

**Medica AccessAbility Solution® (HMO SNBC)
Certificate of Coverage
Special Needs Basic Care – Medicaid Only**

January 1, 2011 – December 31, 2011

This booklet gives you the details about your Medical Assistance health benefits and services and prescription drug coverage from January 1 – December 31, 2011. It explains how to get the health care, services and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

For help or information, please call Medica Customer Service or go to our plan website at www.medica.com.

CALL: Mpls./St. Paul metro area: **(952) 992-2300**
Outside Mpls./St. Paul metro area: **1-800-234-8755** Calls to this number are free.

TTY: Please call the National Relay Center at: **1-800-855-2880** and ask for: **1-800-234-8755**. These TTY numbers require special telephone equipment. Calls to these numbers are free.

This plan is offered by Medica Health Plans, referred throughout the *Certificate of Coverage* as “we,” “us,” or “our.” Medica AccessAbility Solution is referred to as “plan” or “our plan.”

Our Plan will accept all eligible people who choose or are assigned to the Plan. We will not discriminate in regard to your physical or mental condition; health status; need for health services; marital status; age; sex; sexual orientation; national origin; race; color; religion or political beliefs.

2011 Medica AccessAbility Solution (SNBC)-Medicaid Only Certificate of Coverage

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, wac Medica: 1-800-234-8755.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم :Medica 1-800-234-8755

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните Medica: 1-800-234-8755.

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Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite Medica: 1-800-234-8755.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a Medica: 1-800-234-8755.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាន នេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ Medica: 1-800-234-8755 ។

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi Medica: 1-800-234-8755.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu Medica: 1-800-234-8755.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu Medica: 1-800-234-8755.

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This information is available in other forms to people with disabilities by calling 952-992-2300 (voice), or 1-800-234-8755 (toll free), or through the National Relay Center toll free at 1-800-855-2880 (TTY/TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

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 enrollees age 65 years and older this included 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.

If you ask, we will give you this Certificate of Coverage in one of these languages: Spanish; Hmong; Laotian; Russian; Somali; Vietnamese; or Cambodian. Call Medica Customer Service at (952) 992-2300 or 1-800-234-8755 (toll free) or the National Relay Center at: 1-800-855-2880 and ask for: 1-800-234-8755. (TDD/Hearing Impaired).

Table of Contents

WELCOME TO MEDICA ACCESSABILITY SOLUTION	2
SECTION 1. TELEPHONE NUMBERS AND OTHER CONTACT INFORMATION	4
SECTION 2. IMPORTANT INFORMATION ON GETTING THE CARE YOU NEED	8
SECTION 3. ENROLLEE BILL OF RIGHTS	13
SECTION 4. ENROLLEE RESPONSIBILITIES	15
SECTION 5. YOUR HEALTH PLAN MEMBER CARD	16
SECTION 6. COPAYS AND COINSURANCE	18
SECTION 7. COVERED SERVICES	19
SECTION 8. SERVICES WE DO NOT COVER	44
SECTION 9. SERVICES THAT ARE NOT COVERED UNDER THE PLAN BUT MAY BE COVERED THROUGH ANOTHER SOURCE	45
SECTION 10. WHEN TO CALL YOUR COUNTY WORKER	47
SECTION 11. USING THE PLAN COVERAGE WITH OTHER INSURANCE	48
SECTION 12. SUBROGATION OR OTHER CLAIM	49
SECTION 13. GRIEVANCE, APPEAL AND STATE FAIR HEARING PROCESS	50
SECTION 14. DEFINITIONS	56

Welcome to Medica AccessAbility Solution®

We are pleased to welcome you as a member of Medica Health Plan's AccessAbility Solution SNBC product (referred to as "Plan" or "our Plan.>").

Medica Health Plans (referred to as "we," "us", or "our") participates in the Special Needs Basic Care program (SNBC). The Minnesota Department of Human Services designed this voluntary program to provide special care for people with disabilities. It combines your doctor, hospital, nursing home care and other care into one coordinated care system. You will get most of your health services through the plan network of contracted 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 to see.

This Certificate of Coverage (COC), 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 COC includes:

- Contact information
- Information on how to get the care you need
- Your rights and responsibilities as a member of the Plan
- Information about copays
- A listing of covered and non-covered services
- Information on what to do if you have a complaint or want to appeal an action
- Definitions

You are eligible for membership in our plan as long as:

- You are eligible for Medical Assistance.
- You must be certified as disabled through the Social Security Administration (SSA) or the State Medical Review Team (SMRT); and/or have been determined by the county to have a developmental disability (DD) and are receiving DD waiver Services or are living in an intermediate care facility for people with DD.
- You must live in our plan service area.

Note: If you are a Preferred Integrated Network (PIN) member, you must reside in Dakota County but you may receive services from any network provider.

The counties in the Plan service area are as follows:

Aitkin, Anoka, Becker, Benton, Carlton, Carver, Cass, Chisago, Clay, Crow Wing, Dakota, Hennepin, Isanti, Koochiching, Lake, Mahnomen, Mille Lacs, Morrison, Norman, Otter Tail, Pine, Polk, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Todd, Wadena, Washington, Wilkin and Wright.

If you plan to move out of the service area, please contact Medica Customer Service.

Please tell us how we're doing. You can call or write to us at any time. (Section 1 of this COC 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 other contact information

How to contact Medica Customer Service

If you have any questions or concerns, please call or write to Medica Customer Service. We will be happy to help you. Medica Customer Service hours for service are: **8:00 a.m. - 8:00 p.m. CST, seven days a week.** Please note that access to a representative is limited on the weekends and holidays during certain times of the year.

Medica Customer Service	
CALL	Mpls./St. Paul metro area: 952-992-2300 Outside Mpls./St. Paul metro area: 1-800-234-8755. Calls to this number are free.
TTY	Please call the National Relay Center at: 1-800-855-2880 and ask for: 1-800-234-8755. Calls to these numbers are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	(952)-992-3660
WRITE	Medica Customer Service Route CP320 P.O. Box 9310 Minneapolis, MN 55440-9310
WEBSITE	www.medica.com

Our Plan contact information for certain services

Appeals and Grievances: Minneapolis/St. Paul metro area: (952) 992-2300
Outside Minneapolis/St. Paul metro area: 1-800-234-8755. Calls to this number are free.
For calls to request expedited or fast coverage decisions outside of our regular business hours, call 1-866-894-8003. If you call during off hours, your voice message will be returned the next business day. Calls to this number are free. See Section 13 for more information.

Chemical Dependency Services: Medica Behavioral Health manages our network of providers for chemical dependency care. Medica Behavioral Health uses a limited network of providers to provide chemical dependency care; except for emergencies. Medica Behavioral Health must arrange all such benefits; and you must get service authorization for your plan of treatment call Medica Behavioral Health at 1-800-848-8327 (toll free) or for TTY (hearing impaired) dial 1-800-543-7162 (toll free)

Chiropractic Services: ACN Group, Inc. at (952) 992-2300 or 1-800-234-8755 (toll free)

Dental Services: Delta Dental at 1-651-406-5919 or 1-800-459-8574 (toll free)

Durable Medical Equipment Coverage Criteria: Medica Member Service (952) 992-2300 or 1-800-234-8755 (toll free). TTY number for hearing impaired should call the National Relay Center at 1-800-855-2880 and ask for 1-800-234-8755 (toll free).

Interpreter Services (Hearing and Spoken): Medica Member Service (952) 992-2300 or 1-800-234-8755 (toll free). TTY number for hearing impaired should call the National Relay Center at 1-800-855-2880 and ask for 1-800-234-8755 (toll free).

Health Questions Phone Line: Medica CallLink[®] at 1-866-715-0915 (toll free)

Mental Health Services: Medica Behavioral Health manages our network of providers for mental health services. Medica Behavioral Health uses a limited network of providers to provide mental health care; except for emergencies. Medica Behavioral Health must arrange all such benefits; and you must get service authorization for your plan of treatment call Medica Behavioral Health at 1-800-848-8327 (toll free) or for TTY (hearing impaired) dial 1-800-543-7162 (toll free).

Prescriptions: Medica Member Service (952) 992-2300 or 1-800-234-8755 (toll free). TTY number for hearing impaired should call the National Relay Center at 1-800-855-2880 and ask for 1-800-234-8755 (toll free).

Transportation: Medica Member Service (952) 992-2300 or 1-800-234-8755 (toll free). TTY number for hearing impaired should call the National Relay Center at 1-800-855-2880 and ask for 1-800-234-8755 (toll free).

Other important contact information

People with hearing loss or a speech disability may call 711, or the Minnesota Relay Service at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service) to access the resources below. These calls are toll free.

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 State Managed Health Care Programs

The Ombudsman for State 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 651-431-2660 or 1-800-657-3729 (toll free).

Office of Ombudsman for Long Term Care

The Office of Ombudsman for Long Term Care can assist people 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 Medicare beneficiaries with hospital access or discharge concerns. Call 651-431-2555 (Twin Cities metro) or 1-800-657-3591 (toll free).

Disability Linkage Line®

Disability Linkage Line® provides information and assistance on disability-related questions. A resource specialist will answer your call, listen to your needs, explore possible options, and provide you the information you need. Their goal is to provide you information on any topic related to disabilities and community resources. Common requests include information on employment, disability benefits, housing, modifications, assistive technology, personal care assistance and disability awareness and rights. Call 1-866-333-2466 (toll free) Monday through Friday from 8:30 a.m. to 5:00 p.m.

Veterans Linkage Line™

Veterans Linkage Line™ provides information and referral to veterans and their families. The Minnesota Department of Veterans Affairs (MDVA) offers the LinkVet call center provided by trained staff. During business hours, MDVA staff will provide information on veterans' benefits, healthcare, education, and reintegration. The line will roll to Crisis Connection counselors for 24-hour, seven days a week coverage (including holidays) for immediate crisis intervention and psychological counseling. Call 1-888-LinkVet (546-5838) (toll free).

How to Contact the Medicare Program

Medicare is a health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY 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 Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Web sites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

Section 2. Important information on getting the care you need

Primary care:

Each time you get health services, check to be sure the provider is a Plan network provider. Members receive a Provider Directory. It lists Plan network providers. It is current as of the date it is printed. To verify current information, you can call the provider, call Medica Customer Service 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 or clinic. The name of the doctor or clinic you must go to is on your member card. This is your **Primary Care Clinic**. The clinic's phone number is also on your member card.

Your Primary Care Clinic or doctor will arrange most of your medical care. It is important that one doctor knows about all your medical needs. The doctor can make sure you get the care you need.

You do not need a referral to see a Plan network specialist.

Contact your Primary Care Clinic for information about the clinic's hours, and service 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 Medica Customer Service at the phone number in Section 1.

If you require special access to obtain services from a provider you can obtain a listing by calling customer services at the phone number listed on the front cover or visit www.medica.com. This could include but is not limited to access for services such as availability of flexible hours, wheelchair access, or parking lot access.

Service authorizations:

Our approval is needed for some services to be covered. This is called **service 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 Medica Customer Service at the phone number in Section 1.

If you need a covered service that you cannot get from a Plan network provider, you must get a service authorization from us to see a non-network provider. Exceptions to this rule are:

- Open access services: Family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for AIDS or other HIV-related conditions are open access services. You can go to any doctor, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- Emergency and post-stabilization services

For more information, call Medica Customer Service at the phone number listed in Section 1.

The Plan allows direct access to providers in our network, but keeps the right to manage your care under certain circumstances. These circumstances are transplants and related services for transplants or when your PCP or Care Coordinator thinks that you need specialized treatment. We may do this by choosing the provider you use and/or the services you receive.

If we are unable to find you a qualified Plan network provider, we must give you a standing service authorization for you to see a qualified specialist for any of these 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 service authorization from us when needed, the bill may not be paid.
For more information, call Medica Customer Service 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 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 Medica Customer Service at the phone number in Section 1.

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 COC 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 Medica Customer Service at the phone number in Section 1.

We may cover additional or substitute services under some conditions.

Copays and payments:

A copay is an amount that a health plan member is responsible to pay to the provider. You do not have copays for services covered under our Plan. If you disenroll from our Plan, you may have copays for certain services. See Section 6 for more information.

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 Medica Customer Service.

Interpreter services:

We will provide interpreter services to help you access services. This includes spoken language interpreters and hearing interpreters. If you need assistance to help you access services, call Medica Customer Service at the phone number in Section 1.

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. You may have copays for these services. The Plan does not pay for prescriptions that are covered under the Medicare Prescription Drug Program.

Private information:

We, and the health 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 a program for members who have received medical care and have not followed the rules or have misused services. If you are placed in this program, we may replace your regular member card with a Restricted Recipient Program card. You must get health services from one doctor, one drug store, one hospital or other provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). You may also be assigned to a home health agency or other providers. You may not be allowed to use the personal care assistance choice or flexible use options or consumer directed services. 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 health care services will be reviewed. If you still do not follow the rules, 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:

Membership in our Plan is voluntary. Your coverage with us will be canceled if you decide to leave our Plan. You can choose to disenroll at any time. You will remain enrolled until the end of the month. To tell us you want to leave our Plan, you can write or fax a letter to us or fill out a disenrollment form and send it to Member Services or to our fax number listed in Section 1. Be sure to sign and date your letter or form. It would also be helpful to include your date of birth.

Your coverage with us will be canceled for any of the following reasons:

- You are no longer eligible for Medical Assistance.
- You lose eligibility for SNBC because you are no longer disabled.
- You are eligible for Medicare but do not stay continuously enrolled in Medicare Part A and Medicare Part B
- You have a spenddown and you do not pay it.
- You move out of our Plan service area.

If you are no longer eligible for Medical Assistance you may be able to purchase health coverage with us. Call Medica Customer Service at the phone number in Section 1.

Section 3. Enrollee bill of rights

You have the right to:

Be treated with respect, dignity, and consideration for privacy

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

Participate with providers in making decisions about your health care

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

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

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

Request a State Fair Hearing with the Minnesota Department of Human Services (also referred to as “the State”). You may request a State Fair Hearing before or at any time during our appeal process. You do not have to file an appeal with us before you request a State Fair Hearing.

A clear explanation of covered nursing home and home care services

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.

Choose where you will get family planning services

Get a second opinion for medical, mental health, and chemical dependency services

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

Request a copy of this Certificate of Coverage at least once a year

Get the following information from us, if you ask for it:

- Whether we use a physician incentive plan that affects the use of referral services
- The type(s) of incentive arrangement used
- Whether stop-loss protection is provided
- Results of a member survey if one is required because of our physician incentive plan
- Results of an external quality review study from the State
- Get in writing your primary care doctor's name, address, and telephone number. This will be given to you, or, in some cases, your representative.
- Voluntarily disenroll
- Make recommendations about our rights and responsibilities policy
- Exercise the rights listed here.

Section 4. Enrollee responsibilities

You have the responsibility to:

Read this Certificate of Coverage 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 go for 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 before you become ill. This helps you and your primary care doctor understand your total health condition.

Give information asked for by your doctor. Share information about your health history.

Follow all your doctor's instructions. If you have questions about your care, ask your doctor.

Work with your doctor to understand your total health condition. It is important to 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.

Let us know if you have any questions, concerns, problems or suggestions. If you do, please call Medica Customer Service at the phone number in Section 1.

Section 5. Your health plan member card

Each member will receive a member card.

Always carry your member card with you.

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

You must use your health 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 Medica Customer Service 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 member card to show what it looks like:

Sample of Front:

<p>MEDICA®</p> <p>Payer ID: 94265 Rx BIN: 003585 Rx PCN: 99500</p> <p>Group & ID: 05053999999901-00 NAME: JOHN Q 00009/00924/05053 Group: 05053 Care Type: AccessAbility Solution Axis Medicaid Svc Type: Medical/Comp Dental</p>	<p>MEDICA®</p> <p>Provide a Ride 952-992-2292 or 1-800-601-1805</p> <p>MedicaBehav.Health 800-848-8327 Issue Date: 08/31/10</p>
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Sample of Back:

<p>Medical claims: MEDICA, PO Box 30990 Salt Lake City, UT 84130</p> <p>*Dental claims to: Delta Dental Plan of MN PO Box 1328 Mpls, MN 55440-1328</p> <p>MEDICA Cust Svc: (952) 992-2300 or 1-800-234-8755</p> <p>TTY: Call Nat'l Relay Ctr at 1-800-855-2880 and ask for 1-800-234-8755</p> <p>*Delta Dental Svc: 1-800-459-8574</p> <p>In case of EMERGENCY go to the nearest emergency room or call 911</p> <p>Note – All (800) and (866) numbers are toll-free.</p>	<p>MN Dept of Health Appeals: 1-800-657-3916</p> <p>MEDICA CallLink Nurse Line: 1-866-715-0915 or the hearing impaired can call National Relay Ctr at 1-800-855-2880 and request they call 1-866-715-0915.</p> <p>MEDICA Customer Svc PO Box 9310 Rt CP320 Mpls, MN 55440</p> <p>*Dental Admin & U/W by Delta Dental of MN Visit Medica at www.medica.com</p> <p>To file a complaint with the MN DHS Ombudsman, call 651- 431-2660 (metro) or 1-800-657-3729 (greater MN). To file an appeal, write to: MN DHS Appeals Office, PO Box 64941, St Paul, MN 55164</p>
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Section 6. Copays and Coinsurance

A copay is an amount that a health plan member is responsible to pay to the provider. You do not have copays for services covered under our Plan. If you disenroll from our Plan, you may have copays for certain services.

If you have Medicare Part A or Medicare Part B, you must get most of your services through another insurance plan. You may have a coinsurance for some of these services. If you have Medicare, you must get most of your prescription drugs through a Medicare prescription drug (Medicare Part D) plan. You may have a copay with no monthly limit for some of these services.

Section 7. Covered Services

This section describes the major services that are covered under the Plan. It is not a complete list. Some services have limitations or require a service authorization. Get the service authorization before you get the service. All health care services must be medically necessary for them to be covered. Call Medica Customer Service at the phone number in Section 1 for more information.

For members who have Medicare coverage or other insurance, our plan will provide coverage for the services described in this section that are not covered by Medicare Part A, Medicare Part B or Medicare Part D. See Section 11 *Using the Plan Coverage with other insurance* for more information.

CARE COORDINATION

COVERED SERVICES:

- Assisting you in arranging for, getting, and coordinating assessments, tests, health care and continuing care services
- Developing and updating your care plan
- Communicating with a variety of agencies and persons
- Relocation service coordination for residents of a facility
- Other services as outlined in your care plan.

CHEMICAL DEPENDENCY SERVICES

Medica Behavioral Health manages our network of providers for chemical dependency care. Medica Behavioral Health uses a limited network of providers to provide chemical dependency care; except for emergencies. Medica Behavioral Health must arrange all such benefits; and you must get service authorization for your plan of treatment call Medica Behavioral Health at 1-800-848-8327 (toll free) or for TTY (hearing impaired) dial 1-800-543-7162 (toll free).

COVERED SERVICES:

- Assessment/diagnosis
- Outpatient treatment
- Inpatient hospital

- Residential non-hospital treatment
- Outpatient methadone treatment
- Detoxification only if required for medical treatment
- Room and board determined necessary by chemical dependency assessment

NOTES:

See Section 1 for Chemical Dependency Services information on where you should call or write.

A qualified Plan network assessor will decide what type of chemical dependency 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 your 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 chemical dependency standards and the second assessment. You have the right to appeal. See Section 13 of this Certificate.

CHILD AND TEEN CHECKUPS (C&TC)

COVERED SERVICES:

Child and Teen Checkup (C&TC) visits

- Growth measurements
- Developmental screening
- Mental health screening
- Physical exam
- Immunizations
- Laboratory tests
- Vision checks
- Hearing checks
- Regular dental checks

NOTES:

C&TC is a health care program of well-child visits for members **under age 21**. C&TC visits help find and treat health problems early. How often a C&TC is needed depends on age. Ask your Primary Care Clinic for information about scheduling C&TC visits.

CHIROPRACTIC CARE

COVERED SERVICES:

- One annual evaluation
- Office visits that include manual manipulation (adjustment) of the spine to treat subluxation are covered up to twelve visits per year. Additional visits may be authorized by Medica.
- 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
- Chiropractic exams and consultations
- Chiropractic visits that do not include manual manipulation of the spine

DENTAL SERVICES (for adults except pregnant women)

COVERED SERVICES:

Diagnostic services

- comprehensive exam every five years
- periodic exam once per calendar year
- problem focused exams (once per day per facility)
- X-rays are limited to:
 - bitewing once per calendar year
 - single X-rays for diagnosis of problems
 - panoramic:
 - once every five years

- 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 once per calendar year
- fluoride varnish once per calendar year

Restorative services

- fillings
- sedative fillings for relief of pain

Endodontics (root canals) on anterior teeth and premolars only

Periodontics

- gross removal of plaque and tartar 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

Oral surgery limited to extractions, biopsies, and incision and drainage of abscesses

Additional general services

- treatment for pain (once per day)
- general anesthesia only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)

NOT COVERED SERVICES:

- Relines, repairs and rebases of removable prostheses (dentures and partials)
- Lost, stolen, or damaged and un-repairable prostheses

NOTES:

See Section 1 for Dental Services contact information.

DENTAL SERVICES (for children and pregnant women)

COVERED SERVICES:

Diagnostic services

- comprehensive exam
- periodic exam
- problem focused exams
- X-rays are limited to:
 - bitewing
 - single X-rays for diagnosis of problems
 - panoramic
 - full mouth X-rays

Preventive services

- cleaning
- fluoride varnish once every six months
- sealants for children under 21, once every five years per permanent molar

Restorative services

- fillings
- sedative fillings for relief of pain
- individual crowns, must be made of prefabricated stainless steel or resin, unless medically necessary in specific circumstances

Endodontics (root canals)

Periodontics

- gross removal of plaque and tartar
- scaling and root planing

Implants only when medically necessary for very limited conditions

Prosthodontics

- removable prostheses (dentures and partials) once every three years per dental arch

Oral surgery

Orthodontics for children under 21, only when medically necessary for very limited conditions

Additional general services

- Treatment for pain
- General anesthesia

NOTES:

See Section 1 for Dental Services contact information.

Pregnant women age 21 or over are not eligible for sealants or orthodontic treatment

DIAGNOSTIC SERVICES (Lab and X-ray)

COVERED SERVICES:

- Lab tests and X-rays
- Other medical diagnostic tests ordered by your doctor

DOCTOR AND OTHER HEALTH SERVICES

COVERED SERVICES:

- Doctor visits
 - care for pregnant women
 - family planning - **open access service**
 - lab and X-rays
 - physical exams
 - preventive exams
 - preventive office visits
 - specialists
 - telemedicine consultation
 - vaccines and drugs administered in a doctor's office
 - visits for illness or injury
 - visits in the hospital or nursing home

- Immunizations
- 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 (e.g. 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**

NOT COVERED SERVICES:

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

EMERGENCY MEDICAL SERVICES AND POST-STABILIZATION CARE

COVERED SERVICES:

- Emergency room services
- Post-stabilization care
- Ambulance (air or ground)

NOT COVERED SERVICES:

- Emergency care, urgent care, or other health care services received from providers located outside the United States and Canada.

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.

In all other cases, call your primary care doctor, if possible. The clinic's phone number is also on your member card. The number is answered 24 hours a day, seven days a week. The doctor will tell you 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.

You must call your Primary Care Clinic 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 due to damage, loss or theft
- Repairs to frames and lenses for eyeglasses covered under the Plan
- Tints 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
- Bifocal lenses without lines and progressive bifocals
- Protective coating for plastic lenses
- Contact lenses 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 (birth control pills, patch, ring, IUD, injections, implants) - **open access service**
- Family planning supplies with prescription (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**
- Treatment for AIDS and other HIV-related conditions – **NOT** an open access service. You must see a provider in the Plan network.
- Voluntary sterilization - **open access service**

Note: You must be age 21 or older 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.

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

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 SERVICES

COVERED SERVICES:

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

HEALTH AND WELLNESS EDUCATION PROGRAMS

These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, Medica's Smoking Cessation, fitness, and stress management.

SilverSneakers® Fitness Program

Provides free membership at participating fitness centers in certain parts of the service area. Members can use exercise equipment, steam and sauna rooms and participate in exercise classes. Members can choose which activities they wish to participate in. No matter what their current fitness level, this program makes it easy for all members to participate. For a list of fitness facilities that are part of SilverSneakers call Medica Customer Service. You can also go to www.silversneakers.com and enter your zip code to locate facilities near you.

Medica Health & Wellness Coaching Program

Medica's health and wellness coaching program is designed to take a whole-person approach to improving the health of members. Coaches work directly with you to discuss readiness to change, motivation and confidence to make changes, and self management skills you will need to take charge of your health. The program helps you identify the healthy behavior (e.g., taking medications, managing stress, proper nutrition, exercising) you want to adopt and helps you establish priorities for change to achieve better health. You may receive a call from a health coach inviting you into this program or you can request this service through your care coordinator. You can also call the Health and Wellness Coaches to inquire about this program at 1-866-905-7430 (toll free). TTY users please call the National Relay Center at 1-800-855-2880 (toll free) and ask for 1-866-905-7430 (toll free). The hours of operation are Monday through Friday 7 a.m. – 8 p.m., CST. Saturdays 9 a.m. - 5 p.m., CST. If you leave a voice message, your call will be returned within one business day.

Medica's Tobacco Cessation Program.

Medica beneficiaries wishing to quit using tobacco receive confidential coaching services provided by Medica Health Coaches specially trained in tobacco cessation. Members receive over-the-counter nicotine replacement therapy, a personalized quit plan, and self-help materials.

Medica CallLink® 24-hour nursing hotline.

Because your health care needs do not always follow regular business hours, Medica CallLink is an easy-to-use phone service staffed by registered nurses 24 hours per day, seven days per week. Medica CallLink is a valuable health information resource that can help you get the medical care you need—quickly. With one call, the nurses of CallLink can instruct you on the care of minor illnesses and injuries at home, as well as help you find a doctor near your home. An extensive health and wellness audiotape library is also part of this service.

Medica CallLink – 1-866-715-0915 Hearing impaired members, call the National Relay Service at 1-800-855-2880 and request Medica CallLink at 1-866-715-0915. These numbers are available 24 hours per day, seven days per week.

HIV/AIDS SERVICES

COVERED SERVICES:

- Counseling and testing for AIDS and other HIV-related conditions (open access service)
- Treatment for people who are HIV-positive (**not** an open access service)
- Special nutritional products if ordered by a doctor

NOTES:

People with HIV/AIDS who would like an HIV/AIDS specialist as their primary care provider should contact their Care Coordinator or Medica Customer Service at the phone number in Section 1.

If you would like to get a standing service authorization to a specialist, contact your Care Coordinator or Medica Customer Service at the phone number in Section 1.

If you are currently receiving HIV case management services, let your Care Coordinator, or Medica Customer Service at the phone number in Section 1 know.

For services labeled as “open access,” you can go to any provider, even those that are not part of our Plan network.

HOME CARE SERVICES

COVERED SERVICES:

- Skilled nursing
- Rehabilitation therapies (for example, speech, physical, occupational, respiratory)
- Home health aide

NOT COVERED SERVICES:

- Private Duty Nursing (PDN) services
- Personal Care Assistant (PCA) services

HOSPICE

COVERED SERVICES:

- Doctor, nurse, and other professional services
- Medical social services
- Medical equipment and supplies
- Physical, occupational, and speech therapies
- Short-term inpatient care, including respite care
- Counseling, including dietary counseling
- Home health aide and homemaker services
- Outpatient drugs for symptom management and pain relief

NOTES:

You must elect hospice benefits to receive hospice services.

Members under age 21 receiving hospice services will have coverage for services related to treatment of the terminal condition.

If you are interested in using hospice services, please call Medica Customer Service at the phone number in Section 1.

HOSPITAL – INPATIENT

COVERED SERVICES:

- Inpatient hospital stay
- 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

INTERPRETER SERVICES

COVERED SERVICES:

- Spoken language interpreter services
- Hearing interpreter services

NOTES:

Interpreter services are available to help you get services.

Oral interpretation is available for any language.

See Interpreter Services in Section 1 for contact information.

MEDICAL EQUIPMENT AND SUPPLIES

COVERED SERVICES:

- Prosthetics or orthotics
- Durable medical equipment (e.g., wheelchair, hospital bed, walker, crutches, wigs for people with alopecia areata)
- Repairs of medical equipment
- Batteries for medical equipment
- Some shoes when part of a leg brace or when custom molded
- Oxygen and oxygen equipment
- Supplies you may need to take care of a medical problem
- 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 Section 7.

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 order.

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 SERVICES

Medica Behavioral Health manages our network of providers for mental health services. Medica Behavioral Health uses a limited network of providers to provide mental health care care; except for emergencies. Medica Behavioral Health must arrange all such benefits; and you must get service authorization for your plan of treatment call Medica Behavioral Health at 1-800-848-8327 (toll free) or for TTY (hearing impaired) dial 1-800-543-7162 (toll free).

COVERED SERVICES:

- Adult Mental Health Crisis Services (non-residential and residential): assessment, mobile intervention, treatment planning, and stabilization services
- Children’s Mental Health Crisis Services (non-residential): mobile assessment, intervention, and stabilization
- Adult Rehabilitative Mental Health Services (ARMHS): basic living/social skills, community intervention, medication education, and services to help you stay in the community
- Assertive Community Treatment (ACT)
- Certified Peer Specialist Services
- Children’s Therapeutic Services and Supports (CTSS): rehabilitative services including individual, group and family psychotherapy; individual, group and family skills training; mental health behavioral aides (MHBA); and crisis assistance.
- Consultation between your primary care doctor and a psychiatrist about your care
- Crisis assessment and intervention provided in an emergency or urgent care setting
- Day treatment and partial hospitalization
- Diagnostic assessment including screening for the presence of co-occurring mental illness and substance use disorder
- Dialectical Behavioral Therapy (DBT) for persons who have been diagnosed with borderline personality disorder.
- Explanation of findings
- Inpatient psychiatric hospital stay
- Intensive Residential Treatment Services (IRTS)
- Medication management

- Mental health services provided via two-way interactive video, which would otherwise be covered as direct face-to-face services
- Mental Health Targeted Case Management for persons with serious and persistent mental illness (SPMI) or serious emotional disturbance (SED).
- Neuropsychological services
- Psychological testing
- Psychotherapy: individual, family, multi-family, and group
- Subacute psychiatric care for persons under age 21
- Treatment services at children’s residential mental health treatment facilities (Rule 5). Treatment services do not include coverage for room and board. Room and board may be covered by your county. Call your county for information.

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)
- Treatment and room and board services at certain children’s residential mental health treatment facilities (Rule 5) in bordering states

NOTES:

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

Get mental health services from the Plan network of mental health providers.

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 who 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 100 days of nursing home room and board. If you need continued nursing home care beyond the 100 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.
- Skilled nursing care
- 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.

OBSTETRICS AND GYNECOLOGY (OB/GYN) SERVICES

COVERED SERVICES:

- Prenatal, delivery, and postpartum care
- Childbirth classes
- HIV counseling and testing for pregnant women – **open access service**
- Services provided by licensed birth centers. This includes services of certified nurse midwives and licensed traditional midwives. *This is effective upon federal approval.*
- Treatment for HIV-positive pregnant women
- Testing and treatment of sexually transmitted diseases (STDs) - **open access service**
- Pregnancy-related services received in connection with an abortion (does not include abortion-related services)

NOT COVERED:

- Abortion: This service is not covered under the Plan. It may be covered by the State. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) for coverage information. Also see Section 9.

NOTES:

You have “direct access” to OB-GYN providers without a referral for the following services: annual preventive health exam, including follow-up exams that your doctor says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services you must go to a provider in the Plan network. For services labeled as open access, you can go to any doctor, clinic, hospital, pharmacy, or family planning agency.

OUT-OF-AREA SERVICES

COVERED SERVICES:

- A service you need when you are 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 Medica Customer Service 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 care, urgent care, or other health care services received from providers located outside the United States and Canada

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 chemical dependency
- Open access services
- Pregnancy-related services received in connection with an abortion (does not include abortion-related services)

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 physician or pharmacist)

NOT COVERED SERVICES:

- Drugs used to treat impotence
- 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

NOTES:

The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor 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 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. 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 31-day supply at one time.

You can ask us to cover your drug even if it is not on our formulary. You can call Medica Customer Service at the phone number in Section 1 for help.

You and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions. For help with formulary exceptions, you can call Member Service at the phone number in Section 1 for help.

If a pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. 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, you can. You can also call Medica Customer Service at the phone number in Section 1 for help.

PRESCRIPTION DRUGS FOR PEOPLE WHO HAVE MEDICARE

COVERED SERVICES:

- Benzodiazepines, barbiturates, 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 impotence

- 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

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.

REHABILITATION

COVERED SERVICES:

- Physical, occupational, speech, respiratory therapies and audiology

NOT COVERED SERVICES:

- Vocational rehabilitation
- Health clubs and spas

SURGERY

COVERED SERVICES:

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

NOT COVERED SERVICES:

- Cosmetic surgery
- Sex reassignment surgery

TRANSPLANTS

COVERED SERVICES:

- Organ and tissue transplants, including: kidney, cornea, bone marrow, stem cell, heart, heart-lung, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, intestine, intestine-liver, and other transplants

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

COVERED SERVICES:

- Emergency ambulance (air or ground)
- Non-emergency ambulance
- Special transportation (for people who, because of physical or mental impairment, cannot safely use a common carrier and do not need an ambulance)
- Common carrier transportation (e.g., bus or cab)

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 another source. Call your county for more information.

NOTES:

If you need transportation to and from health services that we cover, call the Transportation phone number in Section 1.

The Plan is not required to provide transportation to your Primary Care Clinic if it is over 30 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.

URGENT CARE

COVERED SERVICES:

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

NOT COVERED SERVICES:

- Urgent care, emergency care, or other health care services received from providers located outside the United States and Canada.

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 Medica Customer Service 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 Medica Customer Service 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, guest services
- Cosmetic procedures or treatment
- Experimental or investigative services
- Emergency care, urgent care, or other health care services received from providers located outside the United States and Canada
- Autopsies

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

These services are **not** covered by us under the Plan, but may be covered through another source, such as the State, county, federal government, or tribe. 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).

- Child welfare targeted case management
- Case management for people with developmental disabilities
- Intermediate care facility for people with developmental disabilities (ICF/MR)
- Nursing home stays that exceed 100 days. See “Nursing Home Services” in Section 7.
- Medicare Part A and Medicare Part B services. You must be entitled with Medicare to get these services.
- 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.
- Abortion services
- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance
- Treatment at Rule 36 facilities which 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
- Waiver services provided under Home and Community Based waivers
- Job training and educational services
- Day training and habilitation services

- HIV services under the Ryan White Act
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Room and board associated with treatment services at children's residential mental health treatment facilities (Rule 5). Room and board may be covered by your county. Call your county for information.

Section 10. When to call your county worker

Call your county worker to report these changes:

- Name or address changes
- Pregnancy begin/end dates
- Adding or losing a household member
- Lost or stolen Minnesota Health Care Program ID card
- New insurance or Medicare – begin/end dates.
- New job or income 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:

- Medicare
- No fault car insurance
- Workers’ compensation
- Other 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 payments going 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 Fair Hearing process

If you disagree with a decision or have a complaint, you can do any of the following:

You can call Medica Customer Service 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 listed under “Appeals and Grievances.”

You can write to the Minnesota Department of Human Services to request a State Fair Hearing. You may request a State Fair Hearing at any time during the Plan appeal process. You do not have to file an appeal with us before you request a State Fair Hearing.

You can call or write to the Minnesota Department of Health.

Timelines for filing grievances, appeals, and State Fair Hearings:

You must request a State Fair Hearing **within 30 days** after the date on the notice from us. You have up to 90 days if you have a good reason for being late.

You must file a grievance or appeal with us **within 90 days** after the date on the Notice of Action or from the date of the incident about which you are complaining.

For the Restricted Recipient Program, an enrollee who receives a notice of restriction must file an appeal within 30 days of the date of the notice. You may also request a State Fair Hearing within 30 days of the date of the notice. You have up to 90 days if you have a good reason for being late.

Continuation of services:

If we are stopping or reducing a service, you can keep getting the service if you file a health plan appeal or request a State Fair Hearing **within 10 days after we send you the notice, or before the service is stopped or reduced, whichever is later.** The participating treating provider must agree the service should continue. The service can continue until the appeal or State Fair Hearing is resolved. If you lose the appeal or State Fair Hearing, you may have to pay for these services yourself.

Your Rights:

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

Your provider may file a grievance or appeal, or request a State Fair Hearing, on your behalf. The provider must have your written consent. The treating provider may appeal utilization review decisions with us without your written consent.

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

You may request a State Fair Hearing at any time during the Plan appeal process. You do not have to file an appeal with us before you request a State Fair Hearing.

There is no cost to you for filing an appeal with us or for a State Fair Hearing. We may pay for some expenses such as transportation, childcare, photocopying, etc.

If you have seen a medical provider who is part of our Plan network and want another opinion, you can get a second opinion. You must see another Plan network medical provider.

If you have seen a mental health provider who is part of the Plan network and have been told that no structured mental health treatment is needed, you may get a second opinion. See “Mental Health Services” in Section 7 of this Certificate for more information.

If you have seen a chemical dependency assessor who is part of our Plan network and you disagree with the assessment, you may get a second opinion. See “Chemical Dependency Services” in Section 7 of this Certificate for more information.

If you ask to see your medical records, or want a copy, 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:

A Grievance is an expression of discontent about any matter other than an action. This includes, but is not limited to, discontent with:

- quality of care or services provided
- failure to respect your rights

Call Medica Customer Service 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.

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help.

To file a written grievance with us:

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

We can help you put your grievance in writing. Call Medica Customer Service at the phone number in Section 1 if you need help.

We will notify you within 10 days that the grievance has been received.

We will give you a written decision within 30 days from the day we get your grievance. 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 30 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.

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help.

To file an oral or written appeal with us

An Appeal is your oral or written request for review of our action on a request for services or payment. This includes:

- the denial or limited authorization in the type or level of service
- the reduction, suspension, or stopping of a service that was approved before
- the 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

Call Medica Customer Service at the phone number in Section 1 and request an oral appeal. Tell us why you disagree with the decision. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited resolution. We will help you complete a written and signed appeal.

You can also send a letter about your appeal. In the letter, explain why you disagree with the decision. Send the letter to the address in Section 1 listed under “Appeals and Grievances.”

We can help you write your appeal. Call Medica Customer Service at the phone number in Section 1 if you need help.

If your appeal is about an urgently needed service we will give you a decision within 72 hours. We will try to call you with the decision before we send the written decision.

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 72 hours that we are taking extra time and the reasons why. If we do not grant your request for an expedited review, you may file a grievance.

We will notify you within 10 days that your appeal has been received.

For standard appeals, we will give you a written decision within 30 days from the day we get your appeal. 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 30 days that we are taking extra time and the reasons why.

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

If we are deciding an appeal regarding denial of a service for lack of medical necessity or one that involves clinical issues, the person making the decision will be a health care professional with appropriate clinical expertise in treating the condition or disease.

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

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

If you do not agree with our decision, you can request a State Fair Hearing with the Minnesota Department of Human Services. You can also call the Ombudsman for State Managed Health Care Programs for help.

To file a State Fair Hearing with the Minnesota Department of Human Services

A State Fair Hearing is a hearing at the State to review a decision made by us. You must request a hearing in writing. You may ask for a hearing if you disagree with:

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

You must ask for a State Fair Hearing **within 30 days** of the date of the Notice of Action or the decision in a Plan appeal. You can have up to 90 days to request a State Fair Hearing if you have a good reason for being late.

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

Or fax to: 651- 431-7523

A Human Services Judge from the State Appeals Office will hold a hearing. You may attend the hearing in person or by telephone.

Tell the State why you disagree with the decision made by us.

You can ask a friend, relative, advocate, provider, or lawyer to help you.

The process can take between 30-90 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 medical necessity denial, you may ask for an expert medical opinion. This will be from an outside reviewer. There is no cost to you.

If you do not agree with the Judge's decision, you may ask the Appeals Office to reconsider their decision. To ask for a reconsideration, send a written request to the Appeals Office within 30 days of the date of the decision.

You may also appeal to the district court in your county.

Ombudsman for State Managed Health Care Programs

An Ombudsman for State Managed Health Care Programs may be able to help with your problem. They can help you file a grievance or appeal to us. They can also help you request a State Fair Hearing.

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

Or Call: 651-431-2660 or 1-800-657-3729 (toll free) or 1-800-627-3529 (TDD)

To file a complaint with the Minnesota Department of Health

Write to: Minnesota Department of Health
Health Policy and Systems Compliance Division
Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882

Or Call: 651-201-5100 (Twin Cities metro) or toll free 1-800-657-3916.

Section 14. Definitions

These are the meanings of some words in this Certificate of Coverage.

Action: This includes:

- the denial or limited authorization in the type or level of service
- the reduction, suspension, or stopping of a service that was approved before
- the 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: Your oral or written request to us for review of an action. This request may also be from your provider acting on your behalf with your written consent. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited resolution. We will help you complete a written and signed appeal.

Autopsy: An exam that is done on the body of someone who dies. It is done to find out what caused a person's death.

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

Care System: – A group of certain providers Medica contracts with and that you select. This system takes responsibility for your continuum of care. This system includes the coordination of all health services in this Plan. These systems may change from time to time.

Certificate of Coverage: What the document you are reading is called. This Certificate 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.

Chemical Dependency: Using alcohol or drugs in a way that harms you.

Child: Enrollee under age 21.

Child and Teen Checkups (C&TC): A special health care program of well-child visits for members under age 21. It includes screening to check for health problems. It also includes referrals for diagnosis and treatment, if necessary.

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: An amount a health plan member is responsible to pay to the provider. Copays are usually paid at the time service is provided.

Coinsurance: – A percentage of the total amount paid for a service that a plan member has to pay to the provider when a specific service is received.

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

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

Disenroll or Disenrollment: The process of ending your membership in our plan.

Durable Medical Equipment: Equipment that can withstand repeated use. It is used for a medical purpose. The equipment must be medically necessary and ordered by a doctor.

Emergency: A condition that needs treatment right away. It is a condition that a prudent person believes needs prompt care, and without prompt care, it could cause: serious physical or mental harm; continuing severe pain; serious damage to body functions, organs, or parts; or death. Labor and childbirth can sometimes be an emergency.

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

Experimental: 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: Expression of discontent about any matter other than an action. This includes, but is not limited to, discontent with:

- quality of care or services provided
- failure to respect your rights

Home Health Care: Care that is provided in your home that is medically necessary and ordered by a doctor.

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.

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

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

Medically Necessary: Care that is appropriate for the condition. This includes care related to physical conditions and mental health. It includes the kind and level of service. It includes the number of treatments. It also includes where you get the service and how long it continues. Medically necessary care must:

- be the service that 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 65 years of age or older. It is also for some people under age 65 with disabilities, and people with End Stage Renal Disease.

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

Member: A person who is enrolled in our Plan and who is eligible to get covered services.

Network: Our contracted health care providers for the Plan.

Notice of Action: A form or letter we send you telling you about a decision on a claim, a service, or any other action taken by us.

Ombudsman: A person at the Minnesota Department of Human Services who can help you with access, service or billing problems. He/she can also help you file a grievance or appeal to us or request a State Fair Hearing.

Open Access Services: Federal and state law allow you to choose any physician, 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 which 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 an enrollee by a non-network provider outside of the Plan service area.

Out-of-Network Services: Health care provided to an enrollee by a non-network provider.

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 of coverage. It continues until: the person is discharged; our Plan network doctor begins care; or we, the hospital, and doctor agree to a different arrangement.

Prescriptions: Medicines and drugs ordered by a medical provider.

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 clinic 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 Provider: The doctor or other health professional you see at your Primary Care Clinic. This person will manage your health care.

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

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 doctor, one drug store, one hospital or other 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 chemical dependency 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 Medica Customer Service at the phone number in Section 1 for details about the service area.

Service Authorization: Our approval that is needed for some services before you get them.

Standing Authorization: Written consent from us to see a non-network specialist more than one time (for ongoing care.)

Special Needs Basic Care (SNBC): A voluntary managed care program for people with disabilities. SNBC is for people who have Medical Assistance and are aged 18-64. SNBC covers the basic Medical Assistance Services, except for personal care assistance and private duty nursing.

State Fair Hearing: A hearing at the State to review a decision made by us. You must request a hearing in writing. You may ask for a hearing if you disagree with:

- a denial, termination or reduction of services
- enrollment in the Plan
- denial in full or part of a claim for a service
- our failure to act within required timelines for service 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.

United States: For the purpose of this Certificate of Coverage, 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.

MEDICA®

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