Medica®

Medica Choice Care℠ MSC+
Minnesota Senior Care Plus

Member Handbook

January 1, 2024

This booklet contains important information about your health care services.

Medica Health Plans
State Public Programs
P.O. Box 9310, Route CP540
Minneapolis, MN 55440-9310

Medica Member Service
1 (877) 379-7540 (TTY: 711)
Monday-Friday 8 a.m.-6 p.m.
Medica.com/MSC

Medica Member Services
1 (888) 347-3630 (toll free) TTY: 711

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, veuillex 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.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်၊ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစီနိၣ်ဂံၣ်လၢထးအံၤနူဉ်တက့်၊

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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 (afcelinta) qoraalkan, lambarka kore wac.

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

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

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Civil Rights Notice

Discrimination is against the law. Medica 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

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Medica. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:
Medica Civil Rights Coordinator
P.O. Box 9310, Mail Route CP250, Minneapolis, MN 55443-9310
Toll Free: 1 (888) 347-3630
TTY: 711
Fax: 952-992-3422
Email: civilrightscoordinator@medica.com

Auxiliary Aids and Services: Medica 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** Medica at 1 (888) 347-3630 (toll free), TTY: 711 or at medica.com/contactmedicaid.

Language Assistance Services: Medica 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** Medica at 1 (888) 347-3630 (toll free), TTY: 711 or at medica.com/contactmedicaid.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Medica. You may also contact any of the following 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
- religion (in some cases)

Contact the **OCR** directly to file a complaint:
Office for Civil Rights, U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240 Chicago, IL 60601
Customer Response Center: 800-368-1019, TTY: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)
In Minnesota, you have the right to file a complaint with the MDHR if 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
540 Fairview Avenue North, Suite 201, St. Paul, MN 55104
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
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

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. 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 the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. 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 administrative actions.

Contact **DHS** directly to file a discrimination complaint:
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

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.

Welcome to Medica

We are pleased to welcome you as a member of Medica Choice Care (referred to as “plan” or “the plan”).

Medica (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 qualified health care provider to use.

You will be contacted by Medica, to complete a health assessment by a care coordinator. The assessment will help us connect you to health care services or other services available to you as a member. Based on your answers, we may contact you for additional information. If you have questions about this assessment, please call your care coordinator.

This Member Handbook is our contract with you. It is an important legal document.

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: Aitkin, Anoka, Becker, Benton, Blue Earth, Carlton, Carver, Cass, Chisago, Clay, Crow Wing, Dakota, Faribault, Fillmore, Hennepin, Houston, Isanti, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Mahnomen, Marshall, Mille Lacs, Morrison, Mower, Nicollet, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Rice, Roseau, Scott, Sherburne, St. Louis, Stearns, Todd, Wadena, Washington, Watonwan, Wilkin, Winona, and Wright.

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, call, email, or write to Member Services. We will be happy to help you. Member Services hours of service are 8 a.m. to 6 p.m., Monday through Friday.

CALL: 1 (877) 379-7540 The call is free.
TTY: 711 The call is free.
FAX: (952) 992-3660
WRITE: Medica Health Plans
Route CP540
P.O. Box 9310
Minneapolis, MN 55440-9310
VISIT: Medica, 401 Carlson Parkway, Minnetonka, MN 55305

WEBSITE: Medica.com/MSC
EMAIL: Medica.com/Medica-Contact-Form

Our plan contact information for certain services

Appeals and Grievances Call Medica Member Services at 1 (877) 379-7540 The call is free. (TTY: 711) Refer to Section 13 for more information.

Chiropractic Services Call Medica Member Services at 1 (877) 379-7540 The call is free. (TTY: 711)

Dental Services Your dental benefits are administered through Delta Dental of Minnesota, using the Minnesota Select Dental network. Call Delta Dental of Minnesota Customer Service at (651) 406-5919 or 1 (800) 459-8574 The call is free. (TTY: 711)

Durable Medical Equipment Coverage Criteria Call Medica Member Services at 1 (877) 379-7540 The call is free. (TTY: 711)

Home and Community Based Services (Elderly Waiver) Call Medica Member Services at 1 (877) 379-7540 The call is free. (TTY: 711)

Interpreter Services

American Sign Language (ASL) Please call 711.
Spoken Language If you need an interpreter, call Medica Member Services at 1 (877) 379-7540 The call is free.

Mental Health/Behavioral Health Services Call Medica Behavioral Health at 1 (800) 848-8327 The call is free. (TTY: 711)

Nurse Line
Call Medica's Nurseline™ by Health Advocate℠ – available for you 24 hours a day, 7 days a week at 1 (866) 715-0915 The call is free. (TTY: 711)

Prescriptions Call Medica Member Services at 1 (877) 379-7540 The call is free. (TTY: 711)

Substance Use Disorder Services Call Medica Behavioral Health at 1 (800) 848-8327 The call is free. (TTY: 711)

Transportation Call Medica Member Services at 1 (877) 379-7540 The call is free. (TTY: 711)

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 800-627-3529 (toll free) (TTY, Voice, ASCII, Hearing Carry Over), or 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 Medica Member Services at 1 (877) 379-7540 The call is free. (TTY: 711). More information about health care directives can be found: in the *Important Information* booklet that you receive in the mail in your Medica Welcome Packet or annual Renewing Member Packet. You may also visit the Minnesota Department of Health (MDH) website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/advdir.html

To Report Fraud and Abuse call Member Services at 1 (877) 379-7540 (TTY: 711). The call is free. 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 800-657-3750 or 711 (TTY), or use your preferred relay services (This call is free); 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 (Medicaid) program through counties. If you have questions about your eligibility for Medical Assistance (Medicaid), contact your county worker.

Ombudsperson for Public Health Care Programs

The Ombudsperson for Public Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving access, service, and billing problems. They can help you file a grievance or appeal with us. The Ombudsperson can also help you request a State Appeal (Fair Hearing with the state). Call 651-431-2660 or 800-657-3729 or 711 (TTY), or use your preferred relay services. This call is free. Hours of service are Monday through Friday, 8:00 a.m. to 4:30 p.m.

Office of Ombudsperson for Long-Term Care

Contact the Office of Ombudsperson 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 800-657-3591. This call is free.

How to contact the Medicare program

Medicare is the Federal health insurance program for people 65 years of age or over, 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 800-MEDICARE (800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 877-486-2048. This call is free. 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 800-333-2433 or write to them at Minnesota Board on Aging, P.O. Box 64976, St. Paul, MN 55164-0976. This call is free. You may also find the website 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. The Provider Directory can tell you information about providers such as name, address, phone number, professional qualifications, specialty, and languages spoken by the provider. Call Member Services, if you

would like information about board certification, medical school attendance, residency program, and board certification status. You may ask for a print copy of the Provider Directory at any time. 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.

When you are a member or become a member of Medica you chose or were assigned to a primary care clinic (PCC). Your primary care clinic (PCC) can provide most of the health care services you need, and will help coordinate your care. You may change your primary care clinic (PCC). Contact Medica Member Services at the phone number in Section 1 to change your PCC.

You do not need a referral to use a plan network specialist. However, your primary care clinic can provide most of the health care services you need, and will help coordinate your care.

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

If a drug you are currently taking is not covered under your new plan, you may be able to receive up to a 90-day temporary supply. For more information, call Member Services.

Utilization management

Medica wants you to get the right amount of quality care. We want to make sure that the health care services provided are medically necessary, right for your

condition and are provided in the best care facility. We also need to make sure that the care you get is a covered benefit. The process to do this is called utilization management (UM). We follow policies and steps to make decisions about approving medical services. We do not reward providers or staff for denying coverage. We do not give incentives for UM decisions. We do not reward anyone for saying no to needed care.

Prior Authorizations*:*

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. Please work with your qualified health care provider to get a prior authorization when required. In urgent situations, we will make a decision within 72 hours after we receive the request from your doctor. For more information, call Member Services at the phone number in Section 1.

In most cases, you need to use plan network providers to get your services. If you need a covered service that you cannot get from a plan network provider, you must get a prior authorization from us to use an out-of-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 acquired immune deficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related conditions. You can use any qualified health care provider, 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 Member Services at the phone number listed in Section 1.

The plan allows direct access to the providers in our network, but keeps the right to manage your care under certain circumstances, such as: transplants*.* We may do this by choosing the provider you use and/or the services you receive. When

we manage your care, our nurse care manager and network providers will coordinate your care. For more information, call Member Services at the phone number in Section 1.

If we are unable to find you a qualified plan network provider, we must give you a standing prior authorization for you to use 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 prior authorization from us 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 who is 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 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 Medica, 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 1 (877) 379-7540. This call is free. (TTY: 711). We are available to help Monday through Friday 8 a.m. to 6 p.m. If you need language assistance to talk about these issues, Medica can give you information in your language through an interpreter. For sign language services, call 711. For other language assistance, call Member Services at 1 (877) 379-7540. This call is free.

Covered and not 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. Refer to Sections 7 and 8.

Some services are not covered under the plan, but may be covered through another source. Refer to 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.

Requests to cover new medical procedures, devices, or drugs are reviewed by Medica Medical Technology Assessment Committee (MTAC). This group includes

doctors and other health care experts. They use national guidelines and medical and scientific evidence to decide whether Medica should approve new equipment, procedures, or drugs.

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. If you received a medical bill that should have been 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.

Cultural awareness:

We understand that your beliefs, culture, and values play a role in your health. We want to help you maintain good health and good relationships with your qualified health care provider. We want to ensure you get care in a in a culturally sensitive way.

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 spoken language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. 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, refer to 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 get 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 (RRP) is for members who have misused health services. This includes getting health services that members did not need, using them in a way that costs more than they should, or in a way that may be dangerous to a member's health. Medica will notify members if they are placed in the Restricted Recipient Program.

If you are in the Restricted Recipient Program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. Medica may designate other health services providers. You may also be assigned to a home health agency. You will 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 Medica Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to use 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. 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. You may request a State Appeal (Fair Hearing with the state) after receiving our decision that we have decided to enforce the restriction. Refer to Section 13.

Cancellation:

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

If you are no longer eligible for Medical Assistance (Medicaid) and you do not have Medicare, you may be eligible to purchase health coverage through MNsure. For information about MNsure: call 855-3MNSURE or 855-366-7873 TTY, use your preferred relay services; or visit www.MNsure.org. This call is free.

Section 3. Member 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.

Have an open discussion to get information about appropriate or medically necessary treatment options for your conditions including how treatments will help or harm you, regardless of cost or benefit coverage.

Receive information about our organization, our services, our practitioners and providers, and member rights and responsibilities.

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.

Ask for and get 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 Appeal (Fair Hearing with the state) with the Minnesota Department of Human Services (also referred to as “the state”). You must appeal to us before you request a State Appeal. 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.

Receive 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 make decisions 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, 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.

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

Request a written 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
- The professional qualifications of health care providers

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 ID card and your Minnesota Health Care Program 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 qualified health care provider before you become ill. This helps you and your qualified health care provider understand your total health condition.

Give information asked for by your 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 qualified health care provider to understand your total health condition. Develop mutually agreed-upon treatment goals when possible. Follow plans and instructions for care that you have agreed to with your doctor. If you have questions about your care, ask your 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 vaccinations 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 Identification (ID) Card

Each member will receive a plan member ID card.

Always carry your plan member ID card with you.

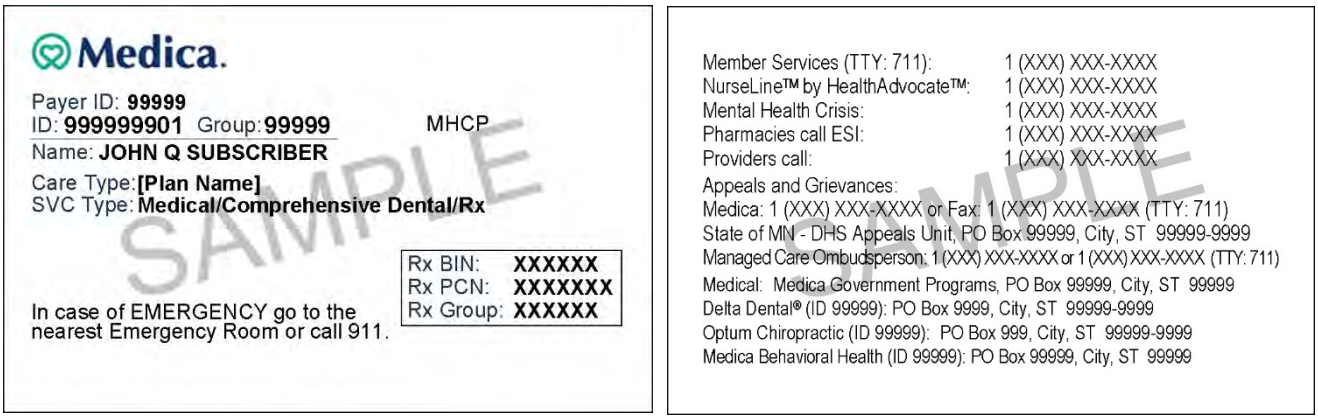
You must show your plan member ID card whenever you get health care.

You must use your plan member ID card along with your Minnesota Health Care Program 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 ID card is lost or stolen. We will send you a new card.

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

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



Section 6. Cost Sharing

Cost sharing is an amount that health plan members may be responsible to pay to their providers for their medical services. It includes deductibles and copays. As of January 1, 2024, **you do not have cost sharing for medical or pharmacy services covered under Medical Assistance.**

Copays

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.	$0.00
Diagnostic procedures (for example, endoscopy, arthroscopy)	$0.00
Emergency room visit when it is not an emergency	$0.00
Brand name prescriptions	$0.00
Generic prescriptions	$0.00

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. If you have a copay, you must pay your copay to your provider.

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. If you need help understanding what services are covered, call Member Services at the phone number in Section 1. Some services have limitations. Some services require a prior authorization. A service marked with an asterisk (*) means a prior authorization is required. Make sure there is a prior authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Refer to Section 2 for more information on prior authorizations. You can also call Member Services at the phone number in Section 1 for more information.

Acupuncture Services

Covered Services:

- Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing.
- Acupuncture services are covered for the following:
    - acute and chronic pain
    - depression
    - anxiety
    - schizophrenia
    - post-traumatic stress syndrome
    - insomnia
    - smoking cessation
    - restless legs syndrome
    - menstrual disorders
    - xerostomia (dry mouth) associated with the following:
        - Sjogren's syndrome
        - radiation therapy
    - nausea and vomiting associated with the following:
        - post-operative procedures
        - pregnancy
        - cancer care

*Requires a prior authorization.

Chiropractic Care

Covered Services:

- One evaluation or exam per calendar year
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine - up to 24 treatments per calendar year, limited to six per month.
- 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) (cannot be performed on same date as a periodic or limited evaluation)
  - periodic exam (once per calendar year) (cannot be performed on same date as a limited or comprehensive evaluation)
  - limited (problem-focused) exams (once per day) (Cannot be performed on same date as a periodic or comprehensive oral evaluation, or dental cleaning service)
  - detailed oral evaluation (cannot be performed on same date as full mouth debridement)
  - periodontal evaluation (cannot be performed on same date as full mouth debridement)
  - teledentistry for diagnostic services
  - imaging services, limited to:
    - bitewing (once per calendar year)
    - single X-rays for diagnosis of problems (four per date of service)
    - panoramic (once every five years and as medically necessary; once every two years in limited situations; or with a scheduled

*Requires a prior authorization.

outpatient hospital facility or freestanding Ambulatory Surgery Center (ASC) procedure.)
    - full mouth X-rays (once every five years)
- Preventive services:
    - dental cleanings (limited to two per calendar year) (up to four times per year if medically necessary)
    - fluoride varnish (once every six months) (cannot be performed on the same date as emergency treatment of dental pain service)
    - sealants (one every five years per permanent molar)
    - cavity treatment (once per tooth per 6 months)
    - oral hygiene instruction (Prior Authorization is required for additional service)
- Restorative services:
    - fillings (limited to once per 90 days per tooth)
    - sedative fillings for relief of pain (cannot be performed on same date as emergency treatment of dental pain service)
    - individual crowns (must be made of prefabricated stainless steel or resin)
- Endodontics (root canals) (once per tooth per lifetime)
- Oral surgery*
- Orthodontics only when medically necessary for very limited conditions*
- Periodontics:
    - gross removal of plaque and tartar (full mouth debridement) (once every five years) (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluation service)
    - scaling and root planing* (cannot be performed on same day as dental cleaning or full mouth debridement) (once every two years for each quadrant)
        - Follow-up procedures (periodontal maintenance) (up to four per calendar year following the completion of scaling and root planing)

*Requires a prior authorization.

- Prosthodontics:
  - removable appliances (dentures and partials) (one appliance every six years per dental arch); partials always require a Prior Authorization
  - adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials) (repairs to missing or broken teeth are limited to 5 teeth per 180 days)
  - replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances
  - replacement of partial appliances if the existing partial cannot be altered to meet dental needs
  - tissue conditioning liners
  - precision attachments and repairs
- Additional general dental services:
  - emergency treatment for dental pain (once per day)
  - general anesthesia, deep sedation (when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery.)
  - extended care facility/house call in certain institutional settings including: nursing facilities, skilled nursing facilities, boarding care homes, Institutions for Mental Diseases (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) (cannot be performed on same date as oral hygiene instruction service)
  - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
  - medications (only when medically necessary for very limited conditions)
  - nitrous oxide
  - oral bite adjustments
  - Oral or IV sedation (only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)

*Requires a prior authorization.

Notes:

If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance (Medicaid).
If you are new to our health plan and have already started a dental service treatment plan, contact us for coordination of care

Refer to Section 1 for Dental Services contact information.

Diagnostic Services

Covered Services:

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

Notes:

Diagnostic tests are covered if they meet Medicare or our coverage criteria and the test is medically necessary. Not every test will be covered.

Services may be provided in a physician office, a clinic setting, an outpatient hospital setting, an independent laboratory or radiology setting.

Doctor and Other Health Services

Covered Services:

- Doctor visits including:
  - allergy immunotherapy and allergy testing
  - care for pregnant women
  - family planning – **open access service**
  - lab tests and X-rays
  - physical exams
  - preventive exams

*Requires a prior authorization.

  - preventive office visits
  - specialists
  - telemedicine consultation
  - vaccines and drugs administered in a qualified health care provider's office
  - visits for illness or injury
  - visits in the hospital or nursing home
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Behavioral Health Home: coordination of primary care, mental health services, and social services
- Blood and blood products
- Clinical trial coverage: Routine care that is: 1) provided as part of the protocol treatment of a 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.
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Clinical Services
- Community health worker care coordination and patient education services
- Community Medical Emergency Technician (CMET) services
  - post-hospital/post-nursing home discharge visits ordered by your primary care provider
  - safety evaluation visits ordered by Primary Care Provider/Physician (PCP)
- Community Paramedic Services: certain services are provided by a community paramedic. The services must be a 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

*Requires a prior authorization.

- Counseling and testing for sexually transmitted diseases (STDs), AIDS and other HIV-related conditions - **open access service**
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Hospital In-Reach Community-Based Service (IRSC) Coordination: coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services.
- Immunizations
- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Respiratory therapy
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must use a provider in the plan network.
- Treatment of End-Stage Renal Disease (ESRD)
- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Tuberculosis care management and direct observation of drug intake

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 includes transport on water)

*Requires a prior authorization.

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:

If you have an emergency and need treatment right away, call 911 or use the closest emergency room. Show them your member ID card and ask them to call your qualified health care provider.

In all other cases, call your primary care qualified health care provider, if possible. 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, use the closest emergency room or call 911. Show them your member ID card and ask them to call your primary care qualified health care provider.

You must call your primary care clinic 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.

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 (for example, birth control pills, patch, ring, Intrauterine Device (IUD), injections, implants) – **open access service**
- Family planning supplies with prescription (for example, condom, sponge, foam, film, diaphragm, cap) – **open access service**
- Counseling and diagnosis of infertility, including related services – **open access service**

*Requires a prior authorization.

- Treatment for medical conditions of infertility – **NOT** an open access service. You must use 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 use a provider in the plan network.
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must use 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**, even if they are not in the plan network.

<u>Hearing Aids</u>

Covered Services:

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

*Requires a prior authorization.

Home Care Services

Covered Services:

- Skilled nurse visit
- Rehabilitation therapies to restore function (for example, speech, physical, occupational, respiratory)
- 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 Companion Services: Non-medical care, supervision and socialization
- Adult Day Services (ADS) and ADS Bath: Licensed individualized program of activities to meet the assessed health, social needs of an older adult . ADS Bath is optional. Also includes Family Adult Day Services (FADS).
- Adult Foster Care: Licensed, adult appropriate residential care and supportive services in a family-like setting.
- Case Management: Management of your health and long-term care services among different health and social service professionals.
- Chore Services: Heavy household services needed to keep your home safe.
- Consumer Directed Community Support Services: Services that you design to meet your needs and manage yourself within a set budget.
- Customized Living/24 Hour Customized Living: A group of individualized services (health related and supported services) provided in a qualified setting.
- Environmental Accessibility Adaptations: Physical changes to your home and vehicle needed to assure health and safety and enable you to be more independent. This also includes an assessment for home or vehicle modifications
- Extended State Plan Home Health Care Services: This includes home health aide services that are over the Medical Assistance (Medicaid) limit.

*Requires a prior authorization.

  - 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 (PCA) (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service): Help with personal care and activities of daily living (ADLs) over the Medical Assistance (Medicaid) limit. PCAs can also assist with instrumental activities of daily living (IADLs).
  - Family and Caregiver Services: Training, education, coaching and counseling for unpaid caregivers. This includes caregiver training, education, and caregiver counseling.
- Home Delivered Meals: An appropriate, nutritiously balanced meal delivered to your home.
- Homemaker Services: Services that help you manage general cleaning and household activities.
- Individual Community Living Support Services: A bundled service to offer assistance and support to remain in your own home including reminders, cues, intermittent supervision or physical assistance.
- Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief.
- Specialized Equipment and Supplies: Supplies and equipment that are over the Medical Assistance (Medicaid) limit or coverage or are not a part of other Medical Assistance (Medicaid) coverage but are specified in your support plan. This includes Personal Emergency Response System (PERS).
- Transitional Supports Services: Items and supports necessary to move from a licensed setting to an independent or semi-independent community based housing
- Transportation: Enables you to gain access to activities and services in the community.

NOTES:

You must have a MnCHOICES assessment done (formerly called a Long-Term Care Consultation (LTCC)) and be found to be nursing home certifiable to get these Elderly Waiver (EW) services. You can ask 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 20 days if you call to ask for a visit.

*Requires a prior authorization.

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.

For members not eligible or are pending a waiver assessment, the plan may cover services to assist the member to live as independently as possible.

People who live on or near the White Earth, Leech Lake, Red Lake, Mille Lacs or Fond du Lac Reservations may be able to choose to get their EW services through the Tribal health or human services division or through our plan. Contact the tribal nation 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 you will continue to get services covered by these programs in the same way you get them now. Your county case manager will continue to authorize these services and 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.

*Requires a prior authorization.

Refer to 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

Notes:

Medicare Election

You must elect hospice benefits to receive hospice services.

If you are both Medicare and Medicaid eligible, and elect hospice, you must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit you from choosing hospice care through one program and not the other when you are eligible for both.

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

*Requires a prior authorization.

Hospital - Inpatient

Covered Services:

Inpatient hospital services are covered if determined to be medically necessary. This includes:

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

Not Covered Services:

- Personal comfort items, such as TV, phone, barber or beauty services, guest services
- Charges related to hospital care for investigative services, plastic surgery or cosmetic surgery are not covered unless determined medically necessary through the medical review process

Notes:

For further information on different types of inpatient admissions including inpatient mental/behavioral health or substance use disorder (SUD), please refer to those specific sections in this member handbook.

Non-emergency care received at a hospital may require a prior authorization. Work with your qualified health care provider to get a prior authorization when required. You can also call Member Services at the phone number in Section 1 for more information.

*Requires a prior authorization.

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
- Observation services- if you're not admitted as an inpatient to the hospital, you may enter "outpatient observation" status until your provider determines your condition requires an inpatient admission to the hospital or a discharge home. Observation services are covered up to 48 hours. Medica will consider observation services up to 72 hours for unusual circumstances when submitted with additional documentation.

Notes:

Non-emergency care received at a hospital may require a prior authorization. Please work with your qualified health care provider to get a prior authorization when required. You can also call Member Services at the phone number in Section 1 for more information.

Housing Stabilization Services

Covered Services:

The plan will pay for the following services for members eligible for Housing Stabilization Services:

- Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services
- Housing transition services to help you plan for, find, and move into housing
    - Housing transition- moving expenses (limited to $3000 per year)

*Requires a prior authorization.

    - Only for people leaving a Medical Assistance funded institution of provider-controlled setting who are moving into their own home.
    - Applications, security deposits, and the cost of securing documentation that is required to obtain a lease on an apartment or home
    - Essential household furnishings required to live in and use in the home, including furniture, window coverings, food preparation items, and bed or bath linens
    - Set up fees or deposits for utility or service access, including telephone, electricity, heating and water
    - Services necessary for the individual's health and safety such as pest removal and one time cleaning prior to moving in
    - Necessary home accessibility adaptations
- Housing sustaining services to help you maintain housing
- Transportation to receive Housing Stabilization Services (within a 60 mile radius)

Not Covered Services:

- Rent or mortgage payments
- Food
- Clothing
- Recreational items, including streaming devices, computers, televisions, cable television access, speakers and so forth
- Any items, expenses or supports that duplicate any other service or are owned or leased by a provider

Notes:

You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. If you need Housing Stabilization Services, you can ask for an assessment or be supported by your provider or case manager. If you have a targeted case manager, or waiver case manager or senior care coordinator, that case manager may support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you.

*Requires a prior authorization.

Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to receive this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.

If you are approved for moving expenses, your provider must send us the receipt for each moving expense. Work with your provider on how to access this benefit.

Interpreter Services

Covered Services:

- Spoken language interpreter services
- Sign language interpreter services

Notes:

Interpreter services are available to help you get covered services.

Refer to Interpreter Services in Section 1 for contact information and to find out which interpreters you can use.

Medical Equipment and Supplies

Covered Services:

- Prosthetics or orthotics
- Durable medical equipment* (for example, wheelchairs, hospital beds, walkers, crutches, standers, bath and toilet equipment, and wigs for people with hair loss due to any medical condition). Contact Member Services for more information on coverage and benefit limits for wigs.
- Repairs of medical equipment
- Batteries for medical equipment
- Some shoes, including therapeutic stock shoes when specific criteria are met and when custom molded or part of a leg brace
- Oxygen and oxygen equipment
- Airway clearance devices
- Electrical stimulation devices

*Requires a prior authorization.

- 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**. (Refer to Family Planning Services in this section.)
- Augmentative communication devices, including electronic tablets
- Seizure detection devices

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 will need to use your qualified health care provider and get a prescription for medical equipment and supplies to be covered.

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:

- Certified Community Behavioral Health Clinic (CCBHC)
- Clinical Care Consultation
- Crisis response services including:
  - screening
  - assessment
  - intervention
  - stabilization including residential stabilization

*Requires a prior authorization.

  - 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)
- Forensic Assertive Community Treatment (FACT)
- Inpatient psychiatric hospital stay, including extended inpatient psychiatric hospital stay
- Mental health provider travel time
- Mental Health Targeted Case Management (MH-TCM)
- 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)
- Telehealth

Not Covered Services:

- Conversion therapy

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

*Requires a prior authorization.

- 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:

Refer to Mental Health/Behavioral Health Services in Section 1 for information on where you should call or write.

Use a plan network provider for mental health services.

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 use 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.

*Requires a prior authorization.

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

Optical Services

Covered Services:

- Eye exams
- Initial eyeglasses, when medically necessary (eyeglass frames selection may be limited)
- Replacement eyeglasses, when medically necessary
    - Identical replacement of covered eyeglasses 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
- Progressive bifocal/trifocal lenses (without lines)
- Protective coating for plastic lenses
- Contact lens supplies

Out-of-Area Services

Covered Services:

- A service you need when temporarily out of the plan service area. Your health care provider can obtain a Prior Authorization Form from Medica.com/Providers under Utilization Management and Prior Authorization or by calling 1 (800) 458-5512. This call is free. (TTY: 711). This form must be returned to the fax number or email address listed on

*Requires a prior authorization.

the form. To facilitate a thorough review, Medica recommends that all information requested in the form be included.
- 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.

Notes:

If you need to use a pharmacy when out of the plan service area, call Member Services at the phone number in Section 1 first before you pay for a prescription drug or over-the-counter drug, even if the drug is on our list of covered drugs (LOCD) (formulary). We cannot pay you back if you pay for it.

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
- 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*

*Requires a prior authorization.

- Services related to the diagnosis, monitoring, and treatment of a rare disease or condition

Notes:

Sometimes members need to see a very specialized type of doctor. We will work with your qualified health care provider to make sure you get the specialist or service when you need it, for as long as you need it, even if the provider is not currently a network provider. There is no cost to you when we authorize the care or service before you see the 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 excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved or authorized by the Food and Drug Administration (FDA)
- Medical cannabis

Notes:

The list of covered drugs (formulary) includes the prescription drugs covered by Medica. 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 Fee-for-Service Medical Assistance (Medicaid). The list also must include drugs listed in the Department of Human Services' Preferred Drug List (PDL).

*Requires a prior authorization.

In addition to the prescription drugs covered by Medica, some over-the-counter drugs are covered under your Medical Assistance (Medicaid) benefits. A list of covered drugs (formulary) is also posted on the website. You can also call Member Services and ask for a written copy of our list of covered drugs (formulary).

If a drug you are currently taking is not covered under your new plan, you may be able to receive up to a 90-day temporary supply. For more information, call Member Services.

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization (PA):** Medica requires you or your doctor or health care provider to get prior authorization for certain drugs. This means that you will need to get approval from Medica before you fill your prescriptions. If you don't get approval, Medica may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, Medica limits the amount of the drug that Medica will cover.
- **Preferred/Non-Preferred (P/NP):** For some groups of drugs, Medica requires you to try the preferred drugs before paying for the non-preferred drugs. In order to receive a non-preferred drug, your doctor or health care provider will have to get prior authorization.
- **Age Requirements:** In some cases, there are age requirements for you to try certain drugs. A prior authorization is needed depending on your age and the specific drug prescribed.
- **Brand-name Drugs:** Brand-name version of the drug will be covered by Medica only when:
    - Your prescriber informs Medica in writing that the brand name version of the drug is medically necessary; OR
    - Medica prefers the dispensing of the brand-name version over the generic version of the drug; OR
    - Minnesota Law requires the dispensing of the brand-name version of the drug

*Requires a prior authorization.

You can find out if your drug requires prior authorization, has quantity limits, has Preferred/Non-Preferred status, or has an age requirement by contacting Member Services or visiting our website at Medica.com/MSC. A drug restriction or limit can be removed if your doctor submits a statement or documentation supporting the request. You can also get more information about the restrictions applied to specific covered drugs by contacting Member Services or visiting our website at Medica.com/MSC.

If Medica changes prior authorization requirements, quantity limits, and/or other restrictions on a drug you are currently taking, Medica will notify you and your prescriber of the change at least 10 days before the change becomes effective.

We will cover a non-formulary drug if your 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 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 antipsychotic 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.

Most drugs and certain supplies are available up to a 30-day supply. Certain drugs you take on a regular basis for a chronic or long-term condition are available up to a 90-day supply and are listed on Medica's List of Covered Drugs as generic drugs, non-Controlled, non-Specialty drugs with the indicator M: Maintenance drugs.

If Medica 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.

*Requires a prior authorization.

- You and/or your health care provider can ask Medica 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.

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

Your health care provider can obtain the Minnesota Uniform Formulary Exception and Prior Authorization Form online from Medica.com/RxPA or by calling 1 (800) 753-2851. This call is free. (TTY: 711) This form must be returned to the fax number or address listed on the document. To facilitate a thorough review, Medica asks that all information requested in the form be provided, including documentation of which medications have been tried and failed, including the dosage used, and the identified reason for failure.

If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your 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 qualified health care provider, you can. You can also call Member Services at the phone number in Section 1 for help.

If the pharmacy staff tells you the pharmacy is out of network, contact Member Services.

Specialty drugs are used by people with complex or chronic diseases. These drugs often require special handling, dispensing, or monitoring by a specially-trained pharmacist.

If you are prescribed a drug that is on the Medica Specialty Drug List, your prescriber will need to send the prescription of that specialty drug to Medica’s Specialty Pharmacy.

Name of Specialty Pharmacy: Accredo
Phone and TTY: 1 (866) 544-6817 This call is free. (TTY: 711)
Fax: 1 (877) 329-4605

*Requires a prior authorization.

Hours of Operation: Accredo Customer Service representatives will be available Monday through Friday 7 a.m. – 10 p.m. and Saturday 7 a.m. – 4 p.m. Central.
Website: Accredo.com

You will also need to call the Specialty Pharmacy at 1 (866) 544-6817 (TTY: 711) (this call is free) to set up an account. You will need to have your Medica Member Identification (ID) card when you call the Specialty Pharmacy.

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 excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved or authorized by the FDA
- Medical cannabis

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.

*Requires a prior authorization.

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
- Augmentative Communication Devices
- Audiology services including hearing tests

Not Covered Services:

- Vocational rehabilitation
- Health clubs and spas

Substance Use Disorder Services (SUD)

Covered Services:

- Screening/Assessment/Diagnosis including Screening Brief Intervention Referral to Treatment (SBIRT) authorized services
- Comprehensive assessments
- Outpatient treatment*
- Inpatient hospital

*Requires a prior authorization.

- Residential non-hospital treatment
- Outpatient medication assisted treatment*
- Detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification)
- SUD treatment coordination*
- Peer recovery support*
- Withdrawal Management*

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.

Notes:

Refer to Section 1 for Substance Use Disorder Services contact information.

A qualified professional who is part of the plan network will make recommendations for substance use disorder services for you. You may elect up to the highest level of care recommended by the qualified professional. You may receive an additional assessment at any point throughout your care, if you do not agree with the recommended services. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment. You have the right to appeal. Refer to Section 13 of this Member Handbook.

Surgery

Covered Services:

- Office or clinic visits and 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

*Requires a prior authorization.

- Gender affirming surgery*

Not Covered Services:

- Cosmetic surgery

Telehealth Services

Covered Services:

- Telehealth services cover medically necessary services and consultations delivered by a licensed health care provider by telephone or video call with the member. The member's location can be their home. Telehealth is defined as the delivery of health care services or consultations through the use of real time, two-way interactive audio and visual communications. The purpose of telehealth is to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment education, and care management of a patient's health care while the patient is at an originating site and the licensed health care provider is at a distant site.

Telemonitoring

Telemonitoring is the use of technology to provide care and support to a member's complex health needs from a remote location such as in a member's home. Telemonitoring can track a member's vital signs using a device or equipment that sends the data electronically to their provider for review. Examples of vital signs that can be monitored remotely include heart rate, blood pressure, and blood glucose levels.

Covered Services:

- Telemonitoring services for members with high-risk, medically complex conditions like congestive heart failure, chronic obstructive pulmonary disease (COPD) or diabetes (when medically necessary)

*Requires a prior authorization.

Tobacco and Nicotine Cessation:

Covered Services:

Medica Partners with Active Health® to offer additional services to help members quit tobacco. They include:

- Confidential telephonic coaching sessions
- Written self-help materials
- Digital support/coaching via app
- Home delivered nicotine replacement therapy not covered under Part D for 8 weeks per year (as medically appropriate)
- Personalized coaching plans have a goal of 30 consecutive days tobacco free. Members may make unlimited attempts to quit tobacco. Coaching plans are customized and structured based on member's individual needs.
    - Visit: www.Medica.com/LS/Resources/Medicaid/Tobacco-Cessation
    - Call: 1 (866) 905-7430 (TTY: 711). This call is free.

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) approved by the state's medical review agent.

Transplants must be done at a transplant center that is a Medicare approved transplant center.

*Requires a prior authorization.

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

Your health care provider must receive prior authorization from Medica before providing transplant-related care (including pre-transplant evaluations). You or your provider can call Medica toll-free at 1 (888) 906-0958 (TTY: 711). Medica can also help you find a Centers of Excellence transplant facility.

Transportation to and from Medical Services

Covered Services:

- Ambulance (air or ground includes transport on water)
- Volunteer driver transport
- Unassisted transport (taxicab or public transit)
- Assisted transport
- Lift-equipped/ramp transport
- Protected transport
- Stretcher transport

Not Covered Services:

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking also including out of state travel. These services are not covered under the plan, but may be available through the local county 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 more than 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 or if you do not have a specialty provider that is available within 60 miles of your home.

Visit Medica.com/Ride or call Member Services to learn more about transportation and how to set up a ride.

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.

You may also call the NurseLine at 1 (866) 715-0915 (TTY: 711). NurseLine provides clinical support 24 hours per day, 7 days a week. This call is free.

It's good to know what in-network urgent care clinic is nearest to you. You can find an urgent care clinic here: Medica.com/Find-Care. Or you can call Member Services.

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

*Requires a prior authorization.

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. The following 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.

- Autopsies (exams that are done on the bodies of people who have died to find out the cause of death)
- Cosmetic procedures or treatments
- 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.
- Experimental or investigative services
- Health care services or supplies that are not medically necessary
- Homeopathic and herbal products
- Hospital inpatient and nursing home incidental services, such as TV, phone, barber and beauty services, and guest services
- Supplies that are not used to treat a medical condition

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 DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672 or 711 (TTY), or use your preferred relay services This call is free.

- Case management for members with developmental disabilities
- Day training and habilitation services
- Except Elderly Waiver services, other waiver services provided under Home and Community Based Services waivers
- HIV case management
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Job training and educational services

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays for which our plan is not otherwise responsible. Refer to “Nursing Home Services” in Section 7.
- 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.
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by federal institutions
- Services provided by a state regional treatment center or a state-owned long-term care facility unless approved by us or the service is ordered by a court under conditions specified in law
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)

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 and end dates
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID card
- New insurance or Medicare – begin and end dates
- Change in 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 (Medicaid) 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 (Fair Hearing with the state) process

This section tells you about the grievance and appeal system including notices, grievances (complaints), health plan appeals, and State Appeals (Fair Hearings with the state). It tells you how and when to use the grievance and appeal system if you are not satisfied with your health care or service 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 made on 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 (Fair Hearing with the state) 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 previously approved
- 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
- denial of your request to dispute your financial liability including copayments and other cost sharing

Your provider may Appeal on your behalf with your written consent. Your treating provider may Appeal a Prior Authorization decision without your consent.

A State Appeal (Fair Hearing with the state) is your request for the state to review a decision we made. You must appeal to Medica before asking for a State Appeal. If we take more than 30 days to decide your appeal and you have not

requested an extension or we did not add an extension, you do not need to wait for our decision to ask for a State Appeal. You may appeal any of these actions (decisions):

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was previously approved
- 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
- financial liability including copayments or other cost sharing
- any other action

Important Timelines for Appeals

You must follow the timelines for filing health plan appeals and State Appeals (Fair Hearing with the state). If you go over the time allowed, we may not review your appeal and the state may not accept your request for an appeal.

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 you have not requested an extension or we did not add 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, but only if state policy allows it.

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. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. You may request a State Appeal after receiving our decision.

To file an oral or written appeal with us:

You may appeal by phone, writing, fax, or in person. The contact information and address is found in section 1 under "Appeals and Grievances."

You may submit any documents and give information in person, by telephone, or in writing. Your records will be kept private according to law. You will receive a letter from us confirming we have received your appeal request.

Your appeal request should include:

- Your name
- Date of birth
- Address
- Member number
- Phone number
- Reasons for appeal

You may also include any information you want us to review, such as medical records, provider's letters, or other information that explains why you need the item or service. Call your provider if you need this information. We recommend keeping a copy of everything you send us for your records.

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 or if you or your provider requests extra time. We will tell you why we are taking the extra time.

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 or if you request extra time. 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.

If you appeal, we will send you or your representative the case file upon request, including medical records and any other documents and records considered by us during the appeal process.

To file a State Appeal (Fair Hearing with the state) with the Minnesota Department of Human Services:

You must file a health plan Appeal with us **before** you ask for a State Appeal. You must ask for a State Appeal **within 120 days** from the date of our appeal decision (resolution).

Your appeal to the state must be in writing. You can write to the Minnesota Department of Human Services to request a State Appeal.

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

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.

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. You can ask your providers or others to give testimony. You can provide documents for the judge to consider.

The process can take 90 days. If your hearing is about an urgently needed service, tell the Judge or the Ombudsperson 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 Medica. 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.

Grievances (Complaints)

You may file a Grievance with us **at any time.** There is no timeline for filing a grievance with us. **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 or if you or your provider requests extra time. 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 a fast 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 in writing 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 or if you or your provider requests extra time. We will tell you we are taking the extra time and why.

If you do not agree with our decision, you can file your complaint 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

Call: 800-657-3916 (This call is free) or (651) 201-5100,

711 (TTY), or use your preferred relay services.

Visit: health.state.mn.us/facilities/insurance/clearinghouse/complaints.html

You can also call the Ombudsperson for Public Managed Health Care Programs for help. The contact information is listed after this section.

Important information about your rights when filing a grievance, appeal, or requesting a State Appeal (Fair Hearing with the state):

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 for your medical records or other documents, we used to make our decision or want copies, we or your provider must provide them to you at no cost. If you ask, we must give you a copy of the guidelines we used to make our decision, at no cost to you. You may need to put your request in writing.

If you need help with your grievance, health plan appeal or a State Appeal, you can call or write to the Ombudsperson for Public 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 Appeal.

Call: 651-431-2660

800-657-3729 or 711 (TTY), or use your preferred relay services. This call is free. Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m.

Or Write to: Ombudsperson for Public Managed Health Care Programs

P.O. Box 64249

St. Paul, MN 55164-0249

Fax to: 651-431-7472

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 previously approved
- 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 or Copayment: A fixed amount you may pay as your share of the 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.

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

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

Cultural Competency: Cultural and language competence is the ability of managed care organizations and the providers within their network to provide care to members with diverse values, beliefs and behaviors, and to tailor the delivery of care to meet social, cultural, and linguistic needs. The goal is a health care delivery system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, sexual orientation, disability, religion, or socioeconomic status.

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 use any provider in the plan network to get these services. You do not need a referral or prior authorization from your PCP or PCC 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 Medica. 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 (FFS): 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 MHCP 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 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 to live comfortably for the rest of the member's time. It offers special services for the member and their family. This is also known as Hospice Services.

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.

Housing Stabilization Services: Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person's transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

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 Health 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 services, supplies and prescription drugs other providers would usually order.
- help you get better or stay as well as you are.
- help stop your condition from getting worse.
- help prevent or 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.

Ombudsperson 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 Ombudsperson can also help you file a grievance or appeal or request a State Appeal (Fair Hearing with the State).

Open Access Services: Federal and state law allow you to choose any 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 another health facility.

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

Out-of-Network Provider or Out-of-Network Facility: A provider or 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 qualified health care provider begins care; or we, the hospital, and 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 refer to "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 most of your care.

Primary Care Provider: Your primary care provider (PCP) is the doctor or other qualified health care provider you use 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.

Quality of Care Complaint: For purposes of this handbook, "quality of care complaint" means an expressed dissatisfaction regarding health care services resulting in potential or actual harm to a member. Quality of care complaints may include: access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that could impact the quality of health care services.

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

Restricted Recipient Program (RRP): 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 MHCP. 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 mental health services, the second opinion may be from an out-of-network provider. For substance use disorder services, the second opinion will be from a different qualified assessor who does not need to be in the plan network. We must consider the second opinion but do not have to accept a second opinion for substance use disorder or mental health services.

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.

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

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.

Standing Authorization: Written consent from us to use an out-of-network specialist more than one time (for ongoing care.)

State Appeal (Fair Hearing with the state): 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 Appeal with your written 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.

Urgently Needed Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. This is also known as Urgent Care.

Section 15. Additional information

Additional Health Benefits

eVisits

Covered Services:

- In addition to in-person doctor's office visits, you have access to online care through virtuwell® at www.virtuwell.com. Available 24 hours a day, 7 days a week, without an appointment.
- eVisits: An online exchange of non-urgent medical information between a health care provider and an established patient, where the provider gives the patient medical advice. An eVisit is conducted over a secure encrypted website, and is an alternative to an office visit.

Healthy Foods Discount Program

Covered Services:

- The Healthy Savings® program provides you with instant savings of up to $50 each week on healthy foods. Register online to receive weekly emails or download the app to see the offers available. It works in addition to other coupons. Simply buy the promoted products and scan the barcode from the card or app at checkout in participating stores.

Pregnancy Program

Covered Services:

- The family of apps from Ovia Health™ include: Ovia Fertility, Ovia Pregnancy and Ovia Parenting and are available for women aged 18-46. App tools include:
    - Health and menstrual cycle tracker
    - Pregnancy calendar and daily baby updates
    - Child's development checklist
    - Daily health and wellness content
    - Data and symptom feedback
    - One-on-one coaching
    - A large library of educational articles

Oral Health Education

Covered Services:

- You will receive a telephone call from a trained Delta Dental staff person who will help you best use all your dental benefits. This help includes assistance to:
    - Find a nearby dentist office
    - Schedule a routine dental appointment
    - Arrange transportation to your dental appointment and back to your home
    - Arrange an interpreter during your dental visit
- This Delta Dental staff person will provide you tips and answer questions about daily oral care of your teeth or dentures

Sanvello App for stress, anxiety, and depression

Covered Services:

- Sanvello is a self-help app that empowers individuals to engage with activities to improve their mental health from the convenience of their mobile device anytime, anywhere. Individuals can relieve symptoms and build life skills that can reduce potential high-cost interventions through:
    - Daily mood tracking
    - Coping tools
    - Guided journeys

- Personalized progress
- Community support

Provider Payment Methodology (including physician incentive plans)

This section describes how we generally pay providers for health services.

Network providers

Network providers are paid using various types of contractual arrangements. These are intended to promote the delivery of health care in a cost efficient and effective manner. These arrangements are not intended to affect your access to health care. These payment methods may include:

1. A fee-for-service method, such as per service or percentage of charges, or

2. A risk-sharing arrangement, such as an amount per day, per stay, per episode, per case, per period of illness, per member or per service with targeted outcome.

The methods by which specific network providers are paid may change from time to time. Methods also vary by network provider. The primary method of payment under Medica Choice Care is fee-for-service.

Fee-for-service payment means that Medica pays the network provider a fee for each service provided. If the payment is per service, the network provider's payment is determined according to a set fee schedule. The amount the network provider receives is the lesser of the fee scheduled or what the network provider would have otherwise billed. If the payment is a percentage of charges, the network provider's payment is a set percentage of the provider's charge. The amount paid to the network provider, less any applicable copayment, coinsurance or deductible, is considered to be payment in full.

Risk-sharing payment means that Medica pays the network provider a specific amount for a particular unit of service. These can be an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per member, or an amount per service with targeted outcome. Sometimes the amount paid is less than the cost of providing or arranging for a member's health services. Then the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging for a member's health services, the network provider may keep some of the excess.

Withhold arrangements

Some network providers are paid on a fee-for-service basis. This includes most network physicians and clinics. Then Medica holds back some of the payment. This is sometimes referred to as a physician contingency reserve or holdback. The withhold amount generally will not exceed 15 percent of the fee schedule amount. In general, Medica does not hold back a portion of network hospitals' fee-for-service payments. However, when it does, the withhold amount will not usually exceed 5 percent of the fee schedule amount.

Network providers may earn the withhold amount based on Medica's financial performance as determined by Medica's Board of Directors and/or certain performance standards identified in the network provider's contract including, but not limited to, quality and utilization. Based on individual measures, the percentage of the withhold amount paid, if any, can vary among network providers.

Non-network providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider.
For more information, call Member Services and ask for information about our physician incentive plans. We will send it to you within 30 days.

Medica participates in the Integrated Health Partnership (IHP) program with the MN Department of Human Services. Through the IHP program, providers are given a cost target for an attributed population. Providers who met quality goals may be paid a portion of the savings from reducing the overall total cost of care. This payment methodology incentivizes well-coordinated, high-quality care at lower costs.

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