



Member Handbook



CareNet
c/o Southern Health Services Inc.
9881 Mayland Drive
Richmond, VA 23233
www.YourCareNet.com
Customer Service: 1-800-279-1878



Welcome to CareNet!

Your decision to join CareNet was a significant one for you and your covered family members. On behalf of all of those associated with our plan, we welcome you. We have built a strong network of area physicians, hospitals and other health care providers to offer a broad range of services for your medical needs.

As a CareNet member, it is important that you understand the way your plan works. This *Member Handbook* contains the information you need to know about your CareNet benefits.

Please take some time to read these materials to know about your CareNet coverage. CareNet's Customer Service Department is available to answer any questions you may have about receiving services. You can reach them at 1-800-279-1878, Monday through Friday, 8:30 a.m. to 5:00 p.m. The TDD number is 1-877-227-3523.

We look forward to serving you and your family.

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Translation Services

CareNet Customer Service
1-800-279-1878

TDD
1-877-227-3523

If you do not understand English, please call 1-800-279-1878 and we will provide the information about your benefits to you in a language you can understand. We can also help you communicate with your doctor.

Si usted no entiende Inglés, por favor llame al: 1 (800) 279-1878 y nosotros le proveeremos la información acerca de sus beneficios en español. También podemos ayudarle a comunicarse con su médico.

Если Вы не говорите по-английски, позвоните, пожалуйста, по телефону 1-800-279-1878 и мы предоставим Вам информацию о Вашей медицинской страховке на русском языке. Мы также можем помочь Вам при разговоре с вашим врачом.

Als u geen Engels spreekt, wilt u dan dit nummer: 1-800-279-1878 kiezen en wij zullen u dan informatie over uw uitkeringen in uw eigen taal verstrekken. Wij kunnen u ook helpen om met uw arts te spreken.

Nếu quý vị không nói được tiếng Anh, xin gọi số điện thoại: 1-800-279-1878. Chúng tôi sẽ thông báo cho quý vị về những quyền lợi của quý vị bằng tiếng Việt. chúng tôi cũng có thể giúp quý vị nói chuyện với bác sĩ của quý vị nữa.

دینک نفلت هرامش نی ا هب آل فطل .دی تسین دلب یسی لگنا رگا 1 (800) 279-1878
امش رایت خا رد یتاع ال طان ات دوخ نابز هب دریگیم قلعت امش هب مک یی ازم فراب رد امش یارب ام ات
میراذگب
مینک کمک ناکش زپ اب تب حص رد امش هب مین اوتیم نان چمه ام

Confidentiality and Request for Your Medical Records

We understand the importance of keeping your personal and health information secure and private. We are required by law to provide you with the Notice of Privacy Practices. This notice informs you of your rights about the privacy of your personal information and how we may use and share your personal information. Changes to this notice will apply to the information that we already have about you as well as any information that we may receive or create in the future. You may request a copy at any time. Both CareNet and your doctors make sure that all member records are kept safe and private. We will limit access to your personal information to those who need it. We maintain appropriate safeguards to protect it. For example, we protect access to our buildings and computer systems. Our Privacy Office also assures the training of our staff on our privacy and security policies.

To properly service your benefits, we may use and share your personal information for “treatment,” “payment” and “health care operations.” We may limit the amount of information that we share about you as required by law. For example, HIV/AIDS, substance abuse and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

In the doctor’s office, your medical record will be labeled with your identification and stored in a safe location in the office where other people cannot see your information. If your medical information is on a computer, there will be a special password needed to see that information.

Your medical record cannot be sent to anyone else without your written permission, unless required by law. When you ask your doctor’s office to transfer records, they will give you a release form to sign. It is the responsibility of the office to do this service for you. If you have a problem getting your records or having them sent to another doctor, please contact CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523. Customer Service will assist you in obtaining records within 10 working days of the record request. Customer Service will assist:

- to provide quick transfer of records to other in- or out-of-network providers for the medical management of your health, or
- when you change primary care physicians, to assure that your medical records or copies of medical records are made available to the new primary care physician.

If you would like a copy of your medical or personal records that are maintained by us, you may send a written request to us. You may also call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 and ask for a form that you or your representative fills out and sends to us. When we get your written request, we will send you the requested records within 30 days unless we let you know in writing that it will take longer. At no time, should it take more than 60 days from the date of your written request for records to send them to you. You have a right to review your requested medical records and ask that they be amended or corrected.

Definitions

Adult

A member who is age 21 or older.

Agreement

The contract between Southern Health Services, Inc. and the Virginia Department of Medical Assistance Services (DMAS). This *Handbook* is a part of the agreement.

CareNet (We, Us, Our)

The Medicaid/FAMIS Plus program offered by Southern Health Services, Inc.

CareNet Provider (Provider)/Participating Provider

A doctor, hospital, skilled nursing facility, drug store or other duly licensed institution or health professional, such as a nurse midwife that has directly or indirectly signed a contract with us to be part of the CareNet network. These providers are also called participating providers. The provider directory will list these CareNet providers. Please be aware that the list changes.

CareNet Provider Directory/CareNet Provider Network

A list of providers that have contracted with us to provide care to CareNet members. This list changes. You will be sent an updated list at least once each year.

Child(ren)

A member who is under age 21.

Contract Year

July 1 through the following June 30.

Cosmetic Services and Surgery

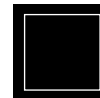
Services and surgery that are mainly to improve your looks. Cosmetic services and surgery do not help your body work better or keep you from getting sick.

Covered Services (Covered Care/Care)

The medical care, services or supplies which we will pay. This care is described in this *Handbook*.

Customer Service Department

The Customer Service staff that can answer questions about your CareNet benefits. The toll-free numbers are 1-800-279-1878 or TDD 1-877-227-3523.



Department of Social Services (DSS)

The agency which decides whether or not a person is eligible for Medicaid/FAMIS Plus.

DMAS

The Virginia Department of Medical Assistance Services.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

A program of preventive health care and well-child checkups with age-appropriate tests and shots.

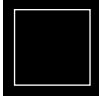
Emergency

A sudden onset of a medical condition that shows itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in: (i) serious jeopardy to the mental or physical health of the member; or (ii) danger of serious impairment of the member's bodily functions; or (iii) serious dysfunction of any of the member's bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental/Investigational

Care or a supply is experimental or investigational if it includes, but is not limited to, any of the following:

- It is in the testing stage or in early field trials on animals or humans.
- It is under clinical investigation by health professionals or is undergoing clinical trial by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration (FDA). Any drug not approved for use by the FDA, any FDA- approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature, or any drug that is classified as an Investigational New Drug (IND) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA. Drugs for the treatment of a specific type of cancer that are not FDA approved will be covered when they are approved for one type of cancer for which the drug has been prescribed in any of the standard reference compendia. Similarly drugs for the treatment of a specific indication that are not FDA approved will be covered so long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed Medical Literature.
- It is a health product or service that is subject to Investigational Review Board (IRB) review or approval.
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered by defined criteria.
- It does not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicare.
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.



Family Planning Care

Family planning care helps you to plan your family size. It gives you information on birth control methods.

FAMIS MOMS

Recipients who are uninsured pregnant females, not eligible for Medicaid, with family income at or below 185% of the federal poverty level, and who are assigned and enrolled in the aid category of 05. FAMIS MOMS receive the full Medicaid benefit package and have no cost sharing responsibilities.

FAMIS PLUS

Children who meet “medically indigent” criteria under Medicaid program rules, under 19 years of age. FAMIS Plus children receive the full Medicaid benefit package and have no cost sharing responsibilities.

HMO

Southern Health Services, Inc., a licensed health maintenance organization (HMO). As an HMO, it is subject to regulation in Virginia by the State Corporation Commission Bureau of Insurance under Title 38.2. It is also subject to regulation by the Virginia Department of Health under Title 32.1. For the purposes of this *Handbook*, an HMO is considered to be a Managed Care Entity (MCE) or a Managed Care Organization (MCO).

Medically Necessary (Medically Needed/Needed)

The use of services or supplies rendered by a hospital, skilled nursing facility, doctor or other provider that is needed to find or treat a member’s illness or injury. We must also feel that the care is: (1) consistent with the symptoms or diagnosis and treatment of the member’s condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the member, his/her doctor, hospital, or other health care provider; and (4) the most appropriate supply or level of service that can be safely given to the member. For members in the hospital, it also means the member’s medical symptoms or condition cannot be diagnosed or treated safely out of a hospital.

Member

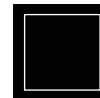
Any person who gets services from DMAS and who has CareNet coverage.

Member Handbook (Handbook)

This book as well as any amendment or related document sent together with this book that tells you about your coverage and your rights.

Post-Stabilization Care

Medically needed care a member gets after an emergency condition has been stabilized.



Preauthorization/Preauthorized

Approval by us that is needed so that we will pay for certain services to be done.

Primary Care Physician (PCP)

The CareNet doctor you pick to give you primary health care. This doctor will arrange for most other care you need as well. All members must pick a PCP. PCPs specialize in the areas of general practice, family practice, internal medicine and pediatrics. For female members age 13 or older, the member can also pick an OB/GYN doctor to give you primary health care and arrange for most other care you need. If you select an OB/GYN doctor, he/she is considered a PCP.

Prudent Layperson

A person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted “reasonably” if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was needed.

Service Area

The geographic area where you can get care under the CareNet program.

Southern Health Services, Inc.

The HMO that contracts with DMAS to offer the CareNet program.

Specialty Care Doctor/Specialist

A doctor who gives health care to members within his or her range of specialty. For the purposes of this *Handbook*, a specialty care doctor does not mean an OB/GYN since an OB/GYN is a PCP.

Standard Reference Compendia

The American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network’s Drugs & Biologics Compendium or the Elsevier Gold Standard’s Clinical Pharmacology.

Urgent Care

Urgent care is medically needed care for an unexpected illness or injury that you need sooner than a routine doctor’s visit.

You, Your

Refers to a member.

Section 1

Important Information About Your CareNet Coverage

In the event you need to contact someone about your CareNet coverage for any reason, please contact us at:
Southern Health Services, Inc.

CareNet Program
Post Office Box 7702
London, Kentucky 40742
1-800-279-1878
TDD 1-877-227-3523

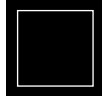
Please make sure you read and understand the grievance procedure in this *Handbook*, and make use of it before taking any other action. We have listed below the addresses and telephone numbers for complaints/grievances and appeals.

<p>Complaints/Grievances Southern Health Services, Inc. CareNet Program Customer Service Department Post Office Box 7702 London, Kentucky 40742 1-800-279-1878; TDD 1-877-227-3523</p>	<p>Appeals Southern Health Services, Inc. CareNet Program Appeals Coordinator 9881 Mayland Drive Richmond, Virginia 23233 1-800-279-1878; TDD 1-877-227-3523</p>
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If you have been unable to contact or obtain help from us, you may contact the Virginia State Corporation Commission’s Bureau of Insurance or the Department of Medical Assistance Services (DMAS) Division of Appeals at:

<p>State Corporation Commission Bureau of Insurance Post Office Box 1157 Richmond, Virginia 23218 1-804-371-9741, local or out-of-state calls 1-800-552-7945, in-state toll-free number 1-877-310-6560, national toll-free number</p>	<p>Division of Appeals Department of Medical Assistance Services (DMAS) 600 East Broad Street, Suite 1300 Richmond, VA 23219 1-804-371-8488</p>
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Writing to the Bureau of Insurance or DMAS is best so that a record of your inquiry is kept.



Facts about CareNet

Southern Health Services, Inc. is a medical plan known as a health maintenance organization (HMO) and is subject to regulation in Virginia by both the State Corporation Commission Bureau of Insurance under Title 38.2 of the Code of Virginia and the Virginia Department of Health under Title 32.1 of the Code of Virginia. CareNet is the name of the Medicaid/FAMIS Plus program offered by Southern Health Services, Inc. Southern Health Services, Inc. contracts with doctors, hospitals, drug stores and other medical providers to give care to our CareNet members. They are CareNet's provider network and are called participating providers. You should use these providers whenever possible.

We do not pay extra money to providers for deciding if you do or do not need care. We only pay providers for the care you receive. If you have questions about how we pay providers, call CareNet Customer Service at 1-800-279-1878 to ask for this information.

Section 2

Your Rights and Responsibilities

Your Rights

As a CareNet member, you have the right:

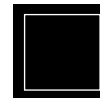
- To be treated with respect and dignity.
- To privacy and confidentiality.
- To private health care visits and to have your health records kept confidential.
- To tell us about any problems you have with us or our CareNet providers. We will look into the problem and address it.
- To get details about our services, CareNet benefits and CareNet providers.
- To get information about your rights and responsibilities.
- To be a part of decisions you and your doctor make about your health care. Your CareNet doctor is required to discuss treatment alternatives and all appropriate treatment options available to you.
- To enroll with other HMOs that contract with DMAS.
- To choose and change your PCP.
- To request and receive a copy of your medical records.
- To see and correct all personal information collected by us about you.
- To tell the doctor that you do not want treatment.
- Not to be held or kept away from others as a way to force, punish or pay back or just for our convenience.
- To be able to exercise these rights without being treated badly by us or our CareNet providers.
- To get information from us in a way that meets your needs based on your condition and/or in a way you can understand.
- To make suggestions for what should be included as member rights and responsibilities.
- To ask for a description of all types of payment arrangements that we use to pay providers for health care services for CareNet members. These payment arrangements may include withholds, bonus payments, capitation, and fee-for-service discounts. Call CareNet Customer Service at 1-800-279-1878 to request this information. We must respond to your request in 10 working days.
- To be told at least 14 days before there are any program or site changes that affect you.

TO RECEIVE THE BEST CARE YOU MUST DO YOUR PART.

Your Responsibilities

As a CareNet member, you have the responsibility:

- To carry your CareNet ID card with you. Show it to all of your health care providers.
- To let your providers know when your CareNet coverage ends.
- To give information needed by health care providers so the providers can treat you.
- **TO MAKE AND KEEP DOCTOR VISITS. CALL AHEAD TO CANCEL WHEN YOU CANNOT MAKE IT TO THE VISIT.**



- To get medical care from providers in the CareNet network. This does not apply to: (a) care for family planning; or (b) care for emergencies.
- To follow instructions given to you by your doctor for how to stay healthy, get the needed shots for you or your children, and know what care you should get for any medical conditions you may have.
- To call us at 1-800-279-1878; TDD 1-877-227-3523 if you lose your ID card. Call us if you do not get your card in the mail.
- To let CareNet Customer Service and your local Department of Social Services (DSS) know if you change your name, address or phone number or have a change in personal information like birth, marriage, death or other health insurance. This way we can reach you and send you information. Call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523. Also, let your local DSS know if you have a change in your income.
- To ask your doctor to get preauthorization for care when required.
- To learn how to tell the difference between emergencies and when you need urgent care. Know where and how to get care for each.
- To use the emergency room only for emergencies. See Section 5 of this *Handbook*.
- To follow the advice of your PCP.
- To learn about prescribed drugs. Know the reasons for taking them. Know how to take them.
- To transfer your health records to your PCP.
- To call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 to change your PCP before you get care from a new PCP.

DMAS pays us a monthly premium for your CareNet coverage. If you are found to be not eligible for CareNet coverage for past months because you did not give truthful information to your case worker or tell your case worker about changes in your circumstances, you may have to pay DMAS back for these premiums even if you do not get medical services under CareNet benefits during these months.

Section 3

Using Your Benefits

Getting Help

We are here to help you! We have a department called CareNet Customer Service. The people in CareNet Customer Service help CareNet members get answers to questions about their health care, ID cards and doctors. You can call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 when you have a problem or question. Call us any time between 8:30 a.m. and 5:00 p.m., Monday through Friday.

If your primary language is not English or you have a hearing impairment, you have the right by law to interpreter services. This is a CareNet covered service; this service is free; and you do not need to rely on a family member or friend to interpret for you. Tell your doctor that you need a translator or sign language interpreter and he or she will call us. We will make arrangements for signing or language interpreter services when treatment, medical history or health education needs to be discussed with you. You may also call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 to ask for a translator or sign language interpreter.

If you need to contact us about your benefits and your primary language is not English, we will contact our language line service, which will translate for you.

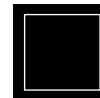
For members with hearing disabilities who have access to TDD telephones, if you need to contact us, you may call CareNet's TDD telephone number 1-877-227-3523. If you cannot reach us at this number, you may contact us through Virginia Relay toll-free at TDD 1-800-828-1120 or Voice 1-800-828-1140.

If you have questions about when you can start getting care under the CareNet program or how long you can receive care from us under the CareNet program, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

You may also be able to find answers to your questions on our website: **www.YourCareNet.com**. Learn more about benefits and services for you and your family in the Special Programs section. Check the prescription drug list and the services that require preauthorization. Read the latest issue of *Bear Facts* newsletter or ask us a question using the online form.

24-Hour Care

You will choose a Primary Care Physician (also called a PCP) who can take care of all of your health needs, 24 hours a day, every day. You can call your PCP for care anytime, day or night. When your PCP is out, he or she will have someone to take his or her place. Your PCP or your PCP's on-call doctor will be able to help you at all hours of the day and night, even on weekends and holidays. For routine and urgent care, call your PCP.



To see your PCP, just call the doctor's office and make plans for a visit. If you need health care and your PCP's office is closed, you should still call his or her office and tell them you are a CareNet member. Your PCP or someone from his or her office will call you back.

24-Hour Nurse Helpline

We encourage CareNet members to work with their PCP for their health care needs. However, if you have a medical question and you are not sure what to do, you can call our 24-hour Nurse Helpline. The Nurse Helpline can help answer specific health questions or give you advice on what to do when you need health care, such as calling your PCP, making an appointment or going immediately to the Emergency Room. The toll-free number for the Nurse Helpline is 1-877-878-8940. This number is also listed on the back of your CareNet ID card.

How to Use CareNet Services

Here are a few easy steps to follow so that we will pay for your health care:

Call your PCP and set up a time for a checkup.

As soon as you get your ID card, even if you are not sick, you should set up a time to see your PCP for a checkup. This way, your PCP can get to know you better and help stop future health problems before they happen, or at least find them sooner.

Your PCP will look for any problems you might have because of your age, weight and habits. Your PCP will also help you find ways to be healthy.

Children should also see their PCP for checkups, shots and screenings as soon as possible. For checkups, shots and screening, try to call your PCP two or three weeks ahead to ask for an appointment.

When you or someone in your family is sick and needs health care, call the PCP and set up a time for a visit. You can see the doctor at his or her office.

Keep your appointments.

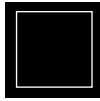
Please do not miss your doctor visits. Your doctor can take better care of you when you are there for each visit. Give your doctor at least 24-hours notice if you cannot keep your appointment.

Your PCP will decide who else you need to see.

If your PCP says you need other tests or you need to see another doctor, he or she will send you to the doctor best suited for your needs. Your PCP will help you make plans with other CareNet providers when you need special care.

You can call your PCP after hours.

If you need health care and your PCP's office is closed, you should still call his or her office if it is not an emergency. Leave a message to tell them you are a CareNet member. In your message, give the reason



for your call and be sure to leave your name and phone number where you can be reached. Your PCP or a doctor on call for your PCP will call you back soon. He or she will tell you where to get care.

CareNet ID Card and Medicaid Card

When you join CareNet, each family member receives his or her own CareNet ID card. Make sure to keep your ID card in a safe place, since this is your only CareNet ID card. Always carry your CareNet ID card and your blue-and-white plastic Medicaid card. Always show both cards when you see a health care provider. These cards will let the provider know you are a CareNet member. The first date you can start using your CareNet ID card and getting care from us under the CareNet program is shown on the CareNet ID card.

Information on the CareNet ID card includes the following:

- Your name
- Your Medicaid ID number
- Your date of birth
- Your CareNet ID number
- Your primary care physician's name
- Your primary care physician's office phone number
- The day your CareNet coverage starts
- The number to call for mental health or substance abuse care
- The number to call for transportation services
- Your ID to obtain prescription drugs and number to call with questions

If you need a CareNet ID card, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523. If a card is lost or stolen, please call CareNet Customer Service at once.

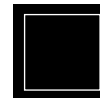
Primary Care Physician (PCP)

CareNet members choose their PCP from the CareNet provider directory. This PCP's name will be listed on your CareNet Member ID card. We will tell you if your PCP stops being a CareNet provider. We will help you pick a new doctor. If you do not pick a new PCP, one will be picked for you.

Each time you need to go to your PCP, you should call to set up your visit. Please show up for your visits. If you cannot get to your PCP for your visit, call your PCP's office to cancel, giving at least 24-hours notice.

If your PCP is not there when you need care, you should ask to see one of the other doctors in the group. Also, there may be a doctor on call for your PCP that you could see.

If you have a disabling condition or chronic illness, you may ask to have a CareNet specialist as your PCP.



Also, CareNet specialists may act as PCPs in giving care for special needs children. Either you or your doctor should contact CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 to make this request.

OB/GYN Physician

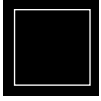
Female members age 13 or older may get female related services directly from a participating obstetrical/ gynecological physician (also called an OB/GYN) without asking their PCP. You will need to see a CareNet OB/GYN. You can pick the doctor from CareNet's provider directory.

Changing Your PCP or OB/GYN

You can change your PCP or OB/GYN online at the CareNet website, www.YourCareNet.com. You make this change in the My Online Services section. Or you can call CareNet Customer Service at 1-800-279-1878; TDD:1-877-227-3523. You need to do this before you visit the new doctor. Your change will happen the first day of the month. If you make your change by the 20th day of the month, you can use the new PCP or OB/GYN by the 1st of the next month.

Change in CareNet Benefits or Services

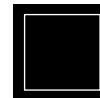
If there is a change in CareNet benefits or services that are available to you, we will let you know. We will let you know by telling you in writing or as an update to this *Handbook*.



Access and Availability Standards

The following are the access and availability standards for different situations for CareNet members:

Indicator	Standard
Physician Availability	
Routine history, physical exam and preventive health appointment offered	6 weeks
Routine primary care, chronic or ongoing problems appointment offered	1 week
Maternity appointments	First trimester – 14 calendar days Second trimester – 7 calendar days Third trimester – 3 working days High risk pregnancy – 3 working days
Semi-urgent complaint appointment offered	2 days
Urgent complaint appointment offered	Same day
Emergency appointment offered	Immediately
24-hour availability	24 hours a day; 7 days a week
Waiting room time	30 minutes
Number of patients per hour	No more than 6 patients per hour
Behavioral Health (Mental Health)	
Routine appointment offered	10 working days
Urgent visit offered	Same day
Crisis/Emergency	Immediately
Post hospital follow up	1 - 5 working days
Specialists	
Routine specialist appointments for an evaluation (unless otherwise specified by the physician)	3 weeks



Continuing Services from Providers

If your CareNet provider leaves the CareNet provider network, you may continue to receive covered services from this provider in the following cases:

You may receive covered services from your PCP for a period of up to 90 days after the date the PCP has given to, or received from us, notice that his or her participation status in the CareNet program is ending. This can only take place if your PCP remains in the CareNet service area and is open to see patients.

You may receive covered services from providers other than your PCP for a period of at least 90 days if you were in an active course of treatment with the CareNet provider before the provider's notice of termination from the CareNet provider network. You must make a request to continue receiving health care services from that provider.

You are able to receive care for extended periods under the following circumstances:

- If you have entered your second trimester of pregnancy at the time your provider's participation is terminated and the services from that provider are directly related to the delivery through postpartum care.
- If you have a medical prognosis of life expectancy that is 6 months or less, you may continue to receive treatment from such provider for the remainder of your life for care directly related to the treatment of the terminal illness.

The continuity of care options described above are not available if your provider is terminated for cause or if you are no longer a CareNet member. We will pay the provider for covered services you receive as described above according to our agreement with the provider.

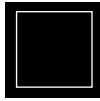
If your provider leaves the network, call CareNet Customer Service for help at 1-800-279-1878; TDD 1-877-227-3523.

When You May Have to Pay for Services

You may have to pay for care you get from a provider who is not part of the CareNet provider network. CareNet Customer Service can tell you if a provider is part of the CareNet provider network by calling 1-800-279-1878; TDD 1-877-227-3523. Sometimes we will pay for your care even if you do not go to a CareNet provider:

- For care in an emergency.
- For urgent care outside CareNet's provider network, when approved by us.
- When your PCP sends you **and** we preauthorize the care before your visit.
- For family planning services.
- For benefits from a drug store that accepts our rate as payment in full.

You must get all your care from your CareNet PCP, unless your PCP has sent you to a specialist. You may have to pay for health care if you do not go to a CareNet provider. The only times you would not have to pay are listed above.



Providers Not in the CareNet Network

Your doctor may tell you that you need to see a doctor or other health care provider who is not a CareNet provider. If so, he or she must send the health information we need to review the request. Our staff will review the information. You can go to a provider outside the CareNet network only if: (1) the care is needed; and (2) there are no CareNet providers who can give the care needed. We have the right to say where the service can be given when no CareNet provider can give the care needed. The care must be preauthorized before your visit. The doctor that wants to give you the care should ask for this preauthorization. When care outside the network has been approved by us, there is no cost to you. If you have questions, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

Referrals

We do not require you to get a referral from your PCP or OB/GYN before you see another CareNet provider. You still should call your PCP to let them know that you are going to the other provider because we must preauthorize the care.

Preauthorized Care

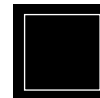
We must preauthorize some health care, drugs and supplies you get. We will give preauthorization to CareNet providers when you need health care, drugs or supplies that are medically needed and are listed below. Your doctor needs to call us for approval at least 3 working days before the scheduled care. We may ask to see written notes showing that the care was medically needed before it is preauthorized. Our staff are available from 8:00 a.m.– 5:00 p.m. (ET). If you have questions, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

You must get your first service on the date or within the dates listed on your preauthorization. If you cannot get the care on the date or within the dates listed on your preauthorization or you need more visits, you must call your doctor. Your doctor will call us to change the preauthorized dates. Preauthorizations are good for a specific amount of time. **The preauthorization does not go past your last covered date.**

Your preauthorization for care is for a specific problem or sometimes for a set number of visits. If you run out of visits and still need more, call your doctor. Your doctor must call us to add more visits.

Preauthorization is required before the date you get care for the care listed below:

- Automatic Internal Cardiac Defibrillator (AICD)
- Behavioral health & substance abuse services: inpatient/outpatient mental health services and substance abuse treatment or rehabilitation services*
- Bi-ventricular pacemaker
- Clinical trials
- CT scans
- Dental treatment for dental accidents
- Durable Medical Equipment (DME): all rentals of DME and repairs, purchase of DME costing over \$500, (except ostomy supplies) and all rentals of DME

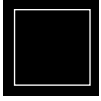


- Genetic testing
 - Home health care (nursing, infusion, respiratory, etc.)
 - Hospital observation stays
 - Hyperbaric oxygen – all places of services
 - Injectable and self-administered injectable drugs
 - Inpatient hospital care
 - Insulin pumps and supplies
 - Intensity Modulated Radiation Therapy (IMRT)
 - Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiogram (MRA)/Positive Emission Tomography (PET Scan)
 - Medical transportation services
 - Non-emergency ambulance transportation
 - Nonimplanted prosthetic devices
 - Nuclear radiology
 - Nutritional formulas and supplements
 - OB ultrasounds (beginning with 3rd ultrasound)
 - Oral surgery
 - Orthotics
 - Outpatient surgery (hospital or freestanding surgical center)
 - Pain management services/programs, including epidural steroid injections
 - Polysomnograms (sleep apnea studies)
 - Psychological or neuropsychological testing
 - Rehabilitative services: includes cardiac rehabilitation, pulmonary rehabilitation, physical, occupational, or speech therapy whether received inpatient or outpatient
 - Services from a non-participating provider except emergency services and family planning
 - Stress echocardiograms
 - Transplant consultations, evaluations and testing/transplant procedures
- * Preauthorization must be requested from the contracted mental health vendor which is listed in the Directory of Health Care Providers and on the member's ID card.

Additional information concerning preauthorization

We update the preauthorization list from time to time. If you are not sure about a certain service or injectable, or if you would like a copy of the most current listing, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

CareNet staff are not paid based on the approval or denial of services. If you have any questions about a utilization management decision, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 or fax your question anytime to 1-302-283-6586.



Carved-Out Services

- As a member of CareNet, you may receive the following services through the Department of Medical Assistance Services (DMAS):
- Community rehabilitation mental health services and intellectual disabilities services
- Substance abuse treatment services including emergency counseling services, intensive outpatient services, day treatment, opioid treatment and case management services
- School health services as outlined in the child's Individual Education Plan (IEP)
- Targeted case management services
- Abortions – for life or health of mother
- Dental services – Smiles for Children
- Early intervention services. These services are provided for members from birth to age 3 with a delay in one or more areas of development. These areas include physical, social, emotional and communication. Services are provided in the child's natural environment. For more information, call your local Infant and Toddler Connection office, or call the main Infant and Toddler Connection office at 1-804-371-6595, or visit www.infantva.org/Families.htm.

Other Services

If your child has elevated blood lead levels, your local health department will investigate and determine the source of the lead contamination.

Section 4

Covered Services and Limits

We manage the benefits covered in this *Handbook* by:

- Working with your doctor to decide what care is needed
- Deciding what care is covered
- Interpreting this *Handbook* when there is a question about coverage

Most care must be given by a CareNet doctor or provider and done at a CareNet facility. The only exceptions will be if: (1) your PCP asks for you to go out of the network, we agree and the service has been preauthorized; (2) you receive family planning services; (3) you get benefits from a drug store that accepts our rate as payment in full; or (4) you have an emergency.

We have contracted with a select network of providers for care. Sometimes there may be no CareNet provider who can give the needed care to a member. If this happens, the member may need to go out of the network for the care, once preauthorized by us.

We will remain current with reviewing new technology to be included as a covered benefit. We will review medical literature to help pick the technologies that will provide medically needed care and is approved by any regulating body required by law to do so. The new technologies must show improvement in the health risk of a member over current products or procedures.

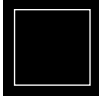
Care or supplies must be medically needed to be covered. Medical need is decided by looking at the generally accepted standards of care. Southern Health decides whether the care meets these standards. We cover any of the services in this section if court-ordered when they are medically needed.

Behavioral Health Care (Mental Health Care/ Substance Abuse)

We contract with a company to manage your behavioral health and substance abuse care. The providers are listed in the CareNet provider directory. If you need behavioral health services, your PCP may send you for care. In the case of a behavioral health emergency or if you want to call the company yourself, please see the number shown in the CareNet provider directory or on your CareNet ID card.

Behavioral health care is covered only when it has been preauthorized. The behavioral health company will review the care to make sure it is medically needed. Inpatient care you get is looked at during your stay. Your care will be covered as long as it is medically needed. If it is decided that all or part of your stay is not needed, the provider will be told that coverage will end.

If you have any questions about behavioral health care, please call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

**Covered Services:**

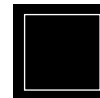
- Outpatient services in a psychiatrist's or licensed clinical psychologist's private office, certified hospital outpatient departments, and in the community mental health clinics approved and/or operated by the Virginia Department of Behavioral Health and Developmental Services.
- Medically necessary outpatient individual, family and group mental health and substance abuse treatment services.
- Short-term inpatient hospital services are covered for all ages in participating hospitals when preauthorized by the CareNet mental health provider. Hospital stays for the treatment of medical conditions that relate to substance abuse (like acute gastritis, seizures, pancreatitis and cirrhosis) need to be preauthorized by us.
- Psychological tests when related to an apparent or diagnosed psychiatric illness and as part of the doctor's plan for deciding what the mental illness or disease is and how to treat it.
- Children who have special needs for medically necessary assessment and treatment services, including children who have been victims of child abuse and neglect, can get this care if: (1) the services are delivered by a doctor or provider whose specialty is in the diagnosis and treatment of child abuse and neglect; (2) the services are provided by a doctor or provider who has similar expertise. A provider who meets these standards will be verified by DMAS.
- Services required by a Temporary Detention Order (TDO).
- All care given in a free-standing psychiatric hospital is covered for members up to the age of 21 and over the age of 64. When a child is admitted as a result of an EPSDT screening, a certification of the need for care must be completed as required by federal and state law.
- Outpatient substance abuse services.

Limits:

- Inpatient hospital stays for:
- Treatment of mental illness
- Functional nervous disorder(s) of any type or cause
- Psychiatric or psychoanalytic care for adults

Not Covered:

- Remedial education
- Day care
- Social behavior modification
- Socialization
- Play therapy
- Telephone consultations
- Inpatient mental health rendered in a state psychiatric facility



Cancer Treatment

High-Dose Chemotherapy, High-Dose Radiation Therapy and Bone Marrow Transplants.

Covered Services:

Members Under Age 21

High-dose chemotherapy and/or high-dose radiation; and any supporting allogeneic or syngeneic bone marrow transplants or other forms of allogeneic or syngeneic stem cell rescue (those with a donor other than the patient) are covered for children with the following diagnoses:

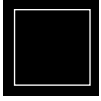
- Aplastic anemia
- Acute leukemia
- Stage IV intermediate or high-grade lymphoma with bone marrow involvement
- Severe combined immunodeficiency
- Wiskott-Aldrich syndrome
- Infantile malignant osteopetrosis
- Chronic myelogenous leukemia
- Stage III or IV Neuroblastoma in a child over one year of age
- Thalassemia Major
- Lysosomal Storage Disorders
- Myelodysplastic Syndrome

High-dose chemotherapy and/or high-dose radiation and any supporting autologous bone marrow transplants or other forms of autologous stem cell rescue (those in which the patient is the donor) are covered for children with the following diagnoses:

- Stage III or IV Hodgkin's disease which has come back after an initial complete remission or is in its first remission with poor prognostic factors, with no bone marrow involvement
- Stage III or IV intermediate or high-grade non-Hodgkin's lymphoma which has come back after an initial complete remission or is in first remission with poor prognostic factors, with no bone marrow involvement
- Advanced Neuroblastoma or other primitive neuroectodermal tumor without bone marrow involvement
- Acute lymphocytic or non-lymphocytic leukemia which has come back after an initial complete remission or is in first remission with poor prognostic factors
- Germ cell tumors with no prospect for complete remission with standard dose therapy

Members Age 21 and Over

High-dose chemotherapy and bone marrow transplants for adults who have been diagnosed with lymphoma, leukemia, myeloma or breast cancer are covered when the attending doctor determines the treatment is justified and preauthorized by us.



The term “high dose” when used to describe chemotherapy or radiation means a dose so high as to predictably require stem cell rescue.

Not Covered:

- Services or procedures that are deemed experimental or investigational

Case Management/Disease Management

If you have a chronic condition, a history of health problems or have had problems following our rules for getting health care, we want to work with you and your doctor to meet your health care needs. Case Management helps you get the best care in the most efficient manner. We can help you make specialist appointments. We will follow DMAS guidelines or nationally recognized guidelines for any alternative care proposed. Alternative care must be preauthorized by us before services are rendered. The care provided under Case Management will be made to meet your special health care needs.

We have special programs for CareNet members with asthma, coronary heart disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, heart failure, and high risk pregnancy. We also have programs for members needing a transplant, babies needing neonatal intensive care (NICU), or to help members transition their care from the hospital. These programs help you take good care of yourself.

If you feel you need Disease Management or Case Management services or if you have any questions about Case Management or Disease Management, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523. Tell the Customer Service staff you want to speak to a Case Manager or Disease Manager.

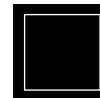
If you do not want Disease Management or Case Management services, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

Dental Services

Dental care for children is provided through the Smiles for Children Program. The toll-free number is 1-888-912-3456. You should call this number with any questions you have about your dental care. We cover hospitalization and anesthesia-related services for medically necessary dental services, if preauthorized.

Durable Medical Equipment (DME) and Medical Supplies

Rental or (at our sole option) purchase of medically needed DME is covered. Repair or replacement of damaged or lost equipment is covered. You must get the equipment from a provider in the CareNet network. All rentals and all DME purchases over \$500 must have preauthorization. Orthotics always require an authorization.



Covered DME includes, but is not limited to:

- Hospital beds
- Bedside commode, shower chair and tub rails
- Canes, crutches, walkers, slings, splints, cervical collars and traction apparatus
- Wheelchairs
- Oxygen and oxygen equipment
- Jet Nebulizers
- Apnea monitors; CPAP machines
- Blood glucose meters
- Jobst stockings or equivalent
- Prosthetic devices – like an artificial arm or leg
- Renal dialysis equipment and supplies
- Orthotics
- Insulin pumps and supplies
- Ostomy supplies
- Nutritional supplements

Limits:

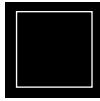
- Orthotics for adults are only covered when part of an approved intensive rehabilitation program.
- Nutritional supplements for adults are covered when they are the only source of nutrition.
- Nutritional supplements for children are covered and billed to DMAS when they are the primary source of nutrition. Medical supplies to administer the nutritional supplements are provided by CareNet.

Not Covered:

- Space-conditioning equipment, such as room humidifiers, air conditioners, and air cleaners
- Furniture or appliances not defined as medical equipment
- Items that are only for the member's comfort and convenience or for the convenience of those caring for the member
- Home or vehicle modifications
- Equipment for which the primary function is vocationally or educationally related
- Non-compression type support stockings
- Diabetic shoes and inserts

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

All children are given the care needed to promote health through the EPSDT Program. Under Medicaid/FAMIS Plus, your child may be eligible to receive certain otherwise noncovered services under EPSDT. EPSDT covers medically necessary services which will cure an illness or condition or at least keep it from getting worse. These benefits include, but are not limited to, services for nursing care, individualized treatments specific to developmental issues and accessing carved-out services. EPSDT allows children regular checkups and the care needed when sick. Your child will get both sick and well care from the same



doctor through this program. This will help your child get to know his or her PCP and help your doctor keep a complete record of your child’s health.

The PCP will give your child checkups and will help plan the care needed to prevent illness. Your child needs to have routine checkups. Routine checkups help catch health problems before they are serious. These checkups include dental, vision and hearing screenings and shots. If your PCP finds a health problem, he or she will make sure your child gets the care needed. Your child will be sent to another doctor if your child needs care that the PCP does not provide. When health problems are found in the screenings, CareNet benefits cover follow-up treatment and testing of these problems.

A complete physical exam includes:

- Physical and mental health and developmental history
- Unclothed physical exam
- Lab tests (including hematocrit/hemoglobin, urinalysis, and blood lead toxicity screening)
- Immunizations (shots)
- Nutritional assessment
- Injury prevention
- Checking and counseling about the growth and development of your child
- Vision, hearing and dental screens

Newborns will get the first hearing screening before leaving the hospital after birth. Follow-up visits to a CareNet audiologist to determine whether or not the child has hearing loss are also covered. Those newborns that were missed for a first hearing screening at the hospital after birth can go to a CareNet audiologist for the screening and any needed follow-up visits.

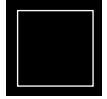
For patients at risk, a screening may also include the following procedures:

- Tuberculin test (at age 9 months, age 15 months and at each EPSDT screening thereafter)
- Cholesterol screening beginning at age 24 months
- Screening for Sexually Transmitted Diseases beginning at age 13
- Pelvic exam beginning at age 13

Children should get checkups regularly, at the ages listed below:

Age	Age
Birth	12 months
Under 6 weeks	15 months
2 months	18 months
4 months	24 months
6 months	30 months
9 months	Annually from age 3 through 21

Sick visits do not take the place of a routine screening visit.

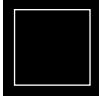


Children need shots that help their body fight disease. Each shot fights a different disease. Children must have a record of these shots in order to begin school. You may be required to provide this when you enroll your children into school.

Children should get each shot at the ages given in the chart below. Some shots need to be given more than once.

Immunization Chart (Shots)

Age	Shot
Shortly after birth	Hepatitis B #1
Between 1 and 2 months	Hepatitis B #2
2 months	Diphtheria, Tetanus, acellular Pertussis (DTaP) H. <i>influenzae</i> type B (Hib) Inactivated Poliovirus (IPV) Pneumococcal Conjugate (PCV) Rotavirus
4 months	Diphtheria, Tetanus, acellular Pertussis (DTaP) H. <i>influenzae</i> type B (Hib) Inactivated Poliovirus (IPV) Pneumococcal Conjugate (PCV) Rotavirus
Between 6 and 18 months	Hepatitis B #3 Inactivated Poliovirus (IPV)
At 6 months then yearly to 18 years	Influenza (Flu) – annually
6 months	Diphtheria, Tetanus, acellular Pertussis (DTaP) H. <i>influenzae</i> type B (Hib) Pneumococcal Conjugate (PCV) Rotavirus
Between 12 and 15 months	H. <i>influenzae</i> type B (Hib) Measles, Mumps & Rubella (MMR) Pneumococcal Conjugate (PCV) Varicella (Chickenpox)
Between 12 and 23 months	Hepatitis A #1 and Hepatitis A #2
Between 15 and 18 months	Diphtheria, Tetanus, acellular Pertussis (DTaP)
After 2 years of age for certain high risk groups	Pneumococcal Polysaccharide (PPV) Meningococcal Conjugate (MCV) HepA Series
4 to 6 years	Diphtheria, Tetanus, acellular Pertussis (DTaP) Inactivated Poliovirus (IPV) Measles, Mumps, Rubella (MMR) Varicella (Chickenpox)
10 to 12 years	Tetanus, Diphtheria, acellular Pertussis (Tdap) Meningococcal Conjugate
9 to 18 years	Human Papillomavirus (HPV) 3 doses



Eye Care and Eye Glasses

We cover certain vision services for adults and children when done by participating licensed CareNet optometrists and opticians. Call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 to find out how to get care from a CareNet provider nearest you. You can also look in the vision section of your CareNet provider directory.

Covered Services: Diagnostic exams and treatment and eye prostheses for all ages. Members under 21 have coverage for eye exercises (orthoptics), lenses, frames, repairs of lenses and/or frames, dispensing fees and medically necessary contact lenses. **Yearly diabetic eye exams are a covered medical benefit. Make an appointment with an optometrist or ophthalmologist from the specialist section of your CareNet provider directory. Let this doctor know that you have diabetes and need a special eye exam.**

Limits:

- One routine eye exam in each 24-month period – all ages
- Members under 21: either 1 pair of covered contact lenses or 1 pair of covered glasses in each 24-month period
- Eye exercises (orthoptics) are limited to 6 sessions.

Exceptions:

- Non-routine eye exams are not limited to a 24-month time frame.
- The member must pay upgrades and add-ons. These services are not covered and payment is between the member and the provider.

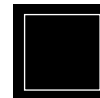
Not Covered:

- For adults: lenses, frames or repair of glasses, contact lenses
- Visual augmentation devices

Additional Services for Adults: Discount off of the provider's usual charge on eyeglass frames, prescription lenses, optical accessories, contact lens exams and contact lens purchases at all participating locations.

Family Planning Services and Supplies

Family planning helps you to plan your family size. It gives you information on birth control methods. Family planning is covered for CareNet members of child-bearing age. Any care given is kept private. You do not need to ask your PCP before getting this care. If you do not want to talk to your PCP about family planning, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523. We will help you pick a family planning provider. You may pick a family planning provider and get covered family planning services and supplies from a CareNet provider or a provider outside the network.



Covered Services: Family planning office visits; tubal ligations; Depo-Provera injections; diaphragm; IUD; vasectomies; prescription contraceptive devices and birth control medications, to include, oral and injectable contraceptive drugs; prescription barrier methods; education and counseling; diagnostic procedures; and lab tests.

Limits:

CareNet benefits cover sterilization of an adult member (over 21) only when:

- The member requests it in writing.
- The member is mentally competent.
- It has been 30 days since the consent form was signed.

Not Covered:

- Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing.
- Treatment of infertility or services to promote fertility.

Foot Care

Covered Services: Diagnostic, medical, and surgical treatment of disease, injury, or defects of the human foot, when treatment is reasonable and necessary; routine foot x-rays as part of the initial exam; additional x-rays when medically needed; comparative x-rays when the cause of the disorder is uncertain; hospital visits by the podiatrist; house calls subject to the limits set forth below; and drugs.

Limits:

- Hospital visits are only covered for the preauthorized number of days of the hospital stay.
- House calls are only covered if you must stay in bed. They are also covered if a trip to the foot doctor's office would harm the member.

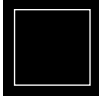
Not Covered:

- Routine foot care, such as treatment for corns, bunions and calluses

Hearing Services

Covered Services:

- Medically necessary diagnostic services for adults
- Diagnosis and treatment for defects in hearing including hearing aids for members under 21



High-Risk Prenatal and Infant Services

Our Baby Matters Program provides case management for high-risk members who are pregnant and children up to age 2. We will work together with your doctor to decide through risk screenings which members need these extra services.

Covered Services:

- Patient education classes
- Nutrition assessment and counseling by a registered dietitian
- Homemaker services for members whose doctor has ordered bed rest
- Coordination of community resources for classes such as childbirth and parenting
- Follow-up monitoring that the member is actually getting the care needed
- Guidance and support for the member through the process
- Blood glucose meters
- Testing for HIV
- Coordination to obtain residential or day treatment for substance abuse and transportation to receive those services

Home Health Care

A licensed or certified nurse or other health care provider may provide care for you in your home. Care is provided in your home when medically necessary. We must preauthorize the care. We will review this care together with your doctor to decide what is appropriate.

Covered Services: Nursing services; home health aide services when considered medically needed (assisting with personal hygiene, eating, walking, meal preparation and feeding, taking and recording blood pressure, pulse and respiration); therapy services; and medical supplies.

Limits:

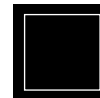
- Licensed nurse visits must be medically necessary and preauthorized.
- You can get up to 32 visits by a home health aide each calendar year. The number of home health aide visits may not be increased.
- Therapy visits are preauthorized based on medical necessity and a therapy plan of care.

Not Covered:

- Community food service delivery and custodial care or housekeeping when not part of EPSDT or high-risk pregnancy

Inpatient Hospital Care

When you do not have an emergency, we must preauthorize your stay before you go to the hospital. You must go to a hospital that is a CareNet provider. You will be under the care of your PCP or other doctor to whom your PCP has sent you.



We help manage all hospital stays. We look at the care you get while you are in the hospital. The care is covered as long as there is a medical need for the care. If all or part of the hospital stay is not medically needed, your doctor will be told that coverage will end and you will not be responsible for payment if you are in a CareNet participating facility.

Never Events: Members are not responsible for any charges when a provider is denied payment because of a Never Event or a Hospital-Acquired Condition (HAC). An example of a Never Event is a procedure that is done on the wrong side, wrong body part, or wrong person. An example of an HAC is an illness the member did not have before being admitted to the hospital.

Covered Services: Semi-private room and board; medical supplies; x-ray, lab, diagnostic/therapeutic services; use of hospital facilities; drugs and biologicals; nursing care; physical therapy; radiation therapy; renal dialysis; chemotherapy; intravenous therapy; inhalation therapy; occupational therapy; speech and hearing services; newborn infant care including hearing screenings; administration of whole blood and blood plasma; supplies, appliances and equipment needed to provide appropriate care and treatment; and rehabilitation services in a certified rehabilitation hospital when the facility is a CareNet provider.

Not Covered:

- Any services that are not medically needed
- Cosmetic surgery done only to make you look better.
- Elective surgery which is not medically needed to restore or materially improve a body function. This includes surgery for breast reduction.
- Supplies and devices that are for comfort or convenience **only** (like radio, TV, phone and guest meals); private rooms, unless a private room is medically needed or a semi-private room is not available. If you stay in a private room, it must be preauthorized by us during your hospital stay.

Maternity

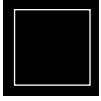
Maternity is pregnancy care, including prenatal, inpatient hospital stay during delivery and postpartum care. Take good care of yourself and your baby. See your doctor as soon as you know you are pregnant. Your doctor will notify us about your pregnancy and we will send you information about our *Baby Matters* program and how you can participate.

If you smoke, CareNet wants to help you stop. We cover counseling from a health care provider to help you stop smoking. We cover over-the-counter nicotine replacement products. There is no charge to you for these services.

Ask your doctor if you need a Tdap shot while you are still in the hospital with your baby. It helps protect against whooping cough.

Not Covered:

- Home birth



Medical Transportation Services

Covered Services: Transportation to medical appointments is a covered benefit. We contract with a transportation company to manage medical transportation services. If you need a ride to a health visit, please call the transportation company using the number shown on your CareNet ID card. You must call at least 3 working days before your visit or we will not be able to guarantee that a ride will be available. We must preauthorize the service. Members can ask for medical transportation to get to their eye, dental, behavioral health and medical visits. Transportation is not covered for picking up prescriptions and refills at a pharmacy when drugs can be delivered or mailed. Transportation is covered if the pharmacy has no delivery services or will not mail the prescription or the prescription cannot be filled at the medical facility. **Normally the prescription should be filled initially on the return trip from the medical appointment.** Transportation may be in the form of a public or private vehicle. This transportation must be used only when:

- The visit is for care covered by the Medicaid/FAMIS Plus program; and
- The member does not have his or her own transportation.

If you have any questions about medical transportation services, please call CareNet Customer Service at 1-800-279-1878; TDD 1-877- 227-3523, 8:30 a.m. to 5:00 p.m., Monday through Friday.

Ambulance transportation: In an emergency, call 911 for transportation. Non-emergency medically necessary ambulance and air ambulance transports must be preauthorized by us.

Not Covered:

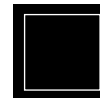
- CareNet benefits do not cover emergency transportation to treat small cuts, scrapes, bruises, fever and other conditions that do not threaten your life or limbs.
- CareNet benefits do not cover fees when you are absent or not ready for your scheduled transportation.

Nurse Midwife

We cover care given by a licensed CareNet nurse midwife. The care can be given in the doctor's office, a hospital, a clinic, or any other place needed to treat an illness, injury or disease.

Not Covered:

- Home birth



Oral Surgery Including Dental Accidents

Oral surgery is covered only for the cases below. Your PCP must send you for the care. We must preauthorize the care. CareNet benefits only cover repairs needed for daily living.

Covered Services:

- Oral surgery is covered for non-dental surgical and hospital procedures for birth defects (like cleft lip and cleft palate).
- Medical or surgical procedures within or next to the oral cavity or sinuses that are medically needed.
- Dental services medically needed because of an accidental injury when your doctor submits a plan of treatment to us within 60 days of the date of your injury and receives our preauthorization for the plan of treatment and the injury did not occur during the act of biting or chewing.
- Medically needed medical or surgical procedures within or next to the oral cavity or sinuses resulting from the removal of tumors and cysts. This also includes diagnosis and treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Not Covered:

- Cosmetic services or repairs we decide are not needed for daily living.
- Any other procedures involving the teeth or areas around the teeth including but not limited to:
 - Shortening of the mandible or maxilla for cosmetic purposes
 - Correction of malocclusion or mandibular retrognathia
 - Treatment of natural teeth due to diseases
 - Repair, removal, or replacement of sound natural teeth

Outpatient Hospital Care

Outpatient hospital care includes:

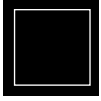
- Care to prevent sickness
- Tests to find sickness
- Care to help you heal

You should tell your PCP when you receive outpatient hospital care. We must preauthorize this care. You can get the care at hospital outpatient departments, clinics, health centers or doctors' offices that are in the CareNet provider directory.

Covered Services: Physical, occupational and speech-language pathology therapy; hematology; chemistry; renal dialysis; chemotherapy; radiation therapy; intravenous therapy; inhalation therapy; diagnostic x-rays; isotope studies; EKG and pulmonary services; thyroid function test; emergency room; medical supplies (e.g. oxygen and splints); special therapy treatments; outpatient surgery room; and 23-hour observation.

Not Covered:

- Spinal manipulation or osteopathic manipulation
- Biofeedback
- Acupuncture



Physician Services

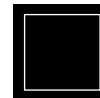
We cover care given by a licensed CareNet doctor or a doctor out of our network if approved in advance by CareNet. The care can be given in the doctor’s office, a hospital, a clinic, or any other place needed to treat an illness, injury or disease. Care can also be given at these places for family planning, maternity care, well-child screenings under the EPSDT program or other preventive care. Regular health exams are covered for adults.

Covered Services: Anesthesia; office visits; chemotherapy; concurrent care; consultations; referrals; treatment for End-Stage Renal Disease; eye care; hospital visits; house calls; therapeutic injections; lab and x-rays; routine screenings (Prostate-Specific Antigen (PSA) testing, rectal examinations, colorectal cancer screening, pap smear and mammography); disposable medical supplies normally used in physician’s office; routine newborn care; newborn circumcision; physical therapy; medically needed surgical procedures; assistant surgeons; diagnostic surgical procedures (biopsy and endoscopy); and preoperative and postoperative care related to surgery.

You are never too old to get immunized. Make sure you have had all the vaccinations you need before you leave your PCP’s office.

Age	19–49 years	50–64 years	65 years & older
Vaccine			
Influenza	Every fall (or winter).		
Pneumococcal	1–2 doses if you smoke cigarettes or if you have certain chronic medical conditions.*		1 dose at age 65 (or older) if you’ve never been vaccinated.
Tetanus, diphtheria, pertussis (whooping cough) (Td, Tdap)	A 1-time dose of “Tdap” vaccine if you are younger than age 65 years, are 65+ and have contact with an infant, are a health care worker, or simply want to be protected from whooping cough. You need a Td booster dose every 10 years.		
Hepatitis B (HepB)	You need this vaccine if you have a specific risk factor for hepatitis B virus infection* or you simply wish to be protected from this disease. The vaccine is given in 3 doses.		
Hepatitis A (HepA)	You need this vaccine if you have a specific risk factor for hepatitis A virus infection* or you simply wish to be protected from this disease. The vaccine is usually given as 2 doses.		
Human papillomavirus (HPV)	You need this vaccine if you are a woman who is age 26 years or younger.		

* Ask your PCP if you need this shot.



Measles, mumps, rubella (MMR)	At least 1 dose of MMR if you were born in 1957 or later. You may also need a 2nd dose.*		
Varicella (Chickenpox)	If you've never had chickenpox or you were vaccinated but received only 1 dose.*		
Meningococcal	If you have not had the shot and are going to college and will live in a dormitory.		
Zoster (shingles)		For ages 60 or older.	

* Ask your PCP if you need this shot.

Limits:

- Routine screenings are provided according to most recent guidelines.

Not Covered:

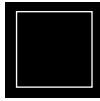
- Telephone consultations.
- Cosmetic surgery done only to make you look better.
- Elective surgery, which is not medically needed to restore or materially improve a body function. This includes surgery for breast reduction.
- Surgery which is experimental/investigational.
- Exams needed only for insurance, employment, school, sports or camp that are not part of a covered routine health assessment.
- Shots needed for travel, school and work that are not part of the recommended immunization schedule.

Prescription Drugs

CareNet will cover drugs on our prescription drug list. This list is included in your enrollment packet. At the drug store, you must show your CareNet ID card to get your medicine. CareNet Customer Service will give you the names of the stores where you may get your medicine or you can look in the CareNet provider directory. You may use a drug store that is not in this directory if the store has agreed to accept our rate as payment in full. We will not pay more than the allowable rate.

Covered Services:

- Medically needed prescribed drugs; mandatory generic drugs when available; brand name drugs, if medically needed and on CareNet's prescription drug list
- Over-the-counter products covered according to DMAS guidelines when prescribed by your doctor
- Over-the-counter nicotine replacement products
- Injectable insulin, syringes, glucose test strips, lancets and glucose monitors
- Growth hormones and Clozaril, when preauthorized by us
- Family planning drugs, such as oral and injectable contraceptive drugs, intrauterine devices (IUDs) and prescription barrier methods



- Prenatal vitamins; pediatric vitamins (in established deficiencies); and vitamins or minerals for dialysis patients
- Self-Administered Drugs on the prescription drug list. If a drug is not on the list, an exception must be requested.

Limits:

- Up to a 31-day supply will be filled per prescription or refill.
- Some drugs have a limit to the number of pills you can get – this is called a quantity limit (QL).
- Some drugs must be prior authorized before you can get it.
- If a doctor prescribes a medicine in a dose that can be filled with two separate strengths, we may require the most cost effective dose. For example, if your prescribed dose is 450 mg daily and the medicine is available in a 150-mg and a 300-mg tablet, we may require two separate prescriptions: one for the 150-mg tablet and one for the 300-mg tablet, instead of covering three of the 150-mg tablets.

Exceptions:

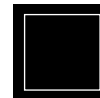
If you need a drug that is not on the CareNet prescription drug list, we have a process for you to get specific medically needed prescription drugs. We must determine, after reasonable review and talking with the prescribing doctor, that the drug on the prescription drug list does not work for the medical condition of the member.

We will also allow a member to get specific medically needed prescription drugs not on the prescription drug list if the member has been getting the drug for at least six months before the change to the prescription drug list. Also, the prescribing doctor must have decided that the drug on the prescription drug list does not work for the member and changing the drug presents a significant health risk to the member.

We will act on the request within 1 working day. Members who want to request a drug that is not on the prescription drug list should have their doctor contact us for review of the request. Either the member or the member's doctor may request an appeal of a previously denied request for a drug not on the prescription drug list.

Not Covered:

- Drugs that are not medically necessary.
- Vitamins, other than those vitamins and minerals listed above.
- Anorexiant, except when medically needed.
- Drugs prescribed mainly for a cosmetic purpose. This includes Retin-A when used for any purpose other than treatment for severe acne and Minoxidil when used to treat baldness.
- Experimental and investigational medications; drugs with no approved Food and Drug Administration (FDA) indications; drugs prescribed for purposes other than the FDA-approved use, unless a drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or other Peer-reviewed Medical Literature. Cancer drugs that are FDA approved for a certain cancer type may be used for treatment of other types of cancer, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia. Any drug approved by the FDA for use in the treatment of cancer pain shall not be denied for coverage



on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with a specific type of cancer. Drugs on the list requiring prior approval that do not meet the criteria for medical necessity.

- Infertility medications.
- Drugs not requiring a doctor's prescription, except for certain over-the-counter drugs.
- Drugs for the treatment of erectile dysfunction.

Pharmacy Lock-in Program

CareNet has a pharmacy lock-in program. We can restrict members to one pharmacy if a pattern of abuse is demonstrated.

A member will be placed in the pharmacy lock-in program if any of these situations occur:

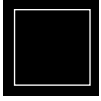
- More than 3 emergency room visits for nonemergency care within a three-month period
- More than 5 prescriptions for controlled drugs with the potential for abuse within a three-month period
- Claims from more than 3 pharmacies within a three-month period
- Claims from more than 3 health care providers within a three-month period for treatment of the same or similar conditions
- Using a CareNet ID card one or more times to obtain drugs under false pretenses, including an attempt to purchase drugs with a forged or altered prescription
- Pharmacist referral
- Physician referral
- Concurrent Review referral
- Case Manager referral
- Medical Director referral
- Coventry Special Investigations Unit referral
- Family member referral

If an individual who has been restricted to one pharmacy disenrolls from CareNet then re-enrolls within 6 months, the individual will be placed back in the lock-in program.

The member may request an appeal (including the right to request a State Fair Hearing) of the decision to restrict the member to one pharmacy.

Second Medical Opinion

You may need a second opinion for an illness, surgery and/or confirming a treatment of care your doctor has told you that you need. Contact your doctor or CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 for help to get a second opinion. The second opinion can be from a participating provider. If there are no participating providers available, you can get a second opinion from a provider outside of our network. There is no cost to you for the second opinion.



Telemedicine Services

We will direct to you to a provider that will be able to provide this service. Call CareNet Customer Service at 1-800-279-1878: TDD 1-877-227-3523 for a list of approved sites.

Therapy Services

Physical therapy, occupational therapy, and speech therapy is based on medical necessity, a physician's order and a treatment plan of care.

Transplant Services: Organ, Tissue and Bone Marrow

Covered Services:

All transplants must meet medical necessity criteria and be preauthorized. You must get all approved transplants at our Transplant Centers of Excellence. When both the donor and recipient are members, each can get the care described in this Section.

Members Under Age 21

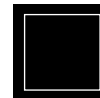
- Corneal transplant
- Heart transplant
- Kidney transplant
- Liver transplant
- Lung transplant
- Heart and Lung transplant
- Bone marrow transplant
- Small bowel transplant
- Small bowel with liver transplant

All medically necessary transplants that are not experimental or investigational are covered for children under 21 years of age when preauthorized.

Members Age 21 and Over

- Corneal transplant
- Heart transplant
- Kidney transplant
- Liver transplant
- Single lung transplant or double lung transplant

Bone marrow transplant for specific diagnoses: myeloma, lymphoma, breast cancer and leukemia when preauthorized.

**Limits:**

Transplant services for liver, heart, and lung transplant procedures for adults are only covered when:

- No other type of medical or surgical therapy is available with outcomes that are at least comparable to the transplant procedure.
- The transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational.
- The patient-selection criteria of the specific transplant center where the surgery is proposed to be performed has been used by the transplant team or program to determine the appropriateness of the patient for the procedure.
- Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management.
- The patient is not in an irreversible terminal state.
- The transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living.

Not Covered: Organ or tissue transplants other than those listed above are not covered. These include but are not limited to the following:

- Artificial heart transplants
- Pancreas transplants
- Adrenal to brain transplants
- Islet cell transplants
- Heart and lung, small bowel and small bowel with liver for members over 21
- Any transplant considered experimental and investigational

Urgent Care

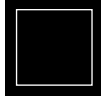
Urgent care is medically needed care for an unexpected illness or injury that you need sooner than a routine doctor's visit. Your PCP can help you determine whether or not you need to receive urgent care. Within the service area, you must receive all of your urgent care from your PCP. If you have a true emergency, go to the hospital emergency room.

Women's Health Care Services

Women's health care services are direct access services to an OB/GYN for care of or related to the female reproductive system.

Covered Services:

- A yearly gynecological exam for female members, age 13 or older, which includes: (1) a breast exam; (2) a pelvic exam; and (3) annual pap smear, to include annual testing performed by any FDA-approved gynecologic cytology screening technologies, when done by a CareNet provider.
- Screening mammograms using the following schedule: One baseline screening for ages 35 to 39; one mammogram annually for ages 40 and over.
- Prenatal care. We will recommend that the mother have HIV testing, which is covered.
- Services to treat any medical condition that may complicate pregnancy.
- Pregnancy related and postpartum services for 60 days after the pregnancy ends.



- If a newborn and mother or newborn alone is released from the hospital less than 48 hours after the day of delivery, at least one follow-up visit will be covered. The follow-up visit will be given within 48 hours after release. The visit will meet the most recent “Guidelines for Perinatal Care” developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. It will also meet the “Standards for Obstetric-Gynecologic Services” prepared by the American College of Obstetricians and Gynecologists.
- Hysterectomies when medically needed.
- Prostheses needed after the medically needed complete or partial removal of a breast for any medical reason.
- Reconstructive breast surgery performed along with, or after a full or partial mastectomy. Inpatient hospital care is covered for at least 48 hours after a radical or modified radical mastectomy. Inpatient hospital care is covered for at least 24 hours after a total mastectomy or a partial mastectomy with lymph node dissection. Inpatient hospital care for lengths stated above can be shorter if you and the doctor treating you both agree on the shorter stay.

Limits:

- Reconstructive breast surgery is covered when it is done: (i) along with a full or partial mastectomy; or (ii) after a full or partial mastectomy performed on or after July 1, 1998, to regain symmetry between the two breasts.

Not Covered:

- Hysterectomy done solely to make the member not be able to reproduce.

Section 5

Emergency Services

YOU AND YOUR FAMILY NEED TO KNOW WHAT TO DO IN AN EMERGENCY. Learn the difference between an emergency and urgent care. Learn what to do in each case. Carry your CareNet ID card with you at all times.

You can find a list of hospitals that provide emergency services and post-stabilization care in your provider directory or by calling CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

What is an Emergency?

Emergency care is care that you need right away. 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 fetus. You do not have to go to a CareNet provider in an emergency. However, if you are in the service area, you can only go to a provider who is not in the CareNet provider network when the delay in getting care from a CareNet provider could reasonably be expected to cause your condition to worsen if left unattended. When you are told you need emergency care by either your PCP or a CareNet representative, we will pay for the medical screening exam and any other medically necessary emergency services rendered in the hospital emergency room. Some examples of an emergency are:

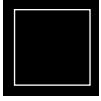
- Trouble breathing
- Poisoning
- Broken bones
- Chest pain
- Unconsciousness (blacking out)
- Severe or unusual bleeding
- Convulsions or seizures
- Sudden onset of severe pain
- Any vaginal bleeding in pregnancy
- Severe burns

In the Service Area:

If you have an emergency, you may not have time to call your PCP. If you do have time to call, he or she will help you decide what to do. If it is after your doctor's regular office hours, you should call the after hours number for your doctor. Keep this number in a place you can get to quickly when you need it.

Your PCP or a doctor on call for your PCP can be reached 24 hours a day. If you need an ambulance for an emergency, call 911. Ambulance service is only covered when there is an emergency or when we have preauthorized it. Hospital emergency rooms that are not in the CareNet network should be used only when the delay of a longer travel time to a hospital within the CareNet network could reasonably be expected by a prudent layperson to cause the member's condition to worsen if left unattended.

If you must stay in the hospital after an emergency, your provider must call us within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday.

**Outside the Service Area:**

If an emergency occurs while you are out of the service area, seek care. If you need to go to a hospital, call CareNet within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday. You may need to keep getting care while you are out of the service area. If so, you must get the visits preauthorized before you go back for any follow-up visits. Call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 to tell us what care you need. We can work with you and the health care providers to review the care you need for preauthorization. However, we will not preauthorize ongoing care out of the service area when you are able to come back to the service area for the care you need.

Show your CareNet ID card to the health care providers and ask that they file the claims with us. In some cases you may be asked to pay for emergency care. If this happens, you can send a statement that shows what care you got and a receipt for the payment of services. We will pay you back for covered emergency care when you were required to pay the providers. Be sure to give us your name, member number and a short statement about what happened.

Post Stabilization Care

This is medically needed care a member gets after an emergency condition has been stabilized. We do not require preauthorization for post stabilization care.

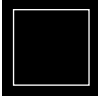
Section 6

General Services Not Covered

If a procedure, service or supply is denied, you or your doctor has the right to request an appeal by sending a request to the CareNet Appeals Department. This process is described in Section 7 of this *Handbook*.

The following services are not covered:

- Any service or supply that is not medically needed or is not a covered service; for example, cosmetic services.
- Any Phase I Clinical Trial or any Phase II, III, or IV Clinical Trial that does not meet defined criteria.
- Care from providers not in the CareNet network, except for family planning services, services received in an emergency or care preauthorized by us.
- Care you get from any provider when the care was not preauthorized by us as required in this *Handbook*.
- Administrative services such as phone calls; filling out forms; copying and/or transfer of health records; returned checks; stop-payment on checks; and other such clerical charges.
- Care at an assisted living facility or nursing facility. Care for rest cures, respite, domiciliary, residential or convalescent care. Private duty nursing except as (1) covered under your home health care benefit; and (2) provided for children when medically needed.
- Fertility services, including but not limited to, in-vitro fertilization and embryo transplants.
- The reversal of sterilization and complications that result from such procedures.
- Procedures, services and supplies related to sex transformations or sexual dysfunction.
- The cost of care for problems that federal, state or local law requires to be treated in a public center. Care or supplies provided or arranged by a government center when no charge would be made if you had no health benefits insurance. The cost of health care covered under the Medicare program or other insurance. Care for military service connected disability and conditions that you are entitled to as long as these centers are reasonably easy for you to get to.
- Health care or remedial care services by Christian Science nurses are not covered. Health care services at Christian Science Sanatoria long-term stay facilities are not covered.
- Medical, surgical or health care supplies that are experimental or investigational are not covered. Care or a supply is experimental or investigational if it includes, but is not limited to, any of the following:
 - It is in the testing stage or in early field trials on animals or humans.
 - It is under clinical investigation by health professionals or is undergoing clinical trial by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration.
 - It is a drug for the treatment of a specific type of cancer that is not FDA approved, is not approved for one type of cancer and the drug has not been recognized as safe and effective for treatment of the specific type of cancer for which the drug has been prescribed in any of the Standard Reference Compendia. It is a drug for the treatment of a specific indication that is not FDA approved, the drug has not been approved by the United States Food and Drug Administration for at least



one indication and the drug is not recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-reviewed Medical Literature.

- It is a health product or service that is subject to Investigational Review Board (IRB) review or approval.
- It does not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicare.
- It is a health product or service that is not considered to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.
- Chiropractic services.
- Any type of health service, supply or treatment not specifically listed or referred to in this *Handbook* is not covered.

The following services are not covered by us but you may receive these services through DMAS or your local health department. Call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 for information on these services. You may also call DMAS to obtain a list of these services.

- Hospice, abortion and skilled nursing facility services are covered by DMAS.
- School-based services. These are therapy, skilled nursing and psychiatric/psychological services outlined in the Individual Education Plan (IEP) and provided to children who qualify under the federal Individuals with Disabilities Act.
- CareNet benefits do not include WIC (the Special Supplemental Nutrition Program for Women, Infants and Children). CareNet benefits do not provide transportation for you to pick up WIC checks. The Department of Health provides the WIC Program. We will send expectant mothers information on WIC in their Baby Matters material. If you want to find out more about WIC, call your local health department, or call toll-free 1-888-WIC-FOOD; 1-888-942-3663.

Section 7

Complaints, Grievances, and Appeals

So that we can meet your needs, complaint, grievance and appeal procedures have been set up. You may use the Complaint, Grievance and Appeal Procedures if:

- You do not agree with the way we interpret this *Handbook*.
- The quality and speed of service does not meet your needs.
- You do not agree with our decision not to preauthorize care.
- You are not happy with a provider assigned to you.
- You suspect Medicaid fraud or abuse.

Inquiries

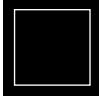
Inquiries are oral or written communications that CareNet Customer Service receives from members or member representatives. Inquiries can be about:

- the rules allowing you or a family member to get and keep CareNet coverage
- the health care services available to you as a CareNet member
- the rules we have for you to get your health care services
- the *Handbook* and other information we send to you
- giving us your new address if you move
- PCP assignment
- translation services

If you want to make an inquiry, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523. We will make every effort to respond to your inquiry on that phone call. If we cannot completely respond to your inquiry on the phone, we will call or write you back within 30 working days of the inquiry. If you want to write to us, please send the information to:

Southern Health Services, Inc.
Attn: CareNet Customer Service Department
Post Office Box 7702
London, Kentucky 40742

We will respond to your written inquiry in writing within 30 working days of the date we received the inquiry.



Complaints/Grievances

If you do not agree with a decision made by Southern Health, are not happy with any services received, or are unhappy about any other part of Southern Health or your provider, you can call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 or write it down and send it to the address listed above. By doing this you are filing a complaint to tell us why you do not like a decision. You have 30 calendar days after you receive our decision with which you are unhappy to file a complaint/grievance.

Also, complaints/grievances are when you call or send a letter to us to tell us you are not happy with any part of your benefits, services or CareNet. If you call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523, we will take all of the information you give us and investigate the problem. We will try to get you an answer in 20 working days. If that is not possible, you will get an answer in no longer than 30 working days from the date the complaint/grievance was filed.

Appeals

If you are not happy with our answer to your complaint/grievance or we have denied any part of your request for a health care service, you or someone with your OK can file something called an appeal. To file an appeal, or to request assistance with filing an appeal, contact CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523. You have 90 calendar days after you receive our decision on your complaint/grievance or you receive denial for any part of your request for a health care service to file an appeal.

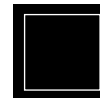
To file an appeal you will need to send us a written request that has:

- your name
- your provider's name
- the date of service
- your mailing address
- an explanation of why we should reverse our decision
- a copy of any information that will support your request, such as additional documents, records or information that are relevant to your appeal

A written appeal needs to be mailed to:

Southern Health Services, Inc.
CareNet Program
Attn: Appeals Coordinator
9881 Mayland Drive
Richmond, Virginia 23233

If you are not able to file a written appeal, you can call us and we will ask for the information listed above and document the appeal for you. We will let you know we have received your appeal and you can get copies of documents, records and information about the appeal. We will give these documents to you for free.



A Committee will look at your appeal. None of the people on the Appeal Committee will have been involved in our first decision to not preauthorize or cover the health services you are appealing. If your appeal involves a medical issue, the Committee will include a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. If your appeal is an administrative appeal (one not based on a medical issue), the Appeal Committee will consist of members of our senior management staff. You can come to the Appeal Committee meeting and talk to the Appeal Committee. In addition, you may ask a doctor, health care provider or member representative to meet with the Appeal Committee in your place. If you decide to meet with the Appeal Committee and you need a special place to stay due to a disability, please call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523. We will try to accommodate you while you are meeting with the Appeal Committee.

An appeal should be resolved within 14 calendar days from the date we receive it. If we need more time or more information for the appeal, or if you want to provide more information, you or we can ask for 14 additional calendar days to finish the appeal. If we need more time or information for the appeal, you will be sent a written notice of the delay and the reasons for it before the 14th day. You will have the right to file a grievance if you disagree with the reason for the delay in the appeal decision. If you want to provide more information to us regarding the appeal, you must request the extension before the 14th day. The time to make a decision on an appeal can be extended up to 14 more days if you or we need the extra time.

Fast (Expedited) Appeals

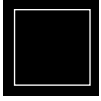
There is a fast appeal process to respond to cases where death or serious injury could result or in cancer patients when a delay in a decision could result in severe pain to the patient. This is also called an expedited appeal. You may call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 for this type of appeal. If we allow the fast (expedited) appeal, we will make a decision within 1 working day of receiving all information needed to make a decision and no later than 48 hours of the request, whether or not all information has been received. For appeals relating to prescriptions for pain for cancer patients, the decision will be made in 24 hours or less.

We do not punish your doctor in any way for requesting a fast appeal or for supporting your request for a fast appeal.

If we decide your appeal is not a fast appeal, we will handle your appeal like a regular appeal. You and your doctor will receive a phone call or a letter letting you know that we will be following the normal appeal process. We will let you know what the normal appeal process time frames are when we call or send you and your doctor the letter.

State Fair Hearings Process

If you are not happy with our appeal and your appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing if it is within 30 days of the notice of the appeal decision from us. You can also request a State Fair Hearing at the same time as or



instead of appealing to us. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously preauthorized service, or failure to provide service timely. Your request for a State Fair Hearing should be in writing and sent to:

Division of Appeals
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
1-804-371-8488

Other Contacts

You may address complaints about HMOs to the following:

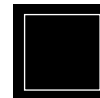
State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
1-804-371-9741, local or out-of-state calls
1-800-552-7945, in-state toll-free number
1-877-310-6560, national toll-free number

Virginia Department of Health
The Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233-1463
1-800-955-1819, in-state toll-free number

You may address complaints about providers to the following:

The Commonwealth of Virginia
Health Professions Department
6603 West Broad Street, 5th Floor
Richmond, Virginia 23230
1-800-553-1560, in-state toll-free number

All claims or complaints of any nature against Southern Health Services, Inc., its employees, agents, board members, or officers, whether filed by a member, or a spouse, heir, or personal representative of a member must first go through the Complaint, Grievance and Appeal Procedures discussed above before any action or proceeding may be sought in court.



If you suspect fraud or abuse and you report your concern to us, we will notify DMAS or the State Corporation Commission Bureau of Insurance right away. In no case will it take more than 48 hours from the date it is reported to us to notify DMAS or the State Corporation Commission Bureau of Insurance.

It is our policy to respond promptly to complaints, grievances and appeals through all stages of the process. For more information or to get a copy of the complete process, please call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

For questions or concerns regarding your Medicaid/FAMIS Plus eligibility, call DSS.

Your Benefits During the Appeal or State Fair Hearing Process

While your appeal or state fair hearing is in process, your CareNet benefits will continue if:

- You or your doctor files the appeal within 10 days of the date on the notice to deny, reduce, change or end payment for your health care services or before the effective date of the notice.
- Your appeal is about our decision to terminate, suspend or reduce a course of treatment that was already preauthorized.
- The services were ordered by an authorized provider.
- The time frame covered by the preauthorization has not passed.
- You request that your benefits be extended.

To request a continuation of benefits, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

While the appeal is pending, your benefits will continue until:

- You withdraw the appeal, or
- the time frame of the preauthorization has been met, or
- the service limit of the preauthorization has been met.

If the final result of your appeal is to uphold the original decision, your benefits will not continue past 10 days after we mail the results. If you request to continue your benefits pending a State Fair Hearing decision, your benefits will continue until a State Fair Hearing officer upholds our original decision.

If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, we may take back the money that was paid for the services while the appeal was in process.

Section 8

Eligibility and Enrollment

Eligibility

No person is eligible to enroll in the CareNet program unless approved by DMAS and DSS. For eligibility questions or concerns, call DSS.

DMAS pays us a monthly premium for your CareNet coverage. If you are found to be not eligible for CareNet coverage for past months because you did not give truthful information to your case worker or tell your case worker about changes in your circumstances, you may have to pay DMAS back for these premiums even if you do not get medical services under CareNet benefits during these months.

Enrollment

DMAS will give us the name, address, age and sex of each member enrolled in CareNet. The effective date of your enrollment will be on your CareNet ID card. DMAS determines your continued enrollment in the CareNet program based upon your Medicaid/FAMIS Plus eligibility. To stay enrolled in the program, it is important to complete any review forms as soon as you receive them from DSS. Return them to DSS by the date requested.

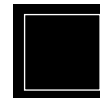
Changes in Enrollment

When your family size changes, you move, or get health insurance other than Medicaid, call CareNet Customer Service and your local DSS. CareNet Customer Service can be reached at 1-800-279-1878; TDD 1-877-227-3523. Call Customer Service if:

- You have a new person in your family.
- Someone leaves your family home.
- You move. If you move from your current address, we may not be able to cover you under the CareNet program but we will help you continue to get services until you are disenrolled. CareNet Customer Service will be able to tell you if your new address is in our service area. Contact your local DSS if you move. You may be disenrolled from the Medicaid program if your mail is returned to DSS.

Babies born to mothers enrolled in the CareNet program will be enrolled automatically in the CareNet program for the birth month plus two more months. **PLEASE CALL YOUR LOCAL DSS TO GET A MEDICAID/FAMIS PLUS ID NUMBER FOR YOUR BABY.** This is important to make sure your baby does not have a problem receiving care. If your baby does not have a Medicaid number by the end of the third month following birth, your baby will no longer be covered by CareNet or Medicaid.

FAMIS MOMS: Babies born to FAMIS MOMS will be enrolled automatically in the CareNet program for the birth month plus 2 additional months. **PLEASE CALL YOUR LOCAL DSS TO GET A MEDICAID/FAMIS PLUS ID NUMBER FOR YOUR BABY.** This is important to make sure your baby



does not have a problem receiving care. If the baby does not have a Medicaid/FAMIS Plus ID number by the end of the third month following birth, the baby will lose coverage.

Waiver Program: If you become enrolled in a waiver program, CareNet will send you a letter letting you know DMAS has told us about your waiver.

- CareNet Medical Services – use your CareNet ID card to receive covered medical services as described in this *Handbook*. For transportation to medical services, call the number on your CareNet ID card.
- Waiver Services – use the DMAS Medicaid blue and white ID card to receive waiver services. For transportation to waiver services, call LogistiCare at 1-866-386-8331.

Disenrollment

You can ask to stop your membership in the CareNet program at any time within the first 90 days of enrollment, for any reason. Just call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523 and someone will tell you what needs to be done to stop your membership. You may also call the Managed Care Helpline directly at 1-800-643-2273.

You will be disenrolled if: (1) Medicaid/FAMIS Plus eligibility is lost; or (2) you lose eligibility for continued enrollment due to a change in eligibility or institutional status (hospice, skilled nursing). Your CareNet coverage will end on the date of termination, even if you are in the hospital on that date.

Termination

All rights to benefits, including hospital care, shall end on the date termination takes effect, except as stated above. Your CareNet coverage will end if:

- DMAS disenrolls you as a member.
- You are no longer eligible for Medicaid through the commission of Medicaid fraud. Your CareNet coverage will end at the end of the month you lose eligibility. In the absence of fraud, all statements made by a member shall be considered representations and not warranties. No statement shall be the basis for voiding coverage or denying a claim after this coverage has been in force for 2 years from its effective date. But, if the statement was material to the risk and was contained in a written application, coverage may be void beyond the 2-year period.
- The contract between Southern Health Services, Inc. and DMAS ends. In such a case, coverage shall end for all CareNet members on the date termination takes effect. DMAS will let you know the date of termination, and the process by which you can continue to get care.

Except as stated in this *Handbook*, care is not covered through us after your CareNet coverage ends. This includes care that relates to an injury or illness that began before your CareNet coverage ended.

Section 9

Terms and Conditions

Filing Claims

Most claims will be filed for you by CareNet providers. You may have to file claims if you get care outside the CareNet network. You can get the claim forms from CareNet Customer Service by calling 1-800-279-1878; TDD 1-877-227-3523. Claims should be sent to:

Southern Health Services, Inc.

CareNet Program

P. O. Box 7702

London, KY 40742

We will pay you back for needed health care you pay for, up to the Medicaid allowed amount. You must send the claim and receipt that shows what you paid to us. **We must receive claims you submit within 365 days from the date of service. Incomplete claim forms will be returned to you.**

Copayments

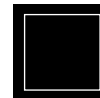
There are no copayments required for any service covered by this *Handbook*.

Relationship to Contracting Parties

CareNet doctors have a doctor-patient relationship with you and are solely responsible for all health care. The relationship between Southern Health Services, Inc. and providers in the CareNet network is an independent contractor relationship. CareNet providers are not employees or agents of Southern Health Services, Inc. Neither Southern Health Services, Inc. nor any person who works for Southern Health Services, Inc. works for or is an agent of any CareNet provider. Members are not agents and do not represent us. Members are not liable for any acts or omissions by Southern Health Services, Inc., its agents or employees. Members are not liable for any acts or omissions of any other person or company with which we have made or will make arrangements for covered care.

Advance Directives

For members 18 years and older, federal law and the Health Care Decisions Act in Virginia give you the right to decide the medical care you want. You should let your doctor or other health care provider know what specific health care you want or do not want if you become very sick or have a life threatening illness. You can also let your doctor or other health care provider know if you want someone else to make medical decisions for you when you are medically or mentally unable to do so. These are called **advance directives**. Advance directives can include a living will or medical power of attorney. Your doctor or other health care provider will write down your wishes or make a copy of your written wishes if you already have them. These advance directives will be made a part of your medical records. You may change your mind at any time by putting your change in writing. We will tell you if the law changes within 90 days of the change.



You should tell your doctor or other health care provider if you have certain moral and/or religious beliefs that would stop you from making advance directives. Your doctor or other health care provider will write down your objections to making advance directives and will make this a part of your medical records.

If you have questions about advance directives, call CareNet Customer Service at 1-800-279-1878; TDD 1-877-227-3523.

Changes

Any statement, term, benefit or condition of coverage and this *Handbook* may be changed or removed to meet the terms of the agreement between Southern Health Services, Inc. and DMAS. DMAS needs to approve any changes. Changes may be made without the member's consent.

Entire Agreement

You are covered under our contract with DMAS. DMAS reimburses us for care provided for in the contract. If there is any difference between what is in this *Handbook* and what is in the contract between Southern Health Services, Inc. and DMAS, the contract will control. You can call DMAS if you have questions about the contract between us and DMAS.

The following items listed make up the entire agreement between you and CareNet:

- The Member *Handbook*, its attachments and amendments
- The CareNet ID card
- The contract between Southern Health Services, Inc. and DMAS, its attachments and amendments

No part of our charter, by-laws or other document shall constitute part of this contract except as set forth in this *Handbook* or in the Group Enrollment Agreement. No verbal statements made by us shall change the terms of the agreement.

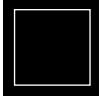
Notice of Insurance Information Practices (Abbreviated)

The following is a brief notice of our Insurance Information Practices. Please be aware of the following:

- Personal information about the individual proposed for coverage may be collected from persons other than that individual.
- Personal information, as well as other personal or privileged information subsequently collected by us, may be disclosed to third parties without your authorization in order to better coordinate your care.
- You have a right of access and correction with respect to all personal information collected.

If you request, we will provide you with a complete description of our Insurance Information Practices, which includes:

- From whom, other than yourself, personal information may be collected.
- The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information.
- To whom we will disclose information and the circumstances under which such disclosures may be made without your prior authorization.



- A description of your rights by law to be able to access, correct, amend or delete recorded personal information.

For further information, you may write to the CareNet Customer Service Department at the address on the back of this *Handbook*.

Medical and other privileged information provided to us is kept confidential. Such information will be used only for administration of your benefits or for coordinating benefits with other plans.

Coordination of Benefits

If you or a dependent is entitled to any other health care coverage besides Medicaid/FAMIS Plus, you need to tell us, DSS and DMAS.

An example would be if you or your child is covered under health care coverage of some other person, such as a grandparent or natural parent who does not have custody.

If a benefit is covered by us through the CareNet program and by another group health care plan (this includes government plans), we will coordinate benefits with such other plan. No more than 100% of the eligible incurred expenses are paid. The benefits provided by us through the CareNet program shall be secondary to any such other plan. If we are secondary, we will provide and arrange for your needed services before coordinating with the other plan.

When we pay a total amount that is more than the highest amount of payment needed to meet the intent of this section, we shall have the right to get back such payments. We shall only have the right to get back the excess amount. We shall have the right to get this back from:

- Any persons to or for or with respect to whom such payments were made; and/or
- Any other plan

Each member must give us any information needed to apply this section.

Transfer of Benefits and Payments

The covered care you get under your *Handbook* belongs only to you. You may not transfer your right to get covered care to someone else.

You may not transfer your right to get payment for covered care. Prior payments to anyone, whether or not there has been a transfer of payment, shall not be a waiver of, and shall not restrict, our right to send future payments to you or any other person or center.

CareNet Service Area

Counties:

Amelia County
Amherst County
Appomattox County
Campbell County
Caroline County
Charles City County
Chesterfield County
Cumberland County
Dinwiddie County
Essex County
Goochland County
Hanover County
Henrico County
King and Queen County

King William County
Lancaster County
Lunenburg County
Mathews County
Mecklenburg County
Middlesex County
New Kent County
Northumberland County
Nottoway County
Powhatan County
Prince George County
Richmond County
Surry County
Sussex County
Westmoreland County

Cities:

Colonial Heights
Hopewell
Lynchburg
Petersburg
Richmond

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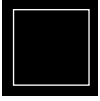
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