**Itasca Medical Care**

**We are your local County health plan**

# Member Handbook

## Minnesota Senior Care Plus (MSC+)

### January 1, 2018

The Evidence of Coverage (EOC) or Enrollee Handbook is now referred to as the Member Handbook.

This booklet contains important information about your health care services.



**Itasca Medical Care (IMCare)**

1219 SE 2nd Avenue

Grand Rapids, MN 55744

**Member Services:**
218-327-6188
1-800-843-9536 (toll free)

**TTY/TDD users call:**
1-800-627-3529 or 711 (toll free)

**Website:**
www.imcre.org

**Hours:**
Monday - Friday
8 a.m. - 8 p.m.

IMCare

DHS Approved 01/10/2018

1-800-843-9536

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်ဓိတခါအံၤနူဉ်, ကိးဘဉ်လီတဲစီနီၵံၢ်လၢထးအံၤနူဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 언락하십시오.

ໂປຣດຊາບ, ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

**Civil Rights Notice**

**Discrimination is against the law**. Itasca Medical Care does not discriminate on the basis of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

**Auxiliary Aids and Services.** Itasca Medical Care provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in our health care programs. **Contact** Itasca Medical Care at 218-327-6188 or toll-free 1-800-843-9536 for more information.

**Language Assistance Services.** Itasca Medical Care provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** Itasca Medical Care at 218-327-6188 or toll-free 1-800-843-9536 for more information.

**Civil Rights Complaints**

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human service agency. You may contact any of the following three agencies directly to file a discrimination complaint.

**U.S. Department of Health and Human Services' Office for Civil Rights (OCR)**

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Age
- Disability
- Sex (including sex stereotypes and gender identity)

Contact the OCR directly to file a complaint:

Director, U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (Voice)
800-537-7697 (TDD)
Complaint Portal – *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*

**Minnesota Department of Human Rights (MDHR)**

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Religion
- Creed
- Sex
- Sexual Orientation
- Marital Status
- Public Assistance Status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (Fax)
Info.MDHR@state.mn.us (Email)

**Minnesota Department of Human Services (DHS)**

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have a right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome period. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administration actions.

Contact **DHS** directly to file a discrimination complaint:
ATTN: Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

**Itasca Medical Care**

You have the right to file a complaint with Itasca Medical Care (IMCare) if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

You have the right to file a complaint with IMCare or IMCare Classic if you believe you have been discriminated against because of any of the items listed above. You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

ATTN: Leah Huso, Compliance Coordinator
Itasca Medical Care (IMCare)
1219 SE 2nd Ave
Grand Rapids, MN 55744-3983
218-327-6183 (voice)
1-800-843-9536 (toll free) ext.2183
711 or 800-627-3529 (MN Relay)
218-327-5545 (Fax)
Email: imcareoffice@co.itasca.mn.us

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

# Table of Contents

**Welcome to IMCare**

We are pleased to welcome you as a member of IMCare's MSC+ product (referred to as "Plan" or "the Plan").

IMCare (referred to as "we," "us," or "our") is part of the Minnesota Senior Care Plus (MSC+) program. We coordinate and cover your medical services. You will get most of your health services through the Plan's network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which doctor/qualified health care provider to see.

This Member Handbook, together with any amendments that we may send to you, is our contract with you. It is an important legal document. Please keep it in a safe place.

This Member Handbook includes:

- Contact information
- Information on how to get the care you need
- Your rights and responsibilities as a member of the Plan
- Information about cost sharing
- A listing of covered and non-covered health care services
- When to call your county worker
- Using the Plan coverage with other insurance or other sources of payment
- Information on what to do if you have a grievance (complaint) or want to appeal a Plan action, as defined in section 13
- Definitions

The counties in the Plan service area are as follows: Itasca County

Please tell us how we're doing. You can call, email, or write to us at any time. (Section 1 of this Member Handbook tells how to contact us.) Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with us. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

# Section 1. Telephone Numbers and Contact Information

**How to contact our Member Services**

If you have any questions or concerns, please call, or write to Member Services. We will be happy to help you. Member Services' hours of service are Monday through Friday from 8:00 a.m. to 8:00 p.m.

CALL: 218-327-6188 or toll free 1-800-843-9536
TTY/TDD: 1-800-627-3529, or 711
FAX: 218-327-5545
WRITE: Itasca Medical Care (IMCare)
1219 SE 2nd Avenue
Grand Rapids, MN 55744
WEBSITE: www.imcare.org

**Our Plan contact information for certain services**

Appeals and Grievances ..... 218-327-6183
See Section 13 for more information.

Chiropractic Services ..... 218-327-6188

Dental Services ..... 218-327-6188

Home and Community Based Services (Elderly Waiver) ..... 218-327-6188

Interpreter Services – American Sign Language (ASL) or Spoken Language ..... 218-327-6188

Quality Assurance Nurses one for the following services by member last name:

- Durable Medical Equipment Coverage Criteria
- Health Questions Phone Line
- Mental Health/Behavioral Health Services
- Prescriptions

Last Name ..... A-F ..... 218-327-5591
Last Name ..... G-K ..... 218-327-5519
Last Name ..... L-R ..... 218-327-6754
Last Name ..... S-Z ..... 218-327-6728

Substance Use Disorder Services ..... 218-327-6188
North Homes ..... 218-327-3000
Northland Recovery Center ..... 218-327-1105
Rapids Counseling Center ..... 218-327-2001

Transportation – Call Rapid Transit ..... 218-327-3365 or 1-877-615-0334

**Other important contact information**

People with hearing loss or a speech disability may call the following numbers to access the resources listed in this Member Handbook: 711, Minnesota Relay Service at 1-800-627-3529 (TTY/TDD, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service). Calls to these numbers are free.

For information and to learn more about health care directives and how to exercise an advance directive, please contact IMCare Member Services at 218-327 6188 or toll free 1-800-843-9536. You may also visit the Minnesota Department of Health (MDH) website at:
http://www.health.state.mn.us/divs/fpc/profinfo/advdir.htm

To Report Fraud and Abuse contact IMCare Compliance Coordinator at 218-327-6766 or toll free 1-800-843-9536. To report fraud or abuse directly to the State, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at (651) 431-2650 or 1-(800)-657-3750; by fax at (651) 431-7569; or by email at DHS.SIRS@state.mn.us.

**Minnesota Department of Human Services**

The Minnesota Department of Human Services (DHS) is a state agency that helps people meet their basic needs. It provides or administers health care, financial help, and other services. DHS administers the Medical Assistance program through counties. If you have questions about your eligibility for Medical Assistance, contact your county worker.

**Ombudsman for Public Managed Health Care Programs**

The Ombudsman for Public Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving service and billing problems. They can help you file a grievance or appeal with us. The ombudsman can also help you request a state fair hearing. Call toll free 1-800-657-3729 (non-metro) or 651-431-2660 (Twin Cities metro area) or 711 (TTY/TDD).

**Office of Ombudsman for Long-Term Care**

Contact the Office of Ombudsman for Long-Term Care for assistance with concerns about nursing homes, boarding care homes, adult care homes (i.e., housing with services, assisted living, customized living, or foster care), home care services, and hospital access or discharge for people with Medicare. Call 651-431-2555 or 1-800-657-3591 (toll free).

**How to contact the Medicare program**

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage Organizations including us.

Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY/TDD users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.

Visit www.medicare.gov. This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Phone Numbers and Websites."

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

**Senior LinkAge Line®**

The Senior LinkAge Line® is a state program that gives free help, information, and answers to your questions about Medicare**.** The Senior LinkAge Line® is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Senior LinkAge Line® counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Senior LinkAge Line® counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

You may contact the Senior LinkAge Line® at 1-800-333-2433 or write to them at Minnesota Board on Aging, P.O. Box 64976, St. Paul, MN 55164-0976. You may also find the Web site for the Senior LinkAge Line® at www.minnesotahelp.info.

# Section 2. Important information on getting the care you need

Each time you get health services, check to be sure that the provider is a Plan network provider. In most cases, you need to use Plan network providers to get your services. Members have access to a Provider Directory that lists Plan network providers. It is current as of the date it is printed. To verify current information, you can call the provider, call Member Services at the phone number in Section 1, or visit our website listed in Section 1.

You chose or have been assigned to a Plan network doctor/qualified health care provider or clinic. You may change your Primary Care Provider (PCP) for any reason, at any time. Also, it is possible that your PCP might leave our plan's network. We can help you find a new PCP. Call Member Services at the phone number in Section 1.

The name of the doctor/qualified health care provider or clinic you must go to is on your Plan member card. This is your primary care clinic. The clinic's phone number is also on your member card. We encourage you to consult with your primary care clinic for health services.

Your primary care clinic or doctor/qualified health care provider will arrange most of your medical care. It is important that one doctor/qualified health care provider knows about all your medical needs. The doctor/qualified health care provider can make sure you get the care you need.

Your clinic or doctor/qualified health care provider will refer you to other doctors or qualified health care providers when needed.

Contact your primary care clinic for information about the clinic's hours, referrals, prior authorizations, and to make an appointment. If you cannot go to your appointment, call your clinic right away.

You may change your primary care provider or clinic. To find out how to do this, call Member Services at the phone number in Section 1.

**Transition of Care:**

If you are a newly enrolled member who is currently receiving care from a provider who is not a Plan network provider, we will help you transition to a network provider.

**Prior Authorizations and referrals:**

Our approval is needed for some services to be covered. This is called prior authorization. The approval must be obtained before you get the services or before we pay for them. Many of these services are noted in Section 7. For more information, call Member Services at the phone number in Section 1.

Some services are only covered when you get a referral. A referral is written consent from your primary care doctor /qualified health care provider or clinic that you need to get before you see certain providers, such as specialists, for covered services. Get the referral before you see the provider.

Almost all health services must be approved by your primary care clinic. Exceptions to this rule are:

- Dental, routine vision care, chiropractic care, and obstetrics and gynecology services. You must get these services from providers in our network.
- Open access services: family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for acquired immune deficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related conditions are open access services. You can go to any doctor/qualified health care provider, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.

- For substance use disorder services, call the phone number listed in Section 1.

- For mental health services, call the phone number listed in Section 1.

- Emergency and post stabilization care: If you get emergency care from a provider not in the Plan network, you must follow some rules. See Section 7. It tells you what emergency care is covered. It also tells you the rules.

For more information, call Member Services at the phone number listed in Section 1.

A written referral may be for one visit or it may be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of the following conditions:

- A chronic (on-going) condition

- A life-threatening mental or physical illness

- A pregnancy that is beyond the first three months (first trimester)

- A degenerative disease or disability

- Any other condition or disease that is serious or complex enough to require treatment by a specialist

**If you do not get a written referral when needed, the bill may not be paid**. For more information, call Member Services at the phone number in Section 1.

If a provider you choose is no longer in our Plan network, you must choose another Plan network provider. You may be able to continue to use services from a provider no longer a part of our Plan network for up to 120 days for the following reasons:

- An acute condition

- A life-threatening mental or physical illness

- A pregnancy that is beyond the first three months (first trimester)

- A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.

- A disabling or chronic condition that is in an acute phase

If your doctor/qualified health care provider certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

For more information, call Member Services at the phone number in Section 1.

At IMCare, we have staff who can help you figure out the best way to use health care services. If you have questions about things like where to get services, getting authorization for services or restrictions on prescription drugs, we can help. Call us at 218-327-6188 between 8:00 a.m. and 8:00 p.m. If you need language assistance to talk about these issues, IMCare can get help in your language through an interpreter. For sign language services, call Minnesota Relay Service at 1-800-627-3529 (TTY/TDD, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service). For other language assistance, call 218-327-6188.

**Covered and non-covered services:**

Enrollment in the Plan does not guarantee that certain items are covered. Some prescription drugs or medical equipment may not be covered. This is true even if they were covered before.

Some services and supplies are not covered. All health services must be medically necessary for them to be covered services. Read this Member Handbook carefully. It lists many services and supplies that are not covered. See Sections 7 and 8.

Some services are not covered under the Plan, but may be covered through another source. See Section 9 for more information. If you are not sure whether a service is covered, call our Member Services at the phone number in Section 1.

We may cover additional or substitute services under some conditions.

**Cost sharing:**

You may be required to contribute an amount toward some medical services. This is called cost sharing. You are responsible to pay your cost sharing amount to your provider. See Section 6 for more information.

**Payments to providers:**

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. If you paid for a service that you think we should have covered, call Member Services.

You may get health services or supplies not covered by the Plan if you agree to pay for them. Providers must have you sign a form acknowledging that you will be responsible for the bill. Providers must have a signed form before providing services or supplies that are not covered by the Plan.

**Interpreter services:**

We will provide interpreter services to help you access services. This includes spoken language interpreters and American Sign Language (ASL) interpreters. Face-to-face oral language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. Please call Member Services at the phone number in Section 1 to find out which interpreters you can use.

**Home and Community Based Services:**

If you need certain services to help you live in the community, see Home and Community Based Services in Section 7 for information on Elderly Waiver services.

**Other health insurance:**

If you have other health or dental insurance, tell us **before** you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate with your other insurance plan. If your other health or dental insurance changes, tell your county worker.

If you have Medicare, you need to get most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services. The Plan does not pay for prescriptions that are covered under the Medicare Prescription Drug Program.

**Private information:**

We, and the health care providers who take care of you, have the right to see information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

**Restricted Recipient Program:**

The Restricted Recipient Program is for members who have misused health services. This includes getting health services that members did not need or using them in a way that costs more than they should. If you are placed in this program, we may replace your regular Plan member card with a Restricted Recipient Program card.

You must get health services from one designated primary care provider, one pharmacy, one hospital, or other designated health services providers. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options, or consumer directed services.

You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your primary care provider and received by the Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to see a non-designated provider who is the same provider type as one of their designated providers.

Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.

At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. See Section 13.

**Cancellation:**

Your coverage with us will be canceled if you are not eligible for Medical Assistance or if you enroll in a different health plan.

If you are no longer eligible for Medical Assistance, you may be eligible to purchase health coverage through MNsure. For information about MNsure, call toll free 1-855-3MNSURE or 1-855-366-7873, or visit www.MNsure.org.

# Section 3. Member Bill of Rights

**You have the right to:**

Get the services you need 24 hours a day, seven days a week. This includes emergencies.

Be told about your health problems.

Get information about treatments, your treatment choices, and how they will help or harm you.

Refuse treatment and get information about what might happen if you refuse treatment.

Refuse care from specific providers.

Know that we will keep your records private according to law.

File a grievance or appeal with us. You can also file a complaint with the Minnesota Department of Health.

Request a state appeal (state fair hearing) with the Minnesota Department of Human Services (also referred to as "the state"). You must appeal to us before you request a state appeal (state fair hearing). If we take more than 30 days to decide your plan appeal, and we have not asked for an extension, you do not need to wait for our decision to ask for a state appeal (state fair hearing).

Receive a clear explanation of covered nursing home and home care services.

Request and receive a copy of your medical records. You also have the right to ask to correct the records.

Get notice of our decisions if we deny, reduce, or stop a service, or deny payment for a service.

Participate with providers in making decisions about your health care.

Be treated with respect, dignity, and consideration for privacy.

Give written instructions that inform others of your wishes about your health care. This is called a "health care directive." It allows you to name a person (agent) to decide for you if you are unable to decide, or if you want someone else to decide for you.

Be free of restraints or seclusion used as a means of: coercion, discipline, convenience, or retaliation.

Choose where you will get family planning services, diagnosis of infertility, sexually transmitted disease testing and treatment services, and AIDS and HIV testing services.

Get a second opinion for medical, mental health, and substance use disorder services.

Request a copy of this Member Handbook at least once a year.

Get the following information from us, if you ask for it. Call Member Services at the phone number in Section 1.

- Whether we use a physician incentive plan that affects the use of referral services, and details about the plan if we use one.
- Results of an external quality review study from the state
- Make recommendations about our rights and responsibilities policy.
- Exercise the rights listed here.

# Section 4. Member Responsibilities

**You have the responsibility to:**

Read this Member Handbook and know which services are covered under the Plan and how to get them.

Show your health plan member card and your Minnesota Health Care Program (ID) card every time you get health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Establish a relationship with a Plan network primary care doctor/qualified health care provider before you become ill. This helps you and your primary care doctor/qualified health care provider understand your total health condition.

Give information asked for by your doctor/qualified health care provider and/or health plan so the right care or services can be provided to you. Share information about your health history.

Work with your doctor/qualified health care provider to understand your total health condition. Develop mutually agreed-upon treatment goals when possible. If you have questions about your care, ask your doctor/qualified health care provider.

Know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.

Practice preventive health care. Have tests, exams and shots recommended for you based on your age and gender.

**Contact us if you have any questions, concerns, problems or suggestions. Call Member Services at the phone number in Section 1.**

# Section 5. Your Health Plan Member ID Card

Each member will receive a Plan member card.

Always carry your Plan member card with you.

You must show your Plan member card whenever you get health care.

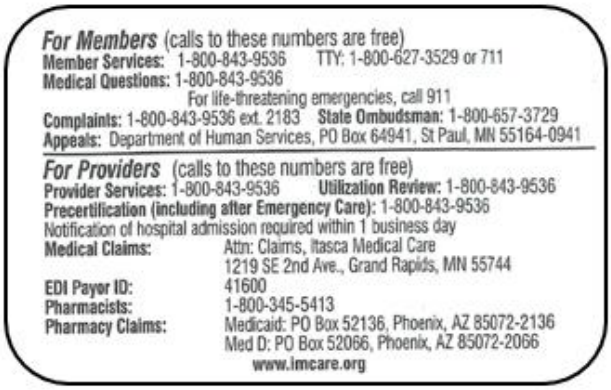
You must use your Plan member card along with your Minnesota Health Care Program (ID) card. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Call Member Services at the phone number in Section 1 right away if your member card is lost or stolen. We will send you a new card.

Call your county worker if your Minnesota Health Care Program (ID) card is lost or stolen.

Here is a sample Plan member card to show what it looks like:


FRONT OF CARD




BACK OF CARD

# Section 6. Cost Sharing

Cost sharing refers to your responsibility to pay an amount towards your medical costs. For people in the Minnesota Senior Care Plus program, cost sharing consists only of copays.

If your income is at or below 100 percent of federal poverty guidelines, you will pay no more than five percent of your monthly family income for cost sharing. This may reduce the copay and deductible amount to less than the amounts listed here. DHS will tell us each month if you have a reduced cost sharing amount.

## Copays

The members listed here **do not** have to pay copays for medical services that are covered by Medical Assistance (MA) under the Plan:

- Members receiving hospice care
- Members residing in a nursing home, hospital, or other long-term care facility for more than 30 days
- American Indians who receive or have received a service(s) from an Indian Health Care Provider, or through Indian Health Service Contract Health Services (IHS CHS) referral from an IHS facility

Copays are listed in the following chart:

| Service | Copay Amount |
|---|---|
| Non-preventive visits – (such as visits for a sore throat, diabetes checkup, high fever, sore back, etc.) provided by a physician, physician assistant, advanced practice nurse, certified professional midwife, chiropractor, acupuncturist, podiatrist, audiologist, or eye doctor. There are no copays for mental health services. | $3.00 |
| Diagnostic procedures (for example, endoscopy, arthroscopy) | $3.00 |
| Emergency room visit when it is not an emergency | $3.50 |
| Brand name prescriptions<br>*The most you will have to pay in copays for prescriptions is $12.00 per month.* | $3.00 |
| Generic prescriptions<br>*The most you will have to pay in copays for prescriptions is $12.00 per month.* | $1.00 |

The most you will have to pay in copays for prescriptions is $12.00 per month. Copays will not be charged for some mental health drugs and most family planning drugs.

If you have Medicare, you must get most of your prescription drugs through a Medicare Prescription Drug Program (Medicare Part D) plan. You may have different copays with no monthly limit for some of these services.

You must pay your copay directly to your provider. Some providers require that you pay the copay when you arrive for the medical service. The hospital may bill you after your non-emergency visit to the emergency room.

If you are unable to pay the copay, the provider must still provide services. This is true even if you have not paid your copay to that provider in the past or if you have other debts to that provider. The provider may still bill you for the unpaid copays.

We get information from the state about which members do not have copays. You may need to pay a copay until you are listed in our system as a person who is exempt from copays.

Examples of services that **do not** have copays:

- Dental services
- Emergency services
- Eye glasses
- Family planning services and supplies
- Home care
- Immunizations
- Inpatient hospital stays
- Interpreter services
- Medical equipment and supplies
- Medical transportation
- Mental health services
- Preventive care visits, such as physicals
- Rehabilitation therapies
- Repair of eyeglasses
- Services covered by Medicare, except for Medicare Part D drugs
- Some mental health drugs (anti-psychotics)
- Some preventive screenings and counseling, such as cervical cancer screening and nutritional counseling
- Substance Use Disorder treatment
- Tests such as blood work and X-rays
- Tobacco use counseling and interventions
- 100% federally funded services at Indian Health Services clinics

This is not a complete list. Call Member Services at the phone number in Section 1 if you have questions.

# Section 7. Covered Services

This section describes the major services that are covered under the Plan for Minnesota Senior Care Plus (MSC+) members. It is not a complete list of covered services. Some services have limitations. Some services require a referral or prior authorization. A service marked with an asterisk (*) means a referral or prior authorization is required or may be required. Make sure there is a referral or prior authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Call Member Services at the phone number in Section 1 for more information.

Some services require cost sharing. Cost sharing refers to your responsibility to pay an amount toward your medical costs. See Section 6 for information about cost sharing and exceptions to cost sharing.

## Chiropractic Care

**Covered Services:**

- One evaluation or exam per year
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine - up to 24 visits per calendar year. Visits exceeding 24 require a prior authorization.
- Acupuncture for pain and other specific conditions within the scope of practice by chiropractors with acupuncture training or credentialing
- X-rays when needed to support a diagnosis of subluxation of the spine

**Not Covered Services:**

- Other adjustments, vitamins, medical supplies, therapies and equipment from a chiropractor

## Dental Services

**Covered Services:**

- Diagnostic services:
  - comprehensive exam *(once every five years)*
  - periodic exam (*once per calendar year)*
  - limited (problem-focused) exams *(once per day per provider )*
  - Teledentistry for diagnostic services
  - x-rays, limited to:
    - bitewing *(once per calendar year)*
    - single x-rays for diagnosis of problems
    - panoramic *(once every five years and as medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma; once every two years in limited situations)*
    - full mouth x-rays *(once every five years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center [ASC]*
- Preventive services:
  - cleaning *(up to four times per year if medically necessary)*
  - fluoride varnish *(once per calendar year)*

- Restorative services:
  - fillings
  - sedative fillings for relief of pain
- Endodontics (root canals) *(on anterior teeth and premolars only and once per tooth per lifetime; retreatment is not covered)*
- Periodontics*:
  - gross removal of plaque and tartar (full mouth debridement) *(once every five years)*
  - scaling and root planing *(once every two years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center [ASC]*
- Prosthodontics:
  - removable prostheses (dentures and partials) *(once every six years per dental arch)*
  - relines, repairs, and rebases of removable prostheses (dentures and partials)
  - replacement of prosthesis that are lost, stolen, or damaged beyond repair under certain circumstances
  - Replacement of partial prostheses if the existing partial cannot be altered to meet dental needs
- Oral surgery *(limited to extractions, biopsies, and incision and drainage of abscesses)*
- Additional general dental services:
  - treatment for pain *(once per day)*
  - general anesthesia *(only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center [ASC]*
  - extended care facility/house call in certain institutional settings. These include: nursing facilities, skilled nursing facilities, boarding care homes, Institutes of Mental Disease/Mental Illness (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities(ICF/DDs) Hospices, Minnesota Extended Treatment Options(METO), and swing beds (a nursing facility bed in a hospital)
  - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
  - oral or IV sedation – Only if covered dental service cannot be performed safely without it or would otherwise require a service to be performed under general anesthesia in a hospital or surgical center.

**Notes:**

See Section 1 for Dental Services contact information.

**<u>Diagnostic Services</u>**

**Covered Services:**

- Lab tests and X-rays
- Other medical diagnostic tests ordered by your doctor/qualified health care provider

## Doctor and Other Health Services

**Covered Services:**

- Doctor visits including:
  - care for pregnant women
  - family planning – **open access service**
  - lab tests and x-rays
  - physical exams
  - preventive exams
  - preventive office visits
  - specialists* (Requires a prior authorization if out of Plan network)
  - telemedicine consultation
  - vaccines and drugs administered in a doctor's/qualified health care provider's office
  - visits for illness or injury
  - visits in the hospital or nursing home
- Immunizations
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Clinical trial coverage: Routine care that is: 1) provided as part of the Protocol Treatment of a cancer Clinical Trial; 2) is usual, customary and appropriate to your condition; and 3) would be typically provided outside of a Clinical Trial. This includes services and items needed for the treatment of effects and complications of the Protocol Treatment.
- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Community health worker care coordination and patient education services
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Blood and blood products
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Tuberculosis care management and direct observation of drug intake
- Counseling and testing for sexually transmitted diseases (STDS), AIDS and other HIV-related conditions - **open access service**
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must see a provider in the Plan network.
- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Acupuncture for certain populations, for pain and other specific conditions, by licensed acupuncturist or within the scope of practice by a licensed provider with acupuncture training or credentialing.
- Respiratory therapy
- Hospital In-reach Community-based Service Coordination: coordination of services targeted at reducing hospital emergency room use under certain circumstances. This service addresses health,

social, economic, and other needs of members to help reduce usage of ED and other health care services.
- Behavioral Health Home: Coordination of behavioral and physical health services
- Treatment of End Stage Renal Disease (ESRD)
- Clinical Services
- Specialty Care
- Community Paramedic Services: certain services provided by a community paramedic. The services are provided by community paramedic. The services must be part of a care plan by your primary care provider. The services may include:
    - health assessments
    - chronic disease monitoring and education
    - help with medications
    - immunizations and vaccinations
    - collecting lab specimens
    - follow-up care after being treated at a hospital
    - other minor medical procedures.
- Community Medical Emergency Technician (CMET) services
- Post-hospital discharge visits ordered by your primary care provider
- Safety evaluation visits ordered by Primary Care Provider (PCP)

**Not Covered Services:**

- Artificial ways to become pregnant (artificial insemination, including in-vitro fertilization and related services, fertility drugs and related services)

**<u>Emergency Medical Services and Post-Stabilization Care</u>**

**Covered Services:**

- Emergency room services
- Post-stabilization care
- Ambulance (air or ground includes transport on water)

**Not Covered Services:**

Emergency, urgent, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

**Notes:**
In an emergency that needs treatment right away, either call 911 or go to the closest emergency room. Show them your member card and ask them to call your primary care doctor/qualified health care provider.

In all other cases, call your primary care doctor/qualified health care provider, if possible. The clinic's phone number is also on your member card. You can call the number 24 hours a day, seven days a week and get instructions about what to do.

If you are out of town, go to the closest emergency room. Show them your member card and ask them to call your primary care doctor/qualified health care provider.

You must call your primary care clinic/qualified health care provider or Member Services within 48 hours or as soon as you can after getting emergency care at a hospital that is not a part of the Plan network.

## Eye Care Services

**Covered Services:**

- Eye exams
- Eyeglasses, including identical replacement for loss, theft, or damage beyond repair
- Repairs to frames and lenses for eyeglasses covered under the Plan
- Tinted, photochromatic (for example, Transition ® lenses) or polarized lenses, when medically necessary
- Contact lenses, when medically necessary under certain conditions

**Not Covered Services:**

- Extra pair of glasses
- Eyeglasses more often than every 24 months, unless medically necessary
- Progressive bifocal/trifocal lenses (without lines)
- Protective coating for plastic lenses
- Contact lens supplies

## Family Planning Services

**Covered Services:**

- Family planning exam and medical treatment – **open access service**
- Family planning lab and diagnostic tests – **open access service**
- Family planning methods (e.g. birth control pills, patch, ring, IUD, injections, implants) – **open access service**
- Family planning supplies with prescription (e.g. condom, sponge, foam, film, diaphragm, cap) – **open access service**
- Counseling and diagnosis of infertility, including related services – **open access service**
- Treatment for medical conditions of infertility – **NOT** an open access service. You must see a provider in the Plan network. Note: This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS, and other HIV-related conditions – **open access service**
- Treatment for sexually transmitted diseases (STDs) - **open access service**
- Voluntary sterilization – **open access service**
  **Note:** You must be age 21 or over and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.

- Genetic counseling - **open access service**
- Genetic testing* – **NOT** an open access service**.** You must see a provider in the Plan network.
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must see a provider in the Plan network.

**Not Covered Services:**

- Artificial ways to become pregnant (artificial insemination, including in-vitro fertilization and related services; fertility drugs and related services)
- Reversal of voluntary sterilization
- Sterilization of someone under conservatorship/guardianship

**Notes:**

Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency to get **open access services**. You can get open access services from any provider, even if they are not in the Plan network.

## Hearing Aids

**Covered Services:**

- Hearing aid batteries
- Hearing aids
- Repair and replacement of hearing aids due to normal wear and tear, with limits

## Home Care Services*

**Covered Services:**

- Skilled nurse visits*
- Rehabilitation therapies to restore function (for example, speech, physical, occupational)
- Home health aide visit *
- Home Care Nursing (HCN) *
- Personal Care Assistant (PCA). Community First Services and Supports (CFSS) replaces PCA services upon federal approval *

## Home and Community Based Services (Elderly Waiver)

**Covered Services:**
The plan will pay for the following services for individuals eligible to get Elderly Waiver (EW) services:

- Adult Day Services (ADS): Health and social services given on a regular basis in a licensed setting.
- Adult Foster Care: A home that provides care in a family-like setting.
- Case Management: Management of your health and long-term care services among different health and social service workers.

- Chore Services: Services needed to keep your home clean and safe.
- Companion Services: Non-medical social support services for members who need supervision.
- Consumer Directed Community Support Services: Services that you manage yourself within a set budget.
- Customized Living/24 Hour Customized Living: A group of services given in an assisted living setting.
- Environmental Accessibility Adaptations: Physical changes to your home and vehicle needed to assure health and safety.
- Extended State Plan Home Health Care Services: This includes home health aide services that are over the Medical Assistance (Medicaid) limit.
- Extended State Plan Home Care Nursing: This includes home care nursing services that are over the Medical Assistance (Medicaid) limit.
- Extended State Plan Personal Care Assistance Services: Help with personal care and activities of daily living over the Medical Assistance (Medicaid) limit.
- Family and Care Giver Training and Education: Training for unpaid caregivers. This includes coaching and counseling – individualized support for caregivers.
- Family Memory Care: coaching counseling service for caregivers living with a family member or friend with dementia. This also includes assessment.
- Home Delivered Meals: Meals delivered to your home.
- Homemaker Services: General household activities to keep up the home.
- Individual Community Living Support Services.
- Residential Care Services: A group of services offered in a licensed board and lodge setting.
- Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief.
- Specialized Medical Supplies and Equipment: Supplies and equipment that are over the Medical Assistance limit or coverage.
- Transitional Supports Services: One-time costs related to setting up a household (such as when a person leaves a nursing home).
- Transportation: A ride to activities and services in the community.

**NOTES:**
You must have a Long Term Care Consultation (LTCC) done and be found to be nursing home certifiable to get these Elderly Waiver (EW) services. You can request to have this assessment in your home, apartment, or facility where you live. Your MSC+ care coordinator will meet with you and your family to talk about your care needs within 15 days if you call to ask for a visit.

Your MSC+ care coordinator will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility.

You have the right to have friends or family present at the visit. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can choose who you want to provide the services and supports from those providers available from our plan's network.

After the visit, your MSC+ care coordinator will send you a letter that recommends services that best meet your needs. You will be sent a copy of the service or care plan you helped put together. Your MSC+ care coordinator will help you file an appeal if you disagree with suggested services or were informed you may not qualify for these services.

People who live on the White Earth, Leech Lake or Fond du Lac Reservations can choose to get their EW services through the White Earth, Leech Lake or Fond du Lac tribal services or through our Plan. Contact your tribe or our Plan if you have questions.

If you are currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver your county case manager will coordinate with your MSC+ care coordinator. If you need transition planning and coordination services to help you move to the community, you may be eligible to get Moving Home Minnesota (MHM) services. MHM services are separate from EW services, but you must be eligible for EW.

If you are no longer eligible for EW services due to a level of care change, you may be eligible to get Essential Community Services.

See Home and Community Based Services in Section 1 for contact information.

## Hospice

### Covered Services

Hospice benefits include coverage for the following services, when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

**Medicare Election**

You must elect hospice benefits to receive hospice services.

If the recipient is both Medicare and Medicaid eligible, and elects hospice, he or she must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit recipients from choosing hospice care through one program and not the other when they are eligible for both.

If you are interested in using hospice services, please call Member Services at the phone number in Section 1.

## Hospital - Inpatient

**Covered Services:**

- Inpatient hospital stay
- Your semi-private room and meals
- Private room when medically necessary
- Tests and x-rays
- Surgery
- Drugs
- Medical supplies
- Therapy services (for example physical, occupational, speech, respiratory)

**Not Covered Services:**

- Personal comfort items, such as TV, phone, barber or beauty services, guest services

## Hospital – Outpatient

**Covered Services:**

- Urgent care for conditions that are not as serious as an emergency
- Outpatient surgical center
- Tests and x-rays
- Dialysis
- Emergency room services
- Post-stabilization care

**Note:**

*All out-of-network outpatient surgical centers and post stabilization care require a prior authorization.

## Interpreter Services

**Covered Services:**

- Spoken language interpreter services
- American Sign language (ASL) interpreter services

**Notes:**

Interpreter services are available to help you get services.

Spoken interpretation is available for any language.

Face-to-face oral language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. See Interpreter Services in Section 1 for contact information and to find out which interpreters you can use.

## Medical Equipment and Supplies

*(Requires a prior authorization for any nonstandard equipment or items over $1,000.)
If available, IMCare covers DME rental – NOT purchase. Members will not acquire ownership of rented DME items.

**Covered Services:**

- Prosthetics or orthotics
- Durable medical equipment (e.g., wheelchair, hospital bed, walker, crutches, and wigs for people with alopecia areata). Contact Member Services for more information on coverage and benefit limits for wigs.
- Repairs of medical equipment
- Batteries for medical equipment
- Some shoes when part of a leg brace or when custom molded
- Oxygen and oxygen equipment
- Medical supplies you need to take care of your illness, injury, or disability
- Diabetic equipment and supplies
- Nutritional/enteral products when specific criteria are met
- Incontinence products
- Family planning supplies – **open access service**. See Family Planning Services in this section.
- Augmentative communication devices, including electronic tablets

**Not Covered Services:**

- Constructive modifications to home, vehicle, or workplace, including bathroom grab bars
- Environmental products (such as air filters, purifiers, conditioners, dehumidifiers)
- Exercise equipment

**Notes:**

You need a prescription/doctor's/qualified health care provider's order in order for medical equipment and supplies to be covered.

Please call the durable medical equipment coverage criteria phone number in Section 1 if you need more information on our durable medical equipment coverage criteria.

## Mental Health/Behavioral Health Services

**Covered Services:**

- Clinical Care Consultation
- Crisis response services including:
  - Screening
  - Intervention
  - Stabilization
  - Community intervention
- Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorders
- Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP)*
- Inpatient hospital stay, including extended psychiatric inpatient hospital stay psychiatric
- Mental Health Provider travel time
- Mental Health Targeted Case Management (MH-TCM)
- Forensic Assertive Community Treatment (FACT)
- Telemedicine
- Outpatient Mental Health Services including:
  - Explanation of findings
  - Mental health medication management
  - Neuropsychological services*
  - Psychotherapy (patient and/or family, family, crisis, and group)
  - Psychological testing
- Physician Mental Health Services including:
  - Health and behavior assessment/intervention
  - Inpatient visits
  - Psychiatric consultations to primary care providers
  - Physician consultation, evaluation, and management
- Rehabilitative Mental Health Services including:
  - Assertive Community Treatment (ACT)
  - Adult day treatment
  - Adult Rehabilitative Mental Health Services (ARMHS)
  - Certified Peer Specialist (CPS) support services in limited situations
  - Intensive Residential Treatment Services (IRTS)
  - Partial Hospitalization Program (PHP)

**Not Covered Services:**

The following services are not covered under the Plan but may be available through your county. Call your county for information. Also see Section 9.

- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)

**Notes:**

See Mental Health Services in Section 1 for information on where you should call or write.

Use a Plan network provider for mental health services. Services obtained outside the Plan network will require prior authorization.

If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to go to any qualified health professional that is not in the Plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision.

We will not determine medical necessity for court-ordered mental health services. Use a Plan network provider for your court-ordered mental health assessment.

## Nursing Home Services

**Covered Services:**

- Nursing Home Daily Rate – We are responsible for paying a total of 180 days of nursing home room and board. If you need continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for your care. If DHS is currently paying for your care in the nursing home, DHS, not us, will continue to pay for your care.
- Nursing services
- Therapy services
- Drugs
- Medical supplies and equipment.

**Not Covered Services:**

- A private room, unless your doctor orders it for a medical reason
- Personal comfort items, such as TV, phone, barber or beauty services, guest services.

## Out-of-area Services

**Covered Services:**

- A service you need when temporarily out of the Plan service area*

- A service you need after you move from our service area while you are still a Plan member*
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- Medically necessary urgent care when you are outside of the Plan service area. (Call Member Services at the phone number in Section 1 as soon as possible.)
- Covered services that are not available in the Plan service area*

**Not Covered Services:**

- Emergency, urgent, or other health care services or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

**Out-of-network Services**

**Covered Services:**

- Certain services you need that you cannot get through a Plan network provider*
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- A second opinion for mental health and substance use disorder
- Open access services
- A Non-emergency medical service you need when temporarily out of the network or Plan service area that is or was prescribed, recommended, or is currently provided by a network provider

**Prescription Drugs (for members who do NOT have Medicare)**

**Covered Services:**

- Prescription drugs
- Medication therapy management (MTM) services
- Certain over-the-counter drugs *(when prescribed by a qualified health care provider with authority to prescribe*

**Not Covered Services:**

- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs or products to promote weight loss
- Drugs not clinically proven to be effective
- Experimental or investigational drugs

**Notes:**

The drug must be on our covered drug list (formulary).

The formulary includes the prescription drugs covered by IMCare. The drugs on the list are selected by the plan with the help of a team of doctors and pharmacists. The list has to be similar to the list covered by Medical Assistance (Medicaid). In addition to the prescription drugs covered by IMCare, some over-the-counter drugs are covered for you under your Medical Assistance (Medicaid) benefits. You can search for prescription drugs using our online search tool at www.imcare.org. A list of over-the-counter drugs is also posted on the website. You can also call Member Services and ask for a written copy of our *Formulary*.

There are limits or restrictions on coverage for some formulary drugs. These restrictions and limits may include:

- Prior Authorization: IMCare requires you or your healthcare provider to get our approval before the plan will cover certain drugs
- Quantity Limits: For certain drugs, IMCare limits the amount or dose of the drug that we will cover
- Step Therapy: In some cases, IMCare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition
- Brand name drugs with generic equivalents on our Formulary. IMCare may require you to try a generic version of formulary medication before covering the brand name version through a prior authorization. IMCare will require a drug authorization request for all Dispense as Written (DAW) medications in which there is a preferred generic equivalent on formulary.

You can get more information about the restrictions applied to specific covered drugs by visiting our website at www.imcare.org.

We will cover a non-formulary drug if your doctor/qualified health care provider shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your doctor/qualified health care provider is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.

We will cover an antipsychotic drug, even if it is not on our drug list, if your provider certifies this is best for you. There is no copay for anti-psychotic drugs. In certain cases, we will also cover other drugs used to treat a mental illness or emotional disturbance even if the drug is not on our approved drug list. We will do this for up to one year if your provider certifies the drug is best for you and you have been treated with the drug for 90 days before: 1) we removed the drug from our drug list; or 2) you enrolled in the Plan.

**For most drugs, you can get only a *34* day supply at one time.**

If IMCare does not cover your drug or has restrictions or limits on your drug that you don't think will work for you, you can do one of these things:

- You can ask your health care provider if there is another covered drug that will work for you.
- You and/or your health care provider can ask IMCare to make an "exception" and cover the drug for you or remove the restrictions or limits. If your exception request is approved, the drug will be covered at the appropriate generic or brand name copay level.

If your doctor/qualified health care provider prescribes a drug that is not on our formulary, you can ask for a formulary exception. The doctor must fill out an IMCare Non-Formulary Drug Request Form and route it to the IMCare office for approval before you can receive the drug.

If a pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor/qualified health care provider. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by us under the Plan. If the pharmacy won't call your doctor/qualified health care provider, you can. You can also call Member Services at the phone number in Section 1 for help.

Specialty drugs are prescribed to treat serious or chronic medical conditions such as multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. These drugs may be oral or injectable. They can be self-administered or administered by a family member. You can find a list of specialty drugs here: www.imcare.org.

We have a program for specialty drugs through a Specialty Pharmacy Network. If you need specialty drugs, you must use one of the providers in the Specialty Pharmacy Network as your specialty drug pharmacy. Specialty drug providers are experts in supplying drugs and services to patients with complex health conditions. They will give you information about your condition and the drugs that have been prescribed to you. You will have 24-hour access to pharmacists who can answer your questions. Please call Member Services at the number listed in Section 1 to find out which providers are in the Specialty Pharmacy Network program.

**Prescription Drugs (for members who have Medicare)**

**Covered Services:**

- Some over-the-counter products, some prescription cough and cold products, and some vitamins that are not covered under the Medicare Prescription Drug Program (Medicare Part D)

**Not Covered Services:**

- Prescription drugs that are eligible to be covered under the Medicare Prescription Drug Program (Medicare Part D)
- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs or products to promote weight loss
- Drugs not clinically proven to be effective
- Experimental or investigational drugs

**Notes:**

Medicare pays for most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). **You must enroll in a Medicare prescription drug plan** to receive most of your prescription drug services. You will get your prescription drug services through your Medicare prescription drug plan – not through our Plan. You may have to pay a copay for prescriptions covered by your Medicare prescription drug plan.

## Preventive Care and Screening Tests

**Covered Services:**

- Immunizations
- Age and risk appropriate routine examinations (e.g., physical, vision, and hearing)
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Health education and counseling (e.g., smoking cessation, nutrition counseling, diabetes education)
- Family planning visit - **open access service**
- Bone mass measurement.

## Rehabilitation

**Covered Services:**

- Rehabilitation therapies to restore function: physical therapy, occupational therapy, speech therapy
- Audiology services including hearing tests

**Not Covered Services:**

- Vocational rehabilitation
- Health clubs and spas

## Substance Use Disorder Services

**Covered Services:**

- Screening/Assessment/Diagnosis
- Outpatient treatment
- Inpatient Hospital
- Residential non-hospital treatment
- Outpatient methadone treatment
- Detoxification (Only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification)

**Notes:**

See Section 1 for Substance Use Disorder Services contact information.

A qualified Rule 25 assessor who is part of the Plan network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of the first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor not in the Plan network. We will do this within five working days of when we get your request. If you agree with the second assessment, we will

authorize services according to substance use disorder standards and the second assessment. You have the right to appeal. See section 13 of this Member Handbook.

**Not Covered Services:**
Payment for room and board determined necessary by substance use disorder assessment is the responsibility of the Minnesota Department of Human Services.

## Surgery

**Covered Services:**

- Office/clinic visits/surgery
- Removal of port wine stain birthmarks
- Reconstructive surgery (for example, following mastectomy, following surgery for injury, sickness or other diseases; for birth defects)*
- Anesthesia services
- Circumcision when medically necessary*
- Gender Confirmation Surgery*

**Not Covered Services:**

- Cosmetic surgery

## Telemedicine Services

- Telemedicine services covers medically necessary services and consultations delivered by a licensed health care provider while the patient is at an originating site and the health care provider is a distant site. Coverage is limited to three (3) telemedicine services per member per calendar week.

## Transplants*

**Covered Services:**

- Organ and tissue transplants, including: bone marrow, cornea, heart, heart-lung, intestine, intestine-liver, kidney, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, stem cell, and other transplants
  - Ventricular Assist Device: inserted as a bridge to a heart transplant or as a destination therapy treatment

**Notes:**
The type of transplant must be: 1) listed in the Minnesota Department of Human Services Provider Manual; 2) a type covered by Medicare; or 3) be approved by the state's medical review agent.

Transplants must be done at transplant centers that meet the United Network for Organ Sharing (UNOS) standards or at Medicare approved transplant centers.

Stem cell or bone marrow transplants centers must meet the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT).

## Transportation to/from Medical Service

**Covered Services:**

- Emergency ambulance (air or ground includes transport on water)
- Non-emergency ambulance
- Volunteer driver transport
- Unassisted transport (taxicab or public transit)
- Assisted transport
- Life-equipped/ramp transport
- Protected transport
- Stretcher transport

**Not Covered Services:**

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. These services are not covered under the Plan, but may be available through the local or tribal agency. Call your local county or tribal agency for more information.

**Notes:**
If you need transportation to and from health services that we cover, call the Transportation phone number in Section 1. We will provide the most appropriate and cost-effective form of transportation.

The Plan is not required to provide transportation to your primary care clinic if it is over 30 miles from your home or if you choose a Specialty provider that is more than 60 miles from your home. Call the Transportation phone number in Section 1 if you do not have a primary care clinic that is available within 30 miles of your home and/or if it is over 60 miles to your specialty provider.

## Urgent Care

**Covered Services:**

- Urgent care within the Plan service area
- Urgent care outside of the Plan service area

**Not Covered Services:**

- Urgent, emergency, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

**Notes:**
An urgent condition is not as serious as an emergency. This is care for a condition that needs prompt treatment to stop the condition from getting worse. Urgent care is available 24 hours a day.

Call Member Services at the phone number in Section 1 as soon as possible when you get urgent care outside the Plan service area.

## Section 8. Services we do not cover

If you get services or supplies that are not covered, you may have to pay for them yourself. Some "not covered" services and supplies are listed under each category in Section 7. Below is a list of other services and supplies that are not covered under the Plan. This is not a complete list. Call Member Services for more information.

- Health care services or supplies that are not medically necessary
- Supplies that are not used to treat a medical condition
- Hospital inpatient and nursing home incidental services, such as TV, phone, barber and beauty services, and guest services
- Cosmetic procedures or treatment
- Experimental or investigative services
- Emergency, urgent, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.
- Homeopathic and herbal products
- Autopsies (exams that are done on the bodies of people who have died to find out the cause of death)

# Section 9. Services that are not covered under the Plan but may be covered through another source

These services are not covered under the Plan, but may be covered through another source, such as the state, county, federal government, tribe, or a Medicare prescription drug plan. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) or 711 (TTY/TDD).

- Case management for members with developmental disabilities
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Nursing home stays
- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center, a state-owned long term care facility, or an institution for mental disease (IMD), unless approved by us or the service is ordered by a court under conditions specified in law
- Services provided by federal institutions
- Except Elderly Waiver services, other waiver services provided under Home and Community Based Services waivers
- Job training and educational services
- Day training and habilitation services
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- HIV Case Management

## Section 10. When to call your county worker

Call your county worker to report these changes:

- Name changes
- Address changes including moving out of Minnesota
- Pregnancy begin/end dates
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID card
- New insurance or Medicare – begin/end dates
- Change of income including employment changes

# Section 11. Using the Plan coverage with other insurance

If you have other insurance, tell us before you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate our payments with them. This is called "coordination of benefits." Examples of other insurance include:

- No-fault car insurance
- Workers' compensation
- Medicare
- Tricare
- Other Health Maintenance Organization (HMO) coverage
- Other commercial insurance

When you become a member of the Plan, you agree to:

- Let us send bills to your other insurance
- Let us get information from your other insurance
- Let us get payments from your other insurance instead of having payments sent to you
- Help us get payments from your other insurance

If your other insurance changes, call your county worker.

## Section 12. Subrogation or other claim

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and state laws provide that Medical Assistance benefits pay only if no other source of payment exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than federal and state laws allow.

# Section 13. Grievance, appeal and state appeal (state fair hearing) process

This section tells you about the grievance and appeal system including notices, grievances (complaints), health plan appeals and state appeal (state fair hearing). It tells you how and when to use the grievance and appeal system if you are not satisfied with your health care or disagree with a decision we made. It tells you about your rights when using the grievance and appeal system.

Please call Member Services at the phone number in Section 1 if you have questions or want help filing a grievance or appeal.

**Grievance and appeal system terms to know:**

**A grievance** is when you are not satisfied with the services you have received and may include any of the following:

- quality of care or services provided
- failure to respect your rights
- rudeness of a provider or health plan employee
- delay in appropriate treatment or referral
- not acting within required time frames for grievances and appeals

**A denial, termination or reduction (DTR) (notice of action)** is a form or letter we send you to tell you about a decision we make on a claim, a request for service, payment of a claim, or any other request. The notice will tell you how to file an appeal with the health plan or request a state appeal if you disagree with our decision.

**A health plan appeal** is your request for us to review a decision we made. You may ask for an appeal if you disagree with our decision in any of the following **actions** (decisions)**:**

- denial or limited authorization of the type or level of service requested by your provider
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of payment for a service
- not providing services (including transportation) in a reasonable amount of time
- denial of a member's request to get services out of network for members living in a rural area with only one health plan
- not providing a response to your grievance or appeal in the required timelines

Your provider may appeal on your behalf with your written consent. Your treating provider (for example, Nurse Practitioner (NP), Physician Assistant (PA)) may appeal a prior authorization decision *without* your consent.

**A state appeal (state fair hearing)** is your request for the state to review a decision we made. You must appeal to IMCare before asking for a state appeal. If we take more than 30 days to decide your appeal and we have not asked for an extension, you do not need to wait for our decision to ask for a state appeal.

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of a payment for a service
- not providing services in a reasonable amount of time
- our failure to act within required timelines for prior authorizations and appeals
- enrollment in the Plan
- any other action

**If you disagree with our decision or have a grievance (complaint) about something other than a decision we made, you can do any of the following:**

You can call Member Services at the phone number in Section 1 to file a grievance or appeal.

You can write to us to file a grievance or appeal. Write to the address listed in Section 1 under "Appeals and Grievances."

You can write to the Minnesota Department of Human Services to request a state fair hearing.

Write to: Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

File online at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG

Or fax to: 651- 431-7523

You can file a complaint (grievance) with the Minnesota Department of Health.

Write to: Minnesota Department of Health
Health Policy and Systems Compliance Monitoring Division
Managed Care Systems
P.O Box 64882
St. Paul, MN 55164-0882
1-800-657-3916 or (651) 201-5100
http://www.health.state.mn.us/hmo

You can call or write to the Ombudsman for State Managed Health Care Programs. They may be able to help you with access, service, or billing problems. They can also help you file a grievance or appeal with us or request a state fair hearing.

Call: Toll free 1-800-657-3729 (non-metro area) or 651-431-2660 (Twin Cities metro area) or 711 (TTY/TDD). Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m.

Or

Write to: Minnesota Department of Human Services
Ombudsman for State Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249

Fax to: 651-431 7472

## Important Timelines

**You must follow the timelines for filing grievances, health plan appeals, and state appeals. If you go over the time allowed, we may not review your grievance or appeal and the state may not accept your request for a hearing.**

You may file a grievance with us **at any time** from the date of the incident about which you are complaining. There is no timeline for filing a grievance with us.

You must appeal to us **within 60 days** from the date of the DTR (notice of action). We can give you more time if you have a good reason for missing the deadline. You must file an appeal with us **before** you request a state appeal. If we take more than 30 days to decide your appeal and we have not asked for an extension, you can request a state appeal without waiting for us.

You must request a state appeal **within 120 days** of our appeal decision.

If we are stopping or reducing a service, you can keep getting the service if you file a health plan appeal **within 10 days** from the date on the notice, or before the service is stopped or reduced, whichever is later. **You must ask to keep getting the service when you file an appeal.** The service can continue until the appeal is decided. If you lose the appeal, you may be billed for these services.

If you lose the appeal you may keep getting the service during a state appeal if you request a state appeal within 10 days from the date of the decision on your plan appeal.

For the Restricted Recipient Program, a member who receives a notice of restriction may file an appeal with us. You must file an appeal **within 60 days** from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. A member may request a state appeal after receiving our decision that we have decided to enforce the restriction.

**To file an oral or written appeal with us:**

Call Member Services at the phone number in Section 1. Tell us why you disagree with our decision. Oral appeals must be followed by a written appeal, unless you are requesting an expedited, or "fast," resolution. We will help you complete a written appeal. We will ask you to sign and return the written appeal.

You can also send us a letter about your appeal. In the letter, explain why you disagree with our decision. Send the letter to the address listed in Section 1 under "Appeals and Grievances." We can help you write the appeal. Call Member Services at the phone number in Section 1 if you need help.

Expedited, or "fast" appeals are for urgently needed services. If we agree that it is urgent, we will give you a decision within 72 hours. We will try to call you with the decision before we send the decision in writing.

We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

If your appeal is not urgent, we will tell you within 10 days that we received it. We will give you a written decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

The person making the decision will not be the same person who was involved in the prior review or decision-making.

If we are deciding an appeal about a service that was denied because it was not medically necessary, the decision will be made by a health care professional with appropriate clinical expertise in treating your condition or disease.

You or your representative may present your information in person, by telephone, or in writing.

You or your representative may review the case file, including medical records and any other documents and records considered by us during the appeal process.

**To file a state appeal with the Minnesota Department of Human Services:**

You must ask for a state appeal **within 120 days** from the date of the decision of the plan appeal.

A human services judge from the state Appeals Office will hold a hearing. You may ask to attend the hearing by telephone, by video, or in person.

Tell the state why you disagree with the decision we made.
You can ask a friend, relative, advocate, provider, or lawyer to help you. Your provider must have your written permission to request a state appeal for you.

The process can take 90 days. If your hearing is about an urgently needed service, tell the Judge or the Ombudsman when you call or write to them.

If your hearing is about a service that was denied because it was not medically necessary, you may ask for review by a medical expert. The medical expert is independent of both the state and IMCare. The state pays for this review. There is no cost to you.

If you do not agree with the human service judge's decision, you may ask the state to reconsider their decision. Send a written request for reconsideration to the Minnesota Department of Human Services Appeals Office within 30 days from the date of the decision. The contact information is listed earlier in this section.

If you do not agree with the state's decision, you may appeal to the district court in your county.

## Important information about your rights when filing a grievance, appeal, or requesting a state appeal:

There is no cost to you to file an appeal or a grievance.

If you decide to file a grievance or appeal, or request a state appeal, it will not affect your eligibility for medical services. It will also not affect your enrollment in our health plan.

You can have a relative, friend, advocate, provider, or lawyer help with your grievance, appeal, or a state appeal.

There is no cost to you for filing a health plan appeal, grievance, or a state appeal. We may pay for some expenses such as transportation, childcare, photocopying, etc.

If you ask to see your medical records or other documents, we used to make our decisions, want copies, we or your provider must provide them to you at no cost. You may need to put your request in writing.

**To file an oral grievance with us:**

Call Member Services at the phone number in Section 1 and tell us about the problem.

We will give you a decision within 10 days. We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 10 days that we are taking extra time and the reasons why.

If your grievance is about our denial of an expedited appeal or a grievance about urgent health care issues, we will give you a decision within 72 hours.

To file a written grievance with us:

Send a letter to us about your grievance. Write to the address listed in Section 1 under "Appeals and Grievances."

We can help you put your grievance in writing. Call Member Services at the phone number in Section 1 if you need help.

We will tell you that we received your grievance within 10 days.

We will give you a written decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

If you do not agree with your decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for Public Managed Health Care Programs for help. The contact information is listed earlier in this section.

# Section 14. Definitions

These are the meanings of some words in this Member Handbook.

Action: This includes:
- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of payment for a service
- not providing services in a reasonable amount of time
- not acting within required time frames for grievances and appeals
- denial of a member's request to get services out of network for members living in a rural area with only one health plan

Anesthesia: Drugs that make you fall asleep for an operation.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing a written or oral appeal.

Care Coordinator: A person who develops, coordinates and provides (in some cases) supports and services stated in the care plan. This person works with us.

Clinical Trial: A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

Copay/Copayment: A fixed amount you may pay as your share of a cost each time you get certain services, supplies, or prescription drugs. Co-pays are usually paid at the time services, supplies, or prescription drugs are provided. For example, you might pay $2 or $5 for services, supplies or prescription drugs.

Cost Sharing: Amounts you may be responsible to pay toward your medical services. See Section 6 for information on cost sharing.

Covered Services: The health care services that are eligible for payment.

Denial, Termination or Reduction (DTR) (Notice of Action): A form or letter we send you to tell you about a decision on a claim, service, or any other action taken by us.

Direct Access Services: You can go to any provider in the Plan network to get these services. You do not need a referral or prior authorization before getting services.

Durable Medical Equipment (DME): Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, oxygen equipment and supplies.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part or could cause serious physical or mental

harm. The medical symptoms may be a serious injury or severe pain. This is also called Emergency Medical Condition.

Emergency Care/Services: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. This is also called Emergency Room Care.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Excluded Services: Services the plan does not pay for. Medical Assistance (Medicaid) will not pay for them either.

Experimental Service: A service that has not been proven to be safe and effective.

External Quality Review Study: A study about how quality, timeliness and access of care are provided by us. This study is external and independent.

Family Planning: Information, services, and supplies that help a person decide about having children. These decisions include choosing to have a child, when to have a child, or not to have a child.

Fee-for-Service: A method of payment for health services. The medical provider bills the Minnesota Department of Human Services (DHS) directly. DHS pays the provider for the medical services. This method is used when you are eligible for Minnesota Health Care Programs but are not enrolled in a health plan.

Formulary: The list of drugs covered under the Plan.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Home and Community Based Services: Additional home health care services that are provided to help you remain in your home.

Home Health Care: Health care services for an illness or injury given in the home or in the community where normal life activities take the member.

Hospice: A special program for members who are terminally ill and not expected to live more than six months. It offers special services for the member and his or her family.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Inpatient Hospital Stay: A stay in a hospital or treatment center that usually lasts 24 hours or more.

Investigative Service: A service that has not been proven to be safe and effective.

Medically Necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and behavioral health (including Mental and Substance Use Disorder). It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

- be the service that most other providers would usually order
- help you get better, or stay as well as you are
- help stop the condition from getting worse
- help prevent and find health problems

Medicare: The federal health insurance program for people age 65 or over. It is also for some people under age 65 with disabilities, and people with End Stage Renal Disease.

Medicare Prescription Drug Plan: An insurance plan that offers Medicare Prescription Drug Program (Medicare Part D) drug benefits.

Medicare Prescription Drug Program: The prescription drug benefit for Medicare members. It is sometimes called Medicare Part D. Drug coverage is provided through a Medicare prescription drug plan.

Member: A person who is receiving services through a certain program, such as a Minnesota Health Care Program or Medicare.

Member Handbook: This is the document you are reading. This document tells you what services are covered under the Plan. It tells what you must do to get covered services. It tells your rights and responsibilities. It also tells our rights and responsibilities.

Minnesota Senior Care Plus (MSC+): A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance (Medicaid) members age 65 and older.

Network: Our contracted health care providers for the Plan.

Network Providers: These are providers who agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called plan providers or participating providers.

Nursing Home Certifiable: A decision that you need a nursing home level of care. A screener uses a process called a Long Term Care Consultation to decide.

Ombudsman for Public Managed Health Care Programs: A person at the Minnesota Department of Human Services who can help you with access, service or billing problems. The ombudsman can also help you file a grievance or appeal or request a state appeal (state fair hearing).

Open Access Services: Federal and state law allow you to choose any doctor/qualified health care provider, clinic, hospital, pharmacy, or family planning agency - even if not in our network - to get these services

Outpatient Hospital Services: Services provided at a hospital or outpatient facility that are not at an inpatient level of care. These services may also be available at your clinic or other health facility.

Out-of-Area Services: Health care provided to a member by an out-of-network network provider outside of the Plan service area.

Out-of-Network Provider or Out-of-Network Facility: A provider or a facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. This is also known as a non-participating provider.

Out-of-Network Services: Health care provided to a member by a provider who is not part of the plan network.

Physician Incentive Plan: Special payment arrangements between us and the doctor or doctor group that may affect the use of referrals. It may also affect other services that you might need.

Physician Services: Services provided by an individual licensed under state law to practice medicine or osteopathy. Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: An organization that has a network of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you.

Post-stabilization Care: A hospital service needed to help a person's conditions stay stable after having emergency care. It starts when the hospital asks for our approval for coverage. It continues until: the person is discharged; our Plan network doctor/qualified health care provider begins care; or we, the hospital, and doctor/qualified health care provider agree to a different arrangement.

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescriptions: Medicines and drugs ordered by a medical provider.

Prescription Drug Coverage: A health plan that helps pay for prescription drugs and medications. Also see "Medicare Prescription Drug Program.:

Preventive Services: Services that help you stay healthy, such as routine physicals, immunizations, and well-person care. These services help find and prevent health problems. Follow-up on conditions that have been diagnosed (like a diabetes checkup) are ***not*** preventive.

Primary Care Clinic: The primary care clinic (PCC) you choose for your routine care. This clinic will provide or approve most of your care. The name of your clinic appears on your member card.

Primary Care Physician: Your primary care physician (PCP) is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Primary Care Provider: Your primary care provider (PCP) is the doctor or other qualified health care provider you see at your primary care clinic. This person will manage your health care.

Prior Authorization: Our approval that is needed for some services before you get them. This is also known as preauthorization or service authorization.

Provider: A qualified health care professional or facility approved under state law to provide health care.

Referral: Written consent from your primary care provider or clinic that you may need to get before you see certain providers, such as specialists, for covered services. Your primary care doctor or clinic must write you a referral.

Rehabilitative Services and Devices: Treatment and equipment you get to help you recover from an illness, accident or major operation.

Restricted Recipient Program: A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated primary care provider, one pharmacy, one hospital or other designated health care provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

Second Opinion: If you do not agree with an opinion you get from a Plan network provider, you have the right to get an opinion from another provider. We will pay for this. For medical conditions, the second opinion will be from another Plan network provider. For mental health services, the second opinion will be from an out-of- network provider. For substance use disorder services, the second opinion will be from a different qualified assessor who is not in the Plan network.

Service Area: The area where a person must live to be able to become or remain a member of the Plan. Contact Member Services at the phone number in Section 1 for details about the service area.

Standing Referral: Written consent from your Primary Care Clinic to see a specialist more than one time (for ongoing care.)

Skilled Nursing Care: Care or treatment that can only be done by licensed nurses.

Skilled Nursing Facility: A facility which provides inpatient skilled nursing care, rehabilitation services or other related health services. Medicare must certify this facility if you are receiving Medicare benefits.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Appeal (State Fair Hearing): A hearing at the state to review a decision made by us. You must request a hearing in writing. Your provider may request a state fair hearing with your consent. You may ask for a hearing if you disagree with any of the following:

- a denial, termination, or reduction of services
- enrollment in the Plan
- denial of part or all of a claim for a service
- our failure to act within required timelines for prior authorizations and appeals
- any other action

Subrogation: Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this Plan for a service that is covered by another source or third party payer.

Substance Use Disorder: Using alcohol or drugs in a way that harms you.

United States: For the purpose of this Member Handbook, the United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, The Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Urgent Care: Care for a condition that needs prompt treatment to stop the condition from getting worse. An urgent condition is not as serious as an emergency. Urgent care is available 24 hours a day.