# After Enrollment

This section is divided into seven parts. The first five address how recipients in the Medicaid and the FAMIS programs access their benefits. The sixth section addresses certain situations where the state might pay for an individual's coverage in a private insurance plan (FAMIS *Select* and HIPP). The last section is sample forms sent by the Local DSS.

### *Part IV: Medicaid for Pregnant Women, FAMIS MOMS and FAMIS Prenatal Coverage*



### *Part V: Plan First*



### *Part VI: FAMIS* Select and HIPP



### *Sample Forms*

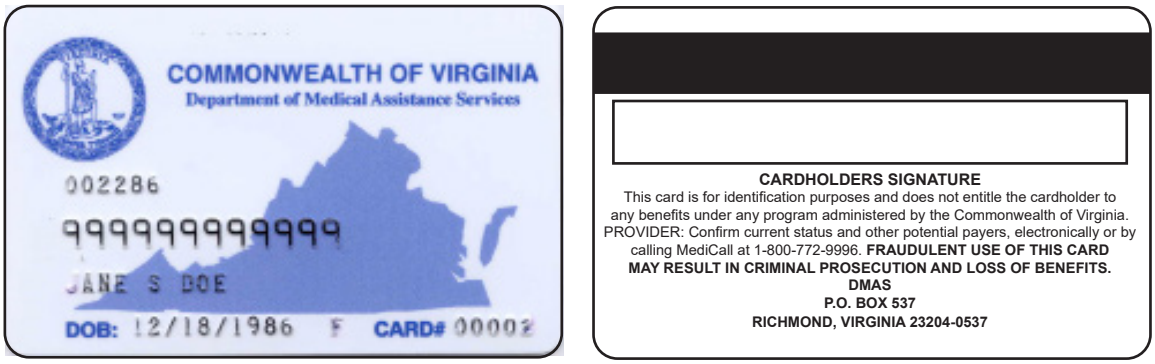
# PART I: New Health Coverage for Adults

## Once Approved

An individual approved for the **New Health Coverage for Adults** will receive a *Notice of Action on Benefits* stating that he/she has been approved. (*A Sample Notice of Action is on page 2.37*.)

In a separate mailing, the recipient will receive a permanent plastic ID card from DMAS. This card enables the individual to receive services from any Medicaid provider while his/her permanent benefits delivery method is determined. Enrollment into managed care takes less than 30 days. This is the period referred to as "Fee-for-Service". Enrollees do not have to wait for the receipt of this card to get services, their Medicaid (Enrollee ID) number is on the *Notice of Action* and the provider can verify enrollment with it.

***FRONT*** ***BACK***




## Selecting a Provider

In Virginia, Medicaid and FAMIS health care services are ultimately delivered through managed care organizations (MCOs). Recipients will access all care through a primary care provider (PCP) that the they will select from the network of primary care providers within the health plan. This PCP will coordinate all of their care within the MCO's network of providers, specialists and hospitals.

The managed care program is called Medallion 4.0 and six MCOs deliver the services:

- Aetna Better Health of Virginia (800) 279-1878
- Anthem Healthkeepers Plus (800) 901-0020
- Molina Complete Care (800) 424-4518
- Optima Family Care (800) 881-2166
- UnitedHealthcare Community Plan (844) 752-9434
- Virginia Premier (800) 727-7536

The enrollee will receive a letter from DMAS about the managed care enrollment process. A comparison chart listing the six MCOs and any "added benefits" they provide will be sent along with this letter. The letter directs

the person to call the **Managed Care HelpLine** at **(800) 643-2273** Monday through Friday between 8:30AM and 6PM to choose an MCO by the date indicated or he/she will be assigned to the MCO listed in the letter. The enrollee can also go online to www.virginiamanagedcare.com to make the selection or download an app to do so. ***Note:*** *The HelpLine has access to* ***interpreter services,*** *if English is not the recipient's primary or preferred language.* *(See sample enrollment letter and MCO comparison chart on pages 3.7-3.8)*

If the enrollee does not respond to the letter by the due date, the MCO listed in the letter will be assigned to them. Once a health plan has been chosen, either actively by calling/going online, or assigned by DMAS because the enrollee failed to choose one, a welcome packet and ID card will be sent by the MCO.

After receiving this information, an enrollee **still has about 60 days to change to another MCO**. After this period, the enrollee can only change MCOs during the annual Medicaid MCO "Open Enrollment Period" in his/her locality or if he/she requests a change and demonstrate good cause as to why he/she should be allowed to switch MCOs. *Note: At any time, a enrollee may switch to a different PCP within their MCO.* (*For clarification of the enrollment process see the chart on page 3.6*)

***Medically Complex Individuals***

If the recipient indicated that help was needed "with everyday things" or that he/she has a long term disease/disability, addiction or mental/emotional illness on the *Application for Coverage* in Question 9 on the paper application (Question 10 for Person 2/Additional people), he/she will be enrolled in the **Commonwealth Coordinated Care Plus (CCC Plus)** program. CCC Plus coverage includes the extra support of a Care Coordinator so that these individuals get help with coordinating all of their health care needs and is provided by the same six MCOs listed on Page 3.1.

The enrollee will receive a letter from DMAS about the CCC Plus enrollment process. A comparison chart listing the six CCC Plus MCOs and any "added benefits" they provide will be sent along with this letter. The letter directs the person to call the CCC Plus **Enrollment HelpLine** at **(844) 374-9159** Monday through Friday between 8:30AM and 6PM to choose an MCO by the due date indicated or he/she will be assigned to the MCO listed in the letter. The enrollee can also go online to www.cccplusva.com to make the selection. ***Note:*** *The HelpLine has access to* ***interpreter services,*** *if English is not the recipient's primary or preferred language.* *(See sample CCC Plus MCO comparison chart on page 3.9)*

If the enrollee does not respond to the letter by the due date, the MCO listed will be assigned to them. Once a health plan has been chosen, either actively by calling/going online, or assigned by DMAS because the enrollee failed to choose one, a welcome packet and card will be sent by the MCO.

After receiving this information, an enrollee **still has about 60 days to change to another MCO**. After this period, the enrollee can only change MCOs during the annual CCC Plus MCO "Open Enrollment Period" in his/her locality or if he/she requests a change and demonstrate good cause as to why he/she should be allowed to switch MCOs.

After enrollment, the MCO will perform a verification screening to make sure the person was enrolled in CCC Plus correctly. If it is determined the person should not be in CCC Plus, he/she will be switched back to the Medallion 4.0 program, but will remain in the same MCO. No service disruption should occur.

## Using the DMAS ID Card and the MCO Health Insurance Card

Upon receipt of the DMAS ID card, the enrollee should check the information on it to be sure it is correct. If it is not correct, he/she must inform her local DSS or the Cover Virginia Call Center of any needed change/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in Section 5 of this *Tool Kit*. If the problem is with the MCO card, the enrollee will need to call the MCO.

The enrollee should **report the loss or theft of his/her DMAS ID card to the local DSS or Call Center** immediately. If the MCO card is lost or stolen, he/she should report this to the MCO. The card should never be lent to anyone.

It is the enrollee's responsibility to show the MCO ID card and the DMAS ID card to providers each time medical services are received and to make sure the provider participates in the Medicaid program. The provider uses the information on the card(s) to verify enrollment prior to delivering services. Failure to present the card(s), or the Medicaid ID number, at the time of service may result in the enrollee being charged for services.

## Covered Services Overview

The New Health Coverage for Adults provides a comprehensive package of benefits. Including:

- Doctor, hospital, and emergency services
- Prescription drugs
- Laboratory and X-ray services
- Maternity and newborn care *(If the pregnant woman reports the pregnancy to the state she will be transferred to Medicaid for Pregnant Women)*
- Long-term care and support services
- Home health services
- Behavioral health services including addition/recovery treatment services
- Rehabilitative services including physical, occupational, and speech therapies
- Transportation to Medicaid-covered services when no alternatives are available
- Family planning services
- Medical equipment and supplies
- Preventive and wellness services, chronic disease management services
- Dental care (effective 7/1/21)
- And more!

It is the same package of benefits received by other adults on Medicaid with enhanced preventive services - annual adult wellness exams; individual and group smoking cessation counseling; nutritional counseling for individuals with obesity or chronic medical diseases; and recommended adult immunizations. (*A detailed listing of Covered Services is on pages 3.15-3.20*)

## Cost Sharing

There are **small copayments** for services rendered **during the initial fee-for-service period**, for example $1 for a clinic visit or $1 for a generic prescription. **Once enrolled in a Managed Care Organization, there are no copayments for any services.**

## Period of Coverage and Reporting Requirements

When a person is determined to be eligible, the New Adult Coverage may **retroactively pay outstanding medical bills for the three months prior to their application date**. The applicant would need to request retroactive coverage at time of application by answering "Yes" to the question "Does this PERSON want help paying for medical bills from the last 3 months?" If no retroactive coverage was requested, coverage begins the first day of the month in which the Application was received.

*Example: if a signed application is received in May and ultimately results in an enrollment, the outstanding medical bills may be covered for February, March, and April, if it is determined that the recipient would have been eligible for coverage during that time and retroactive coverage was requested.*

An individual must report any "changes in circumstances" that might affect ongoing eligibility for this coverage to his/her local DSS or the CVCC **within 10 days**. For example, changes in income or household size must be reported. When a change is reported, the caseworker will reevaluate ongoing eligibility and notify the enrollee of any adjustment to coverage.

Additional reporting requirements related to working/volunteering may be coming to this coverage in the future and are part of the 1115 Waiver DMAS has submitted to CMS. Anyone enrolled in coverage before the changes are approved by CMS will not have to meet the additional requirements until their next renewal date.

***Note:*** *Reporting a **change of address** is especially important because DSS/DMAS/CPU mail is not forwarded, even if the individual has a forwarding order on record with the post office. If any mail is returned to the agency, the case will be closed and coverage will be terminated! DSS also needs a correct address to be able to deliver any renewal information in a timely manner and it needs a "good" address to do so.*

## Annual Renewal (*An example of this form is located on pages 3.51-3.66*)

Eligibility for this coverage must be renewed every 12 months. If, in Step 5 on the initial application for coverage, the person indicated willingness to have income information checked electronically in subsequent years to

renew coverage (5 years maximum), LDSS will initiate an "Ex Parte" renewal. If current income information can be electronically verified as "reasonably compatible" with the prior year's income and the income is still within program guidelines, the individual will be sent a *Notice of Action* indicating that coverage has been renewed for an additional year. *(A sample renewal approval is on pages 3.45-3.47)*

If the electronic income data is not "reasonably compatible" with the information in the recipient's file, a paper renewal application will be issued. Approximately **45 days prior to the enrollee's renewal month**, the person will be sent an 16+ page renewal form pre-populated with the his/her household and income information. If a person has indicated Spanish as his/her primary language, a pre-populated form in Spanish will be sent instead.

Enrollees have **30 days from the receipt of the form** to look it over, correct any errors, add any missing information, sign it, and return it for processing. It can be returned it via mail (in the envelope provided) or hand-delivered to the local DSS. Once the preprinted form is received, enrollees can also complete it by calling the CVCC to report any changes in information or, if they have linked their case in CommonHelp, he/she can complete it online. Instructions on how to link a case in CommonHelp are in Section 5.

Once the information is supplied via any of the above methods, the local DSS will use it to redetermine eligibility. If additional information is needed, the eligibility worker will contact the person in writing to ask for it. If found to be still eligible, the recipient will get a *Notice of Action* stating that coverage has been renewed and giving new dates of coverage.

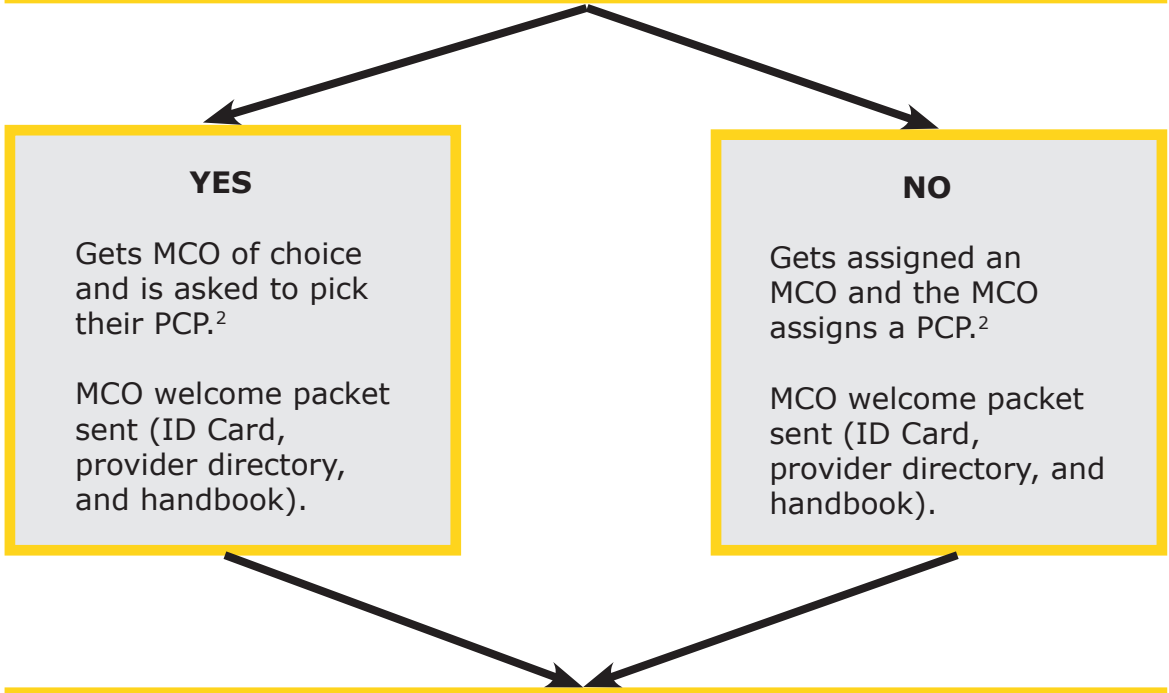
If the individual fails to return the form by the due date, a cancellation notice will be sent, and coverage will be cancelled effective the end of the renewal month. It is important to note, however that the person **still has an additional 90 days to return the form with any needed verification documents and coverage can be reinstated**. If he/she returns the form after that additional 90-day period, coverage cannot be reinstated, and he/she will have to file a new application. (*A sample cancellation letter is on page 3.48*)

If it is found that the person is no longer eligible for Health Coverage for Adults, coverage will be cancelled. The LDSS will send the information to the Health Insurance Marketplace so the person may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a "Special Enrollment Period" allowing the individual to shop on the Marketplace. The person will also be evaluated for Plan First coverage, if his/her income is under 205% FPL. A person can age out of coverage. This coverage category is for people **ages 19 to 64 only**. Coverage will end on the last day of the month in which the enrollee turns 65.

# Managed Care Enrollment - New Health Coverage for Adults[1], FAMIS Plus, Medicaid for Pregnant Women, LIFC, and FFC

A letter is sent from DMAS giving approximately **30 days** for the individual/family to choose an MCO. A comparison chart with the six MCO choices is provided. They are told that if they do not call the Managed Care HelpLine or go to its website to choose, the MCO listed in the letter will be assigned to them.

**Did the enrollee contact the Managed Care HelpLine?[1]**



**YES**

Gets MCO of choice and is asked to pick their PCP.[2]

MCO welcome packet sent (ID Card, provider directory, and handbook).

**NO**

Gets assigned an MCO and the MCO assigns a PCP.[2]

MCO welcome packet sent (ID Card, provider directory, and handbook).

**Does the person want to change to a different MCO?**

Enrollees still have about **60 days left** to contact the HelpLine and change to a different MCO. After that they can only change during MCO "Open Enrollment"[4] or by writing DMAS and providing "good cause" to change.[3]

1. *For Medically Complex individuals the process is almost the same but the place to contact changes - the CCC Plus Enrollment HelpLine or website.*
2. *The recipient can call the MCO and change their PCP at any time.*
3. *Children on Medicaid/FAMIS Plus who are in Foster Care, or receiving adoption assistance, can change their MCO at any time.*
4. *Open enrollment for the New Adult Coverage group is from November 1 to December 31. For the CCC Plus recipients it is either October 1 or November 1 to December 18. For LIFC, FFC, MPW, and FAMIS Plus, MCO open enrollment varies by region and the dates are available at https://www.virginiamanagedcare.com/learn/open-enrollment*

# COMMONWEALTH of VIRGINIA

## *Department of Medical Assistance Services*

KAREN KIMSEY
DIRECTOR

September 20, 2020

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786/7933
804/225/4512 (FAX)
800/343-0634 (TDD)

John Q Sample
1234 ABC Court
Any City, VA 00000-0000

MCF412A_
Case ID: 999-999999-999

Dear Member,

**Welcome to Virginia Medicaid managed care!**
This letter tells how you will get your medical care in the Medicaid program. You and/or your family members will get health care coverage through a health plan starting **October 1, 2020**.

A health plan is a group of doctors, hospitals, and specialists. They work together to give you the care you need. We chose a health plan for the members below.

**You have the right to choose a different health plan**
If you want to keep the health plan we chose, you do not need to do anything. Or you can choose a new health plan. You do not have to choose the same health plan for all family members.

**Make health plan changes by December 31, 2020**
Or you will have to wait until the next open enrollment period to change your health plan.

**How to choose a health plan**
1. To help you choose the best health plan for you, read the comparison chart. It came with this letter.
2. Make a list of all your health care providers and places you get care. Include hospitals, doctors, specialists, pharmacies, and therapists.
3. To find out which health plans work with your providers, or to change your health plan:
   - Go to **www.VirginiaManagedCare.com**.
   - Call the Managed Care Helpline at **1-800-643-2273** (TTY: 1-800-817-6608). We are open Monday through Friday, 8:30 a.m. to 6:00 p.m. Interpreter services are free.
   - Or download the free **Virginia Managed Care App** on your Android or iPhone to compare health plans, find a provider and change your health plan. Search for **Virginia Managed Care** on Google Play or the App Store.

**Your new health plan will send you a welcome packet and member ID card**
They will also call you. Be sure to show your member ID card **and** your Medicaid ID card each time you get care.

| Name | Recipient ID | Health plan |
|---|---|---|
| JOHN Q SAMPLE | 000000000000 | [NAME OF HEALTH PLAN] |

# Medallion 4.0 Comparison Chart

## aetna

Aetna Better Health® of Virginia

**1-800-279-1878**
TTY 711
AetnaBetterHealth.com/Virginia

**Added benefits:**

**Adult vision**
- Eye exam and $250 for glasses or contacts per year

**Healthy moms and kids**
- Maternity incentive program, 300 free diapers, virtual baby showers, and portable cribs for attendees
- Ted E. Bear, M.D.™ Club
- Free swim lessons
- Free youth sports physicals

**Phone and online tools**
- Free smartphone with free unlimited minutes and texts, plus 10 GB of data monthly
- 24/7 Member Services

**Wellness programs**
- Asthma program with 2nd inhaler or nebulizer plus bed and carpet cleaning
- Diabetes Care for Life program
- Weight management
- Wellness rewards card

**Other benefits**
- Free rides to grocery store, farmers market, food pantry, place of worship, DSS, DMV, WIC, certain social activities, and more (30 round trips each year)
- Home meal delivery after hospital stay (14 meals)
- GED certificate incentive

## Anthem. HealthKeepers Plus

Offered by HealthKeepers, Inc.

**1-800-901-0020**
TTY 711
anthem.com/vamedicaid

**Added benefits:**

**Adult vision**
- Eye exam every other year and up to $100 for glasses (frames and lenses) or contacts every year

**Healthy moms and kids**
- Boys & Girls Club membership
- Free diapers, umbrella stroller, $35 Barnes & Noble card for books
- Free sports physical
- Up to $30 baby food Kroger vouchers for well-child visits

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, plus 4.5 GB of data monthly
- Free Chromebook for high school seniors with 3.5 GPA

**Wellness programs**
- $120 of Weight Watchers® vouchers
- Healthy Rewards up to $50

**Other benefits**
- 12 free rides to grocery store or food bank per year
- 14 meals after hospital stay
- $120 in GED testing vouchers
- $25 gift card for good grades
- Coupon book
- Up to $20 Walmart gift card for completing health screener
- Air purifier (with approval)

## MOLINA HEALTHCARE

Molina Complete Care

**1-800-424-4518**
TTY 711
MCCofVA.com

**Added benefits:**

**Adult vision**
- 1 eye exam every other year and up to $100 for glasses (frames and lenses) or contacts every year

**Healthy moms and kids**
- Pregnancy supplies and mobile information tools
- Member baby showers hosted quarterly per region
- Yearly sports physicals for children
- Bicycle helmets for children

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, plus 4.5 GB of data monthly

**Wellness programs**
- Healthy Rewards gift card up to $50
- Yearly routine physicals for adults

**Other benefits**
- Fresh meals delivered to your home after hospital stay
- SaveAround retail coupon book

## OptimaHealth

**1-800-881-2166**
TTY 711
optimahealth.com/familycare

**Added benefits:**

**Adult vision**
- 1 eye exam every other year and up to $100 for glasses (frames and lenses) or contacts every year

**Healthy moms and kids**
- OB care support programs, baby showers and incentives up to $75

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts and free monthly calls to health plan
- Web and mobile app tools

**Wellness programs**
- Weight management
- Wellness rewards up to $50
- Online search tool to find food, housing, jobs, and more

**Other benefits**
- Up to $275 for GED prep and testing vouchers plus coaching
- Up to $75 college applications help (restrictions apply)
- Free sports physicals
- Free rides to grocery stores,community events, and more (24 round trips each year)
- 24-hour doctor access for non-life threatening health questions
- Meals delivered to your home after hospital stay, including OB, 2 meals each day for 7 days

## UnitedHealthcare® Community Plan

**1-844-752-9434**
TTY 711
uhccp.com/virginia

**Added benefits:**

**Adult vision**
- 1 eye exam each year and frames and lenses every 2 years

**Healthy moms and kids**
- Prenatal/maternity incentives up to $100, baby showers
- Free breast pump and hospital breast feeding consult
- Vaccine incentives up to $100 at Footlocker® for ages 5-18
- Free Boys & Girls Club membership
- Free sports physical
- Free mattress cover & pillowcase for members with asthma

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, and 3 GB data monthly
- Stress, anxiety, and depression support with Sanvello app

**Wellness programs**
- Free access to more than 300 fitness centers and local YMCAs
- 14,000 virtual fitness options
- 13 Weight Watchers® vouchers
- Healthy Rewards up to $25
- 6 chiropractor visits per year

**Other benefits**
- 12 free round-trip rides to places of worship, grocery, DMV, & library
- 14 meals after hospital stay

## VirginiaPremier™

**1-800-727-7536** | TTY 711
Northern Virginia members* with Kaiser Permanente: **1-855-249-5025**
virginiapremier.com

**Added benefits:**

**Adult vision**
- Lenses and up to $100 for frames or contacts every 24 months for non-diabetic members and every 12 months for diabetic members

**Healthy moms and kids**
- Baby Showers
- Prenatal & parenting classes, free breast pump, family planning
- Healthy Heartbeats prenatal and postpartum wellness program with incentives
- Childhood wellness program

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, plus 4.5 GB of data

**Wellness programs**
- Nutritional education and personal fitness programs
- Registered nurse & text programs to manage chronic conditions
- Free sports physicals

**Other benefits**
- 3 free non-medical round trips every 3 months

*Kaiser: Arlington, Alexandria, King George, Fairfax, Fairfax County, Falls Church, Fauquier, Loudoun, Manassas Park, Prince William and Stafford.

▶ For a list of **doctors and hospitals** that work with each plan, go to the plan's website or call their toll-free number listed above.

▶ For a list of **basic benefits that all plans offer**, see the brochure in this packet.

M4 COMP CHART ENG 0821

# CCC Plus Comparison Chart

## aetna

Aetna Better Health® of Virginia

**1-855-652-8249**
TTY 711
AetnaBetterHealth.com/Virginia

**Added benefits:**

**Adult vision**
- 1 eye exam and $250 for glasses or contacts per year

**Adult hearing**
- Exam and $1,500 for hearing aids plus 60 batteries per year

**Phone services**
- Free smartphone with unlimited minutes, data, and texts monthly

**Wellness programs**
- Wellness rewards card
- Virtual wellness center
- Personalized weight management with registered dietitian

**Other benefits**
- Free rides to grocery store, farmers market, food pantry, place of worship, DSS, DMV, WIC, Social Security Office and more (30 round trips each year)
- Meals delivered to your home after discharge, 2 meals each day for 7 days
- Memory alarms and devices
- Community health worker
- Diabetic shoes or inserts

## Anthem. HealthKeepers Plus

Offered by HealthKeepers, Inc.

**1-855-323-4687**
TTY 711
anthem.com/vamedicaid

**Added benefits:**

**Adult vision**
- 1 eye exam and $100 for lenses and frames per year

**Adult hearing**
- 1 exam, $1,000 for hearing aids and 60 batteries per year

**Phone services**
- Free smartphone with 350 minutes, 4.5 GB of data and unlimited texts monthly

**Wellness programs**
- Online search tool to find food, jobs and more
- Healthy Rewards gift card (up to $50 per goal)
- Personalized / interactive app

**Other benefits**
- Up to 12 rides a year to community events, grocery stores and more
- Meal delivery after hospital or nursing facility discharge
- Coupons with over $1,000 in savings to local stores
- $100 for assistive devices and wheelchair accessories
- Air purifier (with approval)

## MOLINA HEALTHCARE

Molina Complete Care

**1-800-424-4524**
TTY 711
MCCofVA.com

**Added benefits:**

**Adult vision**
- 1 eye exam every other year and up to $100 for glasses (frames and lenses) or contacts every year

**Phone services**
- Free smartphone with 350 minutes, 4.5 GB of data and unlimited texts monthly

**Wellness programs**
- Healthy Rewards gift cards (up to $50 each year)
- Annual physicals for all adults

**Other benefits**
- Fresh meals delivered to your home after discharge
- Environmental, home and vehicle modifications for all members when needed
- Additional personal care attendant support
- Online directory of community services and organizations
- Bicycle helmets for children
- SaveAround retail coupon book

## OptimaHealth

**1-888-512-3171** or **1-757-552-8360**
TTY 711
optimahealth.com/communitycare

**Added benefits:**

**Adult vision**
- 1 eye exam and $100 for frames per year

**Phone services**
- Free smartphone with 350 minutes, 1 GB of data and unlimited texts monthly

**Wellness programs**
- Weight management
- Online tool to find food, housing, jobs and more

**Other benefits**
- Free rides to grocery stores, community events and more (24 round trips each year)
- Meals delivered to your home after hospital stay, including OB, 2 meals each day for 7 days
- Memory alarms and devices
- 24-hour doctor access for non-life threatening health questions
- Up to $275 for GED prep & testing vouchers plus prep coaching
- Up to $75 college applications help (restrictions apply)

## UnitedHealthcare® Community Plan

**1-866-622-7982**
TTY 711
uhccp.com/Virginia

**Added benefits:**

**Adult vision**
- 1 eye exam per year, lenses and frames every 2 years

**Phone services**
- Free smartphone with 350 minutes, 3 GB of data and unlimited texts monthly

**Wellness programs**
- Vaccine incentives up to $100 at Footlocker® for ages 5-18
- 13 Weight Watchers vouchers per year
- Wellness rewards for healthy behavior, up to $25 per goal

**Other benefits**
- 12 free round trip rides to places of worship, grocery, DMV, health fairs, & library
- 14 meals delivered to home after discharge
- Stress, anxiety, and depression support by Sanvello app
- Environmental and home modifications for all members when needed
- Prenatal and postpartum incentives

## VirginiaPremier

**1-877-719-7358**
TTY 711
virginiapremier.com

**Added benefits:**

**Adult vision**
- 1 eye exam, up to $100 for frames or contacts every 24 months

**Adult hearing**
- 1 hearing aid, exam, fitting (up to $1,250 every 36 months)

**Phone services**
- Free smartphone with 350 minutes, 4.5 GB of data, unlimited texts monthly

**Wellness programs**
- Healthy Heartbeats prenatal, postpartum wellness program with incentives
- Nutritional education and personal fitness program
- Wellness reward gift cards
- Registered nurse and text-based programs to help manage chronic conditions
- Free sports physicals

**Other benefits**
- 3 free non-medical round trips every 3 months
- Up to 14 days meal delivery after hospital or nursing facility discharge
- Online access to health plan services and resources

▶ These benefits start **January 1, 2022**. Call the plan or visit their website to learn about doctors, hospitals and limits that apply.

▶ For the **basic benefits** that **all plans** offer, see the brochure in this packet.

CCC PLUS COMP CHART ENG 0821

# Part II: FAMIS Plus, LIFC, and Former Foster Care Youth (FFC)

## Once Approved

Once a child is approved for FAMIS Plus, a parent/caretaker relative is approved for LIFC, or a young adult for coverage for Former Foster Care Youth (FFC), the enrollee will receive a *Notice of Action on Benefits* stating that they have been approved for coverage. *(An example of this form is located on page 2.37*)

In a separate mailing, the recipient will receive a permanent plastic ID card from DMAS. This card enables the individual to receive services from any Medicaid provider while his/her permanent benefits delivery method is determined. Enrollment into managed care takes less than 30 days. This initial period is referred to as "Fee-for-Service". Enrollees do not have to wait for the receipt of the card to get services, however, their Medicaid number is on the *Notice of Action* and the provider can verify enrollment with it. *(An sample off this card is on page 3.1*)

Once enrolled in the MCO, the enrollee will still use the DMAS ID card for any services not available through the MCO (e.g. school-based services for children.)

## Selecting a Provider

The Medicaid Managed Care Program is called Medallion 4.0. Enrollees must select a Managed Care Organization (MCO) for delivery of their benefits. The six MCOs delivering services to FAMIS Plus children, LIFC parent/caretakers, and FFC recipients are the same as those for the New Health Coverage for Adults and are listed on page 3.1.

Soon after receiving the DMAS ID card, the family will receive a letter from DMAS about the managed care enrollment process. A comparison chart listing the six MCOs and their "added benefits" will be sent along with this letter. (*See sample enrollment letter and MCO comparison chart on pages 3.7-3.8*)

The letter directs the family/enrollee to call the **Managed Care HelpLine** at **(800) 643-2273** Monday - Friday between 8:30AM and 6PM or to go online to www.virginiamanagedcare.com to choose an MCO or download an app to do so. The letter lists the name of an MCO they have been pre-assigned to and give a due date to reply. ***Note:*** *The HelpLine has access to* ***interpreter services,*** *if English is not the family's primary or preferred language.*

If the family/enrollee does not respond to the letter by the date indicated, the health plan listed in the letter will be assigned to them. Once an MCO has been chosen, either actively by calling/going online or assigned by DMAS because the family/enrollee failed to choose one, an MCO welcome packet including an ID card will be sent. An MCO ID card will be issued for each enrolled person.

At this point, there is **still 60 days to switch to another MCO**. After this period, enrollees can only change their plan during the annual Medicaid MCO "Open Enrollment Period" in their locality or if they request a change and demonstrate good cause as to why they should be allowed to switch. *Note: At any time, a family/enrollee may switch to a different PCP within their MCO.* (*For clarification of the enrollment process see the chart on page 3.6*)

## Using the DMAS ID Card and the MCO Health Insurance Card

Upon receipt of the DMAS ID card, the enrollee should check the information on it to be sure it is correct. If it is not correct, he/she must inform the local DSS or the Cover Virginia Call Center of any needed change/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in Section 5. If the problem is with the MCO card, the enrollee will need to call the MCO.

It is the family/enrollee's responsibility to show both the DMAS ID Card and the MCO card to providers each time medical services are received and to make sure the provider participates in the Medicaid/FAMIS Plus program or with the MCO they have chosen. Failure to present the cards at the time of service may result in the person being held responsible for any expenses incurred.

The family/enrollee should stop using the DMAS and MCO cards immediately when notified by the local Department of Social Services that the child or adult is no longer eligible for the program. *Note: the DMAS ID card should be retained in case the person ever becomes eligible for state-sponsored health insurance again. It can be reactivated at that time.*

The family/enrollee should **report the loss or theft of a DMAS ID card** to the local DSS or the Cover Virginia Call Center immediately. If the **MCO card is lost or stolen,** this should be reported to the MCO. These cards should never be lent to anyone.

## Covered Services Overview

**FAMIS Plus** provides a comprehensive package of benefits uniquely designed to meet the needs of lower income children. In addition to covering traditional health care services such as hospitalizations, doctor visits and prescriptions, FAMIS Plus also covers services such as non-emergency transportation to medical appointments, case management and health education for babies with potential health risks, behavioral health and substance abuse treatment services, eye exams and glasses, dental care, and other services not often covered by private health insurance plans. MCOs may provide additional enhanced services such as health education, 24 hour nurse advice line access, disease management programs, and free sports physicals.

Of special note, children covered by FAMIS Plus are entitled to the **EPSDT** (Early Periodic Screening, Diagnosis and Treatment) program. This valuable component of Virginia's FAMIS Plus program provides comprehensive health screenings for children **up to age 21**. Any medical condition diagnosed

through an EPSDT screening must be treated at no cost to the family, even if it is a service not normally covered by FAMIS Plus.

**LIFC/FFC benefits** for adults are similar to those for children and pregnant women, but do not include eyeglasses. If the parent/caretaker or FFC recipient is under age 21, he/she can benefit from the EPSDT program services. Effective July 1, 2021 adult dental care became a covered Medicaid benefit for both programs.

A detailed listing of *Covered Services* is on pages 3.15-3.20.

## Cost Sharing

There are **no copayments** or costs for services to children in **FAMIS Plus**.

While in the initial **fee-for-service** period, the **LIFC or FFC recipient** has to pay **small copayments** for services ($1 for a clinic visit or generic medication). There are **no copayments for LIFC** parent/caretaker relatives or **FFC recipients** once they are enrolled **in an MCO**.

## Period of Coverage and Reporting Requirements

When a person is determined to be eligible, FAMIS Plus/LIFC/FFC may **retroactively pay outstanding medical bills for the three months prior to their application date**. For example, if a signed application is received in March and ultimately results in an enrollment, the outstanding medical bills may be covered for December, January, and February, if it is determined that the recipient would have been eligible for the program during that time and retroactive coverage was requested. The person would need to request retroactive coverage at time of application by answering "yes" to the question "Does this PERSON want help paying for medical bills from the last 3 months?"

If no retroactive coverage was requested, **coverage begins the first day of the month in which the Application was received** and goes for 12 months unless changes are reported.

Enrollees must report any "changes in circumstances" that might affect ongoing eligibility their local DSS or the CVCC **within 10 days**. For example, changes in income or household size must be reported. When a change is reported, the caseworker will reevaluate ongoing eligibility and notify the enrollee of any adjustment to coverage.

***Note:*** *Reporting a* ***change of address*** *is especially important because DSS/DMAS/CPU mail is not forwarded, even if the person has a forwarding order on record with the post offi ce. If correspondence is returned to the agency, the case will be closed and coverage will be terminated! DSS also needs a correct address to be able to deliver any renewal information in a timely manner.*

## Annual Renewal *(An example of the renewal form is located on pages 3.51-3.66)*

Eligibility for FAMIS Plus/LIFC/FFC must be **renewed every 12 months**. If, in Step 5 on the initial application for coverage, the family/individual indicated their willingness to have their income information checked electronically in subsequent years to renew coverage (5 years maximum), LDSS will initiate an "Ex Parte" renewal. If income information can be verified as "reasonably compatible" with the prior year's income and the amount is still within program guidelines, the enrollee will be sent a *Notice of Action* indicating that coverage has been renewed for another year. *(A sample renewal approval is on pages 3.45-3.47)*

If the electronic income data is not "reasonably compatible" with the information in the recipient's file, a paper renewal application will be issued. Approximately **45 days prior to the renewal month**, the enrollee will be sent an 16+ page renewal form pre-populated with the case's household and income information. If the enrollee has indicated Spanish as his/her primary language, a pre-populated form in Spanish will be sent.

Enrollees will have **30 days from the receipt of the form** to look it over, correct any errors, add any missing information, sign it, and return it to LDSS for processing. They can return it via mail (in the envelope provided), hand-deliver it to the local DSS, contact the CVCC to report any changes in information via the telephone, or go online to CommonHelp and complete the renewal there, if after approval for the program they linked their case. Instructions on how to link a case in CommonHelp are in Section 5.

Once the information is provided (via paper, phone or online), the local DSS will use it to redetermine eligibility. If the LDDS worker still needs additional information, a written request will be sent asking for it. If the person is still eligible, a *Notice of Action* will be sent stating that coverage has been renewed and giving new dates of coverage.

If the information is not provided by the due date, a cancellation notice will be sent. Coverage will be cancelled effective the end of the renewal month. It is important to note, however, that the enrollee **still has an additional 90 days to return the form with any needed verification documents and coverage can be reinstated**. If the form is returned after the additional 90 days, coverage cannot be reinstated, and a new application for coverage will be required. (*A sample cancellation letter is on page 3.48*)

***FAMIS Plus***

Many children are terminated from FAMIS Plus at renewal time because of the family's failure to complete the process. A child cancelled from FAMIS Plus for failure to complete annual renewal may reapply for FAMIS Plus at any time.

During the renewal process, if the family's income has risen, the eligibility worker may determine that the child is eligible for FAMIS instead. If he/she is now eligible for FAMIS, the child will be enrolled in that program and the family will receive a *Notice of Action* with the new dates of coverage.
If the child is not eligible for either FAMIS or FAMIS Plus (i.e. the family's

income has risen above 205% of FPL), FAMIS Plus coverage will be cancelled. The LDSS will send the information to the Health Insurance Marketplace so the family may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a Special Enrollment Period that allows the family to shop for private coverage, if eligible.

Coverage will end the last day of the month in which a FAMIS Plus enrolled child turns 19. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

***LIFC***

At annual renewal, if a LIFC parent/caretaker's income has risen above program guidelines, he/she may still be eligible for LIFC coverage for an additional period of time. If the income increase is as a result of an increase in **spousal support**, the LIFC recipient may be eligible for four additional months of coverage. If the income increase is as a result of an increase in **earned income**, the LIFC recipient may be eligible for twelve months of coverage. The second six months of coverage is contingent upon cooperation with reporting requirements during the first six months.

After this additional coverage period, the parent/caretaker can be evaluated for the New Health Coverage for Adults and, if found eligible, be enrolled in that coverage.

If the person's income is over 138% FPL at that time, the LDSS will send the case information to the Health Insurance Marketplace so the person may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a Special Enrollment Period that allows the person to shop for private coverage, if eligible. The individual would also be evaluated for the Plan First program.

A parent/caretaker relative cancelled from LIFC for failure to complete annual renewal may reapply for LIFC at any time. LIFC coverage will also end when there is no longer a dependent child under the age of 18 living in the home. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

***FFC***

Former Foster Care coverage recipients still need to renew their coverage yearly even though income is not counted for that program. Coverage, is however, age limited. An enrollee can only be in this category of coverage until the age of 26. Enrollment will end on the last day of the month in which the person reaches that age. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category and if not eligible, referred to the Health Insurance Marketplace to be evaluated for financial assistance toward purchasing private health insurance. Losing Medicaid coverage at annual renewal opens a Special Enrollment Period that allows the individual to shop for private coverage, if eligible.

# Medicaid Covered Services

***(Covered Services for New Health Coverage for Adults, FAMIS Plus, LIFC, FFC, Medicaid for Pregnant Women, FAMIS MOMS and FAMIS Prenatal Coverage)***

*General Note: New Health Coverage for Adults, LIFC, and FFC recipients in MCOs have no copayments. There are no copayments or costs for services for children enrolled in FAMIS Plus or pregnant women in Medicaid for Pregnant Women, FAMIS MOMS or FAMIS Prenatal Coverage.*

***Addiction and Recovery Treatment Services (ARTS)***

Evidence-based and community based-addiction treatment services including: inpatient detox, residential treatment, partial hospitalization, intensive outpatient programs, opioid treatment programs, case management and peer recovery supports.

***BabyCare (High Risk Pregnancy & Infant Program*)***

The BabyCare program, for pregnant women and infants up to age 2 who are enrolled in Medicaid/FAMIS Plus or FAMIS MOMS/FAMIS Prenatal Coverage/FAMIS, helps pregnant women to determine if they have modifiable health risks or special needs. A nurse or social worker will evaluate the member to screen for potential health risks for either the pregnant woman or her baby. BabyCare services continue up to 60 days post-partum. Services may also be initiated or continued for newborns and babies up to age 2. BabyCare services may include:

- Prenatal education for a variety of topics including tobacco cessation, preparation for childbirth, and parenting
- Nutritional assessment and counseling
- Homemaker services to members for whom the physician has ordered complete bed rest
- Substance Abuse Treatment Services

**Participating Medallion 4.0 MCOs also have their own programs that cover similar services.*

***Breast Pumps and Supplies and Lactation Consultation Services***

Face-to-face breastfeeding consultation services, breast pumps and supplies are covered for Medicaid for Pregnant Women, FAMIS MOMS, FAMIS Prenatal Coverage, FAMIS, and FAMIS Plus recipients. Covered breast pumps include: manual single user (purchase); electric single user (purchase); hospital grade multi-user (rental only); and milk collection kits for use with pumps (purchase). If enrolled with an MCO, contact Member Services to access these services. If enrolled in fee-for-service, ask the participating provider regarding ordering these services.

***Certified Nurse Midwife Services***

Covered as allowed under State licensure requirements and Federal Law.

***Clinic Services***

All clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinics are covered.

***Court Ordered Services***

All medically necessary court ordered services are covered.

***Dental Care Services – (Smiles For Children Program managed by DentaQuest 1-888-912-3456)***

Dental services are available to Medicaid and FAMIS program recipients via the Smiles For Children (SFC) program managed by DentaQuest, DMAS's dental benefits Administrator. Also included is medically necessary oral surgery and associated diagnostic services.

Once a child/pregnant woman/adult is enrolled in FAMIS Plus/Medicaid/FAMIS MOMS/FAMIS Prenatal Coverage program, they are automatically enrolled in SFC as well. SFC covers all the services listed below when provided by a dentist that participates in Smiles For Children. Members will receive a separate *Smiles For Children* handbook detailing the program, covered services, how to find a dentist, what to do in an emergency, etc. Recipients access services by seeing a SFC dentist and showing either their DMAS ID Card or MCO card. Transportation to dental appointments is available if necessary, contact the MCO 24-48 hours prior to the dental appointment to arrange transportation. To find a dentist, call 1-888-912-3456 between 8AM and 6PM, Monday through Friday, or look at the listings posted on www.dmas.virginia.gov or https://dentaquest.com/state-plans/regions/virginia/member-page/. **There are no costs for services accessed through the SFC Program.**

Covered services are: fluoride (every 6 months), sealants, cleanings (every 6 months), space maintainers, X-rays, fillings, crowns (some caps), extractions, anesthesia, root canal treatments, oral disease services, and braces (if qualified). Routine diagnostic, preventative, primary and prosthetic and complex restorative procedures necessary for oral health (i.e. dentures, inlays, onlays, crowns and relining of dentures for a better fit) are covered. Tooth guidance appliances, complete and partial dentures, surgical preparation for prosthetics, single permanent crowns, and bridges are also covered, but can be subject to prior authorization. Routine bases under restorations are not covered. For recipients under age 21, full banded orthodontics and related services are covered when medically necessary. Post treatment stabilization retainers and follow-up visits are included. Some services require pre-authorization.

Medically necessary oral surgery is covered. Medically necessary anesthesia and hospitalization services are covered by the MCO when it is determined such services are required to provide dental care.

***Doula Services***

Doula services will be used to provide support for pregnant individuals throughout the perinatal period. Includes 4 prenatal visits, support during labor and delivery, and 4 postpartum visits. Doulas offer support, guidance, evidence-based education, practical support during childbirth, and linkages to community-based resources. A licensed practitioner's recommendation is necessary prior to a Doula providing this care to a member under the VA Medicaid program.

***Early Intervention Services***

Are covered for FAMIS Plus/Medicaid children via the MCO. Case management and other services designed to meet the developmental needs of infants or toddlers with a developmental delay up to age three.

***EPSDT (Early Periodic Screening, Diagnosis and Treatment)***

A special program eligible to FAMIS Plus/Medicaid enrollees under age 21 that helps to detect and treat health care problems early via regular medical, dental, vision and hearing check-ups. Examination and treatment services are provided at no cost to the recipient. The recipient's primary care provider should provide the medical check-up. Anything diagnosed during an EPSDT screening will be treated, even if the treatment is not normally covered by FAMIS Plus/Medicaid. Inter-periodic screening is available upon request of the caretaker. The schedule for routine checkups follows the recommendations of the American Academy of Pediatrics. Medicaid for Pregnant Women, FAMIS MOMS/FAMIS Prenatal Coverage, LIFC, and FFC recipients under age 21 are also eligible for EPSDT benefits.

EPSDT checkups include:

- Comprehensive unclothed physical exam
- Patient and family medical history including identifying risk factors for health and mental health status
- Developmental, vision and hearing Screening
- Preventive laboratory services, including mandatory lead testing at 12 and 24 months of age.
- Age appropriate immunizations
- Referral to a dentist at age 1
- Age appropriate anticipatory guidance/health counseling
- Referrals for medical necessary health and mental health treatment

***Family-Planning Services/Birth Control***

Covered services include drugs, supplies, and devices which delay or prevent pregnancy provided under the supervision of a doctor for members of child-bearing age. These services may be provided by network or out-of-network providers. Also includes certain elective sterilization procedures (for men and women). Coverage of such services does not include services to treat infertility or services to promote fertility.

***HIV Treatment and Counseling for Pregnant Women***

These services are covered in compliance with State requirements governing HIV testing and treatment counseling

***Home Health Services***

These services (nursing, rehabilitative therapies, and home health aide services) are covered when provided by an authorized home health agency under a plan of treatment prescribed by a doctor up to a specified number of visits. At least 32 home health aide visits are allowed. Skilled home health visits are limited based upon medical necessity.

## 3.16 *Medicaid Covered Services*

***Hospice Services*** *(Via Fee-For-Service, not via MCO)*

Hospice services (palliative as well as curative) offered in certified, Medicaid-enrolled hospices to care for terminally ill patients expected to live no more than six-months, as certified by a physician, are covered.

***Hospital Care:***

***Inpatient***

Inpatient stays in a general acute care or rehabilitative hospital are covered.

***Outpatient***

Treatment in the doctor's office or for outpatient hospital clinic services that allow the recipient to return home the same day after the test or operation is over are covered. Some operations and tests must be performed in the doctor's office or outpatient clinic, as outpatient surgery. The doctor or hospital may not bill the recipient if FAMIS/Medicaid denies payment because the recipient did not need to stay in the hospital overnight, unless it was the recipient's choice to stay overnight and the recipient agreed to pay for the hospital stay.

***Emergency Room***

Emergency room treatment and transportation for real emergencies are covered. Recipients are expected to go to a clinic or make a doctor's appointment for routine, non-emergency medical care. Non-emergency use of the emergency room is monitored and could lead to placement in the Client Medical Management Program.

***Immunizations/Vaccines***

All necessary immunizations are covered for children, consistent with the US Centers for Disease Control and Prevention (CDC) guidelines. No immunizations are available for pregnant women or LIFC/FFC recipients over age 21 except for flu or pneumonia for those at-risk. Several additional immunizations are available to the New Health Coverage for Adult recipients only.

***Laboratory, X-ray, and Anesthesia Services***

FAMIS Plus/Medicaid/FAMIS MOMS and FAMIS Prenatal Coverage covers all laboratory, x-ray, and anesthesia services directed or performed within the scope of the license of a practitioner in appropriate settings, including physician's office, hospital, independent and clinical reference labs.

***Medicaid Home and Community Based Waivered Services:***

Services are available for children with specific health related needs that are not available to all Medicaid/ FAMIS Plus recipients in the State. The Home and Community Based Waivers that primarily impact children include the Elderly or Disabled with Consumer Direction (EDCD) waiver; Developmental Disabilities (DD) Waiver; Intellectual Disability (ID) Waiver; and the Technology Assisted (Tech) Waiver.

These Waivers cover a variety of services, including but not limited to:

- Personal care;
- Skilled and private duty nursing;
- Assistive Technology;
- Case management;
- Crisis stabilization, and
- Respite care.

***Medical Supplies and Equipment***

Supplies and equipment are covered when suitable for use in the home and ordered by a physician as medically necessary. Examples of covered supplies are: ostomy supplies, oxygen, respiratory equipment, and home dialysis equipment and supplies. Nutritional supplements for children and adults are covered. Specially manufactured DME equipment is covered when preauthorized.

***Mental Health Treatment Services***

*Outpatient mental health services*

FAMIS Plus/Medicaid/FAMIS MOMS/FAMIS Prenatal Coverage will cover medically necessary outpatient individual, family and group mental health treatment services. Additional community mental health and rehabilitative services include: intensive in home treatment, therapeutic day treatment, crisis intervention, crisis stabilization, mental health support services and case management services. If mental health services are deemed necessary due to an EPSDT screening, all medically necessary care will be delivered. Includes Electroconvulsive Therapy, pharmacological management, psychological/neuropsychological testing, psychotherapy (individual, group and family).

*Inpatient mental health services*

Medically necessary inpatient mental health services rendered in a freestanding psychiatric hospital are covered for recipients under age 21 or over age 64. For members 21-64, MCO may cover up to 15 days in a calendar month in an IMD. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all enrollees, regardless of age.

*Community Mental Health Rehabilitation Services (CMHRS)*

The following services are covered: behavioral health therapy services, crisis intervention services (available 24/7), crisis stabilization services, day treatment/partial hospitalization, intensive community treatment assessment and treatment services, intensive in-home assessment and treatment services, mental health case management services, mental health skill-building assessment and treatment services, psychosocial rehabilitation assessment and treatment services (limit 936 units annually), and peer support services (for children and adults). Therapeutic day treatment for children and adolescents and treatment foster care case management for children under 21 years.

Six New Mental Health Services (effective December 1, 2021):

- Multisystemic Therapy: Intensive family and community-based treatment for youth ages 11-18 with significant disruptive behaviors and substance use disorders.
- Functional Family Therapy: Short-term treatment for youth ages 11-18 with significant disruptive behaviors who have received referrals from juvenile justice, behavioral health, school or child welfare systems.
- Mobile Crisis Response: 24/7 rapid response, assessment and early intervention for individuals experiencing a behavioral health crisis.
- Community Stabilization: Short-term support for individuals who recently required crisis services or who need assistance to avoid escalation to more intensive treatment models.
- 23-Hour Crisis Stabilization: Up to 23 hours of crisis stabilization services in a community-based setting for individuals experiencing an acute behavioral health emergency.
- Residential Crisis Stabilization Unit: Short-term, 24/7 residential evaluation and intervention for psychiatric and substance use crises. This new service enables some individuals to avoid inpatient admission and offers stepdown support for others who require hospitalization.

***Nutritional Counseling (Individual & Group)***

Covered for New Adult Coverage recipients who are obese or have a chronic disease, available individually and/or in a group setting.

***Organ Transplants***

Transplant services for children and adults, for kidneys, corneas, hearts, lungs and livers (from living or cadaver donors), and bone marrow/stem cell shall be covered when medically necessary and based on evidence based clinical standards of care. Necessary procurement/donor related services are covered. Transplant services for children (under 21 years of age) shall be covered per EPSDT guidelines. No experimental or investigational transplants are covered.

***Out-of-State Medical Coverage***

Virginia Medicaid/FAMIS Plus/FAMIS MOMS/FAMIS Prenatal Coverage/LIFC/FFC covers emergency medical services while an enrolled person is temporarily outside of the state, if the provider agrees to bill Virginia Medicaid. It will not cover services rendered outside of the United States. Contact the MCO regarding procedures for out-of-state treatment.

***Personal Care***

Support services to assist with activities of daily living (bathing, dressing, toileting, transferring, eating, bowel and bladder continence necessary to maintain health and safety), monitoring of self-administered medications, and the monitoring of health status and physical condition. These services are provided for individuals of any age enrolled in a Home or Community Based Waiver who meet established medical necessity criteria, and for members under the age of 21 under EPSDT. Services do not take the place of informal support systems.

***Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services***

Inpatient, outpatient and home health physical and occupational therapy, speech pathology, and audiology services are covered. This includes coverage for acute and non-acute conditions and shall be limited based upon medical necessity.

## 3.18 *Medicaid Covered Services*

***Physician's Services***

Doctor's, or physician extender's, services both in the hospital and in the doctor's office are covered including routine physicals up to age 21 under EPSDT. Most visits to the doctor's office for treatment are covered.

If the recipient is younger than age 19, FAMIS Plus will pay the doctor's bills while the recipient is in the hospital as long as the recipient's stay is medically necessary.

***Podiatry Services (foot care)***

FAMIS Plus/Medicaid coverage is limited to diagnostic, medical, or surgical treatment of disease, injury or defects of the foot. Routine and preventive foot care is not covered.

***Pregnancy-Related Services***

MCOs cover services for pregnant women without copays, including smoking cessation services (counseling and needed medications) The MCO provides additional services including: parenting education, nutritional assessment, counseling and follow-up, homemaker services, and blood glucose meters. Nurse Midwife Services are covered as allowed under State licensure requirements and Federal law. Coverage continues through the post-partum period. (See BabyCare for case management services information.)

***Prescription Drugs***

FAMIS Plus/Medicaid/FAMIS MOMS/FAMIS Prenatal Coverage covers most prescription drug products, including certain over- the-counter drugs covered for nursing home patients and for most FAMIS/Medicaid patients. This includes medicine prescribed by a provider during a physician visit, or other visit covered by third party payer including mental health visits. There is a preferred drug list (PDL). Drugs not on the PDL may be covered if pre-authorized. According to federal law, certain kinds of drugs are not covered (for example drugs used for cosmetic purposes, drugs determined to be less than effective – DESI drugs).

***Prosthetic/Orthotic Devices***

Such devices (arms and legs and their supportive attachments, breasts, and eye prosthesis) are covered when prescribed by a physician as medically necessary. Medically necessary orthotics for children under age 21 and for adults and kids when recommended as part of an intensive rehabilitation program are also covered.

***Renal (Kidney) Dialysis Clinic Visits***

Dialysis is covered for recipients with end-stage renal disease.

***Screenings***

Colorectal cancer screenings are covered in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. Low dose screening mammograms for determining presence of occult breast cancer for enrollees 40 and over are covered. Pap smears are covered consistent with guidelines published by the American Cancer Society. Screening Prostate Specific Antigen (PSA) and related digital rectal exams (DRE) to screen males for prostate cancer are covered.

***School Health Services (LEA-Based Services)***

Services are those therapy, skilled nursing, and psychiatric/psychological services as outlined in the Individual Education Program (IEP) and rendered to children who qualify under the federal Individual with Disabilities Education Act. Billed directly to DMAS Fee-for-Service, not through the MCO. EPSDT screenings for the general Medicaid student population are covered.

***Substance Abuse Treatment Services for Pregnant and Postpartum Women***

Coverage includes residential treatment (up to 300 days per pregnancy, not to exceed 60 days postpartum) and day treatment (2 or more hours/day, multiple times per week, not to exceed ~ 200 hours per pregnancy or 60 days postpartum) for pregnant and postpartum women with serious substance abuse problems for the purpose of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. Includes education and referral for testing, counseling and management of HIV, tuberculosis, and hepatitis.

***Telemedicine Services***

Telemedicine services that are medically necessary are covered. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services.

***Tobacco Dependence Treatment***

Includes counseling and pharmacotherapy at no cost for pregnant women for smoking cessation treatment. These services are available to children and adolescents up to age 21 via EPSDT. Services are included for New Adult Coverage recipients.

***Transportation***

*Emergency*

Pays for emergency transportation to receive medical and mental health treatment.

*Non-Emergency*

Pays for non-emergency transportation if the client has no other transportation available and the transportation is to the nearest enrolled FAMIS Plus/Medicaid provider for a covered medical service. Recipients enrolled in MCOs should arrange transportation through their MCO. The MCO may also cover additional transportation services as an added benefit (i.e. rides to Food banks, etc.)

FAMIS Plus/Medicaid/FAMIS MOMS/FAMIS Prenatal Coverage/LIFC/FFC recipients with Fee-for-Service Medicaid access non-emergency transportation services through LogistiCare, a transportation "broker" under contract with DMAS. The client can contact LogistiCare at (866) 386-8331 who will then make the trip arrangements and pay the transportation provider. The recipient will receive specific information on this service when they are enrolled in state-sponsored coverage.

***Vision Services***

Vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians are covered. Routine eye examinations for recipients of any age (limited to once every 2 years) are covered. Eyeglasses are covered for recipients younger than 21 years of age only.

***Wellness Exam (New Adult Coverage Only)***

Annual adult wellness exam is covered, included an expanded list of adult vaccines.

***FAMIS Plus, Medicaid for Pregnant Women, FAMIS MOMS, FAMIS Prenatal Coverage, LIFC, and FFC do NOT cover the following services:***

- Abortions, unless the pregnancy is life-threatening or health-threatening (then via FFS, not MCO)
- Acupuncture
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Certain experimental surgical and diagnostic procedures
- Chiropractic services (except as provided through EPSDT)
- Christian Science Nurses and Christian Science Sanatoria
- Cosmetic treatment or surgery
- Day care, including sitter services for the elderly (except some home- and community-based service waivers)
- Doctor services during non-covered hospital days
- Drugs prescribed to treat hair loss or to bleach skin
- Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is preauthorized
- Hospital charges for days of care not authorized for coverage
- Immunizations for people age 21 or older (except for flu and pneumonia for those at risk)
- Inpatient hospital care in an institution for the treatment of mental disease for members under age 65 (unless they are under age 22 and receiving inpatient psychiatric services)
- Medical care received from providers not enrolled in Virginia Medicaid or who will not accept payment from Virginia Medicaid as payment in full
- Private duty nursing (except under EPSDT or Home and Community Based Waiver programs)
- Psychological testing done for school purposes, educational diagnosis, school or institution admission and/or placement, or upon court order
- Remedial education
- Routine school or sports physicals (unless an added benefit provided by the MCO)
- Sterilization of recipients younger than age 21
- Weight loss clinic programs

## 3.20 *Medicaid Covered Services*

# Part III: FAMIS

## Once Approved

The family will receive a *Notice of Action on Benefits* from their child's LDSS or the Cover Virginia CPU. It will include information on choosing their MCO and instructions for tracking copayments. *(A sample Notice of Action is on Page 2.37)*

In a separate mailing, the family will receive a permanent blue and white plastic ID card from DMAS for each enrolled child. This card enables FAMIS children to receive services from any FAMIS/FAMIS Plus/Medicaid provider until they are enrolled in the Managed Care Organization that will manage their ongoing care. This period is called "fee-for-service." Enrollment into a MCO usually takes less than 30 days. Once enrolled in the MCO, the family will still use the DMAS ID card for certain services not available through the MCO (e.g. school-based services and dental care). *(A sample of the DMAS ID card is on page 3.1)*

In an additional mailing from DentaQuest, the family will receive information on *Smiles For Children* directing them to visit its website for the dental handbook and a directory of general and pediatric dentists participating in the program.

## Selecting a Provider

In their *Notice of Action*, the family will be given instructions on **how to choose their child's MCO by contacting the Cover Virginia Call Center (CVCC)** at (855) 242-8282. A family may choose the same MCO for all the children in the family, or different MCO's for each, depending on their circumstance, such as a doctor's or provider's participation in an MCO. Included with the *Notice* is a comparison chart listing all six health plans available and any extra "added benefits" they provide. These are the same six MCOs listed on page 3.1.

If the family does not call to choose their child's MCO, one will be assigned to them. *(For added clarification on this process see pages 3.26-3.27. For the FAMIS MCO Comparison Chart see page 3.28)*

The family will receive several items from their MCO:

- An MCO ID Card (includes information on copayment amounts)
- A member handbook, and
- A provider directory.

Once this information is received, the family is told to contact their MCO to choose their Primary Care Provider (PCP). The MCO then reissues the child's MCO insurance card. This card is good for the remainder of the child's 12 month enrollment period. The card will include the name of the child's PCP, the PCP's telephone number, and the MCO's identification number. It will also include information on copayment amounts for services.

**For 90 days from their initial enrollment** in the MCO, **the family can still change their child's MCO by calling the Cover Virginia Call Center.** Once the 90 days has passed, the family can only change their child's MCO at annual renewal of the FAMIS coverage or, if needed sooner, by formally requesting a change and demonstrate "good cause" as to why they should be allowed to switch their child's MCOs.

When the child's FAMIS eligibility is renewed each year, the family will have the chance to switch the child to another MCO or remain with the current health plan. If the family does not proactively make a change at that time, the child will remain with the same MCO.

## Using the DMAS ID Card and the MCO Health Insurance Card

When the family receives the child's blue and white plastic DMAS ID card, they should check the information on it to be sure it is correct. If it is not correct, they must inform the Cover Virginia Call Center at (855) 242-8282 of any needed changes or corrections. If there are errors on the MCO card, they should contact their child's MCO.

It is the family's responsibility to show their child's DMAS ID card **and** the MCO ID card to providers each time medical services are received. The provider uses the information on both cards to verify program enrollment prior to delivering services. Failure to present the cards at the time of service may result in the parent or legal guardian being held responsible for any incurred expenses.

The family should stop using both the DMAS ID card and the MCO card immediately when notified by the State that the child is no longer eligible for the program. However, the family should keep the DMAS ID card in case the child becomes eligible for the program again at some future date. It can be reactivated.

The family should **report the loss or theft of their child's DMAS ID to the Cover Virginia Call Center or LDSS immediately.** A listing of the 120 LDSSs is included in Section 5 of this *Tool Kit*. If the **MCO card is lost or stolen,** this should be reported to the MCO. These cards should never be lent to anyone.

## Period of Coverage and Reporting Requirements

When a FAMIS application is approved, health coverage is **retroactive to the 1st day of the month of application**. For example, if the signed and completed application is received on June 14th and the child is approved and enrolled, the coverage is effective June 1st. In the case of a family applying for a **newborn**, coverage would begin **on the date of birth if the application is filed in the birth month (or within 3 months of the date of birth provided the question about help paying for medical bills on the application is completed**).

A child is guaranteed **12 months of continuous coverage unless the family's income exceeds 205% FPL, the child moves out of state, turns 19, or becomes pregnant.** This means the family does not have to report an increase in income unless it is over that threshold. The FAMIS handbook (available on www.coverva.org) contains a 205% FPL monthly income chart so a family can know when they exceed this amount and detailed instructions on how to report it. The pregnancy of a teen on FAMIS must be reported so that her coverage can be switched to FAMIS MOMS for the duration of the pregnancy. This allows for her to have 12 months postpartum coverage.

If a child is **moving out of state**, this must be reported to the family's local DSS in writing, to the Cover Virginia Call Center by calling (855) 242-8282, or online via the CommonHelp Customer Portal.

A family **may also want to report if their income goes down**. The local DSS will then evaluate ongoing eligibility and notify the family of any adjustment in coverage. If the children are now eligible for FAMIS Plus, the family will have no copayments for services.

If no changes occur, eligibility for FAMIS is reevaluated after 12 months.

**When a child turns 19 his/her FAMIS coverage will be automatically cancelled at the end of the birth month**. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

***Note:*** *Reporting a* ***change of address*** *is especially important because DSS/CPU/DMAS mail is not forwarded, even if the family has a forwarding order on record with the post office. If correspondence is returned, the case will be closed and coverage will be terminated! DSS also needs a correct address to be able to deliver any renewal information in a timely manner and it needs a "good" address to do so.*

## Covered Services Overview

FAMIS children receive a package of benefits that looks a lot like the type of coverage generally available in a comprehensive private health insurance plan. In fact, the FAMIS benefit package is modeled after the state employee health insurance plan. While many medical services are covered, some have annual "caps" or limits on the amount of service. Unlike FAMIS Plus, non-emergency transportation is not covered as an ongoing benefit. Although "well-child" examinations are covered up to age 19, the services provided are slightly less extensive than the FAMIS Plus/Medicaid EPSDT program. Non-emergency transportation and EPSDT are only available to FAMIS children during the initial 30-day fee-for-service period. A complete listing of *FAMIS Covered Services* begins on page 3.30.

Children may receive additional benefits provided by the MCO in which they are enrolled. These may include things like: case management, health education and disease management services, 24-hour nurse advice line, and free sports physicals.

## Cost Sharing

FAMIS enrollees must pay copayments for some covered services. There are, however, no copayments required for preventive services such as well-child visits. The amount of the copayment depends on the family income and the service provided. ***Note:*** *Children of Alaska Native and American Indian descent are not required to pay any copayments.*

The table below shows examples of the copayment amounts for some basic FAMIS services. A full listing of *FAMIS Covered Services* and the corresponding copayments is located on pages 3.30-3.35.

| Service | Family Income At/ Below 150% FPL | Family Income Above 150% FPL |
|---|---|---|
| Outpatient Hospital or Doctor | $2 per visit | $5 per visit |
| Prescription Drugs | $2-$4 per prescription | $5-$10 per prescription |
| Inpatient Hospital | $ 15 per admission | $25 per admission |
| Non-emergency Use of Emergency Room | $10 per visit | $25 per visit |

FAMIS families should keep receipts of all of the copayments paid when receiving medical services. The amount of copayments paid in a year by a family **cannot exceed $180 for families at or below 150% FPL** and **$350 for families above 150% FPL.** Once a family reaches this copayment cap, they should contact the Cover Virginia Call Center and provide proof that the cap has been reached.

A sample *FAMIS Copayment Tracking Form* is included on page 3.29. Once verified by DMAS, the family will not be required to pay any additional copayments for the rest of the 12 month enrollment period. DMAS will notify all interested parties (providers, MCOs, etc.) that additional copayments cannot be charged to this family.

***Note:*** *Families should be made aware that some services may not be fully paid by FAMIS (i.e. FAMIS pays $25 for eyeglass frames, any cost over this amount is the family's responsibility). Costs like these do not apply toward the annual copayment cap.*

## Annual Renewal *(An example of the renewal form is located on pages 3.51-3.66)*

Eligibility for FAMIS must be renewed every 12 months. If, in Step 5 on the initial application for coverage, the family indicated their willingness to have their income information checked electronically in subsequent years to renew coverage (5 years maximum), LDSS will initiate an "Ex Parte" renewal. If current income information can be electronically verified as "reasonably

compatible" with the prior year's income and the income is still within program guidelines, the family will be sent a *Notice of Action* indicating that coverage has been renewed for an additional year. *(A sample renewal approval notice is on pages 3.45-3.47*)

If the electronic income data is not "reasonably compatible" with the information in the recipient's file, a paper renewal application will be issued. Approximately **45 days prior to the child's renewal month**, the family will be sent an 16+ page renewal form pre-populated with the family's household and income information. If a family has indicated Spanish as their primary language, a pre-populated form in Spanish will be sent instead.

The family will have **30 days from the receipt of the form** to look it over, correct any errors, add any missing information, sign it, and return it to the state for processing. They can return it via mail (in the envelope provided), hand-deliver it to the local DSS, or call the CVCC and report the renewal information via phone. The family can also go online to CommonHelp and report the information there if after approval for the program they linked their chid's case. Instructions on how to link a case in CommonHelp are in Section 5.

Once the family returns the information via paper, phone, or online, the local DSS will use it to redetermine eligibility. If the LDSS still needs additional information, the LDSS worker will contact the family in writing asking for the needed verifications. If the child is still eligible, the family will get a *Notice of Action* stating that coverage has been renewed and giving new dates of coverage.

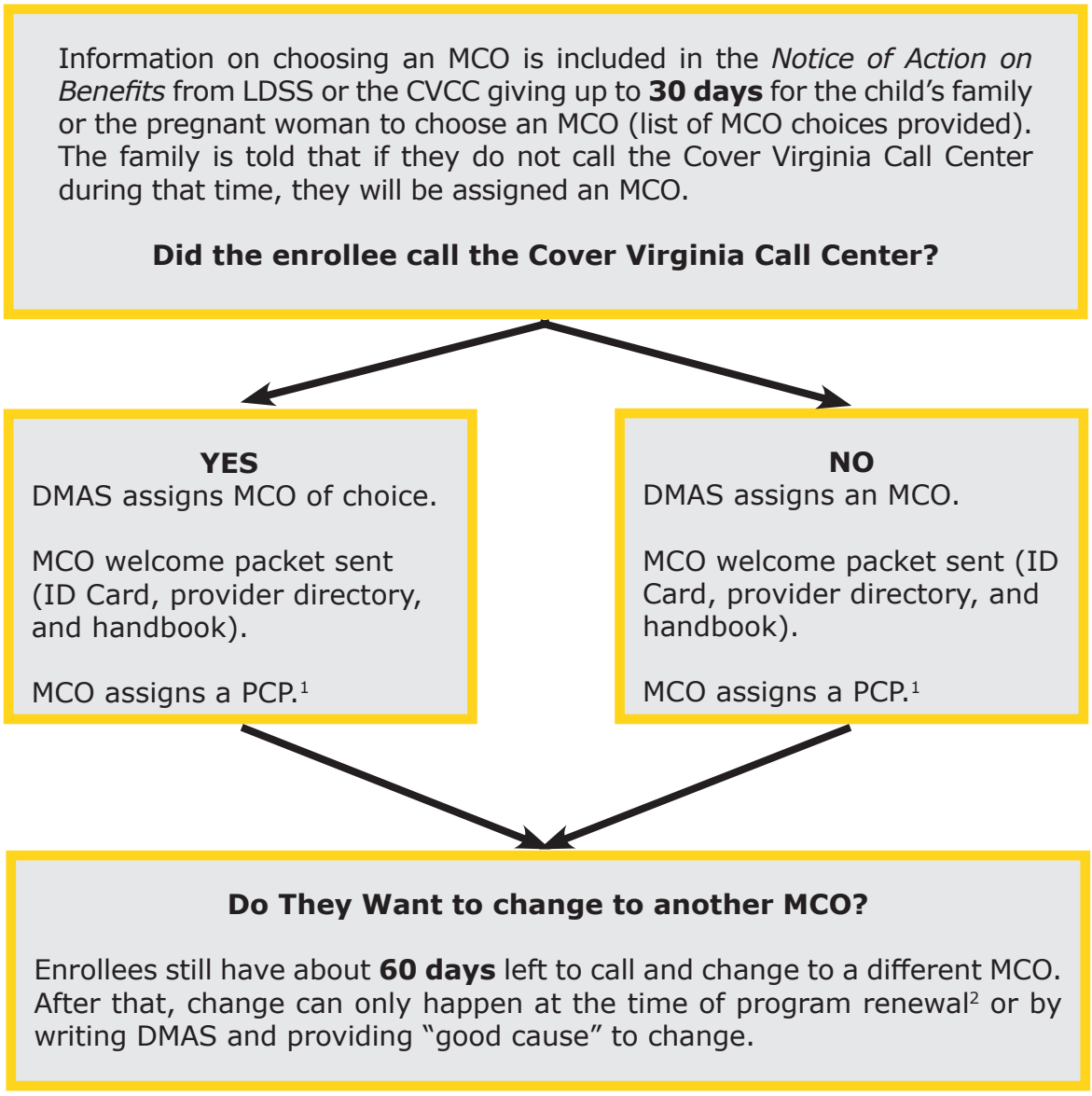
If the family **fails to return the form** by the due date, a **cancellation notice will be mailed**. Coverage will be cancelled effective the end of the renewal month. It is important to note, however, that the family **still has an additional 90 days to return the form and coverage can be reinstated**. If the renewal is returned after that additional 90-day period, coverage cannot be reinstated, and the family will have to file a new application. (*A sample cancellation notice is on page 3.48*)

Many children are terminated from FAMIS at renewal time because of the family's failure to complete the process. A child cancelled from FAMIS for failure to complete annual renewal may reapply for FAMIS at any time.

During the renewal process, the eligibility worker may determine that the child is eligible for FAMIS Plus instead, or is not eligible for FAMIS anymore. If he/she is now eligible for FAMIS Plus, the child will be enrolled in that program. If the child is not eligible for either FAMIS or FAMIS Plus (i.e. the family's income has risen above 205% of FPL), FAMIS coverage will be cancelled. The LDSS will send the family's application information to the Health Insurance Marketplace so the family may be evaluated for financial assistance toward purchasing private coverage available via the Marketplace. Losing coverage at annual renewal opens a Special Enrollment Period with the Marketplace allowing the family to shop for private coverage, if eligible.

**Coverage ends** the last day of the month in which the child **turns 19**. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

## Managed Care Enrollment - FAMIS, FAMIS MOMS, and FAMIS Prenatal Coverage




1. *The family can call the MCO and change their child's PCP at any time.*
2. *There is no program renewal for FAMIS MOMS or FAMIS Prenatal Coverage.*

FAMIS
Covering Children With Affordable Health Insurance

# It's time to choose a health plan!

FAMIS is a statewide program with six participating health plans. Read the following information to see what basic benefits and services are covered by each health plan. Use the chart on the back to compare benefits covered by each plan.

## 1 Read the letter you receive in the mail

Choose a health plan for each person in the FAMIS program.

## 2 How to choose your health plan

- Make a list of your health care providers and places you get care. Include hospitals, doctors, specialists, pharmacies, and therapists.
- Review the comparison chart on the back to compare health plans and choose the best one for you.
- For more information about health plans, call Cover Virginia at **1-855-242-8282** (TTY: 1-888-221-1590). Or go to **www.coverva.org.**

## 3 How to enroll in a health plan

There are 2 ways to enroll in a health plan:

1. Online at **www.commonhelp.virginia.gov** when you apply.
2. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).

You can call Monday to Friday, 8:00 a.m. and 7:00 p.m. or Saturday 9:00 a.m. to 12:00 p.m. (Interpreters are available)

You can get this information in Spanish or other formats, such as large print or audio. (verify this)

Español (Spanish)
ATENCIÓN: Para servicios gratuitos de interprete, llame al 1-855-242-8282 (Númerode TTY: 1-888-221-1590).

FAMIS MCO Comparison Chart 3.27

## All health plans offer these benefits and services:

### Basic health benefits

- Behavioral therapy
- Community Mental Health Rehabilitative Services (CMHRS)
- Dental care services by Smiles for Children
- Durable medical equipment and supplies (DME)
- Early Intervention (EI) services
- Emergency room care
- Family planning and prenatal care services
- Hearing (audiology) services
- Hospital and home health services
- Hospice services
- Physical, occupational and speech therapies
- Prescription drugs ordered by a physician
- Rides to medical appointments (see plan for restrictions)
- Services for special education students
- Vision care (routine eye exams every 24 months, eyeglasses and medically necessary contact lenses)
- Visits to the doctor when you are sick
- Well visits, including routine checkups and annual exams
- X-ray, lab and imaging services

### Special health care needs

Once enrolled, contact your health plan if you or your child needs care for:

- Asthma
- Cancer
- Diabetes
- Heart condition
- High blood pressure
- HIV/AIDS
- Kidney disease or dialysis
- Pregnancy
- Other special health needs

See your member handbook for a full list of services.

## Out of pocket costs

| Service | Co-pay Status 1 | Co-pay Status 2 |
|---|---|---|
| Outpatient hospital or doctor | $2 per visit | $5 per visit |
| Prescription drugs | $2 per prescription | $5 per prescription |
| Inpatient hospital | $15 per admission | $25 per admission |
| Non-emergency use of emergency room | $10 per visit | $25 per visit |
| Yearly-co payment limit per family | $180 | $350 |

Other co-payments may apply to other services

# FAMIS Managed Care Organization (MCO) Plan Choices

## aetna

Aetna Better Health® of Virginia

**1-800-279-1878**
TTY 711
AetnaBetterHealth.com/Virginia

**Added benefits:**

**Healthy moms and kids**
- Baby Matters maternity incentive program with $50 gift card, plus virtual baby showers and portable cribs for attendees
- 300 free diapers
- Ted E. Bear, M.D.™ Club
- Free swim lessons
- Free youth sports physicals

**Phone and online tools**
- Free smartphone with free unlimited minutes and texts, plus 10 GB of data monthly
- 24/7 Member Services

**Wellness programs**
- Asthma program with 2nd inhaler or nebulizer plus bed and carpet cleaning
- Diabetes Care for Life program
- Weight management

**Other benefits**
- Free rides to grocery store, farmers market, food pantry, place of worship, DSS, DMV, WIC, certain social activities, and more (30 round trips each year)
- Home meal delivery after hospital stay (14 meals)
- GED certificate incentive

## Anthem HealthKeepers Plus

Offered by HealthKeepers, Inc.

**1-800-901-0020**
TTY 711
anthem.com/vamedicaid

**Added benefits:**

**Healthy moms and kids**
- Boys & Girls Club membership
- Free diapers, umbrella stroller and $35 Barnes & Noble gift card for books
- Free sports physical
- Up to $30 baby food Kroger vouchers for going to well-child visits

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, plus 4.5 GB of data monthly
- Free Chromebook for high school seniors with 3.5 GPA

**Wellness programs**
- $120 of Weight Watchers® vouchers
- Gift card up to $50 per goal
- Personalized / interactive app

**Other benefits**
- 12 free rides to grocery store or food bank per year
- 14 meals delivered to your home after hospital stay
- $120 in GED testing vouchers
- $25 gift card for good grades
- Coupon book
- Up to $20 Walmart gift card for completing health screener
- Air purifier (with approval)

## MOLINA HEALTHCARE

Molina Complete Care

**1-800-424-4518**
TTY 711
MCCofVA.com

**Added benefits:**

**Healthy moms and kids**
- Pregnancy supplies and mobile information tools
- Member baby showers hosted quarterly per region
- Yearly sports physicals for children
- Bicycle helmets for children

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, plus 4.5 GB of data monthly

**Vision**
- 1 eye exam every other year and up to $100 for glasses (frames and lenses) or contacts every year

**Wellness programs**
- Healthy Rewards gift card up to $50
- Yearly routine physicals for adults

**Other benefits**
- Fresh meals delivered to your home after hospital stay
- SaveAround retail coupon book

## OptimaHealth

**1-800-881-2166**
TTY 711
optimahealth.com/familycare

**Added benefits:**

**Healthy moms and kids**
- OB programs, baby showers and incentives up to $75

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, free monthly calls to health plan
- Web and mobile app tools

**Vision**
- 1 eye exam and $100 for frames each year

**Wellness programs**
- Weight management
- Wellness rewards up to $50
- Online search tool to find food, housing, jobs and more

**Other benefits**
- Free sports physicals
- 24-hour doctor access for non-life threatening health questions or needs
- Up to $275 for GED prep testing vouchers plus prep coaching
- Up to $75 college applications help (restrictions apply)
- Meals delivered to your home after hospital stay, including OB, 2 meals each day for 7 days

## UnitedHealthcare Community Plan

**1-844-752-9434**
TTY 711
uhccp.com/virginia

**Added benefits:**

**Healthy moms and kids**
- Prenatal and maternity incentives
- Free sports physical
- Free Boys & Girls Club membership
- KidsHealth® online resources
- Free mattress cover and pillowcase for members with asthma

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, and 3 GB data monthly
- Online member tools
- On My Way™ interactive website for teens
- Stress, anxiety, and depression support with Sanvello app

**Wellness programs**
- Weight Watchers®
- Wellness rewards for healthy behavior

**Other benefits**
- Rides to non-medical sites, such as WIC appointments and food banks
- 14 meals delivered to home after discharge
- Fresh EBT mobile app
- Fotonovelas health education pamphlet in Spanish

## VirginiaPremier

**1-800-727-7536** | TTY 711
Northern Virginia members* with Kaiser Permanente: **1-855-249-5025**
virginiapremier.com

**Added benefits:**

**Healthy moms and kids**
- Prenatal and parenting classes, and family planning
- Healthy Heartbeats prenatal and postpartum wellness program with incentives
- Safe Sleep education program
- Watch Me Grow: Childhood wellness program with incentives

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, plus 1 GB of data monthly
- Free calls to Member Services

**Vision**
- Up to $100 for frames or contacts every 24 months

**Wellness programs**
- Personal fitness program for your specific needs
- Nutrition education program
- Registered nurse and mobile programs to help manage chronic conditions

*Kaiser: Arlington, Alexandria, King George, Fairfax, Fairfax County, Falls Church, Fauquier, Loudoun, Manassas Park, Prince William and Stafford.

FAMIS COMP CHART ENG 0821

▶ For a list of **doctors and hospitals** that work with each plan, go to the plan's website or call their toll-free number listed above.

▶ For a list of **basic benefits that all plans offer**, see the brochure in this packet.

FAMIS
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# FAMIS Co-payment Tracking Form

Some doctor visits and services require a fee called a co-payment. Use this form to track those fees. Your family's co-payments will end when you reach your yearly limit. If you have questions. call Cover Virginia at 1-855-242-8282.

HERE IS WHAT YOU NEED TO DO:

- ❑ Save your receipts showing what you paid for each FAMIS doctor visit and medicine.
- ❑ List each receipt on this form. [Use additional paper to list more receipts and attach to this form.]
- ❑ Mail this form and your receipts to us when they total your family's co-pay limit.
- ❑ We will review your receipts and tell you if the fees you paid meet the yearly limit.
- ❑ If your family has met the yearly limit for co-payments, we will send you a letter and a new ID card showing $0 co-payment amounts.

Name:_____ Family ID #:_____

Address:_____ Phone Number:_____

| Date of Service | Patient's Name | Who did you pay? | How much? |
|---|---|---|---|
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**Total Paid:** $_____

**Mail this completed form and receipts to:**
**FAMIS**
**PO Box 1820**
**Richmond, VA 23218-1820**

# FAMIS Covered Services

***General Notes:***

Except where noted, these services are delivered by the 6 Medallion 4.0 MCOs.

Annual copayment limits:
*≤150%FPL - $180 per year per family  >150%FPL - $350 per year per family*

Additional services available through the MCOs may include: free smartphones, free sports physicals, case management, health education and disease management services, skilled nursing services, and a 24-hour nurse advice phone line.

The amounts listed for charges & caps follow the pattern:
*[the charge for people in FAMIS ≤150%FPL] / [the charge for people >150% FPL up to 200% FPL].*

Note: There are no copayments for preventive services (well-child checks, dental checkups, etc.) or for American Indians or Alaska Natives

***Ambulance***

Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary. The ambulance service must be prearranged by the Primary Care Physician and authorized by the MCO if, because of the member's medical condition, the member cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the member's condition suddenly becomes worse and must go to a local hospital's emergency room. For coverage of ambulance services, the trip to the facility or office must be to the nearest one recognized by the MCO as having services adequate to treat the member's condition. The services received in that facility or provider's office must be covered services; and if the MCO or the Department requests it, the attending provider must explain why the member could not have been transported in a private car or by any other less expensive means. Transportation services are not provided for routine access to and from providers of covered medical services, unless covered by the MCO as an added benefit.

*Charges & Caps:*

*$2 per trip/$5 per trip*

***Chiropractic Services***

Medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of illness or injury are covered.

*Charges & Caps:*

*$2 per visit/$5 per visit*
*Services capped at $500 per enrollee per calendar year*

***Clinic Services***

Preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to outpatients and that are provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients (health center or ambulatory care center), are covered. With the exception of nurse midwife services, clinical services are furnished under the direction of a physician or dentist. Renal dialysis clinic visits are also covered. There are no copayments for maternity services.

*Charges & Caps:*

*$2 per visit/$5 per visit*

***Dental Care Services – (Smiles For Children Program managed by DentaQuest 1-888-912-3456)***

Dental care in FAMIS is accessed through the *Smiles For Children* (SFC) program managed by DentaQuest. Once children are enrolled in FAMIS, they are automatically enrolled in SFC as well. SFC covers all the services listed below when provided by a dentist that participates in *Smiles For Children*. Members will receive a separate *Smiles For Children* handbook detailing the program, covered services, how to find a dentist, what to do in an emergency, etc. Children access services by seeing a SFC dentist and showing either their DMAS ID Card or MCO card. To find a dentist, call 1-888-912-3456 between 8AM and 6PM, Monday through Friday, or look at the listings posted on

www.dmas.virginia.gov or https://dentaquest.com/state-plans/regions/virginia/member-page/. **There are no costs for services accessed through the SFC Program.**

Covered services are: fluoride (every 6 months), sealants, cleanings (every 6 months), space maintainers, X-rays, fillings, crowns (some caps), extractions (tooth pulling), anesthesia, root canal treatments, oral disease services, and braces (if qualified). Routine diagnostic, preventative, primary and prosthetic and complex restorative procedures necessary for oral health (i.e. dentures, inlays, onlays, crowns and relining of dentures for a better fit) are covered. Tooth guidance appliances, complete and partial dentures, surgical preparation for prosthetics, single permanent crowns, and bridges are also covered, but can be subject to prior authorization. Routine bases under restorations are not covered. Full banded orthodontics and related services are covered when medically necessary. Post treatment stabilization retainers and follow-up visits are included. Some services require pre-authorization.

The MCO is required to cover CPT codes billed by a physician as a result of an accident and medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care. The $2 / $5 copayments may apply to these services.

***Early Intervention Services***

FAMIS covers services provided through the Infant & Toddler Connection of Virginia for children from birth up to age three with developmental concerns. Medically necessary speech, physical and occupational therapies and assistive technology are available, if certified by the Department of Behavioral Health and Developmental Services or applicable Early Intervention Interagency Council under Part C of the Individuals with Disabilities Education Act (IDEA).

***Emergency Services (Using Prudent Layperson Standards for Access)***

FAMIS covers emergency room treatment and services for life-threatening conditions. Coverage includes reasonable reimbursement of services needed to ascertain whether an emergency exists in instances in which the clinical circumstances that existed at the time of the beneficiary's presentation to the emergency room indicate that an emergency may exist. Emergency services are available 24 hours a day/7days a week. FAMIS does cover emergency services provided by out-of-network providers. No prior authorization is needed.

*Charges & Caps:*

*Emergency Room $2 per visit/$5 per visit*
*Physician Care $2 per visit (waived if part of ER visit for true emergency)/$5 per visit (waived if part of ER visit for a true emergency)*
*Diagnostic X-rays, Laboratory Services, Etc. $2 per visit/$5 per visit*
*Non-emergency Use of the ER $10 per visit/$25 per visit**
*(*The hospital may bill for the difference between the Emergency and Non-emergency copayments.)*

Post stabilization care that is medically necessary following Emergency Services are also covered. No pre-authorization is required.

***Family Planning Services***

FAMIS includes services, drugs, and devices for individuals of childbearing age which delay or prevent pregnancy provided under the supervision of a physician. FAMIS does not include services to treat infertility or to promote fertility. Minors are deemed adults for the purpose of consenting to medical services required for birth control, pregnancy or family planning, except for purposes of sterilization.

*Charges & Caps:*

*There are no copayments for family planning services.*

***Home Health Services***

FAMIS covers nursing, personal care, and home health aide services, as well as physical therapy, occupational therapy, speech, hearing, and inhalation therapy. Personal care means assistance with walking, taking a bath, dressing, giving medicine, teaching self-help skills, and performing a few essential housekeeping tasks. FAMIS does not cover medical social services and services that would not be paid for by FAMIS if provided to an inpatient of a hospital; community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services and services related to cosmetic surgery are not covered.

*Charges & Caps:*

*$2 per visit/$5 per visit*
*Capped at 90 visits per enrollee per calendar*

***Hospice Services***

Includes a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a provider licensed to do so, furnished and billed by a licensed hospice, and medically necessary. Care is available if the member is diagnosed with a terminal illness with a life expectancy of six months or fewer and is available concurrently with care related to the treatment of the child's condition with respect to which diagnosis of terminal illness has been made.

*Charges & Caps:*

*There are no copayments for hospice services.*

***Hospital Services – Inpatient***

Inpatient hospital stays in general acute care and rehabilitation hospitals for all enrollees up to 365 days per confinement in a semi-private room or intensive care unit for the care of illness, injury, or pregnancy are covered. (Medically necessary ancillary charges are included.) The MCO shall cover an alternative treatment plan for a patient who would otherwise require more expensive services, including but not limited to long-term inpatient care. The alternative treatment plan must be pre-authorized.

*Charges & Caps:*

*$15 per confinement/$25 per confinement*

***Hospital Services – Outpatient***

Services that are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital are covered. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. Coverage includes: emergency services, surgical services, diagnostic and professional provider services. Facility charges are also covered.

*Charges & Caps:*

*$2 per visit (waived if admitted)/$5 per visit (waived if admitted)*

***Immunizations/Vaccines***

Immunizations are covered in accordance with most current Advisory Committee on Immunization Practices (ACIP). Note: FAMIS enrollees do not qualify for the Free Vaccines for Children Program.

*Charges & Caps:*

*There are no charges for immunizations.*

***Laboratory and X-ray Services***

FAMIS covers all lab and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner in appropriate settings, including physician's office, hospital, independent and clinical reference labs. Includes lead testing at no cost as part of well-baby/well-child care; low-dose screening mammograms at no cost for determining the presence of occult breast cancer; and pap smears.

*Charges & Caps:*

*$2 per visit/$5 per visit**

*Note: there is no copayment for laboratory or x-ray services that are performed as part of an encounter with a physician or for lead testing, mammography or pap smears.**

***Medical Equipment & Supplies (Including Hearing Aids)***

Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) are covered when medically necessary. Also covered are supplies and equipment needed to deliver enteral nutrition. Hearing aids will be covered twice every 5 years.

*Charges & Caps:*

*No copayments for disposable supplies.*

*$2 per item/$5 per item (equipment)*

***Mental Health– Inpatient***

Inpatient mental health services are covered for 365 days per confinement, including partial day treatment services. Coverage includes: rooms, meals, general nursing services, prescribed drugs, and ER services leading directly to admission. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general

acute care hospital are covered. **FAMIS will not cover services received while a child is admitted to a freestanding psychiatric facility or Institute for Mental Disease (IMD).** Services must be pre-authorized.

*Charges & Caps:*

*$15 per confinement/$25 per confinement*

Services in a substance abuse treatment facility are covered by FAMIS.

*Charges & Caps:*

*$15 per confinement/$25 per confinement*

***Mental Health and Substance Abuse Services – Outpatient***

Medically necessary outpatient individual, family, and group mental health and substance abuse clinic services are covered. Emergency counseling services, intensive outpatient services, day treatment, and substance abuse case management services are provided by DMAS, not the MCO.

*Charges & Caps:*

*There are no copayments for mental health or substance abuse services.*

***Mental Health Rehabilitative Services – Community Mental Health Rehabilitative Services (CMHRS)***

Community rehabilitation mental health services, including intensive in-home services, therapeutic day treatment, mental health crisis intervention, case management, behavioral therapies and peer support services.

***Organ Transplantation***

FAMIS covers organ transplants when medically necessary or per industry standards for all eligible individuals, including but not limited to: transplants of tissues; autologous, allogeneic or synegenic bone marrow transplants or other forms of stem cell rescue for children with lymphoma, myeloma or others as described in the Medallion 4.0 contract. FAMIS also covers: kidney (with dialysis dependent kidney failure), heart, pancreas, single lung, and liver transplants. FAMIS will not cover experimental or investigational transplants.

*Charges & Caps:*

*$15 per confinement and $2 per outpatient visit/$25 per confinement and $5 per outpatient visit*
*Services to identify donor limited to $25,000 per member*

***Out of State Medical Coverage***

For FAMIS Fee-For-Service enrollees: FAMIS covers emergency services while an enrolled child is temporarily outside of Virginia, if the provider of care agrees to participate in Virginia's FAMIS/Medicaid program and to bill DMAS for the services provided. FAMIS does not cover medical care provided while the enrollee is outside of the United States.

For FAMIS MCO enrollees: MCOs cover emergency services while an enrolled child is temporarily outside of Virginia, if the provider of care agrees to bill the MCO and accepts the MCO reimbursement for the services provided. The provider should contact the enrollee's MCO. MCOs do not cover medical care provided to the enrollee while outside of the United States.

***Physician Services***

FAMIS covers all symptomatic visits provided by physicians or physician extenders within the scope of their license. Cosmetic services are not covered, unless for medically necessary physiological reasons. This includes services while: admitted in the hospital, outpatient hospital departments, in a clinic setting, or in a physician's office.

*Charges & Caps:*

*Inpatient physician care – no charge*
*Outpatient physician visit in office or hospital*
*Preventive Care (well child visits/annual check-up) no charge*
*Primary Care or Specialty Care $2 per visit/$5 per visit*
*Maternity Care - no charge*

***Pregnancy Related Services***

FAMIS covers services to pregnant teens, including prenatal services.

*Charges & Caps:*

*Maternity Care – no charge*

***Prescription Drugs***

Prescriptions are covered when medically necessary, including those prescribed by an outpatient mental health provider. No DESI drugs are allowed. Over the counter prescriptions are not covered by FAMIS. Check with the MCO to learn which prescriptions are available at retail pharmacies and which are available through mail service.

*Charges & Caps:*

*Retail – up to 34 day supply: $2 per prescription/$5 per prescription*
*Retail – 35-90 day supply: $4 per prescription/$10 per prescription*
*Mail service up to 90 day supply: $4 per prescription/$10 per prescription*
***[If generic is available, enrollee pays the copayment plus 100% of the difference between the allowable charge for the generic drug and the brand name drug, except when the prescribing physician requires the brand name drug.]***

***Private Duty Nursing and Skilled Nursing Facility Care***

FAMIS covers medically necessary private duty nursing when provided by an RN or LPN. The RN/LPN may not be a relative or member of the enrollee's family. The provider must explain why the services are required and what medically skilled services will be provided. Private duty nursing must be pre-authorized. Medically necessary skilled nursing care services that are provided in a skilled nursing facility are covered.

*Charges & Caps:*

*$ 2 per visit/$5 per visit for private duty nursing*
*$15 per confinement/$25 per confinement in a skilled nursing facility*
*Capped at a maximum of 180 days per confinement in a skilled nursing facility*

***Prosthetics/Orthotics***

FAMIS covers prosthetic services and devices (at a minimum: artificial arms, legs and their necessary supportive attachments) and medically necessary orthotics (braces, splints, ankle/foot orthotics, etc.) It also covers orthotics deemed necessary as part of an approved intensive rehabilitation program.

*Charges & Caps:*

*$2 per item/$5 per item*

***Rehabilitation Hospitals – Inpatient***

Rehabilitation services in facilities certified as rehabilitation hospitals and which have been certified by the Department of Health are covered.

*Charges & Caps:*

*$15 per confinement/$25 per confinement*

***School-based Services for Special Education Students***

Physical therapy, occupational therapy, speech language pathology, psychiatric and mental health services, and skilled nursing provided in a school setting are covered. (*Note: These services are reimbursed by DMAS only.)*

*Charges & Caps:*

*There are no copayments for these services.*

***Second Opinions***

Second opinions are covered when requested by the enrollee for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. Must be made by a qualified health care professional within the network, or if necessary, outside of the network. May require pre-authorization.

*Charges & Caps:*

*$2 per visit/$5 per visit*

***Substance Abuse Services-Inpatient***

Inpatient substance abuse services in a substance abuse treatment facility are covered up to 365 days/confinement.

*Charges & Caps:*

*There are no copayments for these services.*

***Substance Abuse Services – Outpatient*** *(See Mental Health and Substance Abuse Services – Outpatient)*

***Telemedicine Services***

Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

*Charges & Caps:*

*$2 per visit/$5 per visit*
*Copayment is based upon the service that is being provided via telehealth)*

***Therapy Services***

FAMIS covers physical therapy, occupational therapy, speech-language pathology, and audiology services that are medically necessary to treat or promote recovery from an illness or injury.

*Charges & Caps:*

*$2 per visit/$5 per visit*

FAMIS also covers renal dialysis, chemotherapy/radiation therapy, intravenous therapy, and inhalation therapy.

*Charges & Caps:*

*Inpatient: $15 per confinement/$25 per confinement*
*Outpatient: $2 per visit/$5 per visit*

***Tobacco Dependence Treatment***

Tobacco or smoking cessation treatment shall be covered for FAMIS members in accordance with SUPPORT Act requirements.

*Charges & Caps:*

*There are no copayments for these services.*

***Vision Services***

FAMIS covers diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine eye exams shall be allowed once every 2 years. Routine refractions are limited to once every twenty-four months. Covers eyeglasses (one pair of frames and one pair of lenses) or contacts prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist.

*Charges & Caps:*

*Routine eye exam $2/$5*
*Reimbursement by plan: Eyeglass frames (one pair) $25; Contacts $100*
*Eyeglass lenses (one pair) $25, Single vision $35, Bifocal $50, Trifocal $88.50*

***Well Baby and Well Child Care (including Hearing Services)***

FAMIS covers routine well baby and well child care visits with health assessments, physical exams, routine lab work, and age appropriate immunizations as recommended by the American Academy of Pediatrics Advisory Committee. The following lab services are covered: blood lead testing, Hemoglobin (HGB), Hematocrit (HCT) or FEP (max. of 2, any combination), Tuberculin Test (max. of 3 covered), Urinalysis (max. of 2 covered), pure tone audiogram for ages 3-5 (max. of 1), machine vision test (max. of 1). Well child visits rendered in the home, office or other outpatient provider location are covered at birth and follow the American Academy of Pediatrics Periodicity Schedule. Coverage also includes the newborn hearing test administered prior to discharge from the hospital.

*Charges & Caps:*

*There are no copayments for well baby or well child checkups.*

***FAMIS DOES NOT COVER THE FOLLOWING SERVICES***

- Abortions (elective)
- Cosmetic services are not covered except to correct deformity resulting from disease, trauma or congenital abnormalities, which cause functional impairment, or complete a therapeutic treatment as a result of such deformity.
- Court Ordered Services
- Temporary Detention Orders
- EPSDT
- Experimental and Investigational Procedures
- Services provided by IMDs (freestanding mental hospital); psychiatric residential treatment services.
- Non-emergency Medical Transportation, unless covered as an extra benefit added by the MCO
- Podiatric Services

# PART IV: Medicaid for Pregnant Women, FAMIS MOMS and FAMIS Prenatal Coverage

## Once Approved

A woman approved for **Medicaid for Pregnant Women (MPW)** will receive a *Notice of Action on Benefits* stating that she has been approved for "MA-PG." *(An example of this form is located on page 2.37.)*

Women approved for **FAMIS MOMS** or **FAMIS Prenatal Coverage** will receive a *Notice of Action on Benefits* stating that they have been approved for "FAMIS MOMS" or "FAMIS Prenatal Coverage." *(A sample form is located on page 2.37.)*

In a separate mailing, she will receive a permanent blue and white plastic ID card from DMAS. This card enables her to receive services from any Medicaid/FAMIS provider while her permanent benefits delivery method is determined. (*A sample of this card can be seen on page 3.1.*)

## Selecting a Provider

The six MCOs providing services to Medicaid for Pregnant Women, FAMIS MOMS, and FAMIS Prenatal Coverage enrollees are listed on page 3.1.

***Medicaid for Pregnant Women***
The enrollee will receive a letter from DMAS about the managed care enrollment process and a comparison chart of the six MCOs. The letter directs her to call the **Managed Care HelpLine** at **(800) 643-2273** Monday through Friday between 8:30AM and 6PM to select her MCO. She can also go online to www.virginiamanagedcare.com to make her choice. ***Note:*** *The HelpLine has access to* ***interpreter services,*** *if English is not the recipient's primary or preferred language.* *(Sample enrollment letter and MCO comparison chart on pages 3.7-3.8 and the enrollment process is charted on page 3.6)*

If she does not respond to the letter by the date indicated, she will be assigned to the MCO listed in the letter. After initial enrollment into the MCO, she still has **90 days to change to another MCO**.

***FAMIS MOMS and FAMIS Prenatal Coverage***
The enrollee will receive information on choosing her MCO in her *Notice of Action*. It directs her to call the **Cover Virginia Call Center** to select her MCO. A list of available health plans is included with the Notice. She is also informed that if she does not call by the indicated deadline, she will be assigned to an MCO. In either case, she will **have an additional 90 days after initial enrollment to switch** to another one. *(See Chart on page 3.26)*

Once the MCO is chosen, either actively by the enrollee or assigned by DMAS, she will receive an ID card and welcome packet from her MCO. This card will be used during her entire enrollment period.

## Using the DMAS ID Card and the MCO Health Insurance Card

Upon receipt of the DMAS ID card, the enrollee should check the information on it to be sure it is correct. If it is not correct, she must inform her local DSS or the Cover Virginia Call Center of any needed change/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in Section 5. If the problem is with her MCO card, she will need to call her MCO.

The enrollee should report the loss or theft of her DMAS ID card to the local DSS or Cover Virginia Call Center immediately. If the MCO card is lost or stolen, she should report this to her MCO. These cards should never be lent to anyone.

It is the enrollee's responsibility to show her MCO ID card and her DMAS ID card to providers each time medical services are received and to make sure the provider participates in the Medicaid/FAMIS MOMS program. The provider uses the information on the card(s) to verify enrollment prior to delivering services. Failure to present the card(s) at the time of service may result in the enrollee being held responsible for any incurred expenses.

## Covered Services Overview (*A detailed listing of Services is on pages 3.15-3.20*)

The MPW, FAMIS MOMS and FAMIS Prenatal Coverage programs provide a comprehensive package of benefits for pregnant women. The coverage is basically the same as FAMIS Plus coverage for children, although certain services are not available to participants over age 21 (i.e. EPSDT, orthodontia, and eyeglasses). In addition to covering traditional health care services such as hospitalizations, doctor visits and prescriptions, they also cover services such as non-emergency transportation to medical appointments, dental care, breastfeeding supports and breast pumps, behavioral health and substance abuse treatment services, case management and health education for new mothers and babies with potential health risks, smoking cessation services, and treatment for substance abuse. MCOs may provide additional "added benefits" such as health education, 24-hour nurse advice line access, and disease management programs.

## Cost Sharing

There are **no** copayments for services provided to Medicaid for Pregnant Women, FAMIS MOMS or FAMIS Prenatal Coverage enrollees.

## Period of Coverage and Reporting Requirements

When a pregnant woman is determined to be eligible for **Medicaid for Pregnant Women**, coverage goes back to the **first day of the month** in which she applied. If she requested **retroactive coverage**, by answering the question on the Application about help paying for medical bills in the last **3 months**, the program may retroactively pay for outstanding medical bills for up to three months prior to her application. For example, if a signed application is received in March and ultimately results in enrollment, the recipient's outstanding medical bills may be covered for December, January,

and February, if she was determined eligible for Medicaid during that time and requested retroactive coverage.

**FAMIS MOMS** and **FAMIS Prenatal** coverage begins the **first day of the month in which the application was received**, so only outstanding medical bills incurred during that month may be covered retroactively by the program.

If a **FAMIS Prenatal Coverage recipient** has outstanding medical bills incurred in the three months prior to the month of application, **she may be evaluated for Emergency Services eligibility for those months**.

Once enrolled in MPW/FAMIS MOMS, the enrollee is **covered for the duration of her pregnancy and 12 months postpartum regardless of any changes in income or insurance status**.

Once enrolled in FAMIS Prenatal Coverage, **the enrollee is covered for the duration of her pregnancy and 60 days postpartum regardless of any changes in income.** Coverage ends the last day of the month in which the 60th day postpartum occurs.

***Note:*** *It important for recipients to report a **change of address** to LDSS or the Cover Virginia Call Center, because DMAS/CPU/DSS mail is not forwarded even if the woman has a forwarding order on record with the Post Office. This information may also be reported on the CommonHelp website if the enrollee has linked her case.*

After the 12 month postpartum period, a **MPW** enrollee may be eligible for LIFC or the New Health Coverage for Adults. At the end of a **FAMIS MOMS** recipient's enrollment if her income is above 138% of FPL, she may be eligible to purchase subsidized coverage through the Health Insurance Marketplace. Coming off of state-sponsored health insurance coverage opens a Special Enrollment Period for her to shop on the Marketplace. She may also be eligible for family planning services thorugh Plan First. *(For more information on Plan First see pages 3.40-3.41)*

A **FAMIS Prenatal Coverage** enrollee will not be eligible for any sort of ongoing coverage after the 60 day post-partum period unless her immigration status has changed.

## Coverage of the Newborn

***Medicaid for Pregnant Women and FAMIS MOMS***
A **child** born to a woman enrolled in **MPW or FAMIS MOMS** is **automatically enrolled in FAMIS Plus (or FAMIS) for one year once she calls her local DSS or the Cover Virginia Call Center to report the birth**. She will report the name of the child, the gender, the race, and the date of birth. This information may also be reported via the CommonHelp website. The hospital or the pregnant woman's MCO may also report the birth to the local DSS on the family's behalf.

***Special Note:*** *A baby born to a teen enrolled in FAMIS/FAMIS Plus can also be deemed eligible and automatically enrolled in FAMIS Plus/FAMIS Plus for one year. The teen must follow the same procedure mentioned above for reporting the birth.*

A renewal is required in order to retain health coverage at the child's first birthday. The family will receive a renewal application in the mail about 45 days before the child turns 1, the family should check it over, correct/add any needed information and return it. If determined to be still eligible, a *Notice of Action* will be mailed indicating coverage has been renewed for a year. **Note: This child's coverage should remain active until the renewal application is processed, even if it is past the child's first birthday.**

***FAMIS Prenatal Coverage***

After the baby's birth, a FAMIS Prenatal Coverage enrollee **must report the birth to the state** by calling Cover Virginia (855) 242-8282 or her local Department of Social Services (*See Section 5 for a listing of all local DSSs and their contact information*), or by going online to CommonHelp (www.commonhelp.virginia.gov). She will report the name of the child, the gender, the race, and the date of birth.

She will also be **asked for proof of application for a Social Security Number** (SSN) **for the child**. The easiest way to apply for a SSN for the child is to do this at the hospital in conjunction with the filing of the birth record at the time of the child's birth.

The LDSS will treat the addition of the child as a "Change in Circumstance." The infant is not a deemed-eligible newborn, but rather has been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage. The child's birth is treated as an "Add A Person" case change in the enrollment system. The child will be enrolled in Medicaid/FAMIS Plus or FAMIS based on the mother's countable income at the time of application and the infant's renewal will be due 12 months from the month of the infant's enrollment.

Once the SSN has been received for the child, the family should report it to their Local DSS.

# PART V: Plan First

## Plan First

Plan First began in January 2008. It is a **limited coverage** Medicaid program that pays for birth control and family planning services for women and men with incomes up to 205% FPL. The income guidelines for this program are on Page 2.11.


## Who is Eligible?

US citizen or qualified legal immigrant* men and women who are residents of Virginia, whose incomes fall within the program guidelines, and who do not qualify for any other full coverage Medicaid program. Medicaid for Pregnant Women and FAMIS MOMS enrollees may be eligible for Plan First coverage at the end of their pregnancy coverage.

**Lawful permanent residents (LPRs) may be eligible after the first 5 years of residence in the US.*

## How to Apply

People wishing to apply for Plan First use the same Application to apply for coverage as for Medicaid/FAMIS. They may also apply over the phone via the Cover Virginia Call Center, online via CommonHelp, or via paper application mailed or delivered to their local DSS. It may take DSS or Cover Virginia CPU up to 45 days to make an eligibility determination of eligibility.

The applicant must play close attention to answering the question re: evaluation for Plan First (***Step 2: Person 1*** Question 8 or ***Step 2: Person 2*** Question 9). Check "Yes" if he/she needs health coverage, and if between the ages of 19 and 64. **Do not check** any of the boxes under question 8a/9a.

## Term of Coverage

Once enrolled, the man or woman is enrolled for up to one year unless any changes of circumstances happen (i.e. increase in income, moving out of state). Annual renewal of coverage is required to retain ongoing coverage. This procedure is the same as that detailed for other programs in this section.

## Covered Services

- Family planning education and birth control counseling
- Pap smears for women to screen for cervical cancer, if appropriate
- Prostate exams for men

- Sexually transmitted infection (STI) testing
- Lab services for family planning and STI testing
- Sterilizations - tubal ligation for women and vasectomies for men (the enrollee must be age 21 or over and wait 30 days after signing the consent form for these services)
- Prescription and over-the-counter contraceptives (with a doctor's order), including implants, ring, patch, IUDs, birth control pills, diaphragms, Depo Provera injections, and condoms
- Non-emergency transportation to a family planning service or to pick up a prescription for birth control

The following services are **not** covered:

- Medical exams for women/men who do not want or no longer need pregnancy prevention services
- Treatment for any medical problems (including STIs or other reproductive health problems)
- Repeat Pap tests due to a problem or Pap tests for women who do not need birth control
- Vaccinations, mammograms, hysterectomies, and treatment for infertility
- Abortions
- Emergency transportation - ground or air ambulance

## Cost Sharing

There are **no** copayments for Plan First family planning services.

## How to Access Services

The enrollees are issued a green and white Plan First ID card (pictured at right) and can see any provider **who takes Medicaid and provides family planning services**. Information on how to access Plan First services can be found at: https://coverva.org/planfirst/

# PART VI: FAMIS *Select* and HIPP

## FAMIS *Select*

FAMIS *Select* is the name for the "premium assistance" component of FAMIS. The program has been streamlined and simplified to be more easily understood by families and employers, and to allow a greater number of families to participate. The program is also open to self-employed families that get their insurance through private insurance plans.

FAMIS *Select* is a "rebate" program. **ONCE A CHILD HAS BEEN ENROLLED IN FAMIS**, the family can select this option that allows them to cover their children with health insurance offered through an employer or a private company, and be reimbursed for a portion of the cost of coverage for the FAMIS children.

If a family decides to participate in FAMIS *Select*, they will fill out an additional **online application form accessed on coverva.org**, and once approved, they will sign up for their employer/private plan. Once they send in their pay stub (cancelled check for a private plan) as proof of payment, the family will be reimbursed up to $100 per FAMIS enrolled child per month.

For example: a FAMIS *Select* family of five (mother, father and three FAMIS children) would receive $300 per month toward the cost of family coverage. *Note: FAMIS* Select *will not reimburse an amount greater than the actual cost of the coverage, so if the total cost paid for insurance was only $200, then this family would only receive $200*.

The FAMIS *Select* option may allow a family to afford family coverage that truly does cover the entire family, including family members not otherwise eligible for FAMIS (i.e. an uninsured spouse, a child over age 19). It may also allow the entire family to see the same providers who all participate in the employer/private plan.

It is important to note that **under FAMIS *Select* any deductibles, co-insurance and copayments required by the employer/private plan are the responsibility of the family.** Over time these can add up to a significant financial outlay. FAMIS has only small copayments for most services and no copayments at all for preventive care. Also, the family will be **limited to the services provided by their employer/private plan** and use that plan's participating providers.

While it may seem like a "deal" to cover the family through FAMIS *Select*, it make more sense in the long run to have children on "regular" FAMIS and just add coverage for a spouse through work. Families will need to consider this carefully when deciding whether to participate in FAMIS *Select*.

If at any time a family in FAMIS *Select* drops the private/employer coverage, the family should notify the FAMIS *Select* Office and the eligible children will revert to regular FAMIS coverage. Children enrolled in this program need to renew their FAMIS Coverage every 12 months in order to stay enrolled.

## Health Insurance Premium Program (HIPP)

The Virginia Department of Medical Assistance Services offers two programs for Medicaid members without Medicare coverage.

**HIPP** is the premium assistant program for adults. It may be available to people with Medicaid and may help pay for part or all of their health insurance premiums. To be eligible:

- A household member must have Medicaid full coverage
- The person must have or be able to get insurance through his/her employer
- The health insurance available must meet program criteria, including cost effectiveness

The cost of the insurance available must be less than Medicaid would pay for his/her care. HIPP does not provide premium assistance for: indemnity plans, plans paying limited amounts for services; plans limited to temporary periods and that are not comprehensive; high deductible health plans; and family plans where there are three or more members on the health plan who are not full coverage Medicaid eligible.

**HIPP for Kids (HFK)** is the premium assistance program that may be available to children under the age of 19 who are also eligible for Medicaid. It pays for their entire health insurance premium. Cost sharing may apply to non-covered copayments, deductibles, and other expenses not covered by the primary insurer. To be eligible:

- A household member must be eligible for Medicaid and be under the age of 19
- The parent(s) must be able to get insurance through his/her employer and the employer must pay at least 40% of the total cost of the health insurance premium
- The health insurance available must meet program criteria

The insurance available must provide comprehensive medical coverage. HFK does not provide premium assistance for: indemnity plans, plans paying limited amounts for services; plans limited to temporary periods or that are not comprehensive; high deductible health plans; and non-medical insurance, such as vision or dental plans.

To contact DMAS for information regarding these programs or to submit an application, people should send an email to HIPPcustomerservice@dmas.virginia.gov, send a fax to the HIPP Unit at (804) 452-5447, or send a letter to:

Virginia Department of Medical Assistance Services
ATTN: HIPP
600 E. Broad Street, Suite 1300
Richmond, VA 23219
Phone: (804) 225-4236 or (800) 432-5924 (in Virginia)

Application forms and additional information are available on the web at: http://www.dmas.virginia.gov/#/hipp

# Virginia Medicaid Dental Coverage

Smiles For Children℠
Improving Dental Care for Children and Adults

## WHAT IS SMILES FOR CHILDREN?

Smiles For Children (SFC) is Virginia's Medicaid and FAMIS dental program for adults and children. The SFC program is managed by DentaQuest.

## HOW DO I FIND A DENTIST?

Contact DentaQuest at 1-888-912-3456 or search the DentaQuest website to find a listing of dentists who accept Medicaid in your zip code.

***Already have a dentist?*** Call and make sure that your provider accepts Medicaid coverage so you can receive quality services at no cost.

## HOW DO I USE SMILES FOR CHILDREN INSURANCE?

There are no costs or co-payments for dental care services in the SFC program. On the day of the appointment, be sure to bring your Virginia Medicaid card and your managed care organization ID card (if you are enrolled in a health plan).

### CHILDREN

- Regular dental checkups
- X-rays
- Cleaning and fluoride
- Sealants
- Space maintainers
- Braces
- Anesthesia
- Extractions
- Root canal treatment
- Crowns

### PREGNANT MEMBERS

- X-rays
- Exams
- Cleanings
- Fillings
- Root canals
- Gum related treatment
- Crowns
- Partials and Dentures
- Extractions and other oral surgeries

### ADULTS

- X-rays
- Exams
- Cleanings
- Fillings
- Root canals
- Gum related treatment
- Dentures
- Extractions and other oral surgeries

***Need a ride?*** Transportation services are available to Medicaid members for their dentist appointments. Visit the Virginia Medicaid website or contact your health plan for contact information to make a reservation.

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

***Sample Renewal Approval***

Charlottesville City (540)
120 Seventh Street, NE
Charlottesville, VA 22902

*[Sample DSS]*

**Commonwealth of Virginia**
**Department of Social Services**
**Questions? Call: (434) 970-3400**

Letter Date: February 11, 2021
Case Number: ##########

Susan Hope
801 E Main ST
Charlottesville, VA 22902

*[Sample Client]*

## News for your household

A renewal has been completed for health coverage from Virginia Medicaid. This letter tells you more about the determination and how it was made. It has information about the household's health coverage choices and what to do next. It also explains what to do if you think we made a mistake.

## Medicaid Decision Summary for Your Household

| Household Member Name | Decision | Coverage | Effective Date(s) |
|---|---|---|---|
| Susan Hope | Eligible | FULL | March 01, 2021 - Ongoing |

**To learn more about how we made our decision for each person, read the rest of this letter.**

## Update for Susan Hope

**Client ID: 2104869120**

You qualify for health coverage from Virginia Medicaid.

## Health Coverage Information for Susan Hope:

| Medicaid ID Number | Coverage | Effective Date |
|---|---|---|
| **351148810017** | **FULL** | **March 01, 2021 - Ongoing** |

**Medicaid Card:** Most Medicaid enrollees receive a Medicaid card. If you do not already have a card with the Medicaid ID above, and do not receive a card in the mail in 10 business days, please call **1-855-242-8282**. *Some people in limited coverage Medicaid do not receive a card.* Your Medicaid health coverage can be used right away by giving your provider the Medicaid ID number listed above.

**Health Coverage must be renewed every year.** The next renewal is due **February 28, 2022.** We will send more information when it is time to renew.

You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282 (TTY: 1-888-221-1590)**.

## Using your health coverage

Medicaid health coverage can be used right away. Services can be received from any doctor, clinic, or other health care provider who accepts Medicaid. To find a provider, call **1-855-242-8282** or visit **www.virginiamedicaid.dmas.virginia.gov** and select "Search for Providers" under the "Provider Resources" menu. Most people get their health coverage through a health plan. If this individual needs to join a plan, we will send information about choosing a health plan. If you had any medical services since your coverage started, make sure to give the provider(s) your Medicaid ID number.

## Health services and costs

Susan Hope qualifies for full coverage Medicaid. This covers services like doctor visits, hospital care, prescriptions and more.

There is no premium (a monthly cost) for Medicaid health coverage. There **may** be co-payments for some services. To learn more, see the Member Handbook at **https://www.coverva.org/handbooks/**. To get a paper copy of the Handbook, call us at **(434) 970-3400**.

## How we made our Medicaid decision

Medicaid has rules and income limits for how people can qualify for health coverage depending on things like age, pregnancy and parenting status, and disability. We counted the household size and income and reviewed the information given to us on the application or available in other data sources. Since the household's monthly income is below the Medicaid income limit, this individual qualifies for Medicaid health coverage. To learn more about Medicaid rules and income limits, go to **www.coverva.org**. We made our decisions based on these rules: Virginia Medical Assistance Manual Reference M0130.300. If your information has changed since you applied or you think we made a mistake call us. You can also file an appeal. For more information on how to file an appeal see the page titled "If you think we made a mistake."

Medicaid may pay past bills, even if you already paid them yourself. If you were not evaluated for health coverage for the three months prior to your application month and you had medical expenses, contact us at **(434) 970-3400**.

## Your household must report changes

You must report any changes that might affect health coverage for anyone in your household who was approved health coverage from Virginia Medicaid. Please report changes for both you and other people in your household within ten days of the change, such as:

» If someone moves
» If someone's income changes
» If your household changes. For example, if someone in your household marries or divorces, becomes pregnant, or has or adopts a child.

To report changes: go to **CommonHelp.Virginia.gov** and click on "Report My Changes," call **1-855-242-8282 (TTY: 1-888-221-1590)**, or call us at **(434) 970-3400**.

## Your CommonHelp Account

**CommonHelp.Virginia.gov** keeps all important information about your family's application and health coverage. You can choose to get letters like this online. Your CommonHelp account is secure.

To create an account, go to **CommonHelp.Virginia.gov** and click "Check My Benefits."
To link your case to your CommonHelp account using the information below, log in and select "Manage My Account."

**Case Number: #########**
**Client ID: ##########**

## Information about other programs

You and others in your household may qualify for other assistance, like help buying food or paying heating and cooling bills. If you already applied for other assistance, information about those programs may come in a separate letter.

To learn more, go to **CommonHelp.Virginia.gov** or call **1-855 635-4370 (TTY: 1-800-828-1120)**.

| Worker Name: | Telephone Number: | For Free Legal Advice Call: |
|---|---|---|
| JOE WORKER | (804) 555-5555 | 1-866-534-5243 |

## Additional Information from Your Case Worker:

*Note: Some pages this notice have been omitted to save space. One would be the "If You Think We Made a Mistake" section that can be viewed on Page 2.41. Another is the "It is important we treat you fairly" wording that can be seen on Page 2.40. The final two pages would be information about the right to get this information in other languages written in Spanish, Korean, Vietnamese, Chinese (Traditional), Arabic, Urdu, Hindi, Farsi, Bengali,Tagalog, Amharic, French, Russian, German, Basa, Ibo, and Yoruba.*

Charlottesville City (540)
120 Seventh Street, NE
Charlottesville, VA 22902

*[Sample DSS]*

**Commonwealth of Virginia**
**Department of Social Services**
**Questions? Call: (434) 970-3400**

Letter Date: February 11, 2021
Case Number: ########

Susan Hope
801 E Main ST
Charlottesville, VA 22902

*[Sample Client]*

## News for your household

A renewal has been completed for health coverage from Virginia Medicaid. This letter tells you more about the determination and how it was made. It has information about the household's health coverage choices and what to do next. It also explains what to do if you think we made a mistake.

## Medicaid Decision Summary for Your Household

| Household Member Name | Decision | Coverage | Effective Date(s) |
|---|---|---|---|
| Susan Hope | Closed | FULL | February 28, 2021 |

**To learn more about how we made our decision for each person, read the rest of this letter.**

## Update for Susan Hope
## February 28, 2021

**Client ID: ##########**

You no longer qualify for health coverage from Virginia Medicaid. To learn more, read the "How we made our Medicaid decision" section below.

## How we made our Medicaid decision

Medicaid has rules and income limits for how people can qualify for health coverage depending on things like age, pregnancy and parenting status, and disability. We counted the household size and income and reviewed the information given to us on the application or available in other data sources. To learn more about Medicaid rules and income limits, go to **www.coverva.org.** If your information has changed since you applied or you think we made a mistake call us. You can also file an appeal. For more information on how to file an appeal see the page titled "If you think we made a mistake."

This individual does not qualify for health coverage from Virginia Medicaid because they moved from the state of Virginia. We made our decisions based on these rules: Virginia Medical Assistance Manual Reference M0230.001.

You might still be able to get full health coverage — and help paying for it — through the Health Insurance Marketplace. We sent your information to them. The Marketplace will send you a letter. **To learn more, read the "How to Complete the Marketplace Application" insert with this letter.**

| Worker Name: | Telephone Number: | For Free Legal Advice Call: |
|---|---|---|
| Jane Smith | (555) 555-5555 | 1-866-534-5243 |

**Additional Information from Your Case Worker:**

*Note: Some pages this notice have been omitted to save space. One would be the "If You Think We Made a Mistake" section that can be viewed on Page 2.41. Another is the "It is important we treat you fairly" wording that can be seen on Page 2.40.*

## What is the Health Insurance Marketplace?

Use the Marketplace to shop for and buy affordable private health insurance online, over the phone, or with in-person help. There is financial help available for people who qualify.

**You or someone in your household was found not eligible for Medicaid. You may still be able to get help paying for health coverage through the Health Insurance Marketplace. Your information has been sent to the Marketplace to start an application, but you must take action to see if you qualify!**

## How to Complete the Marketplace Application:

You must complete the Marketplace application within 60 days of your Medicaid denial. The sooner you apply for coverage; the sooner new coverage can begin. You should complete the Marketplace application as soon as you can to see if you can get coverage now. To complete your application, you can:

1. **Wait for the letter from the Marketplace.** The letter will tell you how to complete your application with them. The Marketplace is starting a health insurance application for the following individual(s): **Susan Hope, Jasmine Hope**

   **Or**

2. **Start a new application.** You can go to **HealthCare.gov** or contact the Call Center at **1-800-318-2596 (TTY: 1-855-889-4325)**. You will need to:
   - » Create a Marketplace user account online or by phone with a Call Center Representative.
   - » Have this letter with you to help answer questions.
   - » Provide the information you gave us already.
   - » Answer "yes" when asked if anyone has been found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days, if this applies.

If you have questions or need help completing your application, call the Marketplace Call Center at **1-800-318-2596 (TTY: 1-855-889-4325)** or go online to **HealthCare.gov/help/statetransfer**.

After you complete your application, the Marketplace will tell you if you qualify to enroll in Marketplace insurance, if you can enroll right away, or have to wait to enroll. The Marketplace will tell you if you qualify for help paying for your coverage. **If you qualify for coverage right away, select and enroll in a plan!**

If the Marketplace tells you that you have to wait, you can reapply during Open Enrollment (November 1st –December 15th). Some individuals who experience a life event will qualify for a Special Enrollment Period and can enroll outside of Open Enrollment. Examples of life events that may qualify you for a Special Enrollment Period include losing Medicaid or other health insurance, having a baby or getting married. You usually only have 60 days after the date of the life change to apply for Marketplace coverage. However, if you are losing coverage, you can apply up to 60 days before the loss, which can help to prevent a gap in health coverage.



*Note: Page 6 of 8 was a blank page and pages 7 -8 of 8 contain information how to get information in other languages. These pages were omitted to save space.*

**3.50 *Sample Cancellation Notice***

Charlottesville City
120 Seventh Street, NE
Charlottesville, VA 22902

*[Sample LDSS]*

Mary Smith
300 East Main Street
Charlottesville, VA 22902

*[Sample Client]*

**Commonwealth of Virginia**
**[VARAIBLE DATA]**
**Questions? Call us: [VARAIBLE DATA]**

Letter Date: [VARIABLE DATA]
**Response due:** [VARIABLE DATA]
Case Number: [VARIABLE DATA]
Case Worker Name: [VARIABLE DATA]
Worker User ID: [VARIABLE DATA]

# It is Time to Renew Your Health Coverage from Virginia Medicaid.

**Please complete your renewal by: [DATE]**

Completing your renewal online (www.commonhelp.virginia.gov) or by phone (1-855-242-8282) can be faster and easier! See below for more information.

**If you do not complete your renewal, you will lose your Medicaid health coverage.**

**Renew your Medicaid in any one of these ways**

❶ **Online*:**
Go to **CommonHelp.Virginia.gov.**
Click on "Renew My Benefits."

To create an account:

- Go to **CommonHelp.Virginia.gov**
- Click "Check My Benefits."
- To link your case to your CommonHelp account using the information below, log in and select "Manage My Account."

**Case Number: 12345678**
**Client Number: 12345678**

❷ **By phone:**
Call 1-855-242-8282/ TTY: 1-888-221-1590; this call is free.

❸ **By mail or fax:**
Charlottesville City
P.O. Box 120
Charlottesville, VA 22902
Fax: [variable data]

❹ **In person:**
Bring the completed from to:
Charlottesville City
120 Seventh Street, NE
Charlottesville, VA 22902

*This is a renewal of your Medicaid benefits. Information regarding open enrollment to change health plans (such as Anthem or Optima) will be mailed separately. Open enrollment dates depend on where you live. Go to https://www.virginiamanagedcare.com for more information.*
**Free Internet access may be available at your local Department of Social Services or public library.*

You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).

| | |
|---|---|
| **How to complete this renewal form** | 1. Answer all the questions on the form.<br>2. Review the information about you and each member of your household or on your tax return. Cross out wrong information. Write in new information and add anything that is missing. information. If you have household members who are new to the home and/or would like to apply, please fill out all applicable sections of the renewal for that person.<br>**3. Sign and date the form at the end of the renewal.** |
| **What we need** | **We filled out the form with the information we have in our records. Cross out wrong information. Write in new information and add anything that's missing. This form will ask about:**<br>▪ Section 1: Information about how we can contact you<br>▪ Section 2: Information about your federal tax returns<br>▪ Sections 3: Information about people in your household<br>▪ Section 4: Other health insurance coverage<br>▪ Sections 5: Household income from jobs or other sources<br>▪ Section 6: Information about resources and nursing facility care (you will only get this section in your packet if it applied to your household.)<br>▪ Next, fill out all appendices, if any, that apply to your household or individuals listed on your tax return:<br>o Appendix A: People in your household who are eligible for new health coverage from a job<br>o Appendix B: People in your household who are an American Indian or Alaska Native<br>o Appendix C: Choose who can help with your application<br>o Appendix D: New people in your home who want to apply for Medicaid<br>o Additional Information: Voter registration and non-discrimination information<br>We need information about each person living in your household or listed on your tax return, including those who:<br>▪ Have Medicaid health coverage now,<br>▪ Do not get Medicaid health coverage, but want to apply<br>▪ Do not have Medicaid health coverage and <u>do not</u> want to apply.<br>We will check your answers using information available in data sources, like the Internal Revenue Service (IRS), the Social Security Administration (SSA), and the Department of Homeland Security (DHS). If the information does not match our records, we may ask you to send more information. |
| **What happens next?** | After you return the renewal form, we will review it to see if you and others in your household are eligible for Virginia Medicaid. If we have more questions, we will contact you. |

You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).

## 1 Information about how we can contact you

| ▼Review the contact information we have on file for you below. | ▼ Cross out wrong information. Write in new information and add anything that is missing. |
|---|---|
| *Mary Smith* | **Name** |
| **Home** address<br>*300 East Main Street*<br>*Charlottesville, VA 22902* | **Home** address Apartment #<br>City State ZIP code |
| **Mailing** address<br>*300 East Main Street*<br>*Charlottesville, VA 22902* | **Mailing** address Apartment #<br>City State ZIP code |

**Phone** number:

**Cell:** *805-555-1234* **Home:** *804-555-1234* **Work:** *804-555-1234*

**Best phone number** to reach you during the day: ☐ Cell ☐ Home ☐ Work

**Email address,** if you have one:

## 2 Information about your federal tax return

You can still renew if you do not file a tax return.

- ▶ Review the information about tax filers and dependents in your household.
- ▶ Cross out any information that is wrong. Write in any new information about how you plan to file your next federal tax return.

| ▼Review your tax information here. | |
|---|---|
| **Person filing tax return:** *Mary Smith*<br><br>If this person is filing a joint return, write the name of the spouse: | Tax dependents (if anyone is missing, write their name below):<br><br>*Annie Smith* |

▶If anyone who lives with you will be claimed as a dependent on someone else's tax return, write the name of the filer and the dependents below. Include only names that do **not** appear above.

**Name** *(first, middle, last & suffix)*

| | |
|---|---|
| | |
| | |

## 3 Your household members

▶Review the information below. Cross out anything that is wrong. Fill in any missing information.

**Person 1:** Mary Smith  This person's Social Security number is ☐ on file ☒ not on file

***If not on file,*** write this person's Social Security number here:

☐ This person is no longer living in the household. Date person left the household: _____ (mm/dd/yyyy)

**Person 2:** Annie Smith  This person's Social Security number is ☐ on file ☒ not on file

***If not on file,*** write this person's Social Security number here, if they have one:

☐ This person is no longer living in the household. Date person left the household: _____ (mm/dd/yyyy)

▶Review people in your household not receiving Medicaid and write in any new people in your household

**Person 1:** John Smith

☐ This person is no longer living in the household. Date person left the household: _____ (mm/dd/yyyy)

**New Household Member Name:** *(first, middle, last & suffix)*:

**If anyone in your household is not currently enrolled in Virginia Medicaid and wants to apply, complete Appendix D.**

▶Answer these questions for **everyone** in your household or on your tax return.

Is anyone in your household or on your tax return pregnant?

☐ Yes ☐ No ***If yes,*** fill in the information below.

| **Name** *(first, middle, last & suffix)* | How many babies are expected? | What is the due date? _____ (mm/dd/yyyy) |
|---|---|---|
| | | |

Is anyone in your household or on your tax return an American Indian or Alaska Native?

☐ Yes ☐ No ***If yes,*** fill out **Appendix B.**

▶Answer these questions for anyone who is **renewing or applying** for health coverage.

▶ Does anyone need help with every day activities, like bathing, dressing, eating, walking, or using the bathroom in order to live safely in your home? **or** Has a doctor or nurse told anyone in your household that they have a physical disability, a long-term disease, a mental or emotional illness, or an addiction problem?

☐ Yes ☐ No ***If yes,*** write the name(s) below.

**Name** *(first, middle, last & suffix)*

Has anyone turned age 65 years old or become blind or disabled?

☐ Yes ☐ No ***If yes,*** fill out **Section 2 of Appendix D.**

Has anyone entered a nursing home, assisted living facility, or started receiving nursing care in the home?

☐ Yes ☐ No ***If yes,*** fill out **Section 3 of Appendix D.**

Is anyone who is renewing or applying for health coverage incarcerated (detained or jailed)?

☐ Yes ☐ No ***If yes,*** write the name(s) below.

**Name** *(first, middle, last & suffix)*

**Facility** Name *(place of incarceration)*

**Plan First** is a limited benefits program that covers services like family planning exams, prescription contraceptives, testing, and family planning related lab services. Learn more: www.coverva.org/planfirst. **Individuals between the ages of 19 and 64 are automatically evaluated for Plan First.**

If you do **not** want household members between the ages of 19 and 64 to be evaluated for Plan First, write their name(s):

**Household Members Younger than 19 and Older than 64:**
If you want us to see if household members younger than 19 and older than 64 qualify for Plan First, write their name(s):

In the past, the following household members chose not to be evaluated for Plan First coverage. If they now want to be evaluated, **circle their name(s) below**:

John Smith, Annie Smith

## 4 Other health insurance coverage

Does any person who is **renewing or applying for health coverage** have other health insurance?

- Review the information about tax filers and dependents in your household.
- Cross out any information that is wrong. Write in any new insurance information for your household.
- If someone in the household has new insurance through an employer complete **Appendix A**.

| **Name(s) of person with other health insurance:** | **Policy number:** |
|---|---|
| **Insurance company name:** | **Monthly Premium Amount: $** |

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Marketplace ☐ Other insurance ☐ Premium Assistance (HIPP or FAMIS Select)

☐ **Check here is this other health insurance has ended. Coverage End Date:**_____
(mm/dd/yyyy)

If you have indicated that health insurance has ended for any household member(s), please provide proof of the date of termination of the member's other health insurance.

List everyone renewing or applying for health coverage who has this other insurance policy:

☐ Check here if this other health insurance coverage is offered through a job.

## 5 Information about income from jobs

- ▶ Provide the information below for anyone in your household or on your federal tax return who has income from a job, whether or not they are renewing or applying for health coverage.
- ▶ If someone has more than one job, tell us about **all of their jobs**.
- ▶ If you need more space, make a copy of this page before filling it out.
- ▶ Cross out wrong information. Write in new information and add anything that is missing.

Person who has the job: **Name** (*first, middle, last & suffix*)

| **Employer name** and address: | City: | State: | Zip code: | Phone number: |
|---|---|---|---|---|
| ABC Employer 123 Main Street | Richmond | VA | 23224-0001 | 804-555-1234 |

**Monthly gross income** currently on file: $

Is this person still employed at this job? ☐ Yes ☐ No ***If No,*** date they left the job: _____
(mm/dd/yyyy)

How often are wages and tips paid?

☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ Yearly ☐ Other _____

☐ Not regularly (for example, if this person works under a contract)

How much does this person earn (before taxes are taken out)? $_____

Average hours worked each week: _____

If anyone in the household has **changed or has a new job**, list him or her and answer the questions below.

Name (*first, middle, last & suffix*):

| Employer name and address: | City: | State: | Zip code: | Phone number: |
|---|---|---|---|---|
| | | | | |

Start Date:

How often are wages and tips paid?

☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ Yearly ☐ Other _____

How much does this person get paid (before taxes)? _____

Average hours worked each week: _____

▶If anyone in your household is **self-employed or does odd jobs,** we need to know about their work.
▶Cross out wrong information. Write in new information and add anything that's missing.

Name *(first, middle, last & suffix):*

Type of work:

What do you expect his or her income to be this year? Amount: $

How much **net income** will this person get from self-employment (or odd jobs) this month?

Amount: $_____

**Net income** means the profits left over after business expenses are paid. For more information about business expenses visit https://www.coverva.org/.

▶**Information about other income.** If anyone in your household has income from sources other than a job, like Social Security income, pensions, Veterans benefits, or annuities.
▶Cross out wrong information. Write in new information and add anything that is missing.

**Name** *(first, middle, last & suffix):*

**Income Type:** **How much? $**

**How often?**

☐ Yearly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Other_____
☐ Not regularly (for example, if this person works under a contract)

**Name** *(first, middle, last & suffix):*

**Income Type:** **How much? $**

**How often?**

☐ Yearly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Other_____
☐ Not regularly (for example, if this person works under a contract)

**Deductions – Only certain individuals are eligible to receive deductions.**
▶If anyone in your household has pre-tax deductions from pay, tell us what kind. Deductions are amounts, listed on your tax return, that are subtracted from your income for certain expenses.
▶You should not include expenses that members of your household subtracted from their self-employment gross income. Common deductions include student loan interest paid, contributions to individual retirement arrangements (IRAs), and contributions to health savings accounts (HSAs).

**Name** *(first, middle, last & suffix):*

**Deduction Type** _____ **How much monthly? $**_____

**Name** *(first, middle, last & suffix):*

**Deduction Type** _____ **How much monthly? $**_____

## 6 Information about resources and nursing facility care (you will only see information in this section if it currently applies to your household)

- ▶This section refers to individuals who are 65 or older, blind, or disabled and/or receiving nursing care in a facility or in the home.
- ▶Cross out wrong information. Write in new information and add anything that's missing.

**Resources include things like checking/savings accounts, stocks, bonds, life insurance, and retirement funds. Resources also include property, vehicles, annuities, and trusts.**

| Owner | Resource | Amount |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |

**If you or your spouse who lives with you are working, do either of you have expenses related to work?**
☐ **No** ☐ **Yes** ***If yes, attach proof.***

Do you or your spouse or child have medical expenses not covered by Medicaid?
☐ **No** ☐ **Yes** ***If yes, attach proof.***

Name of the nursing facility, state institution, or community-based care provider:

**Has this person or their spouse sold or given away any resources within the last year?**
☐ No ☐ Yes ***If yes***, fill out below.

| Resource Type | Value | Date Sold or Given Away |
|---|---|---|
| | $ | |

If married or separated, spouse's name: Name *(first, middle, last & suffix):*

**Does this person's spouse have any home expenses? If yes, tell us below.**

Rent/Mortgage: $_____ Utilities ☐ Yes ☐ No

Homeowner's/Renter's Insurance: $ _____ Real Estate Taxes: $ _____

Maintenance Charges for Condominium: $ _____

**Does this person's dependent(s) have any income? If yes, tell us below.**

Social Security: $ _____ Social Security Income: $ _____

Civil Service: $ _____ Veterans Administration: $ _____

Retirement/Pension: $ _____ Disability: $ _____

Wages: $ _____ Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.): $_____

## 7 STOP Sign the application

**Your rights and responsibilities:** Review the information below and sign the application.

- I know that I must tell my local Department of Social Services if anything changes and is different from what I wrote on this form. I can call 1-855-242-8282 (TTY: 1-888-221-1590), contact or visit my local agency, or visit **CommonHelp.Virginia.gov** to report any changes. A change in my information might affect whether someone in my household qualifies for coverage.
- I understand that if I do not qualify for health coverage, my local Department of Social Services may send my information to the Health Insurance Marketplace (www.healthcare.gov) to see if I qualify.
- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS.
- I have permission from everyone whose information is on this form to submit their information to Virginia Medicaid and to receive any communications about their eligibility and enrollment.

**Renewal of Coverage in Future Years:** Read the statements below and choose.

Giving the Virginia Medicaid program permission to use my federal tax return to confirm my income can make it easier to renew health coverage and may allow renewals to happen automatically. I understand that I can change my mind at any time by contacting my local Department of Social Services.

**I give permission to use updated income information from my tax returns for the next (check one):**

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Do not use my tax information to renew coverage.

**Choose or Change Your Authorized Representative**

To confirm or change your authorized representative, fill out **Appendix C.**

**Choose or Change Your Outreach Worker/Application Assister/Certified Application Counselor**

To confirm or change your Certified Application Counselor/Navigator/Broker, fill out **Appendix C.**

STOP

I am signing this renewal form (including any appendices) under penalty of perjury. I have provided true answers to all questions on this form and I know that I may be subject to penalties under federal law if I provide false or untrue information.

_____ _____

**Signature of Household Contact or Authorized Representative** **Date**

**ALL individuals in the home 21 or older (or 18 or older in a home without a parent) who are renewing or applying for health coverage MUST sign below. A spouse can sign for their spouse.**

| Print Name | Signature | Date |
|---|---|---|
| | | |
| | | |
| | | |

## Appendix A - Renewal

## Complete ONLY if someone in your household is eligible for new health coverage from a job

- Tell us about the job that offers coverage for your household.
- Take the Employer Coverage Tool on the back of this page to the employer who offers the coverage to help you answer these questions.
- If more than one person has coverage offered through a job, make a copy of this page.

**Employee Information**

| **Employee** name *(first, middle, last & suffix)* | **Employee** Social Security number |
|---|---|
| | |

**Employer Information**

| **Employer** name | **Employer** identification number |
|---|---|
| | |
| **Employer** address | **Employer** phone number |
| | |
| **City** **State** | **Zip** Code |

Name and title of person who can be contacted about employee health coverage at this job

| **Name** | **Title** |
|---|---|
| **Phone** number | **Email** address |

If you are currently eligible for coverage offered by this employer, or will become eligible in the next 3 months fill in the information below:

If in a waiting or probationary period, what date can you enroll in coverage? _____
(mm/dd/yyyy)

List the name of anyone else who is eligible for coverage from this job

| **Name** (first, middle, last & suffix) | **Name** (first, middle, last & suffix) |
|---|---|
| | |

**Tell us about the health plan offered by this employer**

Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No
For the lowest-cost plan that meets the minimum value standard offered only to the employee (don't include family plans) provide the premium that the employee would pay is the maximum discount was received for any tobacco cessation without any other discounts. $

How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

What changes will the employer make for the new plan year (if known)?

| | |
|---|---|
| ☐ Health coverage will not be offered | ☐ Employer will offer or change health coverage for the lowest-cost plan available to the employee that meets the minimum value standard*. |

Employee premium cost $_____ Date of change_____
(mm/dd/yyyy)

How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

## Employer Coverage Tool

This section should be completed by the employer to help answer questions about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent or a spouse).

Is the employee currently eligible for coverage or will the employee be eligible in the next three months? ☐ Yes ☐ No (*If yes, write in information below. If no, stop and return form to employee.)*

If in a waiting or probationary period, when can the employee enroll in coverage? _____
(mm/dd/yyyy)

Does the employer offer a health plan that covers an employee's spouse or dependent? ☐ Yes ☐ No
If yes, which people? ☐ Spouse ☐ Dependents

**Tell us about the health plan offered by this employer**

Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No
*(If yes, please complete the information below. If no, stop and return form to employee.)*

For the lowest-cost plan that meets the minimum value standard offered only to the employee (don't include family plans) provide the premium that the employee would pay is the maximum discount was received for any tobacco cessation without any other discounts. $

How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

**If the plan year will end soon and you know that the health plans offered will change, write in the information below. If you do not know, stop and return form to the employee.**

☐ Health coverage will not be offered

☐ Employer will offer or change health coverage for the lowest-cost plan available to the employee that meets the minimum value standard*.

Employee premium cost $_____ Date of change_____
*(Premium should reflect the discount for the wellness program.)*
(mm/dd/yyyy)

How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan if no less than 60 percent of such costs (Section 36B (c)(2)(C)(ii) of the Internal Revenue Code of 1986).

## Appendix B - Renewal

## Complete ONLY if someone in your household is an American Indian or Alaska Native

- Tell us about your American Indian or Alaska Native family member(s).
- American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.
- If more than two people are American Indian or Alaska Native, make a copy of this page.

**1. Name (first, middle, last & suffix):**

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program? ☐ Yes ☐ No

If no, does this person qualify to get these services? ☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

How much income? $

How often?
☐ Weekly ☐ Twice a month
☐ Every two weeks
☐ Monthly ☐ Yearly
☐ Not regularly (for example, if this person works under a contract)
☐ Other _____

**2. Name *(first, middle, last & suffix):***

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program? ☐ Yes ☐ No

If no, does this person qualify to get these services? ☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

How much income? $

How often?
☐ Weekly ☐ Twice a month
☐ Every two weeks
☐ Monthly ☐ Yearly
☐ Not regularly (for example, if this person works under a contract)
☐ Other _____

## Appendix C - Renewal

## Complete ONLY if you are choosing someone to help with your application

►An authorized representative is a trusted friend, partner, or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.
►If we have an authorized representative on file for you, their information is shown below in section one. Review the information. Write in any changes to the information.
►If you want to name an authorized representative, complete section 2 below. Make a copy of this page if you need additional space or if you need to add an additional authorized representative.

1. If you have an authorized representative on file, their name is shown below. Complete this section to confirm this information is still correct.

| We show this person is your authorized representative: | Do you still want this person to be your representative? ☐ Yes ☐ No<br>***If yes,*** has any information changed? ☐ Yes ☐ No |
|---|---|

2. If your authorized representative's information has changed, or if you would like to name a new or different authorized representative, write in the information below.

Name of authorized representative and/or organization:

Address: City State Zip code

Phone number: Phone Type: ☐ Home ☐ Cell ☐ Work ☐ Other

Relationship to Applicant:

Please indicate the duties that you would like to authorize for this person.

☐ Apply for benefits ☐ Receive benefits ☐ Receive letters regarding actions taken on your case
☐ Receive requests for information needed to determine eligibility
☐ Other:

| **Your Signature (person applying or renewing for coverage):** | **Date**: |
|---|---|

**You can choose one Outreach Worker/Application Assister/Certified Application Counselor/ Navigator/Broker**

►Complete this section to authorize a certified application counselor/navigator/broker to be able to access confidential information related to your health coverage case.
►If we have a person/organization on file for you, the information name is shown below. If you want to add/change your certified application counselor /navigator/broker, write in the information below.

Outreach Worker/Application Assister/Certified Application Counselor/Navigator/Broker name and name of organization:

ID Number (if applicable):
Do you still want this person to be your Outreach Worker/Application Assister/Certified Application Counselor/Navigator/Broker? ☐ Yes ☐ No If yes, has any information changed? ☐ Yes ☐ No
Write in any new information below:

## Appendix D - Renewal

## Complete ONLY for someone who is now applying for health coverage from Virginia Medicaid or whose circumstances may have changed.

**Section 1:**

- Fill out this page for people who are listed in Section 3 who are **applying for Medicaid or whose circumstances have changed.**
- Make a copy first if you need space for more people.

**Tell us about this person's citizenship or immigration status.**

**Name** *(first, middle, last & suffix)*

**Date of Birth:** **Social Security Number:**

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No ***If yes,*** go to number 2. ***If no,*** answer all of the questions below.

| Document type | Alien or I-94 number | Card or foreign passport number |
|---|---|---|
| | | |

**Visit www.coverva.org for more information about eligible immigration status and document types.**

☐ Check here if this person has arrived in the U.S. before 1996.
☐ Check here if this person, their spouse, or parent is a veteran or active duty member in the U.S. military.

**2. Tell us more about this person.**

☐ Check here if this person lives with and is the main person taking care of a child under the age of 19.
☐ Check here if this person wants help paying for medical bills from the last three months.
☐ Check here is this person was in foster care at age 18 or older and had Medicaid health coverage.

If this person is Hispanic/Latino, check all that apply. *You do not have to answer this question to be eligible for Medicaid.*

☐ Chincano/a
☐ Cuban
☐ Mexican
☐ Mexican American
☐ Puerto Rican
☐ Non-Hispanic/Uknown

What is this person's race? Check all that apply. *You may choose not to answer this question. You do not have to answer this question to be eligible for Medicaid.*

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Filipino
☐ Japanese
☐ Native Hawaiian
☐ Other Asian
☐ Samoan
☐ White
☐ Black or African American
☐ Chinese
☐ Guamanian or Chamorro
☐ Korean
☐ Other Pacific Islander
☐ Vietnamese

**STOP! Continue to Section 2 ONLY if someone in your household who is 65 or older, blind, or disabled**.

**Section 2: Complete ONLY if someone in your household who is 65 or older, blind, or disabled.**

**1. Person's Name**

**2. What resources does this person or their spouse have? Resources include things like checking/savings accounts, stocks, bonds, life insurance, and retirement funds.**

| Resource | Amount |
|---|---|
| | $ |
| | $ |
| | $ |
| | $ |

**STOP! Continue to Section 3 ONLY if someone in your home is receiving care in a nursing facility or in the home by a medical professional.**

**Section 3: Complete ONLY for someone in your household who is in a nursing facility or receiving nursing care in the home.**

Name of the nursing facility, state institution, or community-based care provider:

If married or separated, spouse's name: Name *(first, middle, last & suffix):*

**Does this person's spouse have any home expenses? If yes, tell us below.**

Rent/Mortgage: $_____ Utilities ☐ Yes ☐ No

Homeowner's/Renter's Insurance: $ _____ Real Estate Taxes: $ _____

Maintenance Charges for Condominium: $ _____

**Does this person's dependent(s) have any income? If yes, tell us below.**

Social Security: $ _____ Social Security Income: $ _____

Civil Service: $ _____ Veterans Administration: $ _____

Retirement/Pension: $ _____ Disability: $ _____

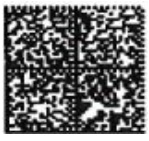
Wages: $ _____ Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.): $_____

**Has this person or their spouse transferred any real or personal property within the last year?**

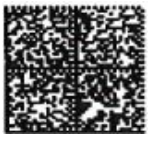
☐ No ☐ Yes ***If yes***, fill out below.

| Property Transferred | Value of Transfer | Date of Transfer |
|---|---|---|
| | $ | |

**Any household members who are 18 or older and not living with a parent or who are 21 and older and are now applying for coverage must also sign Section 7 of this renewal form.**



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



## Additional Information

# Voter registration & non-discrimination information

### Section I: Voter Registration

If you are not registered to vote where you live now, would you like to apply to register?

☐ Yes, I would like to apply to register to vote.

☐ No, I do not want to register to vote.

- IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency.
- If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.
- If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with:

**Secretary of the Virginia State Board of Elections**
**Washington Building**
**1100 Bank Street**
**Richmond, VA 23219-3497**
**804-864-8901**

To register to vote visit: https://vote.elections.virginia.gov or call or go to your local agency to request a paper voter registration form. If you need help completing the form, visit your local agency.

**It is important we treat you fairly.**

We will keep your information secure and private.

This agency complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This agency does not exclude people or treat them differently because of race, national origin, age, disability, or sex. If you believe that this agency has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: Civil Rights Coordinator, DMAS 600 E. Broad St. Richmond, VA 23219, Telephone: (804) 786-7933 (TTY: 1-800-343-0634).

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://hhs.gov/ocr/office/file/index.html.