Medica AccessAbility Solution® Enhanced *Member Handbook*

Jan. 1, 2024 – Dec. 31, 2024

Your Medicare and Medical Assistance Health, and Drug Coverage under Medica AccessAbility Solution® Enhanced (HMO D-SNP)

Member Handbook Introduction

This *Member Handbook,* otherwise known as the Evidence of Coverage, tells you about your coverage under our plan through Dec. 31, 2024. It explains health care services, behavioral health coverage and prescription drug coverage. Key terms and their definitions appear in alphabetical order in Chapter 12 of your *Member Handbook*.

This is an important legal document. Keep it in a safe place.

When this *Member Handbook* says “we”, “us”, “our”, or “our plan”, it means Medica AccessAbility Solution Enhanced.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Member Services at the number at the bottom of this page.

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at 1 (888) 347-3630 (TTY: 711). Someone that speaks your language can help you. This is a free service.

OMB Approval 0938-1444 (Expires: June 30, 2026)

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

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Disclaimers

- Medica AccessAbility Solution® Enhanced is an HMO D-SNP that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in Medica AccessAbility Solution Enhanced depends on contract renewal.

- Medica AccessAbility Solution Enhanced has a Model of Care approved by the National Committee for Quality Assurance (NCQA) and Minnesota until 2024 based on a review of Medica AccessAbility Solution's Enhanced Model of Care.

- Coverage under Medica AccessAbility Solution Enhanced is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Form Approved
OMB# 0938-1421

MULTI-LANGUAGE INSERT

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1 (888) 347-3630.** Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1 (888) 347-3630.** Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，**帮**助**您**解答**关**于健康或药物保险的任何疑 问。如果**您**需要此翻译服务，请致电 **1 (888) 347-3630**。我们的中文工作人员很乐意**帮**助**您**。 这是一项免费服务。

Chinese Cantonese: **您**對我們的健康或藥物保險可能存有疑問，為此我們提供免**費**的翻譯 服務。如需翻譯服務，請致電 **1 (888) 347-3630**。我們講中文的人員將樂意為**您**提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1 (888) 347-3630.** Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1 (888) 347-3630.** Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1 (888) 347-3630** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1 (888) 347-3630.** Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1 (888) 347-3630** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1 (888) 347-3630.** Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة مجانية فوري، ليس عليك سوى الاتصال بنا على **1 (888) 347-3630**. سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1 (888) 347-3630** पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1 (888) 347-3630.** Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1 (888) 347-3630.** Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1 (888) 347-3630.** Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1 (888) 347-3630.** Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、**1 (888) 347-3630** にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

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 တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ်လီတဲစီနိ်ဂ််လၢထးအံၤန့ဉ်တက့်။

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.

LB2 (10-20)

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.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Medica AccessAbility Solution Enhanced, a health plan that covers all of your Medicare and Medical Assistance services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

A. Welcome to our plan

Our plan provides Medicare and Medical Assistance services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.

Medica AccessAbility Solution Enhanced was approved by the State and of Minnesota and the Centers for Medicare and Medicaid Services (CMS) to provide you services as part of Special Needs Basic Care Special Needs Plan (SNBC SNP).

B. Information about Medicare and Medical Assistance

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Medical Assistance

Medical Assistance is the name of Minnesota's Medicaid program. Medical Assistance is run by the state and is paid for by the state and the federal government. Medical Assistance helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

Medicare and the state of Minnesota approved our plan. You can get Medicare and Medical Assistance services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of Minnesota allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medical Assistance services is not affected.

C. Advantages of our plan

You will now get all your covered Medicare and Medical Assistance services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.

D. Our plan's service area

Our service area includes these counties in Minnesota: Aitkin, Anoka, Becker, Carlton, Carver, Chisago, Cook, Crow Wing, Dakota, Fillmore, Freeborn, Hennepin, Isanti, Kanabec, Kandiyohi, Kittson, Koochiching, Lake, Le Sueur, Mahnomen, Mille Lacs, Morrison, Murray, Nicollet, Norman, Olmsted, Ramsey, Red Lake, Rice, Rock, Scott, Sherburne, St. Louis, Todd, Wadena, Washington, Wilkin, and Wright.

Only people who live in our service area can join our plan.

You cannot stay in our plan if you move outside of our service area. Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for Medical Assistance
- are age 18-64
- have a certified disability through the Social Security Administration or the State Medical Review Team

If you lose eligibility but can be expected to regain it within three months then you are still eligible for our plan.

Call Member Services for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 30 days before or after your enrollment effective date.

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

If Medica AccessAbility Solution Enhanced is new for you, you can keep using the doctors you use now for up to 120 days for certain reasons. For more information, refer to Chapter 3.

After 120 days, you will need to use doctors and other providers in the Medica AccessAbility Solution Enhanced network. A network provider is a provider who works with the heath plan. Refer to Chapter 3 for more information on getting care.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, and behavioral health.

Your Care Coordinator works with you, and your interdisciplinary care team to build an individualized, comprehensive care plan based on your assessed needs and preferences. The Care Coordinator ensures that your healthcare needs and preferences regarding your own care is shared across the interdisciplinary care team. Your care plan includes:

- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Your monthly costs for Medica AccessAbility Solution Enhanced

Our plan has no premium.

Many members are required to pay other Medicare premiums.

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medical Assistance (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most Medica AccessAbility Solution Enhanced members, Medical Assistance (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If Medical Assistance (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

I. Your *Member Handbook*

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website at the web address at the bottom of the page.

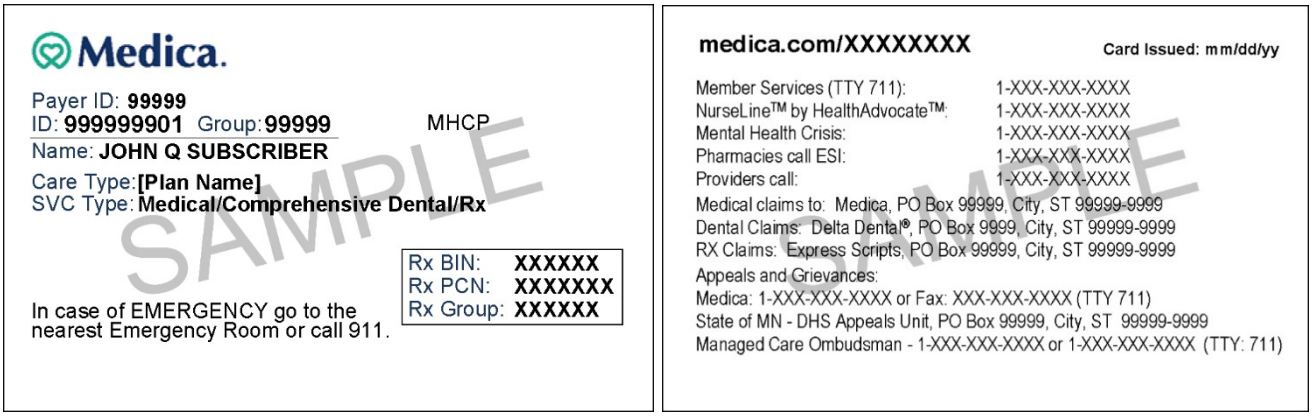
The contract is in effect for the months you are enrolled in our plan between Jan. 1, 2024 and Dec. 31, 2024.

J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs,* also known as a *Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Medical Assistance services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:



If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medical Assistance card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

The Provider and Pharmacy Directory lists our network providers and durable medical equipment suppliers. Network providers are the doctors and other health care professionals including behavioral health providers, medical groups, dentists, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

The Provider and Pharmacy Directory lists our network pharmacies. Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. Refer to Chapter 5, Section A8 for information on when you can use pharmacies that are not in the plan's network.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Medica AccessAbility Solution Enhanced authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at Medica.com/ASE.

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy from Member Services. You can also find this information on our website at Medica.com/ASE.

Definition of network providers

- Our network providers include:
    - doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells you which prescription drugs our plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Member Handbook* for more information.

Each year, we send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at the address at the bottom of the page.

J4. The Explanation of Benefits

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take. **Chapter 6** of your Member Handbook gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you**.

Tell us right away about the following:

- changes to your name, your address, or your phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

In addition, call your county worker to report these changes:

- Name or address changes
- Admission to a nursing home
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID Card
- New insurance
- New job or change in income

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Table of Contents

A. Member Services

CALL	1 (888) 347-3630. This call is free. We are available for phone calls Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. We are available for phone calls Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday.
FAX	(952) 992-3660
WRITE	Medica Member Services: Route CP540 P.O. Box 9310 Minneapolis, MN 55440-9310
EMAIL	CHAWrittenTeam@Medica.com
WEBSITE	Medica.com/ASE

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing
- Coverage decisions about your health care
    - A coverage decision about your health care is a decision about:
        - your benefits and covered services **or**

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

  - the amount we pay for your health services.
- Call us if you have questions about a coverage decision about your health care.
- To learn more about coverage decisions, refer to **Chapter 9** of your *Member Handbook*.

- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook* or contact Member Services.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
  - You can call us and explain your complaint at 1 (888) 347-3630 (TTY: 711).
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.
- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:

  - your benefits and covered drugs **or**
  - the amount we pay for your drugs.
- This applies to your Medicare Part D drugs, Medical Assistance prescription drugs, and over-the-counter drugs.
- For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.

- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or drugs you already paid for
  - We do not allow Medical AccessAbility Solution Enhanced providers to bill you for services. We pay our providers directly, and we protect you from any charges. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the phone number printed at the bottom of this page.
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Member Handbook*.

- If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Member Handbook*.

B. Your Care Coordinator

The Care Coordinator is your primary contact for accessing all benefits under Medica AccessAbility Solution Enhanced. As a representative of Medica, the Care Coordinator manages benefits provided by state plan Home Care Services, Medicare, and Elderly Waiver services (if applicable). The Care Coordinator is in the unique position of assisting you across all settings of care, transitions, and stages of the aging process. To find your Care Coordinator or to change your Care Coordinator, please call Member Services at the number listed in the table below.

CALL	1 (888) 347-3630. This call is free. We are available for phone calls Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. We are available for phone calls Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday.
FAX	(952) 992-3660
WRITE	Medica Member Services Route CP540 P.O. Box 9310 Minneapolis, MN 55440-9310
WEBSITE	Medica.com/ASE

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

Contact your care coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation

C. Senior LinkAge Line®

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Minnesota, the SHIP is called Senior LinkAge Line.

Senior LinkAge Line is not connected with any insurance company or health plan.

CALL	1-800-333-2433 The call is free.
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. The call is free.
WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
EMAIL	Senior.linkage@state.mn.us
WEBSITE	www.seniorlinkageline.com

Contact Senior LinkAge Line for help with:

- questions about Medicare
- Senior LinkAge Line counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Livanta. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta is not connected with our plan.

CALL	1-888-524-9900 Monday through Friday, 9:00 a.m. - 5:00 p.m. Weekend and Holidays, 11:00 a.m. - 3:00 p.m. 24-hour voicemail is available
TTY	1-888-985-8775 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Contact Livanta for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

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, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has documents you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you.

F. Medical Assistance

Medical Assistance helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the Minnesota Department of Human Services.

CALL	Minnesota Department of Human Services 1-651-431-2670 (Twin Cities Metro area) Or 1-800-657-3739 (Outside the Twin Cities Metro area) The call is free.
TTY	1-800-627-3529 (You need special telephone equipment to call this number.) Or 711 or use your preferred relay service (You do **not** need special telephone equipment to call this number.) These calls are free.
WRITE	Department of Human Services of Minnesota 444 Lafayette Road North St. Paul, MN 55155
EMAIL	DHS.info@state.mn.us
WEBSITE	www.mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

G. Ombudsperson for Public Managed Health Care Program

The Ombudsperson for Public Managed Health Care Program works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Ombudsperson for Public Managed Health Care Program also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-651-431-2660 (Twin Cities Metro area) Or 1-800-657-3729 (Outside Twin Cities Metro area) The call is free.
TTY	1-800-627-3529 (You need special telephone equipment to call this number.) Or 711 or use your preferred relay service (You do **not** need special telephone equipment to call this number.) These calls are free.
WRITE	MN Department of Human Services Ombudsperson for Public Managed Health Care Programs PO Box 64249 St. Paul, MN 55164-0249
EMAIL	dhsombudsperson.smhcp@state.mn.us
WEBSITE	www.mn.gov/dhs/managedcareombudsperson

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

H. Office of Ombudsperson for Long Term Care (OOLTC)

The OOLTC helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

OOLTC is not connected with our plan or any insurance company or health plan.

CALL	1-651-431-2555 (Twin Cities Metro area) Or 1-800-657-3591 (Outside Twin Cities Metro area) The call is free.
TTY	1-800-627-3529 (You need special telephone equipment to call this number.) Or 711 or use your preferred relay service (You do **not** need special telephone equipment to call this number.) These calls are free.
WRITE	Minnesota Office of Ombudsperson for Long Term Care PO Box 64971 St. Paul, MN 55164-0971
EMAIL	mba.ooltc@state.mn.us
WEBSITE	www.mn.gov/board-on-aging

I. Programs to Help People Pay for Their Prescription Drugs

The Medicare.gov website (www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, as described below.

I1. Extra Help

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this "Extra Help."

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

I2. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance. For information, call the Minnesota Department of Human Services at 651-431-2414 or 800-657-3761, (TTY 711).

Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of the state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Minnesota Department of Human Services at 651-431-2414 or 800-657-3761, (TTY 711).

J. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S Citizens and lawful permanent residents who are 65 and over, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.ssa.gov

K. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive Medicare through the RRB, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the RRB, contact the agency.

CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1", you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number are *not* free.
WEBSITE	www.rrb.gov

L. Other resources

Disability Hub MN™ is a free statewide resource network that helps you solve problems, navigate the system and plan for your future. This team knows the ins and outs of community resources and government programs, and has years of experience helping people fit them together.

CALL	1-866-333-2466 Calls to this number are free. Monday through Friday from 8:30 a.m. to 5:00 p.m.
TTY	Call the Minnesota Relay Service at 711 or use your preferred relay service. Calls to this number are free.
WRITE	PO Box 64967 St. Paul, MN 55164-0976
WEBSITE	disabilityhubmn.org

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Table of Contents

A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of your *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Member Handbook.*

Providers are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and Medical Assistance. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. 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 mental health. 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 that 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 and find health problems

- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to Section H in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. In this situation, we cover the care at no cost to you.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.
- When you first join the plan, you can continue using the providers you use now for up to 120 days for the following reasons:
  - An acute condition.
  - A life-threatening mental or physical illness.
  - 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.
  - You are receiving culturally appropriate health care services (excluding transportation services) and the plan does not have a network provider with special expertise in the delivery of those culturally appropriate health care services.

- You do not speak English and the plan does not have a network provider who can communicate with you, either directly or through an interpreter.

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.

An exception is made for family planning, which is an open access service covered by us through Medical Assistance. Federal and state laws let you choose any provider, even if not in our network, to get certain family planning services. This means by any doctor, clinic, hospital, pharmacy, or family planning office. For more information refer to the "Family Planning Services" section of the Benefits Chart in Chapter 4.

C. Your care coordinator

C1. What a care coordinator is

A care coordinator is a person who develops and coordinates supports and services stated in the care plan.

All members are assigned a Care Coordinator upon enrollment with Medica. The Care Coordinator will reach out to you to conduct a Health Risk Assessment (HRA). In addition, the Care Coordinator works with you, and your interdisciplinary care team to build an individualized, comprehensive care plan based on your assessed needs and preferences. The Care Coordinator ensures that your healthcare needs and preferences regarding your own care is shared across the interdisciplinary care team.

They also are a consistent point of contact through any transitions of care that may occur (care transitions include admissions to a hospital or nursing home, and return home from these settings).

C2. How you can contact your care coordinator

Call Member Services at the number at the bottom of this page.

C3. How you can change your care coordinator

If you are not satisfied with the services you received from your care coordinator and would like to change who your care coordinator is call Member Services at the number listed at the bottom of this page. You also have the right to complain through the Minnesota Department of Health

(MDH) at (651) 201-5100 or 1 (800) 657-3916 (toll-free) or the Ombudsperson for State Managed Health Care Programs at (651) 431-2660 or 1 (800) 657-3729 (toll-free).

D. Care from providers

D1. Care from a primary care provider (PCP)

You may choose a primary care provider (PCP) to provide and manage your care.

Definition of a PCP and what a PCP does do for you

What a PCP is:

- A Primary Care Provider (PCP) is a provider who meets state requirements and who gives you routine health care. Your PCP will keep your medical records and get to know your health needs over time. When you become a member of our plan, you will choose a network provider who is assigned to one of the plan's Network Care Systems. This provider will be your PCP.

What types of providers may act as a PCP:

- Your PCP is a health care provider who meets state requirements and is trained to give you basic medical care.
- Your PCP is the health care provider you use first for most health problems. They make sure you get the care you need to keep you healthy. They also may talk with other doctors and health care providers about your care and refer you to them. You will usually use your PCP first for most of your routine health or basic care needs.

The role of a PCP in:

- Coordinating covered services
    - Your PCP will provider and coordinate your medical care and services. This includes checking or consulting with other plan providers about your care and how it is going. You should have all of your past medical records sent to your PCP's office.
- Making decisions about or obtaining prior authorization, if applicable

- The network care system also has a Medica Care Coordinator to help you. Please talk with your PCP and Care Coordinator about your health care needs. Your PCP and Care Coordinator will help to arrange all of your medical care and make sure you get the care you need. They may also refer you to other doctors or providers of covered services when needed.

Your choice of PCP

The Medica *Provider and Pharmacy Directory* includes a listing of the Medica contracted providers and Network Care Systems. Call Medica Member Services at the number at the bottom of this page if you need help or would like to request a *Provider and Pharmacy Directory*.

You may choose from one of the following three choices:

1. A Primary Care Provider (PCP)
2. A Primary Care Clinic (this is linked to the PCP you have selected). A Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) can be your PCC.
3. A Network Care System (this is also linked to the PCP you have selected).

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

Medica Member Services can assist you in finding and selecting another provider. You can change your PCP on a monthly basis; the change will be effective the first of the month following the date of the request to change.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;
- any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have certain rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.

- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. For more information, please call Member Services at the number at the bottom of this page.

D4. Out-of-network providers

If you get care from a provider who is not part of our network you will not have in-network benefits and you will be responsible for all charges. Medica has a large number of providers who can help meet your health care needs. We also have a dedicated team to assist you in finding a provider to ensure that your medical needs are met and that you receive the assistance and resources you require. Please contact your Care Coordinator or call Member Services for more information on getting care.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medical Assistance.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medical Assistance.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

You may be able to get long-term services and supports (LTSS), such as home care services. Home health services such as Skilled Nursing, Home Health Aide, Home Therapies and Durable Medical Equipment may be provided to the you at your residence or in the community where normal life activities take you, other than a hospital or long-term facility. If you are on a waiver program, your waiver case manager and your Medica Care Coordinator will work together with you to be sure you have the services you need.

F. Behavioral health (mental health and substance use disorder) services

For more information on behavioral health services, please contact Medica Behavioral Health at 1 (800) 848-8327, 24 hours per day, 7 days per week.

G. Transportation services

If you need transportation to and from health services that we cover, call 1 (888) 347-3630. We will provide the most appropriate and cost-effective transportation. We are not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Call 1 (888) 347-3630 if you do not have a Primary Care Clinic that is available within 30 miles of your home and/or if it is over 60 miles to your specialty provider.

H. Covered services in a medical emergency, when urgently needed, or during a disaster

H1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- In the case of a pregnant woman in active labor, when:
    - There is not enough time to safely transfer you to another hospital before delivery.
    - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories, from any provider with an appropriate state license.
- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. The number to call is located on the back of the plan membership card.

Covered services in a medical emergency

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

H2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it is not possible or reasonable to get to a network provider, we cover urgently needed care you get from an out-of-network provider.

For urgent care needs during clinic hours, please call your clinic. For urgent care after your clinic's regular hours, you have several options:

- Call your clinic's after-hours line, if one is available.
- Call the NurseLine™ by HealthAdvocate℠ at 1 (866) 715-0915 to speak to a registered nurse.
- Visit any urgent care clinic that's listed in your *Provider and Pharmacy Directory*.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other care that you get outside the United States.

H3. Care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster: Medica.com/ASE.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Member Handbook* for more information.

I. What to do if you are billed directly for services our plan covers

We do not allow Medica AccessAbility Solution Enhanced providers to bill you for these services. We pay our providers directly, and we protect you from any charges. If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill.

You should not pay the bill yourself. If you do, we may not be able to pay you back.

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of your *Member Handbook* to find out what to do.

I1. What to do if our plan does not cover services

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the phone number at the bottom of the page.

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of your *Member Handbook*), **and**
- that you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 of your *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

J. Coverage of health care services in a clinical research study

J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Member Services to let us know you will take part in a clinical trial.

J2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- an operation or other medical procedure that is part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare has **not** approved, you pay any costs for being in the study.

J3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

K. How your health care services are covered in a religious non-medical health care institution

K1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

K2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care that is **not voluntary and is required** under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from us before you are admitted to the facility, or your stay will **not** be covered.

Covered services and length of inpatient care will be limited based on Medicare approved amounts (refer to Benefits Chart in Chapter 4)

L. Durable medical equipment (DME)

L1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, you usually will **not** own DME, no matter how long you rent it.

In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about requirements you must meet and papers you need to provide.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will **not** own the equipment.

L2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and MA Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2024* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/medicare-and-you) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments do not count toward the payments you need to make after leaving our plan**.

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

L4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Table of Contents

A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Member Handbook*. This chapter also explains limits on some services.

Because you get assistance from Medical Assistance, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.

If you need help understanding what services are covered, call your care coordinator or Member Services at 1 (888) 347-3630 (TTY: 711)

A1. During public health emergencies

For coverage and flexibilities during public health emergencies, please visit Medica.com/Resources/COVID-19 and MN.gov/DHS/Waivers-and-Modifications/Dynamic-List

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of your *Member Handbook* or call Member Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and Medical Assistance covered services according to the rules set by Medicare and Medical Assistance.
- The services must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical

condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. 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 mental health. 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 that 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 and find health problems.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- When you first join the plan, you can continue using the providers you use now for up to 120 days for the following reasons:
  - An acute condition.
  - A life-threatening mental or physical illness.
  - 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.
  - You are receiving culturally appropriate health care services (excluding transportation services) and the plan does not have a network provider with special expertise in the delivery of those culturally appropriate health care services.

- You do not speak English and the plan does not have a network provider who can communicate with you, either directly or through an interpreter.
- 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.
- An exception is made for family planning, which is an open access service covered by us through Medical Assistance . Federal and state laws let you choose any provider, even if not in our network, to get certain family planning services. This means by any doctor, clinic, hospital, pharmacy, or family planning office.

- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with an asterisk (*). In addition, you must get PA for the following services not listed in the Benefits Chart:
  - **Ambulatory Surgical Center**
    - Interventional Cardiology
    - Musculoskelatal medicine
  - **Behavioral Health**: Contact Medica Behavioral Health (MBH)
    - Transcranial Magnetic Stimulation (TMS)
  - **Diagnostic and Radiology Services**
    - Facility-Based Polysomnography, Adults (Sleep Study)
    - Positron Emission Tomography (PET) Scan
    - Real-Time Mobile Cardiac Outpatient Telemetry (RT-MCOT)
  - **Inpatient/Skilled Nursing Facility**
    - Inpatient Rehabilitation Facility (Acute Rehabilitation)
    - Interventional Cardiology
    - Long-Term Acute Care Hospital (LTACH)
    - Musculoskelatal medicine
  - **Genetic Testing**
    - Whole Exome Sequencing
  - **Medical Equipment and Supplies**
    - Bone Growth Stimulator
    - High Frequency Chest Wall Compression (HFCWC) Devices
    - Microprocessor Controlled Knee Prostheses, with or without Polycentric, Three-Dimensional Endoskeletal Hip Joint System
    - Prosthetics

- Spinal Cord Stimulation of the Dorsal Column for Treatment of Pain
- Vagus Nerve Stimulation
- Wheelchairs, Scooters and Accessories

- **Outpatient Hosptial Services**
  - Interventional Cardiology
  - Musculoskelatal medicine
- **Surgical Procedures**
  - Abdominoplasty / Panniculectomy
  - Bariatric Surgery
  - Blepharoplasty, Blepharoptosis Repair and Brow Lift Rhinoplasty Procedure With or Without Septoplasty
  - Breast Reconstruction (non-mastectomy)
    - Breast Implant Removal, Revision or Re-implantation
    - Female Breast Reduction Surgery – Reduction Mammoplasty
    - Male Gynecomastia Surgery
  - Cervical Spine Surgeries
  - Facet Injections and Percutaneous Denervation Procedures (Radiofrequency and Laser Ablation) for Facet-Medicated Joint Pain
  - Gender reassignment
  - Implanted Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea/Hypopnea Syndrome
  - Intraoperative Neurophysiologic Monitoring (IONM)
  - Lumbar Spinal Surgeries
  - Magnetic Esophageal Ring for the Treatment of Gastroesophageal Reflux Disease
  - Orthognathic Surgery
  - Otoplasty
  - Sacroiliac Joint Fusion, Open and Minimally Invasive
  - Uvulopalatopharyngoplasty (UPPP U3P) for Obstructive Sleep Apnea/Hypopnea Syndrome
  - Varicose Vein and Venous Insufficiency Treatments
- **Transplant**
  - Autologous Cultured Chondrocyte Transplantation for the Knee
  - Bone Marrow or Stem Cell (Peripheral or Umbilical Cord Blood) Transplantation
  - Heart Transplantation
  - Heart/Lung Transplantation
  - Intestinal Transplantation

- Kidney Transplantation
- Liver Transplantation
- Lung Transplantation (Single or Double)
- Pancreas – Kidney (SPK, PAK) Transplantation
- Pancreas Transplantation (Pancreas Alone)
- Pre-transplant Evaluation

- **Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services**
  - Because Medica AccessAbility Solution Enhanced participates Medicare Value-Based Insurance Design program you will be eligible for the following WHP services, including advance care planning (ACP) services:
    - Your Medica Care Coordinator can help you with wellness and health care planning, including advance care planning. Each year, your Care Coordinator will reach out to you to complete a Health Risk Assessment (HRA) and care plan. During the HRA and care planning process, your Care Coordinator will talk with you about wellness and health care planning and ask if you would like information on completing an advance directive. This is your choice. Participating in advance care planning is voluntary. You may also reach out to your provider for assistance with advance care planning.
    - You may contact your Medica Care Coordinator or a Medica network provider at any time for assistance with advance care planning. Your Care Coordinator also will attempt to reach you on at least an annual basis to complete an HRA and care plan.
- All preventive services are free. You will find this apple 🍎 next to preventive services in the Benefits Chart.

Restricted Recipient Program

- The Restricted Recipient Program is for members who have misused health services. This includes getting health services that members did not need, using them in a way that costs more than they should, or using them 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 care 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 (Medicaid Fair Hearing with the state) after receiving our decision that we will enforce the restriction. Refer to Chapter 9, Section F3 for more information about your right to appeal.
- The Restricted Recipient Program does not apply to Medicare-covered services. If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Refer to Chapter 5, Section G3, for more information.

D. Our plan's Benefits Chart

Services that our plan pays for		What you must pay
🍎	**Abdominal aortic aneurysm screening** We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. We may cover additional screenings if medically necessary.	$0
	Acupuncture Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Acupuncture (continued) In addition, we will pay for up to 20 units of acupuncture services per calendar year without authorization or ask for prior authorization if additional units are needed 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	
	Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Alcohol misuse screening and counseling (continued) If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting (refer to the "Outpatient substance use disorder services" section of this chart for additional covered benefits.	$0
	Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. *Ambulance services for other cases (non-emergent) must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Wecome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0

Services that our plan pays for		What you must pay
	Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
	Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and over • Clinical breast exams once every 24 months	$0
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0

Services that our plan pays for		What you must pay
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you are eating well.	$0
	Cardiovascular (heart) disease testing We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0
	Care Coordination You are assigned a county case manager or care coordinator who will help connect you to the services and resources you need to get the best possible care. Care coordinators can also help you learn more about your health, any health conditions you have, and help you follow your care plan. Care coordinators and Medica AccessAbility Enhanced Member Services staff are available to answer questions about Medica AccessAbility Solution Enchanced and the SNBC program. To access this service, please contact Medica Member Services at the phone number printed on the inside back cover of this booklet. Care coordination is always available for you. You can stop using this service at any time by telling your care coordinator **This benefit is continued on the next page**	$0

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

Services that our plan pays for	What you must pay
Care Coordination (continued) Care coordination is always available for you. You can stop using this service at any time by telling your care coordinator or by contacting Medica AccessAbility Solution Enhanced. If you want to change your care coordinator, contact member services at the number listed at the bottom of this page. Covered Services: • An assessment to identify how the care coordinator can help you with health care, housing, food security, and other needs • Help with scheduling, coordinating, and receiving assessments or tests and health care services such as dental, behavioral health, rehabilitative, and primary care • Creation and updating of your care plan, based on your unique needs and working with the people you choose • With your permission, Medica AccessAbility Solution Enhanced care coordinators can communicate with agencies and people who can help meet your needs: ○ Work together with you and others you choose when you have a change in your health care needs or a hospitalization ○ Help you find resources you need in your community ○ Work together with your Home and Community Based Services waiver case managers or other case managers **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay

	Care Coordination (continued)
	• With your participation, Medica AccessAbility Solution Enhanced care coordinators also do the following:
	  ○ Help you set goals for your health and well-being and work with you to reach them
	  ○ Communicate or meet with you regularly to discuss your health and well-being
	  ○ Remind you when you need preventive services, tests, or appointments that are part of your care plan	

🍎	**Cervical and vaginal cancer screening** We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months	$0
	Child and Teen Checkups (C&TC) C&TC preventive health visits include: • growth measurements • health education • health history including nutrition **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Child and Teen Checkups (C&TC) (continued) • developmental Screening • social-emotional or Mental Health Screening • head-to-toe Physical Exam • immunizations • lab tests • vision checks • hearing checks • oral health, including fluoride varnish application C&TC is a health care program of well-child visits for members under age 21. Each visit may include one-on-one time with the healthcare provider. This gives time for questions and discussion about health needs and goals and helps young adults learn to manage their own health**.** Members under age 21 should contact their Primary Care Clinic to schedule C&TC well-child and preventive health visits.	
	Chiropractic services We pay for the following services: • One evaluation or exam per year **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Chiropractic services (continued) • Manual manipulation (adjustment) of the spine to treat subluxation of the spine – up to 24 treatments per calendar year, limited to six per month. Treaments exceeding 24 per calendar year or six per month may require a service authorization. • X-rays when needed to support a diagnosis of subluxation of the spine **Note:** Our plan does not cover other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor.	
	Colorectal cancer screening We pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Colorectal cancer screening (continued) • Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
	***Dental services** Certain dental services, including cleanings, fillings, and dentures, are available through the Medical Assistance Dental Program. Covered Services: • Diagnostic services: ○ comprehensive exam (once per five years)(cannot be performed on same date as a periodic or limited evaluation) ○ periodic exam (cannot be performed on same date as a limited or comprehensive evaluation) **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
***Dental services (continued)** ○ limited (problem-focused) exams (cannot be performed on same date as a periodic or comprehensive oral evaluation,or dental cleaning) ○ detailed oral evaluation (cannot be performed on same date as full mouth debridement) ○ detailed 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) (pregnant women limited to once per five years) ○ single X-rays for diagnosis of problems (four per date of service) (pregnant women limited to once per five years) ○ panoramic (once in a five-year period except when medically necessary; once every two years in limited situations; or with a scheduled outpatient hospital facility or freestanding Ambulatory Surgery Center (ASC) procedure.) ○ full mouth X-rays (once in a five-year period) • Preventive services: ○ dental cleanings (limited to twice per calendar year; up to four per year with Prior Authorization) (limited to twice per calendar year for children; up to four per year as medically necessary) ○ fluoride varnish (once every six months) (cannot be performed on same date as emergency treatment of dental pain service) **This benefit is continued on the next page**	

Services that our plan pays for	What you must pay
***Dental services (continued)** ○ sealants for children under age 21 (one every five years per permanent molar) ○ cavity treatment (once per tooth per six months) (cannot be performed on same date as emergency treatment of dental pain service or fluoride varnish application) ○ oral hygiene instruction • 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) (anterior and premolar are limited to once per tooth per lifetime) • Periodontics: ○ gross removal of plaque and tartar (full mouth debridement) (once per 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) (every three months/91 days for two years) (up to four per calendar year following the completion of scaling and root planing) **This benefit is continued on the next page**	

Services that our plan pays for	What you must pay
***Dental services (continued)** • Prosthodontics: ○ removable appliances (dentures, partials, overdentures) (one appliance every six years per dental arch) ○ adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials), (repairs to missing or broken teeth are limited to five teeth per 180 days) ○ replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances (with Prior Authorization) ○ replacement of partial appliances if the existing partial cannot be altered to meet dental needs (with Prior Authorization) ○ tissue conditioning liners ○ precision attachments and repairs • Oral surgery: ○ including extractions ○ Orthodontics (only when medically necessary for very limited conditions for members age 20 and younger) (with Prior Authorization) • Additional general dental services: ○ emergency treatment of dental pain ○ general anesthesia, deep sedation ○ nitrous oxide **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	***Dental services (continued)** ○ extended care facility/house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMDs), Intermediate Care Facilities for Persons with Developmental Disabilities(ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), nursing facilities, school or Head Start program, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital)(cannot be performed on same date as oral hygiene instruction service) ○ medications (only when medically necessary for very limited conditions) ○ behavioral management when necessary to ensure that a covered dental service is correctly and safely performed ○ oral bite adjustments (limited to once per day) Notes: If you begin orthodontia services, we will not require completion of the treatment plan in order to pay the provider for services received. If you are new to our health plan and have already started a dental service treatment plan, please contact us for coordination of care. We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	***Dental services (continued)** **Additional Medica AccessAbility Solution Enhanced benefits include:** • One additional dental exam each year in addition to the one covered by Medical Assistance • One full mouth x-ray once every five years • One molar root canal per tooth per lifetime • One molar root canal retreatment per tooth per lifetime; only covered if completed at least 24 months after the original root canal	
🍎	**Depression screening** We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals. We may cover additional screenings if medically necessary.	$0
🍎	**Diabetes screening** We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Diabetes screening (continued) Depending on the test results, you may qualify for up to two diabetes screenings every 12 months. We may cover additional screenings if medically necessary.	

🍎	**Diabetic self-management training, services, and supplies**
	
	We pay for the following services for all people who have diabetes (whether they use insulin or not):
	• Supplies to monitor your blood glucose, including the following:
	  ○ a blood glucose monitor
	  ○ blood glucose test strips
	  ○ lancet devices and lancets
	  ○ glucose-control solutions for checking the accuracy of test strips and monitors
	• For people with diabetes who have severe diabetic foot disease, we pay for the following:
	  ○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or**
	  ○ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)
	• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.
		$0

Services that our plan pays for	What you must pay
***Durable medical equipment (DME) and related supplies** Refer to **Chapter 12** of your *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies (For diabetic supplies refer to the "Diabetic self-management training, services, and supplies" section in this benefit chart.) • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment We cover additional items, including: ○ repairs of medical equipment ○ batteries for medical equipment ○ medical supplies you need to take care of your illness, injury or disability ○ incontinence products **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	***Durable medical equipment (DME) and related supplies (continued)** ○ nutritional/enteral products when specific conditions are met ○ family planning supplies (refer to the "Family planning services" section of this chart for more information) ○ augmentative communication devices, including electronic tablets Other items may be covered. We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.	
	***Early Intensive Developmental and behavioral Intervention (EIDBI) Services** (for member under age 21) The purpose of the EIDBI benefit is to provide medically necessary, early and intensive intervention for people with Autism Spectrum Disorder (ASD) and related conditions. Families can learn more about EIDBI by taking the EIDBI 101 online training. The EIDBI Welcome Letter for Caregivers provides more information on the program once a family gets started with services. Families can learn more about autism, as well as resources and supports, by visiting the Minnesota Autism Resource Portal. The benefit is also intended to: • Educate, train and support parents and families **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
***Early Intensive Developmental and behavioral Intervention (EIDBI) Services** (for member under age 21) **(continued)** • Promote people's independence and participation in family, school and community life • Improve long-term outcomes and the quality of life for people and their families. EIDBI services are provided by enrolled EIDBI providers who have expertise in the approved modalities which include: • Applied Behavior Analysis (ABA) • Developmental, Individual Difference, Relationship-Based (DIR)/Floortime model • Early Start Denver Model (ESDM) • PLAY Project • Relationship Development Intervention (RDI) • Early Social Interaction (ESI). Covered Services: • Comprehensive Multi-Disciplinary Evaluation (CMDE) which is needed to determine eligibility and medical necessity for EIDBI services. • Individual Treatment Plan (ITP) Development (Initial) • Individual Treatment Plan (ITP) Development and Progress Monitoring • Direct Intervention: Individual, Group, and/or higher intensity **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	***Early Intensive Developmental and behavioral Intervention (EIDBI) Services** (for member under age 21) **(continued)** • Intervention Observation and Direction • Family/Caregiver Training and Counseling: Individual and/or Group • Coordinated Care Conference • Travel time	
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health or to that of your unborn child; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part. • In the case of a pregnant woman in active labor, when: ○ There is not enough time to safely transfer you to another hospital before delivery. **This benefit is continued on the next page**	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, please let us know and we will try to get network providers to take over your care as soon as possible.

Services that our plan pays for		What you must pay
	Emergency care (continued) ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. This coverage is only available within the U.S. and its territories.	
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. These are called open access services.This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Family planning services (continued) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • *genetic testing	
	Health and wellness education programs <u>Oral Health Education:</u> You will receive a telephone call from a trained Delta Dental staff 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 will provide you tips and answer questions about daily oral care of your teeth or dentures.	$0
	Healthy Foods Program The Healthy Savings® Healthy Foods program provides you with a monthly allowance of $20 to be used on any combination of healthy foods such as fresh fruits, vegetables milk, eggs, bread, and more. Simply scan your Healthy Savings card to receive your savings at participating retail grocers. There is no carry-over month to month. **This benefit is continued on the next page**	$0

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

Services that our plan pays for		What you must pay
	Healthy Foods Program (continued) You can find more information, including a list of participating retail grocers at Medica.com/HealthySavings or contact Member Services for additional benefit details.	
	Health services The plan will pay for the following services: • Advanced Practice Nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist • Allergy immunotherapy and allergy testing • Behavioral Health Home: coordination of primary care, mental health services and social services • Clinical trial coverage o Routine care that is provided as part of the protocol treatment of a clinical trial; is usual, customary, and appropriate to your condition; and would typically be provided outside of a clinical trial. o This includes services and items needed for the treatment of effects and complications of the protocol treatment. o For more information, please refer to Chapter 3. • Community health worker care coordination and patient education services • Community Medical Emergency Technician (CMET) services **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Health services (continued) ○ Post-hospital/post-nursing home discharge visits ordered by your primary care provider ○ Safety evaluation visits ordered by your primary care provider • Community Paramedic: certain services provided by a community paramedic. The services must be a part of a care plan ordered 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 • Enhanced asthma care services (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma, when specific criteria are met) ○ home visits to determine if there are asthma-triggers in the member's home must be provided by a registered environmental health specialist, healthy homes specialist, and lead risk assessor. Your local public health agency can help you find one of these health care professionals to help you or you can contact Member Services **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	Health services (continued) • Hospital In-Reach Community-Based Service Coordination (IRSC): 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. • Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit • Telemonitoring: use of special equipment to send health data to providers from a remote location, like a member's home. Providers use telemonitoring to help manage complex health care without the need for the member to be in a clinic or hospital. • Tuberculosis care management and direct observation of drug intake	
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We cover additional items and services, including: • Hearing aids and batteries • Repair and replacement of hearing aids due to normal wear and tear, with limits	$0

Services that our plan pays for		What you must pay
🍎	**HIV screening** We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy. Additional benefits may be covered by us.	$0
	Home and Community Based Service Information Your SNBC care coordinator will give you information about community services. A county worker will 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. This information can be given to you by mail, phone, or in person. If you choose to have a visit, you have the right to have friends or family present. 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 SNBC 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. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Home and Community Based Service Information (continued) If you are currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, your county case manager will coordinate home health agency services with your SNBC care coordinator. If you need transition planning and coordination services to help you move to the community, you may be eligible to get Relocation Service Coordination.	
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services ○ medical equipment and supplies **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Home health agency care (continued) ○ Respiratory therapy ○ Home Care Nursing (HCN)	
	Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but are not limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0

Services that our plan pays for	What you must pay
***Hospice care** You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Refer to **Section F** of this chapter for more information. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*. **Note:** If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	***Hospice care (continued)** Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	
	***Housing stabilization 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) • Only for people leaving a Medical Assistance funded institution of provider controlled setting that 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 a community-home, including furniture, window coverings, food preparation items, and bed/bath linens • Set up fees or deposits for utility or service access, including telephone, electricity, heating and water **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	***Housing stabilization services (continued)** • 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 get housing stabilization services (within a 60 mile radius) 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 can support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you. Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to get this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.	
🍎	**Immunizations** We pay for the following services: • pneumonia vaccine • flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Immunizations (continued) • hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you are at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of your *Member Handbook* to learn more.	
	***Inpatient hospital care** Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies **This benefit is continued on the next page**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Services that our plan pays for	What you must pay
***Inpatient hospital care (continued)** • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. For heart transplants this also includes a Ventricular Assist Device inserted as a bridge or as a destination therapy treatment. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. • blood, including storage and administration • physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	***Inpatient hospital care (continued)** You can also find more information in a Medicare fact sheet called "Are you a Hosptial Inpatient or Outpatient? If You Have Medicare – Ask!". This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay, including extended psychiatric inpatient hospital stays.	$0
	Interpreter services The plan will pay for the following services: • Spoken language interpreter services • Sign language interpreter services	$0
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Kidney disease services and supplies (continued) • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.	
🍎	**Lung cancer screening** Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.	$0

Services that our plan pays for		What you must pay
	Medical Assistance covered prescription drugs We cover some drugs under Medical Assistance that are not covered by Medicare Part B and Medicare Part D. These include some over-the-counter products, some prescription cough and cold medicines and some vitamins. The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that: • the drug that is normally covered has caused a harmful reaction to you; or • there is a reason to believe the drug that is normally covered would cause a harmful reaction; or • the drug prescribed by your doctor is more effective for you than the drug that is normally covered. • The drug must be in a class of drugs that is covered. If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by our plan. If the pharmacy won't call your doctor, you can. You can also call Member Services at the number at the bottom of this page.	$0
🍎	**Medical nutrition therapy** This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Medical nutrition therapy (continued) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary. We may cover additional benefits if medically necessary.	
🍎	**Medicare Diabetes Prevention Program (MDPP)** Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0
	***Medicare Part B prescription drugs** These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • clotting factors you give yourself by injection if you have hemophilia **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
***Medicare Part B prescription drugs (continued)** • immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • antigens • certain oral anti-cancer drugs and anti-nausea drugs • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: www.Medica.com/ISNBCRx We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit. **Chapter 5** of your *Member Handbook* explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of your *Member Handbook* explains what you pay for your outpatient prescription drugs through our plan.	

Services that our plan pays for		What you must pay
	Mental health services Refer to the following sections for covered mental health services: • Depression screening • Inpatient mental health care • Outpatient mental health care • Partial Hospitalization Services	$0
	Nursing facility care We are responsible for paying a total of 100 days of nursing home room and board. This includes custodial care. If you need continued nursing home care beyond the 100 days, the Minnesota Department of Human Services (DHS) will pay directly for your care. If DHS is currently paying for your care in the nursing home, DHS, not our plan, will continue to pay for your care. Refer to the “Skilled nursing facility (SNF) care” section of this chart for more information about the additional nursing home coverage the plan provides. A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital. Services that we pay for include, but are not limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Nursing facility care (continued) • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
	Obesity screening and therapy to keep weight down **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Obesity screening and therapy to keep weight down (continued) If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more. We may cover additional benefits if medically necessary.	
	Obstetrics and Gynecology (OB/GYN) Services Covered Services: • Prenatal, delivery, and postpartum care • Childbirth classes • HIV counseling and testing for pregnant people– open access service • Treatment for HIV-positive pregnant people • Testing and treatment of sexually transmitted diseases (STDs) – open access service • Pregnancy-related services received in connection with an abortion (does not include abortion-related services) • Doula services by a certified doula supervised by either a physician, nurse practitioner, or certified nurse midwife and registered with the Minnesota Department of Health (MDH) • Services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Obstetrics and Gynecology (OB/GYN) Services (continued) Not Covered Services: • Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) or 711 (TTY) or use your preferred relay service. • Planned home births You have "direct access" to OB-GYN providers without a referral for the following services: annual preventive health exam, including follow-up exams that your qualified health care provider says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as open access, you can go to any qualified health care provider clinic, hospital, pharmacy, or family planning agency.	
	One Pass™ Fitness Program The One Pass fitness program is a fitness benefit that includes access to 20,000+ fitness locations nationwide, exercise equipment and other gym amenities including group exercise classes led by certified instructors. • Online resources include on-demand and live-streaming fitness classes as well as individual exercises • A Home Fitness Kit is available ot members residing 15 miles outside of a participating fitness location, or members physically unable to visit a fitness location **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	One Pass™ Fitness Program (continued) Members get their One Pass code and find locations and classes at Medica.com/Fitness. Members with additional questions should call 1 (877) 504-6830 (TTY: 711), Monday through Friday, 8:00 a.m. – 9 p.m. CT. Access to unlimited public transportation where available to One Pass fitness program locations. Where public transportation is not available you may get up to one (1) round trip per day with a volunteer driver or taxi to One Pass fitness program locations.	
	***Opioid treatment program (OTP) services** Our plan pays for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0
	***Outpatient diagnostic tests and therapeutic services and supplies** We pay for the following services and other medically necessary services not listed here: • X-rays **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	***Outpatient diagnostic tests and therapeutic services and supplies (continued)** • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • other outpatient diagnostic tests	

	***Outpatient hospital services**
	We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:
	• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services
	  ○ Observation services help your doctor know if you need to be admitted to the hospital as "inpatient."
	  ○ Sometimes you can be in the hospital overnight and still be "outpatient."
	  ○ You can get more information about being inpatient or outpatient in this fact sheet: www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf.
	• Labs and diagnostic tests billed by the hospital
	• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it
	This benefit is continued on the next page
		$0

Services that our plan pays for		What you must pay
	***Outpatient hospital services (continued)** • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself	
	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • a Tribal Nations certified professional • a mental heatlh rehabilitative professional • any other Medicare-qualified mental health care professional as allowed under applicable state laws The plan will pay for the following services, and maybe other services not listed here: • Certified Community Behavioral Health Clinic (CCBHC • Clinical care consultation **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Outpatient mental health care (continued) • Crisis response services including screening, assessment, intervention, stabilization (including residential stabilization), and community intervention • Diagnostic assessments including screening for presence of co-occurring mental illness and substance use disorders • Dialectical Behavioral Therapy Intensive Outpatient Program (DBT IOP) • Mental health provider travel time • Mental Health Targeted Case Management (MH-TCM) • Forensic Assertive Community Treatment (FACT) • Outpatient mental health services, including explanation of findings, mental health medication management, neuropsychological services, psychotherapy (patient and/or family, family, crisis and group), and psychological testing • Physician Mental Health Services, including health and behavioral assessment/intervention, inpatient visits, psychiatric consultations to primary care providers, and physician consultation, evaluation, and management **This benefit is continued on the next page**	

Services that our plan pays for	What you must pay
Outpatient mental health care (continued) • Rehabilitative Mental Health Services, including Assertive Community Treatment (ACT), Adult day treatment, Adult Rehabilitative Mental Health Services (ARMHS), Certified family peer specialists (for members under age 21), Certified Peer Specialist (CPS) support services in limited situations, *Certified* family peer specialists (for members under age 21), Children's mental health residential treatment services (for members under age 21), Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment (for members under age 21), Family psychoeducation services (for members under age 21), Intensive Residential Treatment Services (IRTS), Intensive Treatment Foster Care Services (for members under age 21), Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services (for members ages 18 through 20), Partial Hospitalization Program (PHP) o Psychiatric Residential Treatment Facility (PRTF) (for members ages 18 through 20) o Telemedicine 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.	

Services that our plan pays for		What you must pay
	Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0
	***Outpatient substance abuse services** We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling including Screening Brief Intervention Referral to Treatment (SBIRT) authorized services and comprehensive assessments • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment • outpatient medication assisted treatment • substance use disorder treatment coordination • peer recovery support • detoxification (only when inpatient hospitalization is medically necessary because on conditions resulting from injury or medical complications during detoxification) • withdrawal management **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	***Outpatient substance abuse services (continued)** 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 Chapter 9.	
	***Outpatient surgery** We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0
	Over-The-Counter (OTC) Oral Health Items You will also be offered an electric toothbrush kit (once every three years) that contains: • Electric Rechargeable Toothbrush • Two Brush Head Refills	$0
	***Partial hospitalization services and Intensive outpatient services** Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	***Partial hospitalization services and Intensive outpatient services (continued)** Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	
	Personal HealthAdvocate℠ 24/7 telephonic support service through partner HealthAdvocate℠ provides a dedicated nonclinical personal health advocate who will assist you talk to a registered nurse for clinical support, answer your questions about Medica services and benefits, and resolve your health insurance issues.	$0
	Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: o physician's office o certified ambulatory surgical center o hospital outpatient department o consultation, diagnosis, and treatment by a specialist o basic hearing and balance exams given by your primary care provider ***or*** specialist, if your doctor orders them to find out whether you need treatment **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • Certain telehealth services, including: Urgently Needed Services, Primary Care Physician Services, Physician Specialist Services, Individual Sessions for Mental Health Specialty Services, Other Health Care Professional, Individual Sessions for Psychiatric Services, and Individual Sessions for Outpatient Substance Abuse. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services **This benefit is continued on the next page**	

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) ○ Exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers. • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if** ○ you're not a new patient **and** ○ the check-in isn't related to an office visit in the past 7 days **and** ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: ○ you're not a new patient and ○ the evaluation isn't related to an office visit in the past 7 days **and** ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery • Non-routine dental care. Covered services are limited to: ○ surgery of the jaw or related structures **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	Physician/provider services, including doctor's office visits (continued) ○ setting fractures of the jaw or facial bones ○ pulling teeth before radiation treatments of neoplastic cancer ○ services that would be covered when provided by a physician For information about other dental services we cover, refer to the "Dental services" section of this chart. • Preventive and physical exams • Family Planning services. For more information, refer to the "Family planning" section of this chart.	
	Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes • Other non-routine foot care such as debridement of toenails and infected corns and calluses	$0
🍎	**Prostate cancer screening exams** For men age 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0

Services that our plan pays for		What you must pay
	Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here: • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) • Orthotics • Wigs for people with hair loss due to any medical condition • Some shoes when a part of a leg brace or when custom molded We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices. We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.	$0
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0

Services that our plan pays for		What you must pay
🍎	**Sexually transmitted infections (STIs) screening and counseling** We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0
	***Skilled nursing facility (SNF) care** For additional nursing home services covered by us, refer to the "Nursing facility care" section. We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	***Skilled nursing facility (SNF) care (continued)** • blood, including storage and administration • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	
	Smoking and tobacco use cessation If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Smoking and tobacco use cessation (continued) • We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • We may cover additional beenfits if medically necessary **Additional Medica AccessAbility Solution Enhanced benefits include:** In addition to the Medicare-covered face to face counseling sessions, Medica partners with Active Health® to offer additional services to help you 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 8-10 weeks per year (as medically appropriate) Coaching plans run about ten (10) weeks. You may make unlimited attempts to quit tobacco. Coaching plans are customized and structured based on your individual needs.	
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Supervised exercise therapy (SET) (continued) • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	
	***Transportation** If you need transportation to and from health services that we cover, call 1 (888) 347-3630, (TTY 711). We will provide the most appropriate and cost-effective transportation. Our plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Call 1 (888) 347-3630, (TTY 711) if you do not have a Primary Care Clinic that is available within 30 miles of your home and/or you do not have a specialty provider that is available within 60 miles of your home. • Non-emergency ambulance • Volunteer driver transport • Unassisted transport (taxi or public transportation) • Assisted transportation **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	***Transportation (continued)** • Lift-equipped/ramp transport • Protected transportation • Stretcher transport Note: Our plan does not cover 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. For more information on your transportation benefits, please visit Medica.com/Ride	
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • a sudden medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider beause given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). This coverage is only available within the U.S. and its territories.	$0

Services that our plan pays for	What you must pay
Vision care We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans who are age 50 and over • Hispanic Americans who are 65 or over We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. We also cover the following: • Eye exams • Initial eyeglasses, when medically necessary. (eyeglass frame 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 (such as Transitions®) lenses, or polarized lenses, when medically necessary **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Vision care (continued) • Contact lenses, when medically necessary under certain circumstances **Additional Medica AccessAbility Solution Enhanced benefits include:** You are eligible to get anti-glare lens coating on one pair of covered glasses or two covered lenses once per 24 months through our eyewear partner Eye-Kraft®. Note: Our plan does not cover an extra pair of glasses, progressive bifocal/trifocal lenses (without lines), protective coating for plastic lenses, and contact lens supplies.	
	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

E. Benefits covered outside of our plan

We don't cover the following services, but they are available through Medicare or Medical Assistance.

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** *of your Member Handbook.*

Note: If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

E2. Other Services

The following services are not covered by us under the plan but may be available through another source, such as the state, county, federal government, or tribe. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll-free). TTY users should call 1-800-627-3529.

- Case management for people with developmental disabilities
- Child welfare targeted case management
- Consumer Support Grant (CGS)
- HIV services under the Ryan White Act

- Home Care Nursing
- Personal Care Assistant (PCA) services (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service.)
- Relocation Service Coordination (RSC)
- Waiver services provided under Home and Community-Based Services waivers
- Intermediate care facility for people who have a developmental disability (ICF/DD)
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center 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
- Services provided by federal institutions
- Job training and educational services
- Day training and habilitation
- 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 the “Nursing facility care” and the “Skilled nursing facility (SNF) care” sections in the Benefits Chart for additional information.)
- Vulnerable Adult Protective Services
- Medical Assistance covered services provided by Federally Qualified Health Centers (FQHC)

F. Benefits not covered by our plan, Medicare, or Medical Assistance

This section tells you about benefits excluded by our plan. “Excluded” means that we do not pay for these benefits. Medicare and Medicaid do not pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

- services considered not “reasonable and medically necessary”, according Medicare and Medical Assistance standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare or Medical Assistance pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- fees charged by your immediate relatives or members of your household. Exceptions to this may be for some services, such as personal care assistance (PCA) and consumer-directed community supports (CDCS) services.elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- routine foot care, except as described in Podiatry services in the Benefits Chart in Section D
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities.

Chapter 5: Getting your outpatient prescription drugs

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Medical Assistance. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to Chapter 5, Section F3 "If you are in a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section. If a drug is a Part D drug, it cannot be covered under the Medical Assistance benefit.

You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medicaid lists.

You generally must use a network pharmacy to fill your prescription.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short.

- If it is not on the Drug List, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website or contact Member Services or your care coordinator.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for your covered prescription drug.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back. **If you can't pay for the drug, contact Member Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services or your care coordinator.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services or your care coordinator.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
    - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. Drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.

Our plan's mail-order service allows you to order **up to** a 90-day supply. A 90-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, please contact Member Services at the number listed at the bottom of this page.

Usually, a mail-order prescription arrives within 10 days. However, sometimes your mail-order may be delayed. If your shipment is delayed beyond this and you require it to be filled, you will need to contact your physician for an interim prescription to fill at your local retail pharmacy until your supply arrives. If you have difficulty filling your interim prescription please contact Member Services.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. **New prescriptions the pharmacy gets from you**

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets from your provider's office**

   The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

   - You used mail-order services with our plan in the past, **or**
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by calling Express Scripts at 1 (800) 290-7924 (TTY: 711). 24 hours a day, 7 days a week.

   If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by calling Express Scripts at 1 (800) 290-7924 (TTY: 711). 24 hours a day, 7 days a week.

   If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

   - This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it is shipped.
   - Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling Member Services at the number at the bottom of this page.

3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling Member Services at the number at the bottom of this page.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. Access your Express Scripts website through your secure member portal, MyMedica.com, or use the Express Scripts mobile app. Follow steps for mail order. You may also call the Express Scripts Mail Service Pharmacy toll-free number 1 (800) 290-7924 (TTY: 711) 24 hours per day, 7 days a week and be ready with doctor, medicine, and mailing information and prescription payment method.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your care coordinator or Member Services for more information.

You can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If the prescriptions are related to care for a medical emergency or urgently needed care.
- If you are traveling within the United States and become ill or run out of your prescription drugs and a network pharmacy is not available.
- If you are unable to obtain a covered drug in a timely manner because there is no network pharmacy within a reasonable driving distance that provides 24- hour service.

In these cases, check with your care coordinator or Member Services first to find out if there's a network pharmacy nearby.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to **Chapter 7** of your *Member Handbook*.

NOTE: If the drug is covered by Medical Assistance (Medicaid), we do not allow Medica AccessAbility Solution Enhanced providers to bill you for these drugs. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges. If you paid for a drug that you think we should have covered, contact Member Services at the number at the bottom of this page.

B. Our plan's Drug List

We have a *List of Covered Drugs.* We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under Medical Assistance.

Our Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example drugs that are based on a protein) are called biological products. On our Drug List, when we refer to “drugs” this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as brand name drugs or biological products and usually cost less. There are generic drug substitutes available for many brand name drugs. There are similar alternatives for some biological products. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Visit our plan’s website at Medica.com/ASE. The Drug List on our website is always the most current one.
- Call your care coordinator or Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.
- Use our “Real Time Benefit Tool” at https://www.express-scripts.com/login or call your care coordinator or Member Services. With this tool you can search for drugs on the Drug List to get an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.

B3. Drugs not on our Drug List

We don’t cover all prescription drugs. Some drugs are not on our Drug List because the law doesn’t allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List.

Our plan does not pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and Medical Assistance drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Medical Assistance cannot cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction
- Outpatient drugs made by a company that says you must have tests or services done only by them

B4. Drug List cost-sharing tiers

Every drug on our Drug List is in one tier. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

Tier 1 generic drugs, Tier 1 brand name drugs, and over-the-counter drugs and products have a $0 copayment. To find out which cost-sharing tier your drug is in, look for the drug on our Drug List.

Chapter 6 of your *Member Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

1. Limiting use of a brand name drug or original biological products when a generic or interchangeable biosimilar version is available

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. If there is a generic or interchangeable biosimilar version of a brand name drug or original biological product, our network pharmacies give you the generic or interchangeable biosimilar version.

- We usually do not pay for the brand name drug or original biological product when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar will not work for you ***or*** told us the medical reason that the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug.

3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at Medica.com/ASE. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of the *Member Handbook.*

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
   - is no longer on our Drug List **or**

- was never on our Drug List **or**
- is now limited in some way.

2. You must be in one of these situations:
   - You were in our plan last year.
     - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You are new to our plan.
     - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You have been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
     - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our Drug List or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

D3. Asking for an exception

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9** of your *Member Handbook*.

If you need help asking for an exception, contact Member Services.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).

- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when our Drug List changes, you can always:

- Check our current Drug List online at Medica.com/ASE **or**
- Call Member Services at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List happen **immediately**. For example:

- **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of your *Member Handbook* for more information on exceptions.

- **A drug is taken off the market.** If the FDA says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. Contact your provider if you are

notified of a drug being taken off the market to determine other options for treatment.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our Drug List you can take instead **or**
- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

We may make changes to drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change does not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not or if you need more information, contact Member Services.

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require certain drugs (e.g., a pain medication, anti-nausea, laxative, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal prognosis and conditions, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your *Member Handbook* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.

- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services.

G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from a certain pharmacy and/or from a certain doctor
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of your *Member Handbook*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and Medical Assistance prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

Because you are eligible for Medical Assistance, you get "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- Our *List of Covered Drugs*.
    - We call this the "Drug List." It tells you:
        - Which drugs we pay for
        - If there are any limits on the drugs
    - If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at Medica.com/ASE.
- **Chapter 5** of your *Member Handbook*.
    - It tells how to get your outpatient prescription drugs through our plan.

- It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.

- When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in "real time" meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call your care coordinator or Member Services for more information.

- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.

  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Member Handbook* more information about network pharmacies.

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A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information.** This is your total drug costs and total payments made since January 1.
- **Drug price information**. This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our Drug List. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under Medical Assistance. These drugs are included in the Drug List.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

   Here are some times when you should give us copies of your receipts:

   - When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
   - When you pay a copay for drugs that you get under a drug maker's patient assistance program
   - When you buy covered drugs at an out-of-network pharmacy
   - When you pay the full price for a covered drug

   For more information about asking us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.

3. **Send us information about payments others have made for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. **Check the EOBs we send you.**

When you get an EOB in the mail, make sure it is complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call Medica AccessAbility Solution Enhanced Member Services or read the Medica AccessAbility Solution Enhanced *Member Handbook*. You can find the Member Handbook by visiting Medica.com/ASE.

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Medica AccessAbility Solution Enhanced Member Services. You can also find answers to many questions on our website: Medica.com/ASE

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at Medica AccessAbility Solution Enhanced Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- To report fraud or abuse directly to the State, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at 651 431-2650 or 1 800-657-3750 (this call is free); by fax at 651-431-7569; or by email at DHS.SIRS@state.mn.us

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs as long as you follow our rules.

C1. Our cost sharing tiers

- Tier 1 Generic drugs have a $0 copayment.
- Tier 1 Brand name drugs have a $0 copayment.

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

C2. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, **or**
- an out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of your *Member Handbook* to find out when we do that.
- A mail-order pharmacy.

Refer to **Chapter 9** of the *Member Handbook* to learn about how to file an appeal if you are told a drug will not be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of your *Member Handbook* and our *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our *Provider and Pharmacy Directory*.

D. Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).* Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *List of Covered Drugs (Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

D1. What you need to know before you get a vaccination

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.

D2. What you pay for a vaccination covered by Medicare Part D

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook.*
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. If the vaccine is recommended for adults by an organization called the **Advisory Committee or Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you will pay nothing.
   - For other Part D vaccines, you pay nothing for the vaccine.
1. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay nothing to the doctor for the vaccine.
   - Our plan pays for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.

2. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
   - For most adult Part D vaccines, you will pay nothing for the vaccine itself.
   - For other Part D vaccines, you pay nothing for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow Medica AccessAbility Solution Enhanced providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, do not pay the bill and send the bill to us. To send us a bill, refer to Section B.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it is your right to be paid back.
    - If you paid for services covered by Medicare, we will pay you back.
    - If you paid for services covered by Medical Assistance we can't pay you back, but the provider will. Member Services can help you contact the provider's office. Refer to the bottom of the page for the Member Services phone number.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services or your care coordinator if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.

- If the provider should be paid, we will pay the provider directly.
- If you already paid for the Medicare service, we will *f* pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Member Services** at the number at the bottom of this page **if you get any bills.**

- Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, but you feel that you paid too much, send us the bill and proof of any payment you made. We will pay you back for your covered services ***or*** for the difference between the amount you paid and the amount you owed under our plan.

3. If you are retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

4. When you use an out-of-network pharmacy to get a prescription filled

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

5. When you pay the full Medicare Part D prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back.

6. When you pay the full Medicare Part D prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook*.

B. Sending us a request for payment

We do not allow Medica AccessAbility Solution Enhanced providers to bill you for services or drugs. We pay our providers directly, and we protect you from any charges.

You should not pay the bill yourself. Send us the bill. You can also ask your care coordinator for help. Refer to Section A of this chapter or Chapter 9, Section F5.

For Medicare services, send us your bill and proof of any payment you made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your care coordinator for help.

Mail your request for payment together with any bills or receipts to this address:

Medica Member Services
Route CP540
P.O. Box 9310
Minneapolis, MN 55440-9310

You may also call us to ask for payment. Please call Medica AccessAbility Solution Enhanced Member Services at 1 (888) 347-3630 (TTY: 711). We are available for phone calls from Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week. From April 1 – Sept. 30 we are available 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free.

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay for it. If you already paid for the service or drug, we will mail you a check. If you haven't paid, we will pay the provider directly.
- **Chapter 3** of your *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called “making an appeal.” You can also make an appeal if you don’t agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Member Handbook*.

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. Your right to get services and information in a way that meets your needs

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Member Services call 1 (888) 347-3630 (TTY: 711) or write to:

  Medica Member Services:
  Route CP540
  P.O. Box 9310
  Minneapolis, MN 55440-9310

- To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Member Services at the number at the bottom of this page.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Civil Rights Coordinator, Minnesota Department of Human Services, 651-431-3040 or use your preferred relay service
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Member Handbook*.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Member Handbook*.

Chapter 9 of your *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the “Notice of Privacy Practice.”

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don’t give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don’t need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan’s quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws.
- We, and the health providers who take care of you, have the right to look at information about our 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.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. We can also give you information in large print, braille, or audio.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
  - the results of an external quality review study from the State
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
  - Whether we use a physician incentive plan that affects the use of referral services and the type(s) of physician incentive arrangements used
  - Whether stop-loss protection is provided
  - Results of a member survey if one is required because of our physician incentive plan
- Covered services and drugs, including:

  - services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Member Handbook*.

F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Member Handbook:*
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you will get your Medical Assistance benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you**.

- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. The Senior LinkAge Line® is an organization that gives people information about Medicare or Medical Assistance (Medicaid), including resources for getting a form at www.minnesotahelp.info/.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

- Remember, it is your choice to fill out an advance directive or not.

Call Member Services for more information.

G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Office of Health Facility Complaints at the Minnesota Department of Health at 651-201-4201, or toll-free at 1-800-369-7994.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of your *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Member Handbook* – or you want more information about your rights, you can call:

- Member Services.
- The Senior LinkAge Line at 800-333-2433. For more details about the Senior LinkAge Line, refer to Chapter 2.
- The Minnesota Ombudsperson for Public Managed Health Care Programs at 800-657-3729. For more details about this program, refer to Chapter 2 of your Member Handbook.

Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook.* Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook.*
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Establish a relationship with a plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Practice preventive health care. Have tests, exams, and shots recommended for you based on your age and gender.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.

- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most Medica AccessAbility Solution Enhanced members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9 to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call your care coordinator or Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells about our service area.
  - We can help you find out if you're moving outside our service area.
  - Tell Medicare and Medical Assistance your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and Medical Assistance.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Call your care coordinator or Member Services for help if you have questions or concerns.**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

If you are having a problem with your care, you can call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service. This chapter explains the different options you have for different problems and complaints, but you can always call the Ombudsperson for Public Managed Health Care Programs to help guide you through your problem.

For more information about Ombudsperson programs that can help you address your concerns, refer to Chapter 2.

Table of Contents

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it’s confusing to start or follow the process for dealing with a problem. This can be especially true if you don’t feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the Senior LinkAge Line

You can call the Senior LinkAge Line. Senior LinkAge Line® counselors can answer your questions and help you understand what to do about your problem. The Senior LinkAge Line is

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

not connected with us or with any insurance company or health plan. The Senior LinkAge Line has trained counselors in every county, and services are free. The Senior LinkAge Line phone number is 800-333-2433.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from the Ombudsperson for Public Managed Health Care Programs

If you need help, you can always call the Ombudsperson for Public Managed Health Care Programs. The Ombudsperson for Public Managed Health Care Programs can answer your questions and help you understand what to do to handle your problem. Refer to Chapter 2, section H for more information on Ombudsperson programs.

The Ombudsperson for Public Managed Health Care Programs is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Ombudsperson for Public Managed Health Care Programs is 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service. The services are free.

C. Understanding Medicare and Medical Assistance complaints and appeals in our plan

You have Medicare and Medical Assistance. Information in this chapter applies to **all** of your Medicare and Medical Assistance benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medical Assistance processes.

Sometimes Medicare and Medical Assistance processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a Medical Assistance benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.	
Yes. My problem is about benefits or coverage. Refer to **Section E,** "Coverage decisions and appeals."	**No.** My problem is not about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment).

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to Chapter 4, Section H) of your *Member Handbook.*

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what is covered for you and how much we pay. In some cases, we may decide a service or drug is not covered or is no longer covered for

you by Medicare or Medical Assistance. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or “fast coverage decision” or “fast appeal” of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals. If your problem is about a coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- Call the State Health Insurance Assistance Program (SHIP) for free help. The SHIP is an independent organization. It is not connected with this plan. In Minnesota the SHIP is called the Senior LinkAge Line®. The phone number is 1-800-333-2433 or TTY MN Relay 711 or use your preferred relay service. These calls are free.

- Call the Ombudsperson for Public Managed Health Care Programs for free help. The Ombudsperson for Public Managed Health Care Programs helps people enrolled in Medical Assistance (Medicaid) with service or billing problems. The phone number is 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.

- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.

- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.

- **A lawyer**. You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.

    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"

- **Section G**, "Medicare Part D prescription drugs"

- **Section H**, "Asking us to cover a longer hospital stay"

- **Section I**, "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page.

If you need other help or information, please call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.

F. Medical, behavioral health, and long-term care services

This section explains what to do if you have problems getting coverage for medical, behavioral health and long-term care services or if you want us to pay you back for your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to "medical care coverage" or "medical care" in the rest of this section. The term "medical care" includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.

   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **"integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 1 (888) 347-3630, TTY: 711.
- Faxing: (952) 662-3660
- Writing:
  Medica Member Services
  Route CP540
  P.O. Box 9310
  Minneapolis, MN 55440-9310

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a**:**

- Medical service or item within 14 calendar days after we get your request.

- Medicare Part B prescription drug within 72 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can't take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

> The legal term for "fast coverage decision" is "**expedited determination**."

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can't take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.

- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
    - We automatically give you a fast coverage decision if your doctor asks for it.
    - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at 1 (888) 347-3630 or write to:

Medica Member Services
Route CP540
P.O. Box 9310
Minneapolis, MN 55440-9310

Ask for a standard appeal or a fast appeal in writing or by calling us at 1 (888) 347-3630.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.

- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:

    - We dismiss your request, and

    - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.

- You must ask for an appeal within 60 calendar days from the date on the letter we sent to tell you our decision.

- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had

a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.

- If you do not appeal before these dates, then your service or item will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.

- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.**

  - If we need extra days to make the decision, we tell you in writing.

  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.

  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Minnesota a Fair Hearing is called a State Appeal.

- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.

- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.

- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.

- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.**
    - If we need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
    - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
    - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Minnesota a Fair Hearing is called a State Appeal.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.

- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.

- If your problem is about coverage of a Medical Assistance service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Medical Assistance, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.

- If your problem is about a service or item that Medical Assistance usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.

- If your problem is about a service or item that **both Medicare and Medical Assistance may** cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.

- If your problem is about a service usually covered only by Medical Assistance, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity"**, sometimes called the **"IRE"**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.

- We send information about your appeal (your “case file”) to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:
    - Authorize the medical care coverage **within 72 hours, or**

  - Provide the service within **14 calendar days** after we get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.

- **If the IRO says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal,** it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and Medical Assistance

A Level 2 Appeal for services that Medical Assistance usually covers is a Fair Hearing with the state. In Minnesota a Fair Hearing is called a State appeal. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your

Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

You must ask for a State Appeal (Medicaid Fair Hearing with the state) within 120 days of the date of the plan's appeal decision.

Mail, fax, or submit your written request to:

Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941
Fax: 651- 431-3600

Online Appeal Form:
edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG

A Human Services Judge from the State Appeals Office will hold the hearing. Your meeting will be by telephone unless you ask for a face-to-face meeting. During your hearing, tell the Judge why you disagree with the decision made by the plan. You can ask a friend, relative, advocate, provider, or lawyer to help you.

The process can take between 30 and 90 days. If your hearing is about an urgently needed service and you need an answer faster, tell the State Appeals Office when you file your hearing request. If your hearing is about a medical necessity denial, you may ask for an expert medical opinion from an outside reviewer. There is no cost to you.

If you need help at any point in the process, call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service**,** we must authorize or provide the service or item **within 72 hours** after we get their decision.

- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

We can't reimburse you directly for a Medicaid service or item. If you get a bill that is more than your copay for Medicaid covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to **Chapter 7** of your *Member Handbook*.

For more information*,* refer *to* **Chapter 7** of your *Member Handbook*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

- If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send your provider the payment for the service or item within 60 calendar days after we get your request.

- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.

- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.

- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Medical Assistance usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medical Assistance may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medicaid follow the process in **Section E** on page 171.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
    - cover a Medicare Part D drug that is not on our plan's Drug List or
    - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**.	Refer to **Section G4.**	Refer to **Section G4.**	Refer to **Section G5**.

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that is not on our Drug List**

- You can't get an exception to the required copay amount for the drug.

2. **Removing a restriction for a covered drug**

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
    - Being required to use the generic version of a drug instead of the brand name drug.
    - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
    - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
    - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally do **not** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling1 (888) 347-3630 (TTY: 711),writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.

- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

- Refer to **Section E3** to find out how to name someone as your representative.

- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.

- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.

- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.

- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

> A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
    - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
    - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.

- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.

- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.

- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.

- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.

- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.

- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.

- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.

- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.

- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling 1 (888) 347-3630, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
    - We give you our answer sooner if your health requires it.
    - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
- If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an d reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.

- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.

    - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.

- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity",** sometimes called the **"IRE".**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO . The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.

- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**.

- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.

- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.

- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.

- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.

- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
    - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook.*

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
    - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
    - Be a part of any decisions about the length of your hospital stay.
    - Know where to report any concerns you have about the quality of your hospital care.
    - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
    - You or someone acting on your behalf can sign the notice.
    - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In Minnesota, the QIO is Livanta. Call them at 1-888-524-9900 (TTY: 1-888-985-8775). Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the QIO about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Senior LinkAge Line at 1-800-333-2433 or TTY MN Relay 711.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **“fast review”** is **“immediate review”** or **“expedited review.”**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.

- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.

- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.

- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.

- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.

- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-524-9900 (TTY: 1-888-985-8775).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H4. Making a Level 1 Alternate Appeal

The deadline for contacting the QIO for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

The legal term for “fast review” or “fast appeal” is **“expedited appeal”.**

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the IRO within 24 hours of saying **No** to your Level 1 Appeal. We do this automatically. You don’t need to do anything.

If you think we didn’t meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.

- **Ask for help if you need it.** If you have questions or need help at any time:

    - Call Member Services at the numbers at the bottom of the page.

    - Call the Senior LinkAge Line at 1-800-333-2433 or TTY MN Relay 711.

- **Contact the QIO.**

    - Refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.

    - Ask them to review your appeal and decide whether to change our plan's decision.

- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**.

> The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.
- If the QIO says **No** to your appeal:
- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.

- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends

- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-524-9900 (TTY: 1-888-985-8775).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.

- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.

- We will provide coverage for the care for as long as it is medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.

- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I4. Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the QIO to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review”.

> The legal term for “fast review” or “fast appeal” is **“expedited appeal”.**

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.
- If we say **Yes** to your fast appeal:
- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- We agree to pay you back for the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
  - Our coverage for these services ends on the date we told you.
  - We will not pay any of the costs after this date.
  - You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
  - We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

I5. Making a Level 2 Alternate Appeal

During the Level 2 Appeal:

- We send the information for your Level 2 Appeal to the IRO within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

- If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

- The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.

- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.

    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.

- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medical Assistance appeals

You also have other appeal rights if your appeal is about services or items that Medical Assistance usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process. If you disagree with the ruling from the State Appeal process, you may appeal to the District Court in your county by calling the county clerk. You have 30 days to file an appeal with District Court.

If you need help at any stage of the process, you can call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.

- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.

- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.

Complaint	Example
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Member Services at 1 (888) 347-3630 (TTY 711). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is

about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.

- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

- If you submit a written complaint, it may be either by letter or complaint form. You will receive a written acknowledgement letter from a Consumer Affairs Advisor within 10 calendar days of receiving your complaint. Your case will be reviewed to determine if the original decision was appropriate. We must notify you of our decision about your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.
    - Mail the complaint to:
      Medica Member Services
      Attention: Consumer Affairs
      Route CP540
      P.O. Box 9310
      Minneapolis, MN 55440-9310

      Medica.com/Medica-Contact-Form

> **The legal term** for “fast complaint” is **“expedited grievance.”**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don’t make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.

- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx. You do not need to file a complaint with Medica AccessAbility Solution Enhanced before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell the Minnesota Department of Health about your complaint:

Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882

You can also make a complaint at
https://www.health.state.mn.us/facilities/insurance/clearinghouse/complaints.html

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

Office of Civil Rights, Midwest Region, at 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. Call 1 800-368-1019, fax 1-202-619-3818, or email ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act (ADA).

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook*.

In Minnesota, the QIO is called Livanta. The phone number for Livanta is 1-888-524-9900 (TTY: 1-888-985-8775).

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and Medical Assistance programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medical Assistance, you may be able to end your membership with our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for Medical Assistance or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP) at 1-800-333-2433., In Minnesota, the Senior LinkAge Line®. TTY MN Relay 711 users should call 711 or use your preferred relay service. These calls are free.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to Chapter 5 of your Member Handbook for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 221.

C. How to get Medicare and Medical Assistance services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another Medicare health plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433 (TTY users call 711 or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. **OR** Enroll in a new Medicare plan. You will automatically be disenrolled from our plan when your new plan's coverage begins. If you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You can re-enroll in the non-integrated SNBC plan you were enrolled in before Medica AccessAbility Solution Enhanced enrollment by filling out a new enrollment form.

2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433 (TTY users call 711 or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. **OR** Enroll in a new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. If you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You can re-enroll in the non-integrated SNBC plan you were enrolled in before Medica AccessAbility Solution Enhanced enrollment by filling out a new enrollment form.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare prescription drug plan **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Senior LinkAge Line at 1-800-333-2433 (TTY users call 711 or use your preferred relay service). For more information or to find a local Senior LinkAge Line® office in your area, please visit https://mn.gov/senior-linkage-line/.	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433 (TTY users call 711 or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. You will automatically be disenrolled from Medica AccessAbility Solution Enhanced when your Original Medicare coverage begins. If you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You can re-enroll in the non-integrated SNBC plan you were enrolled in before Medica AccessAbility Solution Enhanced enrollment by filling out a new enrollment form.

C2. Your Medical Assistance services

If you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You can re-enroll in the non-integrated SNBC plan you were enrolled in before Medica AccessAbility Solution Enhanced enrollment by filling out a new enrollment form.

Your medical items, services and drugs until your membership in our plan ends

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Medica AccessAbility Solution Enhanced ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medical Assistance. Our plan is for people who qualify for both Medicare and Medical Assistance.
    - If you have Medicare and lose eligibility for Medical Assistance, our plan will continue to provide plan benefits for up to three months.
    - If after three months you have not regained Medical Assistance, coverage with our plan will end.
    - You will need to choose a new Medicare Part D plan in order to continue getting coverage for Medicare covered drugs.
    - If you need help, you can call the Senior LinkAge Line® at 1-800-333-2433 (TTY MN Relay 711 users call 711 or use your preferred relay service). These calls are free.

- If you do not pay your medical spenddown, as applicable.
- If you move out of our service area
- If you are away from our service area for more than six months.
- If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
    - Refer to **Chapter 4** of your Member Handbook for information on getting care through our visitor or traveler benefits when you're away from our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medical Assistance first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook.*

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in the *Member Handbook*. The main laws that apply are federal laws about the Medicare and Medical Assistance programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights. Midwest Region, at 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. You can also call the toll-free numbers above, fax 1 202 619 3818, or email ocrmail@hhs.gov.
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and Medical Assistance as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medical Assistance is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Actions: These include:

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

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

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 an appeal. **Chapter 9** *of your Member Handbook* explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Biosimilar: A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to

substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Direct access services: You can use any provider in our plan's network to get these services. You do not need a referral or prior authorization before getting services.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one tier.

Dual eligible individual: A person who qualifies for Medicare and Medicaid coverage.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency 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 or serious impairment to a bodily function *(*and if you are a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Emergency medical transportation: Ambulance services, including ground and air transportation for an emergency medical condition.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that are not covered by this health plan.

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

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy”, or “LIS”.

Family planning: Information, services and supplies to 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.

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

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 or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It’s used to learn about your health and how it might change in the future.

Home and Community-Based Services (HCBS): Additional services that are provided to help you remain in your home.

Home health aide: A person who provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don’t have a nursing license or provide therapy.

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

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.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital outpatient care: Care in a hospital that usually doesn't require an overnight stay. An overnight stay for observation could be outpatient care.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand. As a plan member, you only pay our plan's cost-sharing amounts when you get services we cover. We do **not** allow providers to bill you more than this amount.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the Independent Review Entity.

Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

List of Covered Drugs **(Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't

have to go to a nursing facility or hospital. LTSS can be provided in your home, apartment, or facility where you live.

Low-income subsidy (LIS): Refer to “Extra Help”

Medical Assistance: This is the name of Minnesota’s Medicaid program. Medical Assistance is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. 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 mental health. 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 that 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 and find health problems.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage: A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual”.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to Chapter 5 of your *Member Handbook* for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

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 enrollees age 65 and older.

Minnesota Senior Health Options (MSHO): A program in which the State and CMS contract with health plans, including our plan, to provide services only for seniors eligible for both Medicare and Medical Assistance, including those covered by MSC+.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers”.

Notice of Action: A form or letter we send to you telling you about a decision on a claim, a service or any other action taken by our plan. This is also called a Denial, Termination, or Reduction (DTR).

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.

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

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 plan's network – to get these services.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of your *Member Handbook* explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

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. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Palliative care: Palliative care helps people with serious illnesses feel better. It prevents or treats symptoms and side effects of disease and treatment. Palliative care also treats emotional, social, practical, and spiritual problems that illnesses can bring up. Palliative care can be given at the same time as treatments meant to cure or treat the disease. Palliative care may be given when the illness is diagnosed, throughout treatment, during follow-up, and at the end of life.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Physician services: Health care services provided or coordinated by a medical physician licensed under state law (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

Prescription drugs: Drugs and medications that can be dispensed only with an order given by a properly authorized person.

Primary care clinic (PCC): The facility where you get most of the health care services you need, such as annual checkups, and helps coordinate your care. You may need to choose a primary care clinic when you enroll in our plan.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Member Handbook*.
- Our plan covers some drugs only if you get PA from us.
- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Provider: The general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services.

Quality of care complaint: In this handbook, "quality of care complaint" means an expressed dissatisfaction about health care services resulting in potential or actual harm to a member. Complaints may be about access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that can have a negative effect on the quality of health care services.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** *of your Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the

same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

Restricted Recipient Program: A program for members who got 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 clinic, one hospital used by the primary care provider, and one pharmacy. Medica may designate other health care providers. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months. The restricted recipient program does not apply to Medicare-covered services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

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

State Appeal: A hearing at the state to review a decision made by our plan. You must ask for a hearing in writing. You may ask for a hearing if you disagree with any of the following:

- A denial, termination or reduction of service
- Enrollment in the Plan
- Denial in full or part of a claim or service
- Our failure to act within required timelines for prior authorization and appeals
- Any other action

State Medicaid agency: In Minnesota, this agency is the Minnesota Department of Human Services.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Medica AccessAbility Solution Enhanced Member Services

CALL	1 (888) 347-3630 Calls to this number are free. We are available for phone calls Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are available for phone calls Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday.
FAX	(952) 992-3660
WRITE	Medica Member Services: Route CP540 P.O. Box 9310 Minneapolis, MN 55440-9310
WEBSITE	Medica.com/ASE

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P.O. Box 9310, Minneapolis, MN 55440-9310

If you have questions, please call Medica AccessAbility Solution Enhanced at 1 (888) 347-3630, (TTY 711), Oct. 1 – March 31 from 8 a.m. – 9 p.m. CT, 7 days a week and April 1 – Sept. 30 from 8 a.m. – 9 p.m. CT, Monday – Friday. The call is free. **For more information**, visit Medica.com/ASE.