OptimaHealth

Optima Family Care

Member Handbook

optimahealth.com/familycare

Effective July 1, 2022

Updated June 1, 2023

MEMBER HANDBOOK

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Updated June 1, 2023

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Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including on-line, large print, braille or audio CD. To request this handbook in an alternate format and/or language, please contact Member Services at 757-552-8975 or toll free 1-800-881-2166, and it will be provided within 5 business days.

If you are having difficulty understanding this information, please contact our Member Services staff at 757-552-8975 or toll free 1-800-881-2166 (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 Optima Health 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 1-855-687-6260 or TTY: 1-844-552-8148. 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

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

Korean

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

Vietnamese

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

Chinese

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

Arabic

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

ه الصم والبكم: 1-844-552-8148

Tagalog

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

Farsi

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

Amharic

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

Urdu

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

French

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

Russian

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

Hindi

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

German

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

Bengali

লয্ করনঃ যদ আপনি বাংলা, কথা বললত পারেন, তাহেল ন নঃখরচায় ভাষা সহায়তা পিরষবা
উপল আআছ। আ ফান করন ১-855-687-6260 (TTY: ১-844-552-8148)।

Bassa

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ ké m̀ [Ɓàsɔ́ ɔ̀ -wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ ìn m̀ gbo kpáa. Đá 1-855-687-6260 (TTY:1-844-552-8148)

1. Medicaid Managed Care Plan

Welcome to Optima Health

Thank you for choosing Optima Health 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 Optima Health Member Services at 757-552-8975 or toll free 1-800-881-2166 (TTY: 711), visit our website at https://www.optimahealthmedicaid.com or call Virginia Medicaid Managed Care Helpline at 1-800-643-2273 (TTY: 1-800-817-6608) Monday through Friday, 8:30 a.m. – 6:00 p.m. for help. This handbook is also available on the Optima Health website located at https://www.optimahealthmedicaid.com.

How to Use This Handbook

This handbook will help you understand your benefits and how you can get help from Optima Health. This handbook is a health care and Optima Health 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 Optima Health Member Services at 757-552-8975 or toll free 1-800-881-2166, visit our website at https://www.optimahealthmedicaid.com or call Virginia Medicaid Managed Care Helpline free of charge at 1-800-643-2273 (TTY: 1-800-817-6608) Monday through Friday, 8:30 a.m. – 6:00 p.m. You may also access the app from an Android or Apple device. To get the app, look for Virginia Medallion on Google Play or the App Store.

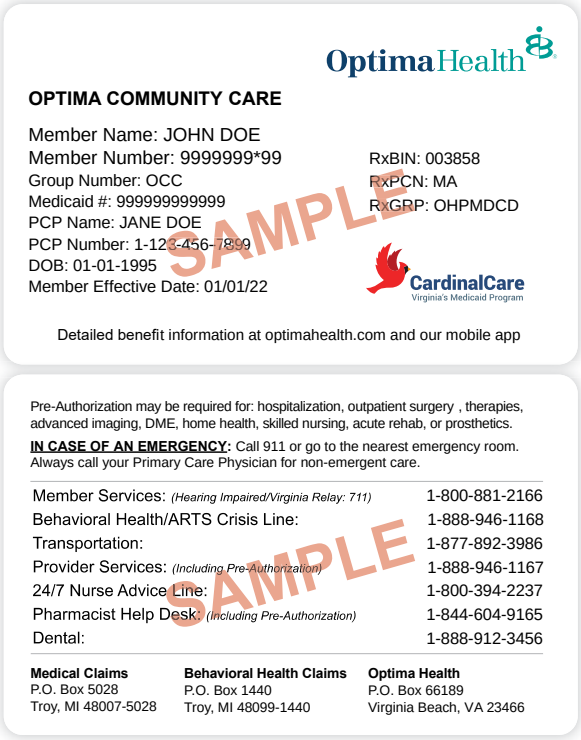
Member Services, our website, and your Care Coordinator can also provide the latest information related to COVID-19.

Your Welcome Packet and Member ID Card

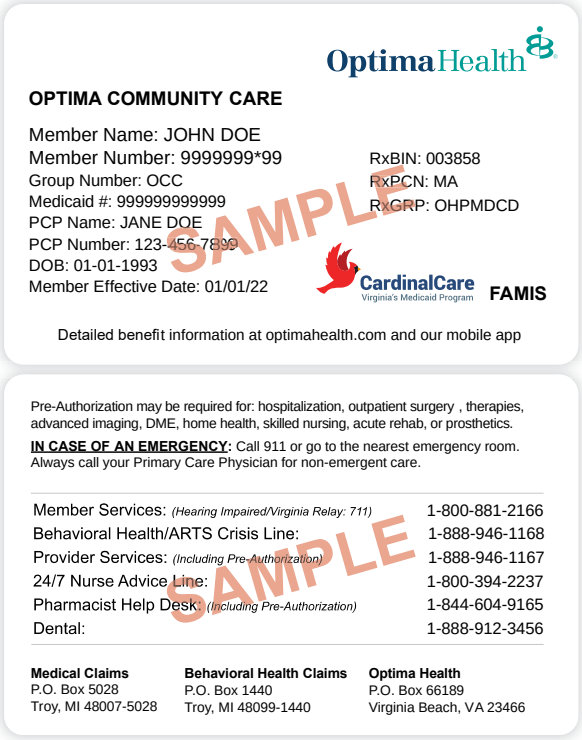
You should have received a welcome packet that included your Optima Health Member ID Card. Your Optima Health Member ID Card is used to access Medicaid managed care program health care services and supports at

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:

Non-FAMIS



FAMIS



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 Optima Health Provider and Pharmacy Directories. These directories list the providers and pharmacies that participate in the Optima Health 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 https://www.optimahealthmedicaid.com/.

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

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

What Is the Optima Health Service Area?

The Optima Health service area is the entire state of Virginia. Only people who live in our service area can enroll with Optima Health. If you move outside of our service area, you cannot stay in this plan. If this happens, you will receive a letter from the 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 (TTY: 1-800-817-6608), visit the website at virginiamanagedcare.com or access the app from an Android or Apple device. To get the app, look for Virginia Medallion on Google Play or the App Store.

Only people who live in our service area can enroll with Optima Health. 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.

Optima Health provides a variety of enhanced or extra benefits to support our member's health and well-being. Some of these extra benefits include the following. Additional information is provided later in the handbook:

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

- Adult literacy program ((HEAL Program sponsored by Optima Health Read, Learn, Grow)
- Adult vision services - members age 21 and up get one eye exam and $100 for frames yearly. The benefit is limited to in-network providers only
- College application assistance up to $75, sponsored by Optima Health Read, Learn, Grow
  (Restrictions apply. Authorization required.)
- Community Based Education. Our Outreach Workers are in your community to help members understand benefits, complete health screenings and more
- Diabetes Prevention - **Does not apply to FAMIS**
- ** Financial Wellness Program – tools and experts to help manage your spending and saving for major expenses, emergencies and retirement.
- Free smartphone
- GED Voucher Program - up to $275 for testing voucher and online prep program (Authorization required.)
- Heathy Moms: Welcoming Baby
- Healthy Savings Program

- Home-delivered meals after hospital stay, including OB
- Healthy member incentives
- Memory alarms and devices – additional home security devices, such as door/window alarms and memory devices, bed alarms, chimes and "baby monitor" type. Care Coordinator will coordinate.
- Online resource guide - search tool to find food, housing, jobs, and more
- Welcoming Baby program
- Reading program for children - sponsored by Optima Health Read, Learn, Grow
- Sports Physicals
- Transportation Services (Non-Medical) 24 round trips to community events, grocery store and more. Additional information is provided later in the handbook **Non- Medical transportation does not apply to FAMIS.**
- Weight Management Wellness Program (online only)

List of Covered Drugs

You can access or download the Provider and Pharmacy Directory at https://www.optimahealth.com/ or receive a printed copy by calling 757-552-8975 or toll free 1-800-881-2166.

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

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

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

We will generally cover a drug on the Optima Health List of Covered Drugs. You can also get drugs that are not on the list when medically necessary. Your physician may have to obtain a service authorization for you to receive some drugs.

List of Covered and Non-Covered Services

See Section 8 of this handbook or you can access or download the Optima Health Covered Services at https://www.optimahealthmedicaid.com/ or receive a printed copy by calling 757-552-8975 or toll free 1-800-881-2166.

Optima Health pays for medically necessary services. Some services may require pre-authorization. Your doctor will work with us to get approval for services.

There are no doctor visit limits for covered services. Referrals are not required. Our members have no cost-sharing responsibilities for in-network 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 Optima Health, 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 1-833-5CALLVA or TDD: 1-888-221-1590. **These calls are free.**

Getting Help Right Away

Optima Health Member Services

Our Member Services Staff are available to help you if you have any questions about your benefits, services, or procedures or have a concern about Optima Health.

How to Contact Optima Health Member Services

CALL	757-552-8975 or toll free 1-800-881-2166 **This call is free**. 8:00 am – 8:00 pm Monday – Friday We have free interpreter services for people who do not speak English.
TTY	(TTY/TDD: 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. They will help you reach our Member Services staff. Monday – Friday 8:00 am – 8:00 pm
WRITE	PO Box 66189, Virginia Beach, VA 23466
WEBSITE	optimahealth.com or the Optima Health app

How Optima Health Member Services Representatives Can Help You

- Answer questions about the Optima Health
- Answer questions about claims, billing, or Member ID Cards
- Assistance finding or checking to see if a doctor is in the Optima Health 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 an Optima Health Care Manager/Coordinator

Care Coordinators are here to help you with the coordination of any needed appointments or services. They are also here to provide education about chronic

disorders and wellness opportunities at Optima Health.

Our Care Coordinators work under the direction of our Care Managers. Care Managers here at Optima Health are licensed staff members with the training and education to use a collaborative process of assessing, planning, implementing, coordinating, monitoring and evaluating the options, services and resources to meet our member's health needs.

We will ask for your permission during your first call to participate in our program. It is your right to stop the program at any time. You may also change your Care Coordinator or Care Manager by simply telling them of your request to do so.

Members can reach a Care Coordinator, through Member Services at 757-552-8975 or toll free 1-800-881-2166., TTY/TDD: 711.

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 questions at 757-552-7250 or toll-free at 1-800-394-2237. We will ask you to describe your medical situation in as much detail as possible when you call the Medical Advice Line. Be sure to mention any other medical conditions you have, such as diabetes or hypertension.

The staff at our Medical Advice Line have training in emergency medicine, acute care, OB/GYN and pediatric care. They are well prepared to answer your medical health questions However, since they are unable to access medical records, they cannot diagnose or medically treat conditions, order labs, write prescriptions, order home health services or initiate hospital admissions or discharges. If necessary, you may be directed to an urgent care center or emergency department.

Behavioral Health Crisis Line

Our Behavioral Health Crisis Line is manned by professionals in triaging and assisting those in crisis.

Contact Optima Health if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call 757-552-7174 or toll free 1-800-648-8420. 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.**

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. Optima Health 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 Care-Takers

*Categories do not apply to FAMIS

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- Does not apply to FAMIS
- 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 - Does not apply to FAMIS
- 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.

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

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

Disenrollment

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

- An adverse change in the member's health status
- Utilization of medical services
- Diminished mental capacity
- Uncooperative or disruptive behavior resulting from his or her special needs

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

A member may request disenrollment as follows:

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

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 am to 6:00 pm. 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.

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 can also change your help plan upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity or when the Department has imposed sanctions on the MCO (consistent with 42 CFR 438.702[a][4]).

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 or access the app using an Android or Apple device. To get the app, look for Virginia Medallion on Google Play or the App store.

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 Optima Health. You will be sent a re-enrollment letter from the Department of Medical Assistance Services.

What Are the Advantages of Choosing Optima Health?

Optima Health is a local, Virginia-based company with over 30 years of experience in providing care to our members with a commitment to improving the lives of the members and communities we serve. Optima Health has access to high-quality health care through a large network of primary and specialty care providers. We use person-centered, care coordination from a dedicated member services team and provide personalized customer service experience with local representatives throughout Virginia.

Optima Health also offers enhanced or extra benefits that are not covered by Medicaid like GED vouchers and free classes to help you improve your health. Please see Section 8 of this handbook. Some of the advantages include:

- You will have access to the Optima Health Care Managers. The Optima Health Care Manager works with you and with your providers to make

sure you get the care you need.

- You will be able to take control over your care with help from the Optima Health care team and Care Managers.
- The care team and Care Managers 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 757-552-7250 or toll free at 1-800-394-2237 at any time.

What is a Health Risk Assessment?

Within the first few weeks after you enroll with Optima Health, 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 Optima Health 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 Optima Health 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 the Optima Health network, then you may be asked to select a new provider that is in the Optima Health provider network. If your doctor leaves the Optima Health 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. Optima Health 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 refer 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 on weekends, leave a message and 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 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, behavioral health providers, provider addresses, phone numbers, web site URLs, and new patient acceptance (open or closed panels) who work with Optima Health. We can also provide you with a paper copy of the provider directory. You can also call Optima Health Member

Services at the number on the bottom of this page for assistance.

Choosing Your PCP

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

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 include routine check-ups, follow-up care if there is a problem, and regular care during a pregnancy. Women do not need a PCP referral to see an OB/GYN provider in our network.

If you do not select a PCP by the 25th of the month before the effective date of your coverage, Optima Health will auto-enroll you with a PCP. Optima Health 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 the Optima Health Network

You can continue to see your current PCP for up to 30 days even if they are not in the Optima Health network. During the first 30 days of your enrollment with Optima Health, your Care Coordinator can help you find a PCP in the Optima Health network. At the end of the 30-day period, if you do not choose a PCP in the Optima Health network, Optima Health 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. Optima Health 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 Optima Health 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 Optima Health network. We will tell you within 30 days of the provider's intent to leave our network. We are happy help you find a new PCP.

You may also change your PCP at any time by signing into your MyOptima account at optimahealth.com. If you do not have a MyOptima account, please visit optimahealth.com and select Register for Secure Access to create your account. (Please have your Member ID Card available.) Changes made online usually take 24 hours to process.

Once registered and signed in:

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

Getting an Appointment with Your PCP

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

Appointment Standards

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

- For an emergency - immediately.
- For urgent care 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 fourteen (14) calendar days of request.
- Second trimester (3 to 6 months) - Within seven (7) calendar days of request.
- Third trimester (6 to 9 months) - Within five (5) business days of request.
- High Risk Pregnancy - Within three (3) business days or immediately if an emergency exists.
- If you are unable to receive an appointment within the times listed above, call Member Services at the number below, and they will help you get the appointment.

Travel Time and Distance Standards

Optima Health 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

Optima Health 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

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

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

Telehealth services are easy to use:

1. Go to www.optimahealth.com
2. Click Sign In/Register
3. Click on Member
4. Enter User name/New users must select "Register Now" to create an account.

5. Click on Virtual Visit
6. Or you may call 1-877-552-7401 for assistance in registering.

For more information on pharmacy benefits and filling prescriptions, please see Section 7 *How to Get Prescription Drugs* in this handbook.

What If a Provider Leaves the Optima Health 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?

The Optima Health 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 the Optima Health website can give you the most up-to-date information about changes in our network pharmacies and providers.

4. How to Get Specialty Care and Services

What are Specialists?

If you need care that your PCP cannot provide, your PCP may refer you to a specialist. Most of the specialists are in the Optima Health 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?

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

To find out if a doctor or specialist is in our network:

- Sign in to optimahealth.com/members;
- Select Find Doctors, Drugs and Facilities from the top menu;
- Select Find a Doctor and Search Your Network;
- All relevant information, such as your health plan network and address, will be pre-populated;
- Choose what type of doctor or facility you are looking for. You may need to fill- in additional information. The results of your network will display.

Your provider of care should contact Optima Health to verify coverage and will submit any service authorizations. Please see Section 11 of this handbook for information about which services require pre-authorization.

How to Get Care from Out-Of-Network Providers

If we do not have a specialist in the Optima Health network to provide the care

you need, we will get you the care you need from a specialist outside of the Optima Health network. We will also get you care outside of the Optima Health network in any of the following circumstances:

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

If your PCP or Optima Health 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

Optima Health 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 Optima Health 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 Optima Health Member. Ask them to call Optima Health at the number on the back of your Member 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 the Optima Health 24/7 medical advice line at: 757-552-7250 or toll free 1-800-394-2237.

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 Optima Health Member ID Card. Tell them you are in Optima Health 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. 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 Optima Health About Your Emergency

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

After An Emergency

Optima Health will provide necessary follow-up care, including two 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 Optima Health as soon as possible. By keeping Optima Health 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 is not 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 optimahealth.com or the Optima Health app.

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 the Optima Health Outpatient Drug Coverage

Optima Health 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 the Optima Health List of Covered Drugs. If it is not on the Drug List, we may be able to cover it by giving you an authorization. Please call Member Services at the bottom of the page for more information.
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, Optima Health will pay for prescriptions only if they are filled at Optima Health network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our members. You may go to any of our network pharmacies.

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

To fill your prescription, show your Member ID Card at your network pharmacy. The network pharmacy will bill Optima Health for the cost of your covered prescription drug. If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call Optima Health 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

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

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

To search for a drug on optimahealth.com:

- Sign in to your MyOptima account at optimahealth.com. If you do not have a MyOptima account, please visit optimahealth.com and select Register for Secure Access to create your account. (Please have your Member ID Card available).
- In the left menu bar, click on Pharmacy Resources. Then click Access Pharmacy Resources. You will be sent to the Pharmacy Dashboard, where you can manage your prescriptions and pre-authorizations, as well as look up which drugs are covered and nearby pharmacies.

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

We will generally cover a drug on the Optima Health 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 Explained* in Section 11 of this handbook.

If Optima Health is new for you, you can keep getting your authorized drugs for the duration of the authorization or for 30 days after you first enroll, whichever is sooner. Refer to *Transition of Care Period* in Section 2 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 Optima Health before you fill your prescription. Please note that approved pharmacy services authorizations will not exceed one (1) year in duration. If you don’t get approval, Optima Health 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 optimahealth.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; and,
- Any drugs marketed by a manufacturer who does not participate in the Virginia Medicaid Drug Rebate program.

Changing Pharmacies

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

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

What if You Need a Specialized Pharmacy?

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

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

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

Can You Get a Long-Term Supply of Drugs?

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

prescription-drug-lists.

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

Can You Use a Pharmacy that is not in the Optima Health Network?

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

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

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

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works. The 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* in Section 12 of this handbook.

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

Members who are enrolled in PUMS will receive a letter from Optima Health

that provides additional information on PUMS including all of the following information:

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

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

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 Optima Health. In most cases, Optima Health will not pay for care you get from an out- of-network provider unless the service is authorized by Optima Health. 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 11 includes more information about service authorizations
4. If Optima Health is new for you, you can keep seeing the doctors you go to now for the first **30 days** after enrollment. 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 2.

Benefits Covered Through Optima Health

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

Some benefits are not covered under the FAMIS program. See the FAMIS exception note for more information.

- **Abortion services** - coverage is only available in cases where there would be a substantial danger to life of the mother.
- **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.
- Adult (Annual) wellness exams

- **Clinic services**
- **Clinical Trials** (Not covered for FAMIS)
- **Colorectal cancer screening**
- **Court ordered services** - Not covered for FAMIS unless the service is both medically necessary and is a FAMIS covered service.
- **Doula Services –** a doula is a trained individual in the community who provides support to member and their families throughout pregnancy, during labor and birth, and up to one year after giving birth.
- **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. Not covered for FAMIS.
- **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 and post stabilization services.** Additional information about emergency and post stabilization services is provided in Sections 5 and 6 of this handbook.
- **Emergency custody orders (ECO)**
- **Emergency services** including emergency transportation services (ambulance, etc.)
- **End stage renal disease services**
- **Eye examinations**
- **Family planning services**, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of the Optima Health network. Optima Health does not require you to obtain service authorization or PCP referrals on family planning services.
- **Gender dysphoria treatment services**
- **Glucose test strips**
- **Hearing (audiology) services** Hearing Aids covered for children under

age 21 under EPSDT and for FAMIS up to two (2) times every five (5) years under DME. Pre-authorization is required.

- **Home health services**
- **Hospice services** Covered for FAMIS only
- **Hospital care** – inpatient/outpatient
- **Human Immunodeficiency Virus (HIV) testing and treatment counseling**
- **Immunizations** recommended for children and adults are covered.
- **Inpatient psychiatric hospital services**
- **Laboratory, Radiology and Anesthesia Services**
- **Lead investigations**
- **Mammograms**
- **Maternity care** including pregnancy care, doctors/certified nurse-midwife services. Additional information about maternity care is provided in Section 6 of this handbook.
- **Mental health services**, including, outpatient psychotherapy services, community-based, crisis and inpatient services. Community and facility based services include:
    - Mental Health Case Management
    - Therapeutic Day Treatment (TDT) for Children
    - Mental Health Skill-building Services (MHSS)
    - Intensive In-Home
    - Psychosocial Rehabilitation
    - Applied Behavior Analysis (ABA)
    - Mental Health Peer Recovery Supports Services
    - Mental Health Partial Hospitalization Program
    - Mental Health Intensive Outpatient
    - Assertive Community Treatment
    - Multisystemic Therapy (MST)
    - Functional Family Therapy (FFT)
    - Mobile Crisis Response
    - Community Crisis Stabilization
    - 23-Hour Crisis Stabilization
    - Residential Crisis Stabilization

FAMIS enrollees and FAMIS MOMS enrollees under age 21 who are covered by Medallion 4.0 have limited mental health services benefits that include:

- Mental Health Partial Hospitalization Program (MH-PHP)
- Mental Health Intensive Outpatient (MH-IOP)
- Assertive Community Treatment (ACT)
- Multi-systemic Therapy and Functional Family Therapy along with continuation of Applied Behavior Analysis
- Intensive In-Home Services
- Therapeutic Day Treatment
- Mental Health Mobile Crisis Response, Community Stabilization and 23- Hour Crisis Stabilization Services
- Mental Health Case Management for Children at Risk of Serious Emotional Disturbance Children with Serious Emotional Disturbance
- Peer Recovery Support Services

Medallion 4.0 MCOs manage mental health services for their enrolled members.

- **Nurse Midwife Services** through a Certified Nurse Midwife provider
- **Organ transplants**
- **Orthotics**, including braces, splints and supports - for children under age 21 or adults through an intensive rehabilitation program
- **Outpatient hospital services**
- **Pap smears**
- **Personal care** for FAMIS and children under age 21 through EPSDT
- **Physical, occupational, and speech therapies**
- **Physician's services** or provider services, including doctor's office visits
- **Podiatry services** (foot care)
- **Prenatal and maternal services**
- **Prescription drugs**- see Section 7 of this handbook for more information on pharmacy services
- **Preventive care**, including regular check-ups, well baby/child care. See Section 3 of this handbook for more information about PCP 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**
- **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.
- **Renal (kidney) dialysis services**
- **Rehabilitation services** – inpatient and outpatient including physical therapy, occupational therapy, speech pathology and audiology services
- **Second opinion services** from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out-of-network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.
- **Surgery services** when medically necessary and approved by Optima Health
- **Telemedicine services**
- **Temporary detention orders (TDO)** – when admitted to an acute care hospital or when a member younger than 21 or older than 64 is admitted to a freestanding behavioral health facility
- **Tobacco Cessation Services** education and pharmacotherapy for all members
- **Transportation services**, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs. Optima Health will also provide transportation to/from most carved-out services. You may use 24 round trips for non-medical trips as a value-added transportation benefit. Any unused trips do not carry over. Additional information about transportation services is provided later in this section of the handbook. Non-medical transportation does not apply to FAMIS.
- **Vision services**

- **Well Visits** – Children **should** be seen by their doctor more often than adults and should get well visits as follows:
  - Newborn
  - Before six (6) weeks of age
  - Two (2) months of age
  - Four (4) months of age
  - Six (6) months of age
  - Nine (9) months of age
  - One (1) year of age
  - 15 months of age
  - 18 months of age
  - Two (2) years of age

Extra Benefits We Provide That are not Covered by Medicaid

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

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

- **Adult Literacy Program** (HEAL Program)
- **Adult vision** - Members age 21 and up get one eye exam and $100 for frames each year. The benefit is limited to in-network providers only.
- **Baby Showers**
- ****Diapers** - Member will receive 400 diapers. Members receive one fulfillment of diapers per live birth, pending completion of prenatal and postpartum visits – both requirements must be met
- **College application assistance** – up to $75 Sponsored by Optima Health Read, Learn, Grow. (Restrictions apply. Authorization required.)
- **Community Based Education** - our Outreach Workers are in your community to help members understand benefits, complete health screenings and more
- **Diabetes Prevention** – does not apply to FAMIS
- ****Diapers** - Member will receive 400 diapers. Members receive one fulfillment of diapers per live birth, pending completion of prenatal and postpartum visits – both requirements must be met
- ****Feminine Hygiene** - members may purchase up to $20 per quarter
- ****Financial Wellness** - program to help achieve financial goals

- **Free smartphone** - eligible members receive 350 minutes, 1GB unlimited texts, and free monthly calls to the plan. ** Free unlimited wireless, texts, minutes and hotspot (1 per household). Members can check for eligibility.
- **GED Prep & Testing Voucher** – up to $275 for GED testing voucher and online prep program for eligible members. [(Authorization required.)] Member Outreach will coordinate service limits.
- **HEAL Program: Health Literary Program**
- **Healthy member incentives** for eligible members - prenatal & postpartum follow-up, HPV, baby, well-child and adolescent well-child checkup, childhood immunizations, diabetic eye
- **Healthy Moms: Welcoming Baby**
- ****Health Savings Program -** healthy food, discounts on over-the counter medications and products, baby items and cleaning products. Members can check for eligibility.
- **Home-delivered meals -** 14 meals delivered at home for eligible members post discharge from hospital stay, including OB or transitioning from a nursing home to the community. Must use the approved network. (Authorization required.)
- ****Incontinence** – eligible members may purchase up to $30 per quarter. (Authorization required.)
- ****Mattress Cover/Pillowcase** – All eligible members with asthma can receive one (1) free mattress cover/ protector and one (1) pillowcase every two (2) years, 2 set fulfillment maximum. All eligible members with asthma.
- **Memory alarms and devices** - additional home security devices, such as door/window alarms and memory devices, bed alarms, chimes and "baby monitor" type devices for eligible members diagnosed with dementia or Alzheimer's disease. Must use approved network. (Authorization required.)
- **Non-medical transportation services** – 24 round trips to community events, grocery store and more. Does not apply to FAMIS.
- ****Nutritious Food Program –** pregnant women can receive healthy savings grocery card to purchase healthy food items, including fresh

produce. Members will receive $75 per quarter. Dollars can roll over each quarter but will expire 12 months after live birth or miscarriage.

- ****Online Community Resource Guide** - online search tool to find food, housing, jobs, and more for eligible members
- ****Pedometer** - one (1) free pedometer for all eligible members over 5 years old.
- **Reading program** for children through Optima Health Read, Learn, Grow - ages 0 - 13 years old
- **Sports Physicals** - free sports physicals for all eligible members
- **Transportation services (non-medical)** - eligible members may use free 24 round trips each year for non-medical trips to grocery store, place of worship, community events, laundromat and more. Any unused trips do not carry over.
- **Wellness Program**: Weight Management (online only) – *Eating for Life* materials to assist eligible members improve current eating and exercise habits.
- ****Wellness Program**: Smoking Cessation for eligible members (online only)
- ****Wellness Rewards** – up to $50 for wellness rewards for healthy behavior. Member Outreach will coordinate. (Restrictions apply.)

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

Early and Periodic Screening, Diagnostic 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 healthcare 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) – Checkup that occur at regular intervals.
- Sick visits (EPSDT/Inter-periodic Screenings) – unscheduled check-up

or problem focused assessment 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 – EPSDT is not covered for FAMIS.

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

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 he or she has (i) a 25% developmental delay in one or more areas of development; (ii) atypical development; or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

For more information call your Care Coordinator. Your Care Coordinator can help. If your child is enrolled in Optima Health 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 www.infantva.org or by calling 1-800-234-1448.

Foster Care and Adoption Assistance

Optima Health 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, Optima Health 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 1-866-503-5828.

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.

Optima Health 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

Optima Health knows that pregnancy can be a life-altering journey. Even the most experienced mom may need some extra support. That is why we developed the **Welcoming Baby** program – a program dedicated to providing guidance, support, and education to all expectant moms with Optima Health insurance. Your provider may ask you to visit more often or may ask you to consent to HIV testing and counseling.

While you are pregnant, we encourage you to eat well, practice stress management, and visit your family care provider regularly. You should begin looking for a participating family care provider for your baby. Also, you will receive information about immunizations and check-up schedules for your new

baby. A Case Manager will contact you regularly during your pregnancy and for a short time after the birth of your baby to help you get the support and services you need to keep you and your baby safe and healthy. This program is available at no charge to you during your pregnancy while you are enrolled with Optima Health.

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 1-833-5CALLVA to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child.

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

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

How to Access Family Planning Services

Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of the Optima Health network.

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. Substance use may also be a factor.

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

long timeframe. All services are performed by qualified individuals and organizations.

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

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

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

How to Access Behavioral Health Services

To access behavioral health services, you can call Optima Health Member Services 1-800-881-2166 TTY/TDD 711, 8:00 am to 8:00 pm, Monday through Friday. The call is free and you can also be connected to your care coordinator during the call. You can also contact your Care Coordinator directly.

Behavioral Health Services Administrator (BHSA)

Some behavioral health services, such children's residential treatment and therapeutic foster care case management, are covered for you through Magellan of Virginia.
Magellan of Virginia is the behavioral health services administrator (BHSA) for the Department of Medical Assistance Services (DMAS). Optima Health's Member Services Department can help coordinate the services you need, including those that are provided through the BHSA.

How to Access Medicaid Behavioral Health Services

To access behavioral health services, you can call Optima Health Member Services at 1-800-881-2166 TTY/TDD 711 8:00 am to 8:00 pm, Monday through Friday. The call is free, and you can also be connected to your care coordinator during the call. You can also contact your Care Coordinator directly.

Mental Health Services (MHS) and Trauma Informed Care

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

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

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

Optima Health follows the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements for service authorizations. For emergency services, please see Behavioral Health Crisis Line in Section 1 of this handbook for more information.

Access Addiction and Recovery Treatment Services (ARTS)

Optima Health offers a variety of services that help individuals who are struggling with substance abuse . This includes alcohol and drug use. Addiction is a medical illness, just like diabetes. Many people face addiction and can benefit from treatment. If you need treatment for addiction, we cover services that can help you.
Optima Health covers the following ARTS services:

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

Medication-assisted treatment options are also available for addiction

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

How to Access Addiction and Recovery Treatment Services (ARTS)

Talk to your Primary Care Provider (PCP) or call an Optima Health 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 do any of the following:

- look in the Provider and Pharmacy Directory
- visit our website at optimahealth.com
- call your Optima Health Care Coordinator
- contact Member Services at 1-800-881-2166 TTY/TDD 711 8:00 am to 8:00 pm, Monday through Friday

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

Prior Authorizations for Behavioral Health and ARTS

Optima Health requires a prior service authorization for:

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

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

- mental health case management
- therapeutic day treatment (TDT) for children
- mental health partial hospitalization program (MH-PHP)
- Mobile Crisis Response
- Community Crisis Stabilization
- 23-Hour Crisis Stabilization
- Residential Crisis Stabilization

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

To find out more about how to request approval for these treatments or services, contact Member Services at 1-800-881-2166 TTY/TDD 711, 8:00 am to 8:00 pm, Monday through Friday, or call your Care Coordinator.

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

Optima Health follows the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements for service authorizations. For emergency services, please see Behavioral Health Crisis Line in Section 1 of this handbook for more information.

How to Access Non-Emergency Transportation Services Covered by Optima Health Not covered for FAMIS unless available under enhanced or extra benefits.

Non-Emergency transportation services are covered by Optima Health for covered services, carved out services, and enhanced or extra benefits.

Rides may be provided if you have no other means of transportation and need to go to an appointment for a covered service. Call 1-877-892-3986 (TTY: 711), Monday – Friday 6:00 am – 6:00 pm to set up a ride. Trips need to be scheduled at least five (5) business days beforehand. Weekends and holidays do not count toward these days.

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

Benefits for FAMIS Members

FAMIS Summary of Benefits In partnership with Optima Health No Copayment, covered at 100% unless otherwise stated
PHYSICIAN SERVICES
Pre-Authorization is required for in-office surgery and therapy and rehabilitation services. Includes covered services performed in the Physician's office during the Physician office visit. No Copayment, covered at 100%.

PHYSICIAN SERVICES No Copayment, covered at 100%.

- Primary Care Physician (PCP) Office Visit. Includes covered services performed in the physician's office including outpatient clinic services.
- Specialist Office Visit. Includes covered services performed in the specialist's office including outpatient clinic services.

PREVENTIVE, MATERNITY, WELL-BABY, WELL-CHILD CARE

- Preventive Care. Includes routine physicals, GYN exam, and PAP smears.
- Maternity Care. Includes routine prenatal and postnatal care rendered by the OB/GYN. Includes outpatient clinic services. Pre-authorization is required.
- Well-Baby and Well-Child Care. Includes routine office visits with health assessments and physical exams, routine lab work including blood lead testing and age appropriate immunizations.

OUTPATIENT THERAPY, REHABILIATION & DIAGNOSTIC SERVICES
Optima Health will cover therapy services that are medically necessary to treat or promote recovery from illness or injury. No Copayment, covered at 100%.

OUTPATIENT THERAPY, REHABILITATION & DIAGNOSTIC SERVICES

- Outpatient Therapy Services. Includes physical, occupational, and speech therapy or visit.

- Outpatient Rehabilitation Services. Includes cardiac, pulmonary, and vascular rehabilitation treatment or visit.
- Outpatient, Chemotherapy, Radiation Therapy, IV Therapy, and Inhalation Therapy. Pre-authorization is required for IV Therapy with medications and inhalation therapy.
- Outpatient Dialysis Services. A physician referral is required.
- Diagnostic Procedures. Includes outpatient lab, X-ray, and other diagnostic procedures, including MRI, PET and CT Scans. Pre-authorization is required.

Note: Outpatient lab work is covered at 100%.

INPATIENT AND OUTPATIENT SERVICES
Includes inpatient hospital services and transfers to a Skilled Nursing Facility. No Copayment, covered at 100%.

INPATIENT SERVICES

- Inpatient Services. Includes maternity care, lab, X-ray, surgery, and other services. Coverage provided for up to 365 days per confinement in a semi- private room. Pre-authorization is required. Transplants are covered at contracted facilities only. Services to identify donor limited to $25,000 per member.
- This also includes inpatient rehabilitation services at facilities certified by the Department of Health. Pre-authorization is required.
- Skilled Nursing Facilities/Services. Services following inpatient hospital care in lieu of hospitalization. Coverage provided for up to 180 days of skilled care level of service. Pre-authorization is required.

OUTPATIENT SERVICES

- Outpatient Services. Pre-authorization is required.
- Clinic Services. Includes services that are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative and are provided to outpatients by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

EMERGENCY CARE SERVICES
Includes Emergency Department (ED) facility, physician, and ancillary services that are rendered during the visit. No Copayment, covered at 100%.

EMERGENCY CARE SERVICES

- Emergency Department. Emergency care is retrospectively reviewed to determine medical necessity and level of coverage.
- Urgent Care Center. Includes urgent care facility, physician, and ancillary services rendered during an urgent care center visit.
- Ambulance. Covered for emergency transportation only.

BEHAVIORAL HEALTH CARE & SUBSTANCE ABUSE SERVICES – INPATIENT

No Copayment, covered at 100%.

- Inpatient Behavioral Health Services. Services are covered for 365 days per confinement, including partial day treatment services. Pre-authorization is required.
- Inpatient Substance Abuse Services. Covered for services rendered in a substance abuse treatment facility. Pre-authorization is required.

BEHAVIORAL HEALTH CARE & SUBSTANCE ABUSE SERVICES – OUTPATIENT

No Copayment, covered at 100%. Pre-authorization is required.

FAMIS AND FAMIS MOMS

FAMIS enrollees and FAMIS MOMS enrollees under age 21 who are covered by Medallion 4.0 have limited mental health services benefits that include:

- Mental Health Partial Hospitalization Program (MH-PHP)
- Mental Health Intensive Outpatient (MH-IOP)
- Assertive Community Treatment (ACT)
- Multi-systemic Therapy and Functional Family Therapy along with continuation of Applied Behavior Analysis
- Intensive In-Home Services
- Therapeutic Day Treatment
- Mental Health Mobile Crisis Response, Community Crisis Stabilization

and 23- Hour Crisis Stabilization Services
- Mental Health Case Management for Children at Risk of Serious Emotional Disturbance Children with Serious Emotional Disturbance
- Peer Recovery Support Services

Medallion 4.0 MCOs manage mental health services for their enrolled members.

OTHER COVERED SERVICES

No Copayment, covered at 100%.

- Chiropractic Services. Includes medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury. Benefit limited to $500 per calendar year.
- Diabetic Supplies are covered at 100% if prescribed by your physician, including insulin pumps. No copayment is applied. Includes FDA-approved supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy.
- Durable Medical Equipment (DME). Pre-authorization is required for items over
  $1,200. Pre-authorization is required for the initial rental of DME. As necessary, the need for purchase will be re-evaluated.
- Early Intervention Services. Includes services for children up to age three. Pre-authorization is required.
- Family Planning Services. Does not include services to treat infertility or to promote fertility. Pre-authorization is **not** required.
- Hearing Aids. Covered up to two times, every five years. Pre-authorization is required.
- Home Health Care Services. Includes services following inpatient hospital care in lieu of hospitalization. Coverage up to 90 visits per calendar year. Pre- authorization is required.
- Hospice Care. Pre-authorization is required.
- Lead Investigations and Testing. Pre-authorization is required.
- Orthopedic and Prosthetic Appliances. Includes medically necessary prosthetic services and devices, including artificial limbs. Pre-authorization is required for items over $1,200.
- Private Duty Nursing. Pre-authorization is required.

- Telehealth Visits.
- Vision Services. The benefit includes one (1) annual exam from in-network providers. Optima Health will contribute $100 for frames annually. In addition, the benefit pays up to the following allowed amounts toward the cost of each vision service listed below:
  - $35 Single Vision Lenses
  - $50 Bifocal Lenses
  - $88.50 Trifocal Lenses
  - $100 Contact Lenses

PRESCRIPTION DRUGS
For covered drugs on the Preferred Drug List (PDL), or Formulary, copayments are $0. Some maintenance drugs are eligible for mail order through Express Scripts Pharmacy® 1-855-864-6793

Quantities for initial prescriptions or refills may be limited to manufacturer's packaging and are limited to:

- 34-day supply of pills or tablets, or
- 34-day supply of insulin, or
- 34-day supply of insulin syringes, insulin needles, or disposable insulin syringes with needles (maximum of 100), or
- 12-month supply of contraceptives including all oral tablets, patches, vaginal rings and injections that are used on a routine basis when dispensed from a pharmacy.
- This is a brief description of benefits. All services must be received by participating providers unless pre-authorized by Optima Health.
- Emergency services should be obtained from the nearest hospital to your home.
- Transportation services are not covered for routine access to and from providers of covered medical services for FAMIS members unless available under enhanced or extra benefits.
- No copayments will be charged to American Indians and Alaska Natives.

9. Services Not Covered by Optima Health

The following services are not covered by Medicaid or Optima Health. 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**
- **Care outside of the United States**
- **Certain drugs** not proven effective
- **Certain experimental** surgical and diagnostic procedures
- **Chiropractic services** - Covered for FAMIS.
- **Christian Science nurses**
- **Cosmetic treatment or surgery**
- **Daycare**, including sitter services for the elderly except in some home- and community-based service waivers
- **Deliveries** at free-standing birth centers
- **Dentures** for members age 21 and over
- **Drugs prescribed to treat hair loss or to bleach skin**
- **Elective abortions**
- **Erectile Dysfunction drugs**
- **Experimental or Investigational Procedures**
- **Eyeglasses or their repair** for members age 21 or older (unless available under enhanced or extra benefits)
- **Home births**
- **Immunizations** if you are age 21 or older except for flu and pneumonia for those at risk and as authorized by Optima Health
- **Medical care other than emergency services, urgent services, or family planning services, received from providers outside of the network unless authorized by Optima Health**
- **Personal care services** - except for FAMIS, children under age 21 under EPSDT

and through some home- and community-based services

- **Prescription drugs** covered under Medicare Part D, including the Medicare copayment
- **Private duty nursing** except through some home- and community-based services under EPSDT
- **Services rendered while incarcerated**
- **Weight loss clinic programs** unless authorized Optima Health

If You Receive Non-Covered Services

If you get services that are not 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 12 provides instructions for how to appeal Optima Health coverage decisions. You may also call Member Services to learn more about your appeal rights or to obtain assistance in filing an appeal.

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

- Services are medically necessary, and
- Services are listed as *Benefits Covered Through Optima Health* in Section 8 of this handbook, and
- You receive services by following plan rules.

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 Optima Health 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 a DMAS Dental Benefits Administrator to coordinate the delivery of all Medicaid dental services for children, pregnant women, and adults. 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, Monday through Friday, 8:00 AM - 6:00 PM EST. 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/
- Optima Health provides coverage for non-emergency transportation for any dental services covered through the DMAS Dental Benefits Administrator, as described above. Contact Optima Health Member Services at the number below if you need assistance.
- Optima Health 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 Optima Health 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 age 21).
- You are receiving care in a Nursing Facility.
- You are receiving care in a Long Term Care Facility.

11. 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. Service authorizations, including Pharmacy, will not exceed one (1) year in duration.

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.

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

We look at standards of care based on:

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

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

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

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

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

- All acute rehabilitation
- All inpatient hospitalizations
- All intensive outpatient programs
- All out-of-area services **except emergency care**
- All outpatient surgeries/short stays/observations

- All partial hospitalizations
- All rehabilitation programs (cardiac, pulmonary and vascular rehabilitation)
- All services by non-participating providers
- Any surgical or diagnostic procedure in which anesthesiology or conscious sedation is billed
- Applied behavior analysis
- Augmentative speech devices
- Durable medical equipment – single items over $1,200 and all rentals
- Genetic testing
- Hyperbaric therapy
- Injectable drugs, including not but limited to Synvisc/Hyalgan, Synagis, Remicade, IVIG
- Oral surgery and related services
- Orthotics/Prosthetics – single items over $1,200 and all rentals
- Outpatient advanced imaging services – CT, CTA, MRI, MRA, MRS or, PET scans
- Oxygen (rental)
- Plastic surgery
- Transplants
- Wheelchairs and seating

You do **not** need a service authorization to see your regular doctor or specialist.

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

Service Authorizations and Transition of Care

If you are new to Optima Health 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

Your doctor or other healthcare provider will submit your service authorization requests for most medical services. The plan informs your doctor of the proper procedures forgetting a service authorization through their contract, Provider Manual and newsletters.

What Happens After Submitting A Service Authorization Request?

Optima Health 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 or Expedited Review Process)	Within 14 calendar days for standard or as quickly as your condition requires. Within 3 calendar days or 72 hours for urgent/expedited
Outpatient Services (Standard Review Process)	Within 14 calendar days or as quickly as your condition requires.
Outpatient Services (Expedited Review Process)	Within 72 hours or 3 calendar days 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. Please note that approved pharmacy service authorizations will not exceed one (1) year in duration.	

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 Optima Health to help decide your case. This can be done by calling Member Services at the bottom of this page.

You or someone you trust can file a complaint with Optima Health 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 Optima Health 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 12 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 12 of this handbook.

We will tell you and your provider in writing if your request is denied. A denial includes when the request is approved for an amount that is less than the amount requested.

We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain what options for appeals you have if you do not agree with our decision. Also see *Your Right to Appeal*, in Section 12 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 Optima Health even if we later deny payment to the provider.

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

Your Right to Appeal

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

For example, you can appeal if Optima Health denies:

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

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

Authorized Representative

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

Adverse Benefit Determination

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision we make to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. Refer to *Service Authorization and Benefit Determinations* in Section 11 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 the number shown below if you need help filing an appeal or if you need assistance in another language or require an alternate format. We will not treat you unfairly because you file an appeal.

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

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

Send your Appeal request to:

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

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

Continuation of Benefits

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

- Within ten (10) days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

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

What Happens After We Get Your Appeal

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

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

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

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

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

You can also call Member Services at the number shown 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 two (2) calendar days after receiving your appeal if we need more information. A written notice of our decision will be sent within two (2) calendar days from when we make the decision.

Expedited Appeals

If we have all the information we need, expedited appeal decisions will be made within **72 hours** of receipt of your appeal 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 Optima Health to help decide your case. This can be done by calling Member Services at the bottom of this page or writing to:

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

You or someone you trust can file a complaint with Optima Health 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 Optima Health 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 contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain your right to appeal through the State Fair Hearing Process if you do not agree with our decision.

Your Right to a State Fair Hearing

If you disagree with our decision on your appeal request, you can appeal directly to DMAS. This process is known as a State Fair Hearing. You may also submit a request for a State Fair Hearing if we deny payment for covered services or if we do not respond to an appeal request for services within the times described in this handbook. The State requires that you first exhaust (complete) the Optima Health 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 Optima Health. 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, family member, or an attorney written permission to help you with your State Fair Hearing request. This person is known as your authorized representative.

Where to Send the State Fair Hearing Request

There are a few ways to ask for an appeal with DMAS. Your deadline to ask

for an appeal with DMAS is 120 calendar days from when we issue our final MCO internal appeal decision.

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

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

After You File Your State Fair Hearing Appeal

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

State Fair Hearing Timeframes

Expedited Appeal

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

Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will give you an answer within 90 days from the date you filed your appeal with Optima Health. 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 (10) days from being told that your request is denied or care is changing;
- By the date the change in services is scheduled to occur.

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. **You may, however, have to repay Optima Health for any services you receive during the continued coverage period if the Optima Health 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 Does not apply to FAMIS members

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

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

If services were provided while the State Fair Hearing was pending

If the State Fair hearing decision is to reverse the denial and services were provided while the appeal is pending, Optima Health 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

Optima Health 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 the Optima Health complaint process.

<u>Complaints about quality</u>

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

<u>Complaints about privacy</u>

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

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

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

<u>Complaints about accessibility</u>

- 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.

<u>Complaints about communication access</u>

- 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 Optima Health 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 Optima Health. An external complaint is filed with and reviewed by an organization that is not affiliated with Optima Health.

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 find a copy of the Complaints Packet at optimahealth.com/members/optima-family-care/member-appeals-and-grievances. You can file a complaint in writing, by mailing or faxing it to us at:

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

So that we can best help you, include details on who or what the complaint is about and any information about your complaint. Optima Health 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 Optima Health to the Managed Care Helpline at 1- 800-643-2273 (TTY: 1-800-817-6608) Monday - Friday, 8:30 a.m. – 6:00 p.m.

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.

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

13. Member Rights

Your Rights

It is the policy of Optima Health 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;
- Take part in decisions about your health care, including your right to choose your providers from Optima Health network providers and your right to refuse treatment;
- Choose to receive long term services and supports in your home or community or in a nursing facility;
- Confidentiality and privacy about your medical records and when you get treatment;
- Receive information and to discuss available treatment options and alternatives presented in a manner and language you understand;
- Get information in a language you understand - you can get oral translation services free of charge;
- Receive reasonable accommodations to ensure you can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services;
- Receive information necessary for you to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of your medical records and ask that the records be amended or corrected;
- Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to you or others or when there is a specific medical necessity. Seclusion and restraint will never be used a s a means of coercion, discipline, retaliation, or convenience;
- Get care without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be informed of where, when and how to obtain the services you need from Optima Health, including how you can receive benefits from out-of-network providers if the services are not available in the Optima Health network.

- Complain about Optima Health to the State. 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 virginiamanagedcare.com for more information.
- Appeal any adverse benefit determination (decision) by Optima Health that you disagree with that relates to coverage or payment of services. See *Your Right to Appeal* in this Section 15 of the handbook.
- File a 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 15 of this handbook.
- To receive information from us about our plan, your covered services, providers in our network, and about your rights and responsibilities.
- To make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this section of the handbook.)
- Exercise your rights and to know that you will not have any retaliation against you by Optima Health, any of our doctors/providers or state agencies

Your Right to be Safe

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

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

Your Right to Confidentiality

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

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Optima Health protect the confidentiality of your health information. We will not use or further release your health information except as necessary for treatment, payment, and health plan operations, as permitted or required by law, or as authorized by you.

Optima Health is required by law to maintain the confidentiality and security of your health information. We will only use or share your health information as needed to provide you with the care you need or as allowed by law unless you give us written permission to share it with others.

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

A complete description of your rights under HIPAA can be found in the Sentara Healthcare Notice of Privacy Practices. A copy of the notice is included in this handbook.

Your Right to Privacy

You have the legal right to see and receive a copy of your health information including your claims records. You have the right to correct your health information, request confidential communications, ask us to limit the information we share, and get a copy of the Sentara Healthcare Notice of Privacy Practices. You also have the right to request a list of who we have released your information to for certain circumstances. This is called an Accounting of Disclosures and may be obtained by calling Member Services at the number shown below.

You may file a complaint with Optima Health or with the Secretary of the U.S.

Department of Health and Human Services, if you believe your privacy rights have been violated. Call Member Services to file a complaint with Optima Health.

NOTICE OF PRIVACY PRACTICES

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

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

Our Pledge Regarding Your Protected Health Information

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

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

We are required by law to:

- _Maintain the privacy of your medical information;
- _Provide you this Notice describing our legal duties and privacy practices with respect to your medical information;
- _Notify you following a breach of your unsecured medical information; and
- _Follow the terms of this Notice.

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

The following sections describe different ways that we may use and disclose your protected health information without your authorization (permission). For each category of uses or disclosures, we will describe them and give some examples. Some medical information, such as

certain genetic information, certain drug and alcohol information, HIV information, and mental health information, may be entitled to special restrictions by state and federal laws. We abide by all applicable state and federal laws related to the protection of such medical information. Not every use or disclosure will be listed, but all of the ways we are permitted to use and disclose protected health information about you will fall within one of the following categories.

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

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

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

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

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

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

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

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

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

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

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

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

- **_Disaster-Relief Efforts**: We may disclose protected health information about you to an

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

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

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

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

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

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

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

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

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

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

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

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

We are not able to take back any uses or disclosures that we already made in reliance on your written permission.

Your Rights Regarding Protected Health Information About You

You have the following rights regarding your protected health information:

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

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

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

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

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

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

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

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

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

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you have previously agreed to receive this Notice electronically. Copies of this Notice are available by contacting the Sentara Health Plans Privacy Officer (contact information

below). This notice is posted on our website and can be downloaded at: www.optimahealth.com.

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

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

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

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

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

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

APPENDIX A

AFFILIATE

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

State Laws

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

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

*The Sentara Healthcare affiliated covered entities are:
SENTARA HEALTHCARE
SENTARA MEDICAL GROUP
SENTARA HOSPITALS
SENTARA LIFCORPORATION
HALIFAX REGIONAL HOSPITAL, INC.
SENTARA ENTERPRISES
POTOMAC HOSPITAL CORPORATION OF PRINCE WILLIAM
SENTARA HEALTHCARE CAROLINA
MARTHA JEFFERSON HOSPITAL
OPTIMA HEALTH OF NORTH CAROLINA, L.L.C.
OPTIMA BEHAVIORAL HEALTH SERVICES, INC.
OPTIMA FAMILY CARE OF NORTH CAROLINA, INC.
OPTIMA HEALTH GROUP
OPTIMA HEALTH INSURANCE COMPANY
SENTARA QUALITY CARE NETWORKS
MARTHA JEFFERSON MEDICAL GROUP, LLC
MEDICAL TRANSPORT, LLC
SENTARA RMH MEDICAL CENTER
RMH MEDICAL GROUP, LLC
SENTARA ALBEMARLE REGIONAL MEDICAL CENTER, LLC
SENTARA BLUE RIDGE, LLC
SENTARA DOMINION HEALTH GROUP, LLC
SENTARA ENTERPRISES
SENTARA HALIFAX PROFESSSIONAL SERVICES, LLC
SENTARA SOUTHSIDE HEALTH SERVICES, INC.
SENTARA HEALTH PLANS OF OHIO, INC
SENTARA HEALTH PLANS OF NORTH CAROLINAS, INC.
SENTARA HEALTH PLANS, INC.

SENTARA PRINCESS ANNE HOSPITAL
SENTARA VENTURES
HALIFAX REGIONAL LONG TERM CARE, INC.
SENTARA SOUTHSIDE HEALTH SERVICES, INC.
SENTARA DOMINION HEALTH GROUP, LLC
SENTARA HALIFAX PROFESSIONAL SERVICES, LLC
DOMINION HEALTH MEDICAL ASSOCIATES, LTD
SMG ANESTHESIA SPECIALISTS, LLC
HOSPTIAL FOR EXTENDED RECOVERY
VALLEY WELLNESS CENTER
MARTHA JEFFERSON MEDICAL ENTERPRISES, INC.
ALBEMARLE PHYSIICAN SERVICES – SENTARA
PROPRIUM, LLC
SARMC ANESTHESIA SPECIALISTS, LLC

How to Join the Member Advisory Committee

Optima Health would like you to help us improve our health plan. We invite you to join our Member Advisory Committee. On the committee, you can let us know how we can better serve you. Going to these meetings will give you and your caregiver or family Member the chance to help plan meetings and meet other Members in the community. These educational meetings are held once every three months. If you would like to attend or would like more information, please contact Optima Health 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, medical conditions, health status or need for healthcare services, sexual orientation, gender identity or expression, and income status.

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

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

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

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

Optima Health:

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

If you need these services, contact:

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

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

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

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

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

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

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

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

Rev. 05/01/2023

14. Member Responsibilities

Your Responsibilities

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

- Present your Optima Health Membership card whenever you seek medical care.
- Provide complete and accurate information to the best of your ability on your health and medical history.
- Participate in your care team meetings, develop an understanding of your health condition, and provide input in developing mutually agreed upon treatment goals to the best of your ability.
- Keep your appointments. If you must cancel, call as soon as you can.
- Receive all of your covered services from the Optima Health network.
- Obtain authorization from Optima Health prior to receiving services that require a service authorization review (see Section 14).
- Call Optima Health whenever you have a question regarding your Membership or if you need assistance toll-free at the number shown below.
- Tell Optima Health when you plan to be out of town so we can help you arrange your services.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after hours.
- Tell Optima Health 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 the number shown 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: https://www.vdh.virginia.gov/OLC/documents/2011/pdfs/2011-VA-AMD-Simple.pdf.

You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicaid such as Sentara Healthcare (https://www.sentara.com/hampton-roads-virginia/patientguide/advance-care-planning.aspx), Five Wishes (https://www.agingwithdignity.org/), the Virginia Department of Medical Assistance Services (DMAS),and Virginia Insurance Counseling and Assistance Program (VICAP), may also have advance directive forms.

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: http://www.virginiaadvancedirectives.org

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

If Your Advance Directives Are Not Followed

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

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

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

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

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

15. 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

Optima Health provides its members a way to report situations or actions they think may be potentially illegal, unethical, or improper. If you or someone you know suspects Medicaid fraud or abuse, please let us know. Your information will be investigated and you may remain anonymous. If you don’t mind being contacted, you can leave your name and phone number.

Contact us by phone, email or postal service:

Optima Health Fraud & Abuse Hotline Phone: 1-866-826-5277
Email: compliancealert@sentara.com
Mail:Optima Health
c/o Special Investigations Unit
PO Box 66189
Virginia Beach, VA 23466
If you would prefer to refer your fraud, waste, or abuse concerns directly to the State, you can report to the contacts listed below.

Department of Medical Assistance Services Fraud Hotline
Recipient Fraud: 1-800-371-0824 or (804) 786-1066
Provider Fraud: 1-800-371-0824 or (804) 786-2071

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

Virginia Office of the State Inspector General
Fraud, Waste, and Abuse Hotline
Phone: 1-800-723-1615
Fax: 804-371-0165
Email: covhotline@osig.virginia.gov
Mail: State FWA Hotline
101 N. 14th Street
The James Monroe Building 7th Floor
Richmond, VA 23219

Virginia Department of Social Services
www.dss.virginia.gov
1-804-726-7000 (Main Phone Number)

Virginia Managed Care
www.virginiamanagedcare.com, 1-800-643-2273

Cover Virginia
1-833-5CALLVA

Department of Health and Human Services
www.hhs.gov/ocr
1-800-368-1019

16. Key Words and Definitions Used In This Handbook

- **Adverse benefit determination**: Any decision to deny a service authorization request or to approve it for an amount that is less than requested.
- **Appeal**: A way for you to challenge an adverse benefit determination (such as a denial or reduction of benefits) made by Optima Health 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 Optima Health'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 Optima Health 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.
- **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."

- **Coverage decision**: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services.
- **Covered drugs**: The term we use to mean all of the prescription drugs covered by Optima Health.
- **Covered services**: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by Optima Health.
- **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.
- **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 care**: Health care services a person receives in the home including nursing care, home health aide services and other services.
- **Hospitalization**: The act of placing a person in a hospital as a patient.
- **Hospital outpatient care**: Care or treatment that does not require an overnight stay in a hospital.
- **List of Covered Drugs (Drug List):** A list of prescription drugs covered by Optima Health. Optima Health chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."
- **Long-term services and supports (LTSS):** A variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and maintain maximum independence. Examples include assistance with bathing, dressing, toileting, eating, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital.
- **Managed Care Organization (MCO)**: An organization which offers managed care health insurance plans (MCHIP), as defined by *Code of Virginia* § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered

person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Additionally, for the purposes of this Contract, and in accordance with 42 CFR § 438.2, means an entity that has qualified to provide the services covered under this Contract to qualifying Medallion 4.0 members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served, and meets the solvency standards of 42 CFR § 438.116.

- **Medically Necessary**: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.
- **Medicaid (or Medical Assistance):** A program run by the federal and the state government that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Most health care costs are covered if you qualify for both Medicare and Medicaid.
- **Member Services**: A department within Optima Health responsible for answering your questions about your membership, benefits, complaints, (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 the Optima Health and accept our payment and

not charge our Members an extra amount. While you are a Member of Optima Health, you must use network providers to get covered services. Network providers are also called “plan providers.”

- **Network pharmacy**: A pharmacy (drug store) that has agreed to fill prescriptions for Optima Health Members. We call them “network pharmacies” because they have agreed to work with Optima Health. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
- **Non-participating provider**: A provider or facility that is not employed, owned, or operated by Optima Health and is not under contract to provide covered services to Members of Optima Health.
- **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 Optima Health and is not under contract to provide covered services to Members of Optima Health.
- **Participating provider**: Providers, hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports that are contracted with Optima Health. 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.
- **Health Plan**: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.
- **Prescription drug coverage**: Prescription drugs or medications covered (paid) by your Optima Health. 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 is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often

they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.

- **Prosthetics and Orthotics**: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.
- **Provider**: A person who is authorized to provide your health care or services. Many kinds of providers participate with Optima Health, 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 Optima Health'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 a Optima Health is allowed to operate. It is also generally the area where you can get routine (non-emergency) services.
- **Service authorization: Approval needed before you can get certain services or drugs. Some** network medical services are covered only if your doctor or other network provider gets an authorization from Optima Health.
- **Specialist**: A doctor who provides health care for a specific disease, disability, or part of the body.
- **Urgently needed 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.

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/
Non-Medical Transportation	1-877-892-3986
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
Magellan of Virginia; DMAS Behavioral Health Services Administrator	Toll-free:1-800-424-4046 TDD: 1-800-424-4048 Or dial 711 to reach a relay operator http://www.magellanofvirginia.com/
Department of Health and Human Services' Office for Civil Rights	1-800-368-1019 or visit the website at www.hhs.gov/ocr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