your doctors

The Notice of Privacy Practices lists your rights under HIPAA. You have the right to see, correct and get copies of your PHI. Members can complete the authorization use and disclosure form to provide consent to share your PHI with authorized individuals. MCC will go over the authorization use and disclosure form with you if necessary. This form asks if you want to share your information with others involved in your care. This helps to coordinate your health care. This form can be found on the MCC website. Member Services can also provide you with the form. You can cancel your permission at any time.

If you need help, call Member Services toll-free at 1-800-424-4518 (TTY 711).

How to Join the Member Advisory Committee

MCC 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 MCC 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.

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

15. Member Responsibilities

Your Responsibilities

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

- Present your MCC membership card whenever you seek medical care
- Provide complete and accurate information to the best of your ability on your health and medical history to MCC and its practitioners and providers need in order to provide care
- Report unexpected changes in your health status
- Participate in your care team meetings (if applicable), develop an understanding of your health problems and provide input in developing mutually agreed upon treatment goals to the best of your ability
- Keep your doctor appointments. If you must cancel, call as soon as you can
- Follow your provider's conduct rules and regulations
- Follow plans and instructions for care that you have agreed to with your practitioners
- Receive all of your covered services from MCC's network
- Obtain authorization from MCC prior to receiving services that require a service authorization review (see section 11)
- Call MCC whenever you have a question regarding your membership or if you need assistance toll-free at one of the numbers below
- Tell MCC 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
- Follow plans and instructions for care you have agreed to with your providers
- Tell MCC 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. You can also contact Member Services to ask for the form.

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: 1-804-367-4691
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
FAX	1-804-527-4424
EMAIL	enfcomplaints@dhp.virginia.gov
WEB SITE	http://www.dhp.virginia.gov/PractitionerResources/Enforcement/

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: 1-804-367-2106
WRITE	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1463
FAX	1-804-527-4503
EMAIL	OLC-Complaints@vdh.virginia.gov
WEB SITE	http://www.vdh.virginia.gov/licensure-and-certification/

16. 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 him/herself 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

If you think someone, including a provider, is committing fraud, waste or abuse, please report it to us. We have several ways for you to make a report. For example, our Corporate Compliance hotline is available 24 hours a day, seven days a week. It is handled by an outside company. Callers do not have to give their names. All calls are confidential and reports made will be reviewed carefully.

To report fraud, waste, and abuse to MCC:

- Molina Alert Line: 1-866-606-3889
- Website: https://molinahealthcare.alertline.com

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
Recipient Fraud: 1-800-371-0824 or 1-804-786-1066
Provider Fraud: 1-800-371-0824 or 1-804-786-2071

Virginia Medicaid Fraud Control Unit (Office of the Attorney General)
Email: MFCU_mail@oag.state.va.us
Fax: 1-804-786-3509
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: 1-804-371-0165
Email: covhotline@osig.virginia.gov
Mail: State FWA Hotline
101 N. 14th Street
The James Monroe Building 7th Floor
Richmond, VA 23219

17. Other Important Resources

24-Hour NurseLine

Call when you need medical advice and don't have time to go to the doctor. Available 24/7 and 365 days per year. 1-800-424-4518

Care Connection for Children

This statewide network of providers for Children and Youth with Special Health Care Needs (CYSHCN) offers the following services:

- leadership in the enhancement of specialty medical services
- care coordination
- insurance benefits evaluation and coordination
- information and referral to CYSHCN resources
- family-to-family support
- training and consultation with community providers on CYSHCN issue

http://www.vdh.virginia.gov/care-connection-for-children/

Cover Virginia

Cover Virginia provides information about Virginia's Medicaid and FAMIS programs for children, pregnant women and adults. You can also get information about health insurance options available through the Federal Marketplace for individuals who don't qualify for Medicaid. You can apply online or search for someone who can assist you with your application in person.

833-5CALLVA (TDD: 1-888-221-1590)

http://www.coverva.org

Employment Services

These resources can help you find employment opportunities in your area.

https://mccofva.auntbertha.com/

https://www.resourceva.com/

Head Start

This national child development program for children from birth to age five provides services to promote academic, social and emotional development for income-eligible families.

http://www.headstartva.org/

Virginia Housing Development Authority (VHDA)

The VHDA offers affordable housing opportunities for Virginians who otherwise might not be able to afford quality housing. They also provide developers of low-to-moderate-income housing with access to financial resources and tax incentives.

https://www.vhda.com

Virginia Department of Health (VDH)

The VDH protects the health and well-being of all people in Virginia. They provide resources to help find local health screenings and services. They have a local directory of all health departments in Virginia on their website.

http://www.vdh.virginia.gov/

Lead Environmental Investigations

The VDH has posted information about the dangers of elevated blood lead levels in children, and how to request a screening for your family.

https://www.vdh.virginia.gov/epidemiology/epidemiology-fact-sheets/elevated-blood-lead-levels-in-children/

Virginia Department of Medical Assistance (DMAS)

DMAS is the agency that administers Medicaid and the State Children's Health Insurance program in Virginia. Its website includes a wealth of information on all Medical Assistance programs in Virginia.

Recipient Help Line: 1-804-786-6145

http://www.dmas.virginia.gov/

WIC (Women, Infants and Children)

WIC is a supplemental nutrition program for pregnant women, breastfeeding women, women who have had a baby within the last six months, infants, and children under the age of five. WIC provides eligible applicants with:

- breastfeeding support
- nutrition education
- referrals to appropriate health agencies
- nutritious foods
- and counseling at WIC clinics

WIC is administered by the State Department of Health through a grant provided by the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA).

1-877-835-5942

http://www.vdh.virginia.gov/wic/

18. Key Words and Definitions Used in this Handbook

The definitions below apply throughout the entirety of this Handbook and will help you understand important terms regarding your health care. Please call us at 1-800-424-4518 (TTY 711) if you have any questions or need assistance with any of the information below.

- **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 MCC 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 MCC's 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 MCC 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.

- **NurseLine (or 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.
- **Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."
- **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 MCC.
- **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 MCC.
- **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 MCC. MCC 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.
- **Member Services:** A department within MCC responsible for answering your questions about your membership, benefits, grievances, and appeals.
- **Model of care:** A way of providing high-quality care. The 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 MCC and accept our payment and not charge our members an extra amount. While you are a member of MCC, 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 MCC members. We call them "network pharmacies" because they have agreed to work with MCC. 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 MCC and is not under contract to provide covered services to members of MCC.
- **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.
- **Out-of-network provider or Out-of-network facility:** A provider or facility that is not employed, owned, or operated by MCC and is not under contract to provide covered services to members of MCC.
- **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 MCC. Participating providers are also "in-network providers" or "plan providers."
- **Physician services:** Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.
- **Plan (or 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.
- **Premium:** A monthly payment a health plan receives to provide you with health care coverage.
- **Prescription drug coverage:** Prescription drugs or medications covered (paid) by MCC. 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 MCC, including doctors, nurses, behavioral health providers and specialists.
- **Referral:** In most cases you PCP must give you approval before you can use other providers in MCC's 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 MCC 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 MCC.
- **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.
- **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.

CALL	1-800-424-4518 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m. local time, Monday through Friday. Member Services also has free language interpreter services available for non-English speakers.
TTY	TTY 711 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m. local time, Monday through Friday.
FAX	1-855-472-8574
WRITE	3829 Gaskins Road, Richmond VA 23233
WEB SITE	www.mccofva.com

19. Summary of FAMIS covered services

If you have a child who is a FAMIS member, his or her covered services will be different from Medallion services. Please see the chart below for a list of FAMIS covered services. FAMIS benefits are provided within at least an equal amount, duration, and scope as the benefits that are available under the State Medicaid fee-for-service program, and as further defined in the Medicaid State Plan, DMAS policy and guidance documents.

If you have questions or need help with any of these services, please call Member Services at 1-800-424-4518 (TTY 711).

Service	**FAMIS-covered**	**Network cost-sharing & benefit limits**		**Notes and day limitations**
		<150% poverty	**>150% poverty**	
Inpatient hospital services	Yes	$15 per stay	$25 per stay	MCC will cover inpatient stays in general acute care and rehabilitation hospitals for up to 365 days.
Outpatient hospital services	Yes	$2 per visit (waived if admitted)	5$ per visit (waived if admitted)	MCC will cover outpatient hospital services that: • Are meant to prevent illness. • Diagnose an illness or condition. • Treat an illness or condition. • Restore your health after an illness • Reduce the symptoms of an illness or condition.

				Outpatient services include: • Emergency services. • Surgical services. • Diagnostic services. • Professional provider services. Facility charges will also be covered.
Chiropractic services	Yes	$2 (limited to $500 per calendar year)	$5 (limited to $500 per calendar year)	MCC will provide $500 per year toward spinal manipulation and outpatient chiropractic services that are medically needed to treat an illness or injury.
Clinic services	Yes	$2	$5	MCC will cover clinic services. These services are provided at a clinic that is not part of a hospital. A clinic provides outpatient medical care. These services: • Are meant to prevent illness. • Diagnose an illness or condition. • Treat an illness or condition. • Restore your health after an illness. • Reduce the symptoms of an illness or condition. With the exception of nurse-midwife services, these services are provided by a doctor or dentist. Renal dialysis clinic visits are also covered. There are no copayments for maternity services.
Outpatient doctor visit in the office or hospital *Primary care* *Specialty care* *Maternity Services*		$0	$0	

Court-ordered services	No	N/A	N/A	MCC does not cover court-ordered services in most cases. However, if these services are both medically needed and are covered by FAMIS, they will be covered.
Dental services	No, except in certain cases	N/A	N/A	MCC covers anesthesia and hospitalization services if they are needed to provide dental care as determined by a physician. Pediatric dental services are covered through the Smiles for Children program. This applies to eligible children up to age 21. For more information on these benefits, call 1-888-912-3456.
Early intervention services	Yes	N/A	N/A	MCC will cover early intervention services that meet the developmental needs of children and enhance the development of children from birth to the day before their third birthday. We will cover other medically needed and appropriate rehabilitative and developmental therapies for children enrolled in early intervention services. These services are based on programs required by the Commonwealth of Virginia.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	No	N/A	N/A	EPSDT services are not covered under FAMIS. Well-baby and well-child care services are covered.

Emergency services using prudent layperson standards for access	Yes			If you or your covered family member have a medical emergency and you feel you need to go to the emergency room, MCC will reimburse you for the services needed to determine if your condition is an emergency. Members who visit the emergency room shall pay the emergency room co-payment. If it is found that the visit is a non-emergency, the hospital may bill you only for the difference between the emergency room and non-emergency co-payments. The hospital may not bill you for additional charges. We will cover all emergency services provided by out-of-network providers. We do not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services that you need in an emergency.
Hospital emergency room		$2 per visit	$5 per visit	
Physician care		$2 per visit waived if part of ER visit for true emergency	$5 per visit waived if part of ER visit for true emergency	
Non-emergency use of the emergency room		$10 per visit	$25 per visit	

Post-stabilization care following emergency services	Yes	N/A	N/A	MCC will cover services following an emergency that a treating doctor believes are medically needed AFTER an emergency medical condition has been stabilized. These services do not need an authorization even if the provider is not in network with MCC.
Experimental and investigational procedures	No	N/A	N/A	Experimental and investigational procedures are not covered under FAMIS.
Family planning services	Yes	$2 per visit	$5 per visit	MCC will cover all family planning services. This includes services, drugs and devices for individuals of childbearing age that delay or prevent pregnancy. This does not include services to treat infertility or to promote fertility. FAMIS-covered services include drugs and devices provided under the supervision of a doctor. You may go to any provider you choose for these services. In Virginia, minors are considered adults in this case and can consent to medical services needed to receive birth control, pregnancy or family planning, except for sexual sterilization.
Hearing aids	Yes	$2	$5	MCC will cover hearing aids twice every five years.

Home health services	Yes	$2 per visit	$5 per visit	MCC will cover home health services. This includes: • Nursing and personal care services. • Home health aide services. • Physical therapy. • Occupational therapy. • Up to 90 visits per calendar year for speech, hearing and inhalation therapy. Personal care means a person can get help with: • Walking. • Taking a bath. • Dressing. • Taking medicine. • Learning self-help skills. • Doing a few needed housekeeping tasks. The following services are not covered by FAMIS: • Medical social services. • Services that would not be paid for by FAMIS if provided to patient in a hospital. • Community food service delivery arrangements. • Domestic or housekeeping services that are not related to patient care.

				• Custodial care. (This is patient care that mostly requires protective services rather than medical and skilled nursing care services.) • Services related to cosmetic surgery.
Hospice services	Yes	$0	$0	MCC will cover hospice care services. This can be home or inpatient care as long as it is provided directly by or under the direction of a licensed hospice and is medically needed. Hospice care services are available if the member is diagnosed with a terminal illness with a life expectancy of six months or fewer. Hospice care is available to your child along with any other care they are receiving if a diagnosis of terminal illness has been made.
Immunizations	Yes	$0	$0	MCC will cover immunizations. We will also provide education about immunization services to members. **FAMIS-eligible members do not qualify for the Free Vaccines for Children Program.**

Inpatient behavioral health services	Yes	$15 per stay	$25 per stay	MCC covers inpatient behavioral health services for up to 365 days per stay. This includes partial day treatment services. These services may include: • Room. • Meals. • General nursing services. • Prescribed drugs. • Emergency room services leading directly to admission MCC does not cover any services provided in a free-standing psychiatric hospital to members up to 19 years of age. MCC does cover medically necessary inpatient psychiatric services provided in a psychiatric unit of a general hospital for FAMIS members. Psychiatric residential treatment (level C) services are not covered under FAMIS.
Inpatient rehabilitation hospitals	Yes	$15 per stay	$25 per stay	MCC will cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and that have been certified by the Department of Health.
Inpatient substance abuse services	Yes	$15 per stay	$25 per stay	MCC covers inpatient substance abuse services received in a substance abuse treatment facility.

Laboratory and X-ray services	Yes	$2 per visit	$5 per visit	MCC covers all laboratory and x-ray services ordered, prescribed and directed or performed by a licensed provider. For example, a doctor, or practitioner in appropriate settings such as a doctor's office, hospital, or lab. There is no copay for laboratory or x-ray services provided as part of a doctor visit.
Lead testing	Yes	$0	$0	MCC covers blood lead testing as part of well-baby and well-child care.
Lead investigations	Yes	$0	$0	MCC covers lead investigations by local health departments. These find sources of lead contamination in the homes of children who have been diagnosed with high levels of lead in their blood. Environmental investigations are done by local health departments. MCC covers two environmental investigations per residence. Contact your local health department for more information on lead and environmental investigations: https://www.vdh.virginia.gov/epidemiology/epidemiology-fact-sheets/elevated-blood-lead-levels-in-children/
Mammograms	Yes	$0	$0	MCC covers low-dose screening mammograms for finding the presence of breast cancer.

Medical supplies *Medical equipment*	Yes	$0 for supplies $2 per item for equipment	$0 for supplies $5 per item for equipment	MCC covers durable medical equipment (DME) and other medically related or remedial devices. This includes: • Prosthetic devices. • Implants. • Eyeglasses. • Hearing aids. • Dental devices. • Adaptive devices. Durable medical equipment, prosthetic devices and eyeglasses are covered when medically needed. MCC also covers supplies and equipment needed to provide tube feeding. Specialized DME will be covered if approved by MCC. There is no copayment for medical supplies. Medical equipment will require a copayment.

Medical transportation	Yes	$2	$5	MCC covers medically needed professional ambulance services when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically needed. It also includes transportation to a doctor visit if your child cannot ride safely in a car due to a medical condition. This could be a condition you or your child have. These rides must be set up by your doctor and approved ahead of time. Ambulance services will be covered if a member's condition suddenly becomes worse and he or she must go to a local hospital's emergency room. **Transportation services are not provided for routine access to and from providers for routine medical services.**

Organ transplantation	Yes	$15 per stay and $2 per outpatient visit (Services to identify donor limited to $25,000 per member)	$25 per stay and $5 per outpatient visit (Services to identify donor limited to $25,000 per member)	MCC covers organ transplantation services. These must be medically needed and based on industry treatment standards for all eligible individuals. This includes : • Tissue transplants. • Autologous, allogeneic or synegenic bone marrow transplants or other forms of stem cell rescue for children with lymphoma and myeloma. • Kidney transplants for patients with dialysis dependent kidney failure. • Heart, liver, pancreas, and single lung transplants. Any necessary procurement or donor-related services are also covered. Transplant procedures determined to be experimental or investigational may not be covered.

Outpatient behavioral health and substance abuse services	Yes	$2 per visit	$5 per visit	MCC will cover outpatient behavioral health and substance abuse treatment services. The following services are covered by DMAS: • Emergency counseling services. • Intensive outpatient services. • Day treatment. • Substance abuse case management services.
Community Mental Health Rehabilitative Services (CMHRS)	Yes	N/A	N/A	The following CMHRS services are covered under FAMIS: • Intensive in-home. • Therapeutic day treatment. • Behavioral health crisis intervention. • Substance abuse crisis intervention. • Behavioral health case management services.
Pap smears	Yes	$0	$0	MCC will cover annual pap smears.

Physical therapy, occupational therapy, speech pathology and audiology services	Yes	$2 per visit	$5 per visit	MCC will cover therapy services that are medically needed to treat or promote recovery from an illness or injury. This includes: • Physical therapy. • Speech therapy. • Occupational therapy. • Inhalation therapy. • Intravenous therapy. Services provided by a school health clinic as part of an individualized education plan (IEP) may not be covered.

Physician services (services provided by a doctor)	Yes	$0	$0	MCC covers all symptomatic visits provided by doctors or doctor extenders within the scope of their licenses. This includes doctors' services while in a hospital, outpatient hospital departments, in a clinic or at a doctor's office. We do not cover cosmetic services unless they are performed for medically needed reasons.
Inpatient doctor care		$2 per visit	$5 per visit	
Outpatient doctor visit in the office or hospital		$2 per visit	$5 per visit	
Primary care *Specialty care* *Maternity services*		$0 per visit	$0 per visit	
Pregnancy-related services	Yes	$0	$0	MCC covers services to pregnant women, including prenatal services for FAMIS and FAMIS MOMS. There is no co-pay for pregnancy-related services. **No cost-sharing at all will be charged to members enrolled in FAMIS MOMS.**

Prescription drugs	Yes	N/A	N/A	MCC covers all medically needed drugs for its members that require a prescription. We cover all FAMIS-covered prescription drugs prescribed by licensed providers, such as doctors, or outpatient behavioral health providers. Drug Efficacy Study Implementation (DESI) drugs or over-the-counter prescriptions may not be covered. If a generic is available, you must pay the copayment **plus** 100% of the difference between the allowable charge of the generic drug and the brand drug.
Retail up to 34-day supply		$2 per prescription	$5 per prescription	
Retail 35-90-day supply		$4 per prescription	$10 per prescription	
Mail service up to 90-day supply		$4 per prescription	$10 per prescription	
Private duty nursing services	Yes	$2 per visit	$5 per visit	MCC covers private duty nursing services only if: • The services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). • The services are medically needed. • The nurse is not a relative or part of the member's family. • Your provider explains why the services are required. • Your provider describes the medically skilled service to be provided. Private duty nursing services must be pre-authorized.

Prosthetics/ orthotics	Yes	$2 per item	$5 per item	MCC covers prosthetic services and devices. This includes artificial arms, legs and their necessary supportive attachments for all members. We will cover medically needed orthotics when recommended as part of an approved intensive rehabilitation program. This will include braces, splints, ankle, and foot orthoses.
Psychiatric residential treatment services	No	N/A	N/A	This service is not covered under FAMIS.
School health services	Yes*	N/A	N/A	MCC does not cover school-based services provided by a local education agency or public school system. But, if your child is receiving these services, we will not deny medically needed outpatient or home setting therapies based on the fact that the child is also receiving therapies at school. Services provided by a school health clinic as part of an individualized education plan may not be covered.

Second opinions	Yes	$2 per visit	$5 per visit	MCC will cover doctor visits for second opinions when requested. We will do this for the purpose of diagnosing an illness and/or confirming a treatment plan. We will cover second opinions from a qualified health care professional within our network, or arrange for you to get one outside the network, at no cost to you. We may ask for an authorization to receive specialty care for an appropriate provider.
Skilled nursing facility care	Yes	$15 per stay	$25 per stay	MCC will cover medically needed services that are provided in a skilled nursing facility for up to 180 days per stay.
Telemedicine services	Yes	N/A	N/A	MCC will cover medically needed telemedicine services. These services use an interactive audio/video connection for medical diagnosis and treatment. A doctor or nurse practitioner must provide these services to be covered.
Temporary detention orders	No	N/A	N/A	Temporary detention order services are not covered under FAMIS. Coverage may be available through the State Temporary Detention Order program.
Therapy services	Yes	$15 per stay if inpatient $2 per visit outpatient	$25 per stay if inpatient $5 per visit outpatient	MCC will cover the costs of: • Renal dialysis. • Chemotherapy. • Radiation therapy. • Intravenous and inhalation therapy.

Tobacco dependence treatment (i.e., help quitting tobacco or smoking) for pregnant women	Yes	N/A	N/A	MCC covers tobacco dependence treatment **for pregnant women without cost-sharing**. This treatment includes counseling and pharmacotherapy.
Transportation	No	N/A	N/A	Transportation services are not covered under FAMIS for routine access to and from providers for routine medical services.
Well-baby and well-child care	Yes	$0	$0	MCC covers all routine well-baby and well-child care. This includes routine office visits with health assessments and physical exams. It also includes routine lab work and immunizations. Well-child visits provided at home, office and other outpatient provider locations are covered according to the American Academy of Pediatrics' recommended periodicity schedule. Hearing services: All newborn infants will be given a hearing screening before discharge from the hospital after birth.

Vision services **Once every 24 months:**		N/A	N/A	MCC covers diagnostic exams and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions are allowed at least once in 24 months. You can get a routine eye exam once every two years. We will cover eyeglasses (one pair of frames and one pair of lenses) or contact lenses prescribed as medically needed by an eye doctor or by an optometrist..
Routine eye exam		$2 member payment	$5 member payment	
Eyeglass frames (one pair)		$25 reimbursed by plan	$25 reembolsados por el plan	
***Eyeglass lenses (one pair)*:**				
single vision		$35 reimbursed by plan	$35 reimbursed by plan	
bifocal		$50 reimbursed by plan	$50 reimbursed by plan	
trifocal		$88.50 reimbursed by plan	$88.50 reimbursed by plan	
contact lenses		$100 reimbursed by plan	$100 reimbursed by plan	

Inpatient behavioral health services provided in a freestanding psychiatric hospital	No	N/A	N/A	Services received in free-standing psychiatric hospitals by members up to 19 years of age are not covered by FAMIS. However, medically needed inpatient psychiatric services provided in a psychiatric unit of a general acute care hospital are covered for all FAMIS members.
Abortions	No	N/A	N/A	Abortion services are not covered under FAMIS.
Cost-sharing: *Annual co-payment limit*		Calendar year limit: $180 per family	Calendar year limit: $350 per family	Once you and your family have reached the yearly limit for co-payments, you will no longer be charged until the start of the next 12-month period. No cost-sharing will be charged to American Indians and Alaska Natives. No cost-sharing will be charged for well-child visits, or for pregnancy-related services.
FAMIS MOMS				These benefits are the same as those available under MEDALLION 4.0.

20. FAMIS Appeals and Complaints (Grievances)

Your Right To Appeal

You have the right to appeal decisions that affect you or your child's services. For example, you can appeal if MCC denies:

- A request for a health care service, supply, item or drug that you think you or your child should be able to get,
- Services that have been decreased or stopped, or
- A request for payment of a health care service, supply, item, or drug that MCC denied.

You can also appeal if MCC stops providing or paying for all or a part of a service or drug you or your child receives 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 MCC 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 and giving them permission to act on your behalf.

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 12 of this handbook.

If you exhaust your appeal process with MCC, you or your authorized representative has the right to have your case reviewed by an independent External Review Organization. Your appeal to the External Review Organization must be filed within 30 calendar days of your notices of final determination you received from us.

How to Submit Your Appeal to DMAS

If you are not satisfied with a decision we made about your service authorization request, you have 60 calendar days after hearing from us to file an appeal. You or your designee must submit a written request to DMAS for external review within 30 calendar days of receipt of the final MCC Appeal Decision Letter. 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 another 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. FAMIS members must exhaust MCC's internal appeals process before initiating external review.

You or your designee must submit a written request to DMAS for external review within 30 calendar days of receipt of the final MCC Appeal Decision Letter, if you disagree with our final decision.

Please mail external review requests to:

FAMIS External Review c/o KePro
2810 N. Parham Road Suite 305
Henrico, VA 23294

Or via web at: https://dmas.kepro.com/

Please include: your name, your child's name and ID number, your phone number with area code, and copies of any relevant notices or information. Or you can call 1-800-424-4518 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday through Friday.

If you request your standard appeal by phone, it must be followed up in writing within 10 calendar days of your verbal request. 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

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 writing:
Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

In person:
Appeals & Grievance
Molina Healthcare, Inc.
3829 Gaskins Road
Richmond, VA 23233

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

Expedited Appeals

If MCC has all the information needed, expedited appeal decisions will be made within 72 hours of receipt of your appeal. We will tell you our decision by phone and send a written notice within 2 calendar days from when we make the decision.

If MCC Needs 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 MCC to help decide your case. This can be done by calling or writing to:

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030

or 1-800-424-4518 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday through Friday.

You or someone you trust can file a complaint with MCC 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 complaint about the way MCC handled your appeal to the State through the Help Line at 1-800-643-2273.

Written Notice of Appeal Decision

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

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 name of the person responsible for making the adverse determination. We will explain your right to appeal through the external review process if you do not agree with our decision.

Your Right to an External Review

If you disagree with our decision on your appeal request, you can appeal directly to the external review organization within 30 days of receipt of the final MCC Appeal Decision Letter. This process is known as an external review. You may also submit a request for an external review 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) MCC appeals process before you can file an appeal request through the external review process. If we do not respond to your appeal request timely DMAS will count this as an exhausted appeal.

Standard or Expedited Review Requests

For, appeals that will be heard by the external review organization you will have an answer generally within 90 days from the date you filed your appeal with MCC. The 90-day timeframe does not include the number of

days between our decision on your appeal and the date you sent your external review. If you want your external review request to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to the external review organization that explains why you need an expedited appeal. The external review organization will tell you if you qualify for an expedited appeal within 72 hours of receiving the letter from your doctor.

Authorized Representative

You can give someone like your PCP, provider, friend, 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 External Review Request

You or your representative must send your standard or expedited appeal request to mail or email. Send external review requests to the external review organization 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 internet at https://www.dmas.virginia.gov/media/1767/medicaid-or-famis-appeal-request-form.pdf. You should also send the external review organization a copy of the letter we sent to you in response to your Appeal.

You must sign the appeal request and send it to:
FAMIS External Review c/o KePro
2810 N. Parham Road Suite 305
Henrico, VA 23294

Or via web at: https://dmas.kepro.com/

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

Standard and Expedited Appeals may also be made by calling 1-804-371-8488.

After You File Your External Review Appeal

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

External Review 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 will still 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 give you an answer within 90 days from the date you filed your appeal with MCC. The 90-day timeframe does not include the number of days between our decision on your appeal and the date you sent your State fair hearing request to DMAS. 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 the External Review Organization 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 MCC for any services you receive during the continued coverage period if MCC's adverse benefit determination is upheld and the services were provided solely because of the requirements described in this section.

If the External Review Organization Reverses the Denial

If services were not continued while the external review was pending

If the external review decision is to reverse the denial, MCC must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date MCC receives notice from the State reversing the denial.

If services were provided while the external review was pending
If the external review decision is to reverse the denial and services were provided while the appeal is pending, MCC must pay for those services, in accordance with State policy and regulations.

If You Disagree with the External Review Organization's Decision

The external review 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 Complaint

MCC 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 complaint or as an appeal.

What Kinds of Problems Should be Complaints

The complaint 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 MCC's complaint process.

Complaints about quality

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

Complaints about privacy

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

Complaints about poor customer service

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

Complaints 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

Complaints 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

Complaints 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 MCC staff

Complaints about cleanliness

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

Complaints 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 Complaints

You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by MCC. An external complaint is filed with and reviewed by an organization that is not affiliated with MCC.

Internal Complaints

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

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030
Phone: 1-800-424-4518 (TTY 711)

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

We will notify you of the outcome of your complaint within a reasonable time, but **no later than 30 calendar days after we receive your complaint.**

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

External Complaints

You Can File a Complaint with the Managed Care Helpline

You can make a complaint about MCC to the Managed Care Helpline at 1-800-643-2273 (TTY 1-800-817-6608) from 8:30 a.m. to 6 p.m. local time, Monday through Friday.

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.

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

21. FAMIS Claims Filing and Payment for Services

There may be times when you need to see an out-of-network provider. The day your child receives services from an out-of-network provider, you (the parent or guardian) are responsible for the applicable copay, if any, for that service.

MCC will pay the cost of the service, but only if:

- The service is medically necessary
- Your child's coverage with MCC has begun

If these conditions are not met, you will be responsible for paying the cost of the service. Make sure you know the effective date that your child's coverage with MCC begins.

Your provider will file claims for services rendered on your behalf. Your provider should file all claims for medically necessary, covered services rendered to the address below:

MCC Claims Service Center
1 Cameron Hill Circle Ste 52
Chattanooga, TN 37402-0052

22. 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 Level (FPL).

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 833-5CALLVA (TDD: 1-888-221-1590) with any Medicaid eligibility questions. The call is free. For more information you can visit Cover Virginia's website at http://www.coverva.org.

Enrollment for a Medicaid Expansion Member

You can change your health plan during the first 90 days of your Medallion program enrollment for any reason. You can also change your health plan during your annual open enrollment period for any reason. You may contact the Managed Care Helpline at 1-800-643-2273 (TTY 1-800-817-6608) or visit www.virginiamanagedcare.com to find out the open enrollment period for your region. You will get a letter from DMAS during the open enrollment period with more information. Members and providers can access this information using their Android or Apple device after downloading the Medallion app. To get the app, search for Virginia Managed Care on Google Play or the App Store.

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 MCC.

If you are an eligible Medicaid expansion member, in addition to the standard Medicaid services available to all Medicaid members, you will also receive the following four health benefits:

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

MCC will also encourage you to take an active role in your health. This may mean taking part in disease management programs, getting a flu shot, quitting smoking or using tobacco/nicotine products, or accessing services that are not typically covered by traditional medical practices like gym memberships or vision services.

If you frequently visit the emergency room, MCC 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.

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

What is a Health Screening?

Within four months after you enroll with MCC, an MCC representative will contact you or your authorized representative via telephone or in person to ask some questions about your health needs and social circumstances. 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 MCC understand your needs and identify whether or not you have medically complex needs.

If you meet the medically complex criteria, you will transfer from the Medicaid Managed Care Medallion 4.0 program to the Commonwealth Coordinated Care Plus (CCC Plus) program. If it is determined you do not have medically complex needs, you will remain in the Medallion 4.0 program. Also, if MCC is unable to contact you,

or you refuse to participate in the entire health screening, you will remain enrolled in the Medallion program. You will stay with MCC 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.

If you do not meet medically complex criteria and do not agree, you have a right to submit a complaint or grievance to MCC. See the Your Right to File a Complaint (Grievance) section for details.

Please contact MCC if you need accommodations to participate in the health screening.

If you have questions about the health screening, please contact 1-800-424-4518 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday through Friday. This call is free.

MCC Member Services

CALL:	1-800-424-4518 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m. local time, Monday through Friday. Member Services also has free language interpreter services available for non-English speakers.
TTY:	711 Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m. local time, Monday through Friday.
FAX	1-855-472-8574
WRITE	Molina Complete Care 3829 Gaskins Rd Richmond, VA 23233-1437
EMAIL	MCCVA@molinahealthcare.com
WEBSITE:	www.mccofva.com

Molina Complete Care

28696HBMDVAEN
211204