BlueCross BlueShield Minnesota

Blue Plus

Member Handbook

Minnesota Senior Care Plus (MSC+)

January 1, 2022

This booklet contains important information about your health care services.

Blue Plus, 1800 Yankee Doodle Road, Eagan, MN 55122
Website: **bluecrossmn.com/publicprograms**
Blue Plus Member Services: Call **1-800-711-9862**, TTY **711**
Hours of service: Monday through Friday 8 a.m. to 5 p.m. Central Time

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Blue Advantage[SM] and MinnesotaCare
Toll Free 1-800-711-9862, 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။

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請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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

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

ပတ်သူဉ်ပတ်သးဘဉ်တက့်၊ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂ်ၢ်လၢထးအံၤနူဉ်တက့်၊

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 cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

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Civil Rights Notice

Discrimination is against the law. Blue Plus 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 Blue Plus. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:
Blue Plus
1800 Yankee Doodle Road, Eagan, MN 55122
Toll Free: **1-800-711-9862** TTY: **711**
Fax: **651-662-9478** Email: Civil.Rights.Coord@bluecrossmn.com

Auxiliary Aids and Services: Blue Plus 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** Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Advantage[SM] and MinnesotaCare Member Services at **1-800-711-9862** (this call is free), or your preferred relay services.

Language Assistance Services: Blue Plus 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** Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Advantage[SM] and MinnesotaCare Member Services at **1-800-711-9862** (this call is free), or your preferred relay services.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Blue Plus. 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.

MEMBER HANDBOOK
Minnesota Senior Care Plus (MSC+)
TABLE OF CONTENTS

Welcome to Blue Plus

We are pleased to welcome you as a member of Blue Plus Blue Advantage[SM] Minnesota Senior Care Plus (referred to as "Plan" or "the Plan").

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

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

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

This Member Handbook includes:

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

The counties in the Plan service area are as follows: Aitkin, Anoka, Becker, Benton, Blue Earth, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Cook, Cottonwood, Crow Wing, Dakota, Faribault, Fillmore, Houston, Isanti, Jackson, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Redwood, Rice, Rock, Roseau, St. Louis, Scott, Sherburne, Stearns, Swift, Todd, Wadena, Washington, Watonwan, Wilkin, Winona, Wright, and Yellow Medicine

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

Member Handbook tells how to contact us.) Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with us. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Section 1. Telephone numbers and contact information

How to contact our Member Services

If you have any questions or concerns, please call or write to Member Services. We will be happy to help you. Member Services hours of service are 8 a.m. to 5 p.m. Central Time, Monday through Friday.

CALL: **(651) 662-5545** or toll free at **1-800-711-9862** (This call is free.)
TTY: **711**
WRITE: Blue Plus, P.O. Box 64033, St. Paul, MN 55164-4033
VISIT: Blue Plus, 1800 Yankee Doodle Road, Eagan, MN 55122
WEBSITE: **bluecrossmn.com/shop-plans/minnesota-health-care-programs/blue-plus-minnesota-senior-care-plus-msc**

Our Plan contact information for certain services

Appeals and Grievances Call Blue Plus Member Services at **1-800-711-9862**, TTY call **711**(this call is free), or write to us at Blue Plus, P.O. Box 64033, St. Paul, MN 55164-4033. Refer to Section 13 for more information.

Chiropractic Services Call Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free.

Dental Services Call Minnesota Select Dental Customer Service toll free at **1-800-774-9049**. TTY call **711**. This call is free. Delta Dental of Minnesota is independent from Blue Cross. Delta Dental provides administrative services for dental benefits.

Durable Medical Equipment Coverage Criteria Call Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free.

Health Questions Telephone Line: Members may call 24/7 NurseLine at **1-800-711-9862** (this call is free) any time they are experiencing symptoms or need health care information. The service is staffed by registered nurses who will assess your symptoms and direct you to the best possible care. This service is available for you 24 hours a day, 7 days a week to speak with a registered nurse. TTY call **711**.

Home and Community Based Services (Elderly Waiver) Call Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free.

Interpreter Services

American Sign Language (ASL) TTY **711**
Spoken Language **1-800-711-9862** This call is free.

Mental Health Services Call Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free.

Prescriptions Call Prime Therapeutics at **1-844-765-5939**. TTY call **711**. This call is free.

Substance Use Disorder Services Call Blue Plus Member Services at **1-800-711-9862**.TTY call **711**. This call is free.

Transportation Call BlueRide at **(651) 662-8648** or toll free at **1-866-340-8648** (this call is free). TTY call **711**.

Other important contact information

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

For information and to learn more about health care directives and how to exercise an advance directive, please contact Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free. You may also visit the Minnesota Department of Health (MDH) website at: **https://www.health.state.mn.us/facilities/regulation/infobulletins/advdir.html**

To Report Fraud and Abuse, contact Blue Plus Member Services at **1-800-711-9862**. TTY call**711**. This call is free. To report fraud or abuse directly to the State, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at **(651) 431-2650** or **1-800-657-3750** or **711** (TTY), or use your preferred relay services; by fax at **(651) 431-7569**; or by email at DHS.SIRS@state.mn.us. This call is free.

Minnesota Department of Human Services

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

Ombudsman for Public Health Care Programs

The Ombudsman for Public Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving access, service, and billing problems. They can help you file a grievance or appeal with us. The Ombudsman can also help you request a state appeal (Fair Hearing with the state). Call **(651) 431-2660** or **1-800-657-3729** or **711** (TTY), or use your preferred relay services. This call is free. Hours of service are Monday through Friday, 8 a.m. to 4:30 p.m.

Office of Ombudsman for Long-Term Care

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

How to contact the Medicare program

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

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

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

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

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

Senior LinkAge Line®

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

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

You may contact the Senior LinkAge Line® at **1-800-333-2433** or write to them at

Minnesota Board on Aging, P.O. Box 64976, St. Paul, MN 55164-0976. This call is free. You may also find the website for the Senior LinkAge Line® at **minnesotahelp.info**.

Section 2. Important information on getting the care you need

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

When you are a member or become a member of Blue Plus, you chose or were assigned to a primary care provider (PCP)/primary care clinic (PCC). Your primary care provider (PCP)/primary care clinic (PCC) can provide most of the health care services you need and will help coordinate your care. This provider will also advise you if you need to go to a specialist. You may change your primary care provider (PCP)/primary care clinic (PCC) or care system.

Call Blue Plus Member Services at **1-800-711-9862, TTY 711** for selecting and changing a primary care provider/primary care clinic. This call is free.

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

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

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

Transition of Care:

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

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

Prior Authorizations

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

In most cases, you need to use Plan network providers to get your services. If you need a covered service that you cannot get from a Plan network provider, you must get a prior authorization from us to go to an out-of-network provider. Exceptions to this rule are:

- Open access services: family planning, diagnosis of infertility, testing and treatment

of sexually transmitted diseases (STDs), and testing for acquired immune deficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related conditions. You can go to any doctor, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.

- Emergency and post-stabilization services

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

The Plan allows direct access to the providers in our network but keeps the right to manage your care under certain circumstances, such as: transplants. We may do this by choosing the provider you use and/or the services you receive. For more information, call Member Services at the phone number in Section 1.

If we are unable to find you a qualified Plan network provider, we must give you a standing prior authorization for you to see a qualified specialist for any of the following conditions:

- A chronic (on-going) condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first three months (first trimester)
- A degenerative disease or disability
- Any other condition or disease that is serious or complex enough to require treatment by a specialist

If you do not get a prior authorization from us when needed, the bill may not be paid.
For more information, call Member Services at the phone number in Section 1.

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

- An acute condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first three months (first trimester)
- A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year or is likely to result in death.
- A disabling or chronic condition that is in an acute phase

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

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

At Blue Plus, we have staff who can help you figure out the best way to use health care services. If you have questions about things like where to get services, getting authorization for services, or restrictions on prescription drugs, we can help. Call us at **1-800-711-9862** Monday through Friday, 8 a.m. to 5 p.m. If you need language assistance to talk about these issues, Blue Plus can give you information in your language through an interpreter. For sign language services, call TTY **711**. For other language assistance, call **1-800-711-9862**. These calls are free.

Covered and non-covered services:

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

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

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

We may cover additional or substitute services under some conditions.

Cost sharing:

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

Payments to providers:

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

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

What to do if you get a bill from a provider

In most cases, you should not receive a bill from a provider. But you may have to pay charges if:

- You agreed in writing ahead of time to pay for care that is not offered by us after you asked for an OK from us
- You agreed ahead of time in writing to pay for care from a provider who does not work with us, and you did not receive our OK ahead of time

If you receive a bill and you do not think you should have to pay for the charges, call Member Services at **1-800-711-9862, TTY 711**. This call is free. Have the bill with you when you call and tell us:

- The date of service
- The amount being charged
- Why you're being billed

You can also send a letter saying you have been sent a bill. Send the letter and the bill to the address below:
Claims
Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560

Sometimes, you may get a statement from a provider that is not a bill. Call us if you have any questions, and we will help determine if you have to pay the bill.

To verify current information or to get more information on a provider, you can call the provider, call Member Services at the phone number in Section 1, or visit our website listed in Section 1.

Cultural awareness:

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

Interpreter services:

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

Home and Community Based Services:

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

Other health insurance:

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

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

Private information:

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

Restricted Recipient Program:

The Restricted Recipient Program (RRP) is for members who have misused health services. This includes getting health services that members did not need, using them in a way that costs more than they should, or in a way that may be dangerous to a member's health. Blue Plus 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 in your local trade area, one clinic, one hospital used by the primary care provider, and one pharmacy. Blue Plus may designate other health service providers. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options, or consumer directed services.

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

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

At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. You must file an appeal within 60 days from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. A member may request a State Appeal (Fair Hearing with the state) after receiving our decision that we have decided to enforce the restriction. Refer to Section 13.

Cancellation:

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

If you are no longer eligible for Medical Assistance (Medicaid) and you do not have Medicare,you may be eligible to purchase health coverage through MNsure. For information about MNsure: call **1-855-3MNSURE** or **1-855-366-7873** TTY, use your preferred relay services, or visit **MNsure.org**. This call is free.

Section 3. Member Bill of Rights

You have the right to:

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

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

Be told about your health problems.

Get information about treatments, your treatment choices, and how treatments will help orharm you.

Participate with providers in making decisions about your health care.

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

Refuse care from specific providers.

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

Ask for and get a copy of your medical records. You also have the right to ask to correct the records.

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

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

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

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

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

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

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

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

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

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

- Whether we use a physician incentive plan that affects the use of referral services, and details about the plan if we use one.
- Results of an external quality review study from the state
- The professional qualifications of health care providers

Make recommendations about our rights and responsibilities policy.

Exercise the rights listed here.

Section 4. Member Responsibilities

You have the responsibility to:

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

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

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

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

Work with your primary care doctor to understand your total health condition. Develop mutually agreed-upon treatment goals when possible. Follow plans and instructions for care that you have agreed to with your doctor. If you have questions about your care, ask your doctor.

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

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

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

Section 5. Your Health Plan Member Identification (ID) Card

Each member will receive a Plan member ID card. Always carry your Plan member ID card with you.

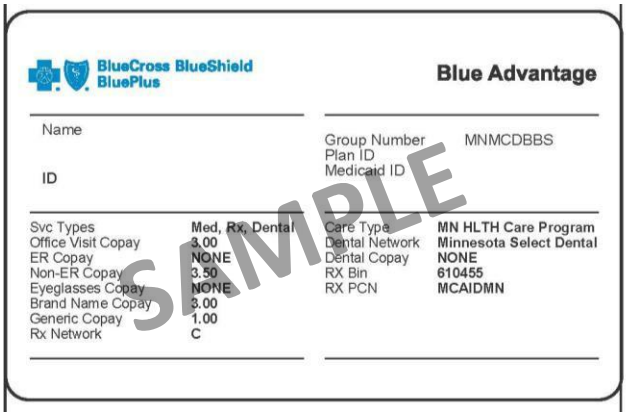
You must show your Plan member ID card whenever you get health care.

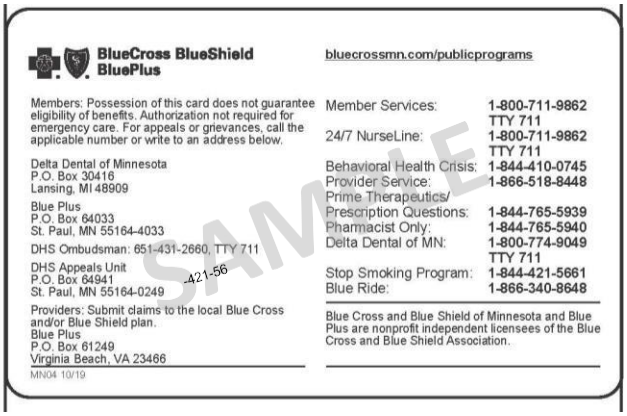
You must use your Plan member ID card along with your Minnesota Health Care Program card. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

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

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

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





Section 6. Cost Sharing

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

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

Copays

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

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

Some services require copays. A copay is an amount that you will be responsible to pay to your provider.

Copays are listed in the following chart:

Service	Copay Amount
Non-preventive visits (such as visits for a sore throat, diabetes checkup, high fever, sore back, etc.) provided by a physician, physician assistant, advanced practice nurse, certified professional midwife, chiropractor, acupuncturist, podiatrist, audiologist, or eye doctor. There are no copays for mental health services.	$3.00
Diagnostic procedures (for example, endoscopy, arthroscopy)	$3.00
Emergency room visit when it is not an emergency	$3.50
Brand name prescriptions	$3.00

The most you will have to pay in copays for prescriptions is $12.00 per month.	
Generic prescriptions *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$1.00

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

If you have Medicare, you must get most of your prescription drugs through a Medicare Prescription Drug Program (Medicare Part D) plan. You may have different copays with nomonthly limit for some of these services.

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

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

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

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

- Dental services
- Emergency services
- Eyeglasses
- Family planning services and supplies
- Home care
- Immunizations
- Inpatient hospital stays
- Interpreter services
- Medical equipment and supplies
- Medical transportation
- Mental health services
- Preventive care visits, such as physicals
- Rehabilitation therapies
- Repair of eyeglasses
- Services covered by Medicare, except for Medicare Part D drugs
- Some mental health drugs (antipsychotics)
- Some preventive screenings and counseling, such as cervical cancer screenings and nutritional counseling
- Substance use disorder treatment
- Tests such as blood work and X-rays

- Tobacco use counseling and interventions
- 100% federally funded services at Indian Health Services clinics

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

Section 7. Covered Services

This section describes the major services that are covered under the Plan for Minnesota Senior Care Plus (MSC+) members. It is not a complete list of covered services. If you need help understanding what services are covered, call Member Services at the phone number in Section 1. Some services have limitations. Some services require a prior authorization. A service marked with an asterisk (*) means a prior authorization is required or may be required. Make sure there is a prior authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Refer to Section 2 for more information on prior authorizations. You can also call Member Services at the phone number in Section 1 for more information.

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

Acupuncture Services

Covered Services:

- Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing
- Up to 20 units of acupuncture services are allowed per calendar year without authorization. Ask for prior authorization if additional units are needed.*
- Acupuncture services are covered for the following:
  - Acute and chronic pain
  - Depression
  - Anxiety
  - Schizophrenia
  - Post-traumatic stress syndrome
  - Insomnia
  - Smoking cessation
  - Restless legs syndrome
  - Menstrual disorders
  - Xerostomia (dry mouth) associated with the following:
    - Sjogren’s syndrome
    - Radiation therapy
  - Nausea and vomiting associated with the following:
    - Postoperative procedures
    - Pregnancy
    - Cancer care

Chiropractic Care

Covered Services:

*Requires or may require a prior authorization.

- One evaluation or exam per calendar year
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine − up to 24 visits per calendar year, limited to six per month. Visits exceeding 24 per calendar year or six per month may require a prior authorization.*
- X-rays when needed to support a diagnosis of subluxation of the spine

Not Covered Services:

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

Dental Services

Covered Services:

- Diagnostic services:
  - Comprehensive exam *(once every five years) (cannot be performed on same date as a periodic or limited evaluation)*
  - Periodic exam (*once per calendar year) (cannot be performed on same date as a limited or comprehensive evaluation)*
  - Limited (problem-focused) exams *(once per day) (cannot be performed on same date as a periodic or comprehensive oral evaluation or dental cleaning service)*
  - teledentistry for diagnostic services
  - imaging services, limited to:
    - bitewing *(once per calendar year)*
    - single X-rays for diagnosis of problems *(four per date of service)*
    - panoramic *(once every five years and as medically necessary; once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure)*
    - full mouth X-rays *(once every five years and only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery)*
- Preventive services:
  - dental cleanings *(up to four times per year if medically necessary with Prior Authorization)*
  - fluoride varnish *(once per calendar year) (cannot be performed on the same date as emergency treatment of dental pain service)*
- cavity treatment *(once per tooth per 6 months) (cannot be performed on same date as fluoride varnish service or emergency treatment of dental pain service)*
- Restorative services:
  - fillings *(limited to once per 90 days per tooth)*
  - sedative fillings for relief of pain *(cannot be performed on same date as emergency treatment of dental pain service)*
- Endodontics (root canals) *(on anterior teeth and premolars only and once per tooth per lifetime; retreatment is not covered)*
- Oral surgery (limited to extractions, removal of impacted teeth or tooth roots, biopsies,

*Requires or may require a prior authorization.

and incision and drainage of abscesses)

- Periodontics:
  - gross removal of plaque and tartar (full mouth debridement) *(once every five years) (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluation service)*
  - scaling and root planing* (with Prior authorization) (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) (four (4) per calendar year)
- Prosthodontics:
  - removable appliances (dentures and partials) (one appliance every six years per dental arch); partials always require a Prior Authorization)
  - adjustments, modifications, relines, repairs, and rebases of removable prostheses (dentures and partials)
  - 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 (once per appliance)
  - precision attachments and repairs
- Oral surgery *(limited to extractions, biopsies, and incision and drainage of abscesses)*
- Additional general dental services:
  - Emergency treatment for dental pain *(once per day)*
  - general anesthesia, deep sedation *(when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery)*
    - *General anesthesia may be covered in a clinic setting under certain circumstances:*
      - *Coverage for a child under age five*
      - *A person who is severely disabled*
      - *A person who has a medical condition and requires hospitalization or general anesthesia for dental care treatment*
  - extended care facility/house call in certain institutional settings including: nursing facilities, skilled nursing facilities, boarding care homes, Institutions for Mental Diseases (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) Hospices, Minnesota Extended Treatment Options (METO), and swing beds (a nursing facility bed in a hospital) (cannot be performed on same date as oral hygiene instruction service)
  - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
  - oral or IV sedation (only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)

Notes:

*Requires or may require a prior authorization.

If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance (Medicaid).

If you are new to our health plan and have already started a dental service treatment plan, please contact us for coordination of care.

Refer to Section 1 for Dental Services contact information.

Diagnostic Services

Covered Services:

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

Doctor and Other Health Services

Covered Services:

- Doctor visits including:
  - allergy immunotherapy and allergy testing
  - care for pregnant women
  - family planning – **open access service**
  - lab tests and X-rays
  - physical exams
  - preventive exams
  - preventive office visits
  - specialists
  - telehealth consultation
  - vaccines and drugs administered in a doctor's office
  - visits for illness or injury
  - visits in the hospital or nursing home
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Behavioral Health Home: coordination of behavioral and physical health services
- Blood and blood products
- Clinical trial coverage: Routine care that is: 1) provided as part of the protocol treatment of a clinical trial; 2) is usual, customary and appropriate to your condition; and 3) would be typically provided outside of a clinical trial. This includes services and items needed for the treatment of effects and complications of the protocol treatment.*
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Clinical Services
- Community health worker care coordination and patient education services

*Requires or may require a prior authorization.

- Community Medical Emergency Technician (CMET) services
  - post-hospital/post-nursing home discharge visits ordered by your primary care provider
  - safety evaluation visits ordered by primary care provider/physician (PCP)
- Community Paramedic Services: Certain services are provided by a community paramedic. The services must be a part of a care plan by your primary care provider. The services may include:
  - health assessments
  - chronic disease monitoring and education
  - help with medications
  - immunizations and vaccinations
  - collecting lab specimens
  - follow-up care after being treated at a hospital
  - other minor medical procedures
- Counseling and testing for sexually transmitted diseases (STDs), AIDS and other HIV-related conditions — **open access service**
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Hospital In-Reach Community-Based Service (IRSC) Coordination: coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services.
- Immunizations
- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Respiratory therapy
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Treatment for AIDS and other HIV-related conditions — **NOT** an open access service. You must go to a provider in the Plan network.
- Treatment of End-Stage Renal Disease (ESRD)
- Treatment for sexually transmitted diseases (STDs) — **open access service**
- Tuberculosis care management and direct observation of drug intake

Not Covered Services:

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

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

Covered Services:

- Emergency room services

*Requires or may require a prior authorization.

- Post-stabilization care*
- Ambulance (air or ground includes transport on water)

Not Covered Services:

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

Notes:
If you have an emergency and need treatment right away, call **911** or go to the closest emergency room. Show them your member ID card and ask them to call your primary care doctor.

In all other cases, call your primary care doctor, if possible. You can call the number 24 hours a day, seven days a week and get instructions about what to do.

If you are out of town, go to the closest emergency room or call **911**. Show them your member ID card and ask them to call your primary care doctor.

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

Family Planning Services

Covered Services:

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

*Requires or may require a prior authorization.

You must go to a provider in the Plan network.

Not Covered Services:

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

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

Hearing Aids

Covered Services:

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

Home Care Services

Covered Services:

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

Home and Community Based Services (Elderly Waiver)

Covered Services:

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

- Adult Day Services (ADS) and ADS Bath: Licensed program that delivers a set of health, social and nutritional services. ADS Bath is optional.
- Adult Foster Care: Licensed, adult appropriate, sheltered living arrangement in a family-like setting.
- Case Management: Management of your health and long-term care services among different health and social service workers.

*Requires or may require a prior authorization.

- Chore Services: Heavy household services needed to keep your home clean and safe.
- Companion Services: Non-medical care, supervision and socialization.
- Consumer Directed Community Support Services: Services that you manage yourself within a set budget.
- Customized Living/24 Hour Customized Living: A group of individualized servicesprovided in an assisted living setting.
- Environmental Accessibility Adaptations: Physical changes to your home and vehicle needed to assure health and safety and enable you to be more independent.
- Extended State Plan Home Health Care Services: This includes home health aideservices that are over the Medical Assistance (Medicaid) limit.
- Extended State Plan Home Care Nursing: This includes home care nursing services that are over the Medical Assistance (Medicaid) limit.
- Extended State Plan Personal Care Assistance Services: Help with personal care and activities of daily living over the Medical Assistance (Medicaid) limit.
- Family and Care Giver Training and Education: Training for unpaid caregivers. This includes coaching and counseling – individualized support for caregivers.
- Family Memory Care: coaching counseling service for caregivers living with a family member or friend with dementia. This also includes assessment.
- Home Delivered Meals: Meals delivered to your home.
- Homemaker Services: General household activities to keep up the home. These range from general household cleaning to incidental assistance with home management and/or activities of daily living.
- Individual Community Living Support Services: A bundled service to offer assistance and support to remain in your own home.
- Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief.
- Specialized Medical Supplies and Equipment: Supplies and equipment that are over the Medical Assistance (Medicaid) limit or coverage. This includes Personal Emergency Response System (PERS).
- Transitional Supports Services: One-time costs related to setting up a household when a person leaves a nursing home and moves to the community.
- Transportation: Enables you to gain access to activities and services in the community.

Notes:
You must have a MnCHOICES assessment (formerly called a Long-Term Care Consultation (LTCC)) done and be found to be nursing home certifiable to get these Elderly Waiver (EW) services. You can ask to have this assessment in your home, apartment, or facility where you live. Your MSC+ care coordinator will meet with you and your family to talk about your care needs within 20 days if you call to ask for a visit.

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

*Requires or may require a prior authorization.

nursing home or other facility.

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

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

People who live on or near the White Earth, Leech Lake, Red Lake, Mille Lacs, or Fond du Lac Reservations may be able to choose to get their EW services through the Tribal health or human services division or through our Plan. Contact the tribal nation or our Plan if you have questions.

If you are currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, you will continue to get services covered by these programs in the same way you get them now. Your county case manager will continue to authorize these services and coordinate with your MSC+ care coordinator.

If you need transition planning and coordination services to help you move to the community, you may be eligible to get Moving Home Minnesota (MHM) services. MHM services are separate from EW services, but you must be eligible for EW. Refer to Home and Community Based Services in Section 1 for contact information.

Hospice*

Covered Services:

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

- Physician services
- Nursing services
- Medical social services
- Counseling
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational, and speech therapy

*Requires or may require a prior authorization.

- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

Notes:
Medicare Election

You must elect hospice benefits to receive hospice services.

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

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

Hospital – Inpatient

Covered Services:

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

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

Not Covered Services:

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

Notes:
See Substance Use Disorder (SUD) Services section for more information on inpatient (SUD) benefits

Hospital – Outpatient

Covered Services:

- Urgent care for conditions that are not as serious as an emergency
- Outpatient surgical center*
- Tests and X-rays*

*Requires or may require a prior authorization.

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

Housing Stabilization Services

Covered Services:

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

- Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services
- Housing transition services to help you plan for, find, and move into housing
- Housing sustaining services to help you maintain housing
- Transportation to receive Housing Stabilization Services (within a 60 mile radius)

Notes:
You must have a Housing Stabilization Services eligibility assessment done and be found eligiblefor these services. If you need Housing Stabilization Services, you can ask for an assessment orbe supported by a provider or case manager. If you have a targeted case manager, or waivercase manager or senior care coordinator, that case manager may support you in accessing services, or the person 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 receive this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.

Interpreter Services

Covered Services:

- Spoken language interpreter services
- Sign language interpreter services

Notes:
Interpreter services are available to help you get services.

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

*Requires or may require a prior authorization.

Medical Equipment and Supplies

Covered Services:

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

Not Covered Services:

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

Notes:
You will need to go to your doctor and get a prescription in order for medical equipment and supplies to be covered.

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

Mental Health Services*

Covered Services:

- Certified Community Behavioral Health Clinic (CCBHC)
- Clinical Care Consultation
- Crisis response services including:
  - Screening
  - Assessment
  - Intervention
  - Stabilization including residential stabilization

*Requires or may require a prior authorization.

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

Not Covered Services:

- Conversion therapy

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

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

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

Use a Plan network provider for mental health services. If we decide no structured mental health treatment is necessary, you may get a second opinion.For the second opinion, we

*Requires or may require a prior authorization.

must allow you to go to any qualified health professional that is notin the Plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision. We will not determine medical necessity for court-ordered mental health services. Use a Plan network provider for your court-ordered mental health assessment.

Nursing Home Services

Covered Services:

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

Not Covered Services:

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

Optical Services

Covered Services:

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

Not Covered Services:

- Extra pair of glasses
- Progressive bifocal/trifocal lenses (without lines)
- Protective coating for plastic lenses
- Contact lens supplies

*Requires or may require a prior authorization.

Out-of-Area Services

Covered Services:

- For more details on how to obtain services, call Blue Plus Member Services at **1-800-711-9862**, TTY **711**
- A service you need when temporarily out of the Plan service area
- A service you need after you move from our service area while you are still a Plan member
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care*
- Medically necessary urgent care when you are outside of the Plan service area. (Call Member Services at the phone number in Section 1 as soon as possible.)
- Covered services that are not available in the Plan service area

Not Covered Services:

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

Out-of-Network Services

Covered Services:

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

Prescription Drugs (for members who do NOT have Medicare)

Covered Services:

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

Not Covered Services:

- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs excluded from coverage by federal or state law

*Requires or may require a prior authorization.

- Experimental drugs, investigational drugs, or drugs not approved by the FDA
- Medical cannabis

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

The list of covered drugs (formulary) includes the prescription drugs covered by Blue Plus. The drugs on the list are selected by the plan with the help of a team of doctors and pharmacists. The list has to be similar to the list covered by Fee-for-Service Medical Assistance (Medicaid). The list also must include drugs listed in the Department of Human Services' Preferred Drug List (PDL).

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

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

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

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

You can find out if your drug requires prior authorization, has quantity limits, has Preferred/Non-Preferred status, or has an age requirement by contacting Member Services or visiting our website at **https://www.bluecrossmn.com/shop-plans/minnesota-health-care-programs/blue-plus-minnesota-senior-care-plus-msc**. A drug restriction or limit can be removed if your doctor submits a statement or documentation supporting the request. You can also get more information about the restrictions applied to specific covered drugs by contacting

*Requires or may require a prior authorization.

Member Services or visiting our website at **https://www.bluecrossmn.com/shop-plans/minnesota-health-care-programs/blue-plus-minnesota-senior-care-plus-msc**.

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

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

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

Most drugs and certain supplies are available up to a 34-day supply. Certain drugs you take on a regular basis for a chronic or long-term condition are available up to a 90-day supply and are listed on the 90-Day Supply Program.

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

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

Formulary Exception Process

As a new member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary, but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug during the first 90 days you are a member of our plan. Please contact Member Services if you have questions regarding this coverage.

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 us under the Plan. If the pharmacy won't call your doctor, you can. You can also call Member Services at the phone number in Section 1 for help.

*Requires or may require a prior authorization.

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

If you are prescribed a drug that is on the Blue Plus Specialty Drug List, your prescriber will needto send the prescription of that specialty drug to one of Blue Plus's Specialty Pharmacies listed below.

Accredo Health Group, Inc.
Toll free **1-866-470-2245**, TTY **711**
Fax: **(888) 302-1028**
24 hours a day, seven days a week

Children's Home Care (for hemophilia medications only)
Toll free **1-866-656-1020**, TTY **711**
Fax: **(877) 828-3939**
Monday through Friday, 8 a.m. to 5 p.m. Central Time

Fairview Specialty Pharmacy Service
Toll free **1-800-595-7140**, TTY **711**
Fax: **(877) 828-3939**
Monday through Friday, 8 a.m. to 7 p.m.; Saturday, 8 a.m. to 4 p.m. Central Time

North Memorial Health Pharmacy – Specialty Center
3435 W. Broadway Ave.
Robbinsdale, MN 55422
Pharmacists available by phone 24/7 at **1-877-520-5307** (toll free), TTY **711** or **(763) 581-6333**
This call is free.
Fax: **(763) 581-2814**
Monday through Friday, 8 a.m. to 5 p.m. Central Time

Thrifty White Specialty Pharmacy
Pharmacists available by phone 24/7 by phone at **(855) 611-3399**, TTY **711**
Fax: **(855) 423-8300**
Monday through Friday, 8 a.m. to 8 p.m., Saturday, 9 a.m. to 5 p.m. Central Time

You will also need to call the Specialty Pharmacy that receives your prescription to set up an account. You will need to have your Blue Plus member ID card when you call the Specialty Pharmacy.

Prescription Drugs (for members who have Medicare)

Covered Services:

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

*Requires or may require a prior authorization.

Part D)

Not Covered Services:

- Prescription drugs that are eligible to be covered under the Medicare Prescription Drug Program (Medicare Part D)
- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved by the FDA
- Medical cannabis

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

Preventive Care and Screening Tests

Covered Services:

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

Rehabilitation*

Covered Services:

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

Not Covered Services:

- Vocational rehabilitation
- Health clubs and spas

*Requires or may require a prior authorization.

Substance Use Disorder Services (SUD)

Covered Services:

- Screening/Assessment/Diagnosis
- Outpatient treatment
- Inpatient hospital
- Residential non-hospital treatment
- Outpatient methadone treatment
- Detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification)
- SUD treatment coordination
- Peer recovery support
- Withdrawal management

Not Covered Services:

Payment for room and board determined necessary by substance use disorder assessment is the responsibility of the Minnesota Department of Human Services.

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

A qualified assessor who is part of the Plan network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment, you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor. We will do this within five working days of when we get your request. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment. You have the right to appeal. Refer to Section 13 of thisMember Handbook.

Surgery*

Covered Services:

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

Not Covered Services:

- Cosmetic surgery

*Requires or may require a prior authorization.

Telehealth Services

Covered Services:

- Telehealth services cover medically necessary services and consultations delivered by a licensed health care provider by telephone or video call with the member. The member's location can be their home.

Telemonitoring

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

Covered Services:

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

Transplants*

Covered Services:

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

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

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

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

The Blue Plus Transplant Process

Members must use Blue Distinction Centers® of Excellence for the transplants below. Medically necessary human organ transplants, marrow, and stem cell support procedures that are

*Requires or may require a prior authorization.

covered include:

- Autologous bone marrow and peripheral stem cell support
- Allogeneic bone marrow and peripheral stem cell support
- Heart
- Heart-lung
- Liver — cadaver or living donor
- Lung — single or double, cadaver or living donor
- Organ and bone marrow transplants
- Pancreas — cadaver or living donor segmental
- Pancreas transplantation alone (PTA)
- Pancreas transplantation after kidney transplantation (PAK)
- Simultaneous pancreas and kidney transplantation (SPK)
- Small bowel (intestine)
- Small bowel (intestine) — liver
- Syngeneic bone marrow and peripheral stem cell support

Notes:

Members must use Blue Distinction Centers® of Excellence for the following surgeries:

- Bariatric surgery
- Cardiac care
- Complex and rare cancers
- Knee and hip replacement
- Spine surgery
- Transplants*

Eligible providers:

- All organ transplants must be performed at transplant centers meeting United Network for Organ Sharing (UNOS) criteria or be a Medicare approved heart, heart-lung, lung, liver, liver or intestinal (small bowel) transplant center
- Stem cell and bone marrow transplants must be performed in a tissue transplant center which is certified by and meets the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT), or be approved by the Advisory Committee on Organ and Tissue Transplants
- For all transplants, the provider must have a current Blue Plus transplant contract for the specific transplant type being performed
- As technology changes, the covered transplants listed above will be subject to modifications in the form of additions or deletions, when appropriate
- Kidney, cornea, and autologous pancreatic islet cell transplants are eligible procedures that are covered on the same basis as any other eligible service and are not subject to the special requirements for transplants listed above. See “Doctor and Other Health Services” and “Hospital Inpatient.”
- Prior authorization is required for all transplant procedures. All requests for prior authorization must be submitted in writing to: Blue Plus Transplant Coordinator, P.O. Box 64179, St. Paul, MN 55164, or fax to **(651) 662-1624**, TTY **711**.

*Requires or may require a prior authorization.

If you have specific questions on transplants, call the Transplant Coordinator, Monday through Friday, from 8 a.m. to 4:30 p.m. Central Time toll free at **1-866-309-6564**, TTY **711**. This call is free.

Not Covered:

- Reimbursement for meals and lodging expenses
- Services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- Services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered
- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow transplant and peripheral stem cell support procedures that are considered investigative or not medically necessary
- Living donor organ and/or tissue transplants unless otherwise specified in this Plan
- Services for the collection and storage of infant cord blood
- Transplantation of animal organs and/or tissue

Transportation to/from Medical Services

Covered Services:

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

Not Covered Services:

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

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

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

*Requires or may require a prior authorization.

that is available within 30 miles of your home and/or if you do not have a specialty provider that is available within 60 miles of your home.

The Blue Plus transportation program, BlueRide, is available to those who do not have other means of transportation to their medical and dental appointments. For a ride, please call at least two business days in advance before your appointment. If your appointment changes, call at least four hours before your pickup time to change or cancel your ride. BlueRide is for medical or dental appointments. Do not ask the driver to drop you off at another location. Call BlueRide for more information at toll free at **1-866-340-8648**, TTY **711**. This call is free. Hours of operation are Monday through Friday, 8 a.m. to 5 p.m.

Urgent Care

Covered Services:

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

Not Covered Services:

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

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

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

*Requires or may require a prior authorization.

Section 8. Services we do not cover

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

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

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

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

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

Section 10. When to call your county worker

Call your county worker to report these changes:

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

Section 11. Using the Plan coverage with other insurance

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

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

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

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

If your other insurance changes, call your county worker.

Section 12. Subrogation or other claim

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

Section 13. Grievance, Appeal, and State Appeal (Fair Hearing with the State) process

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

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

Grievance and appeal system terms to know:

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

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

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

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

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

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

A State Appeal (Fair Hearing with the state) is your request for the state to review a decision we made. You must appeal to Blue Plus before asking for a State Appeal. If we take more than 30 days to decide your appeal and we have not asked for an extension, you do not need to wait for our decision to ask for a State Appeal. You may appeal any of these actions (decisions):

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

Important Timelines for Appeals

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

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

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

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

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

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

To file an oral or written appeal with us:

You may appeal by phone, writing, fax, or in person. The contact information and address are found in Section 1 under “Appeals and Grievances.”

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

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

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

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

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

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

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

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

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

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

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

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

Or fax to: **(651) 431-7523**

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

A human services judge from the state Appeals Office will hold a hearing. You may ask to attend the hearing by telephone, by video, or in person. You can ask your providers or others to give testimony. You can provide documents for the judge to consider.

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

If your hearing is about a service that was denied because it was not medically necessary, you may ask for review by a medical expert. The medical expert is independent of both the state and

Blue Plus. The state pays for this review. There is no cost to you.

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

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

Grievances (Complaints)

You may file a Grievance with us **at any time.** There is no timeline for filing a grievance with us.

To file an oral grievance with us:

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

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

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

To file a written grievance with us:

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

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

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

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

If you do not agree with our decision, you can file your complaint with the Minnesota Department of Health.

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

Call: **1-800-657-3916** (this call is free) or **(651) 201-5100**
711 (TTY), or use your preferred relay services.
Visit: **https://www.health.state.mn.us/facilities/insurance/clearinghouse/complaints.html**

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

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

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

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

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

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

If you need help with your grievance, appeal, or a State Appeal, you can call or write to the Ombudsman for Public Managed Health Care Programs. They may be able to help you with access, service, or billing problems. They can also help you file a grievance or appeal with us or request a State Appeal.

Call: **(651) 431-2660**
Toll-free **1-800-657-3729** or **711** (TTY), or use your preferred relay services. This call is free. Hours of service are Monday through Friday 8 a.m. to 4:30 p.m.

Or

Write to: Ombudsman for Public Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249
Fax to: **(651) 431-7472**

Section 14. Definitions

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

Action: This includes:

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

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

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

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

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

Coinsurance: An amount you may be required to pay as your share of the cost for services or items. Coinsurance is usually a percentage (for example, 10%).

Copay/Copayment: A fixed amount you may pay as your share of the cost each time you get certain services, supplies, or prescription drugs. Copays are usually paid at the time services, supplies, or prescription drugs are provided. For example, you might pay $1 – $3.50 for services, supplies or prescription drugs.

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

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

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

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

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

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

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part, or could cause serious physical or mental harm. The medical symptoms may be a serious injury or severe pain. This is also called Emergency Medical Condition.

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

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

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

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

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

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

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

Formulary: The list of drugs covered under the Plan.

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

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

Home Health Care: Health care services for an illness or injury given in the home or in the

community where normal life activities take the member.

Hospice: A special program for members who are terminally ill and not expected to live more than six months to live comfortably for the rest of the member's time. It offers special services for the member and his or her family. This is also known as Hospice Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

Network: Our contracted health care providers for the Plan.

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

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

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

Open Access Services: Federal and state law allow you to choose any physician, clinic, hospital,pharmacy, or family planning agency — even if not in our network — to get these services.

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

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

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

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

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

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

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

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

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

Prescriptions: Medicines and drugs ordered by a medical provider.

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

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

Primary Care Clinic: The primary care clinic (PCC) you choose for your routine care. This clinicwill provide most of your care.

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

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

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

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

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

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

Restricted Recipient Program (RRP): A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must

get health services from one designated primary care provider, one pharmacy, one hospital or other designated health care provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

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

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

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

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

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

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

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

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

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

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

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

United States: For the purpose of this Member Handbook, the United States includes the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, The Virgin Islands,

Guam, American Samoa, and the Northern Mariana Islands.

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

Section 15. Additional information

What is a health care directive?
A health care directive is a written document that informs others of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a health care directive.

How do I make a health care directive?
There are forms for health care directives. You don't have to use a form, but your healthcare directive must meet the following requirements to be legal in Minnesota.

- It must be in writing and dated
- It must state your legal name
- It must be signed by you or someone you authorize to sign for you in the event that you cannot understand or communicate your health care wishes
- You must have your signature verified by a notary public or two witnesses
- You must include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider.

Why should I have a health care directive?
A health care directive is important if your attending physician determines you can't communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your directive may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

Must I have a health care directive?
No. You don't have to have a health care directive. But writing one helps to make sure your wishes are followed.

What happens if I don't have a health care directive?
You will still receive medical treatment if you don't have a written directive. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a health care directive.

Do I have to use the Blue Cross and Blue Shield of Minnesota advance health care directive form?
No, only if you wish. Other forms are available through hospitals and attorneys. The form provided is for Minnesota use only. Other states have different forms for advance directives.

How do I choose a health care agent?
The person you choose to make the health care decisions for you in the event that you cannot make decisions for yourself is called your health care agent or proxy. Some forms use the term *durable power of attorney for health care.* The person you choose as your agent should be:

- at least 18 years old (a legal requirement)

- willing to follow your wishes and preferences about your case
- not easily intimidated by medical professionals or the medical system
- able to make difficult, emotional decisions in a time of crisis
- nearby or readily available when needed

You may name anyone to be your agent.

Can I choose more than one health care agent?
You may name one or more people to act as your agents. If you do this, you may identify one person to be the primary agent and the others(s) to be alternate agent(s). Or, you may indicate that you want your agents to act together.

It is very important that you talk to each person you want to name as an agent **before** you complete your directive so that you can:

- find out if the person is willing to accept the responsibility
- tell the person about your wishes and preferences for care
- be sure the person is willing and able to follow your wishes

I prepared my health care directive in another state. Is it still good?
Health care directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements, but requests for assisted suicide will not be followed in Minnesota.

What can I put in a health care directive?
You have many choices of what to put in your health care directive. For example, you may include:

- The person or persons you trust as your agent(s) to make health care decisions for you
- Your goals, values and preferences about health care
- The types of medical treatment you would want (or not want)
- How you want your agent or agents to decide
- Where you want to receive care
- Instructions about artificial nutrition and hydration
- Mental health treatments
- Instructions if you are pregnant
- Donations of organs, tissues, and eyes
- Funeral arrangements
- Who you would like as your guardian or conservator if there is a court action

You may be as specific or as general as you wish. You can choose which issues or treatment to deal with in your health care directive.

Are there any limits to what I can put in my health care directive?
There are some limits about what you can put in your health care directive. For instance:

- Your agent must be at least 18 years of age
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reason for the naming of the agent in your directive

- You cannot request health care treatment that is outside of reasonable medical practice
- You cannot request assisted suicide

In my health care directive, can I designate my health care agent to make financial decisions for me?
No. The person you choose as your health care agent can only make health care decisions. If you want to appoint someone to handle your financial or legal affairs, you should consult an attorney.

How long does a health care directive last? Can I change it?

Your health care directive lasts until you change or cancel it. Any changes must meet the health care directive requirements. You may cancel your directive by any of the following:

- Writing a statement saying you want to cancel your existing health care directive
- Destroying your existing health care directive
- Telling at least two other people you want to cancel your existing health care directive
- Writing a new health care directive

What if my health care provider refuses to follow my health care directive?
Your health care provider will generally follow your health care directive or any instructions from your agent, as long as the health care follows reasonable medical practice. However, neither you, nor your agent can request treatment that will not help you or that the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agent to arrange to transfer you to another provider who will follow the agent's directions.

What if I believe Blue Cross and Blue Shield of Minnesota or Blue Plus has not followed healthcare directive requirements?
Complaints of this type can be filed with the Minnesota Department of Health at:

Health Policy and Systems Compliance
Monitoring Division Manage Care
System
P.O. Box 64882
St. Paul, MN 55164-0882
Phone: **(651) 201-5100** or **1-800-657-3916** (This call is free)
TTY **711**

What should I do with my health care directive after I have signed it?
You should inform others of your health care directive and give people copies of it. You may wish to inform family members, your health care agent(s) and your health care providers that you have a health care directive. You should give them a copy. It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.

How can I get more information about health care directives?
You can discuss your health care directive and your wishes with your primary care provider, or if you live in Minnesota, contact the Minnesota Board on Aging at **(651) 431-2500** or toll free at **1-800-882-6262,** TTY Service at **1-800-627-3529,** or visit **mnaging.org**. This call is free.

CASE MANAGEMENT

Providers, nurses, social workers, and members or their representative may make a referral to case management in one of two ways:

Phone: **1-866-902-1690, TTY 711** (This call is free.)
Fax: **1-855-417-1289**

A case manager will respond to a faxed request within three business days.

Case management
Health care can be overwhelming. We're here to help you stay on top of it. Your case manager will help you:

- Figure out your care plan
- Answer questions
- Help you receive the services you need
- Coordinate with your doctors and support system

If you've experienced a critical event or health issue that is complex, we'll help you learn more about your illness and develop a plan of care through our complex case management program.

Access to complex case management
We use data to find out which members qualify for our complex case management program.You can be referred to complex case management through our:

- 24/7 NurseLine
- Disease Management program
- Discharge planner
- Utilization management
- Member or care giver referral
- Your doctor or other provider

If you have one of these health issues or another complex or special health issue and want tolearn more about case management, call Member Services at **1-800-711-9862, TTY 711,** Monday through Friday, 8 a.m. to 5 p.m. Central Time.

Access to Utilization Management Staff

If you have Utilization Management (UM) questions, call Member Services at **1-800-711-9862,TTY 711**, Monday through Friday from 8 a.m. to 5 p.m. Central Time. This call is free. They can assist if you need help in another language.

You can leave a voice message with UM questions outside of working hours and the UM associate will return your call. The UM associate will identify themselves when initiating or returning calls by their name, title, and health plan name. Communications received after normal business hours are

returned on the next business day, and communications received after midnight on Monday–Friday are responded to on the same business day.

UM procedures include, but are not limited to:

- Preservice review
- Urgent concurrent review
- Postservice review
- Filing an appeal

PROVIDER PAYMENT METHODS

Participating Providers

Blue Plus contracts with a large majority of doctors, hospitals, and clinics in Minnesota to be part of its network. Each provider is an independent contractor and is not an agent or employee of Blue Plus. These health care providers are referred to as "Participating Providers." They have agreed to accept as full payment (less deductibles, coinsurance and copayments) an amount that a Blue Cross and/or Blue Shield Plan has negotiated with its participating providers (the "Allowed Amount"). The Allowed Amount may vary from one provider to another for the same service. Several methods are used to pay participating health care providers. If the provider is "participating," they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

Non-Institutional or Professional (i.e., doctor visits, office visits) Provider Payments

- **Fee-for-Service –** Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.

- **Discounted Fee-for-Service –** Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.

- **Discounted Fee-for-Service, Withhold and Bonus Payments –** Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5 to 20%) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per member per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

- **Minnesota Health Care Programs Fee Schedule –** Providers may be paid at a certain percent of the public program fee schedule.

Payment for high-cost cases and preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is

excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.

Institutional (i.e., hospital and other facility) Provider Payments

- **Inpatient Care**
  - **Payments for each case (case rate) –** Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
  - **Payments for each day –** Providers are paid a fixed amount for each day the patient spends in the hospital or facility.
  - **Percentage of billed charges –** Providers are paid a percentage of the hospital's or facility's billed charges for inpatient or outpatient services, including home services.

- **Outpatient Care**
  - **Payments for each category of services –** Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
  - **Payments for each visit –** Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
  - **Payments for each patient –** Providers are paid a fixed amount per patient per calendar year for certain categories of outpatient services.
  - **Minnesota Health Care Programs Fee Schedule –** Providers may be paid at a certain percent of the public program fee schedule. The Minnesota Department of Human Services publishes its fee schedule for public programs from time to time.

Pharmacy Payment

Four (4) kinds of pricing are compared and the lowest amount of the four (4) is paid:

- The average wholesale price of the drug, less a discount, plus a dispensing fee; or
- The pharmacy's retail price; or
- The maximum allowable cost we determine by comparing market prices (for generic drugs only); or
- The amount of the pharmacy's billed charge.

Nonparticipating Provider

Generally, there is no coverage for services you receive from a Nonparticipating Provider, that is, a non-network provider. There are certain exceptions to this rule that are described in your Evidence of Coverage. To the extent Blue Plus covers services, you receive from a Nonparticipating Provider, payment will be based on a payment methodology Blue Plus uses to pay a similar type of Participating Provider. In certain circumstances, payment may be limited to the Minnesota Health Care Programs Fee Schedule, the amount upon which payment is based for a given covered service of a specific provider.

The Allowed Amount may vary from one provider to another for the same service. All benefits are based on the Allowed Amount, except as noted in the "Benefit Chart."

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

The above is a general summary of our provider payment methodologies only. Provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Please note that some of these payment methodologies may not apply to your particular plan. Detailed information about payment allowances for services rendered by Nonparticipating Providers in particular is available on our website at ***bluecrossmn.com****.*

WOMEN'S HEALTH AND CANCER RIGHTS

Under the Women's Health and Cancer Rights Act of 1998, health plans are required to provide coverage for breast reconstruction following a mastectomy. The benefit includes:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Care is to be coordinated with your primary care provider and is covered under your medical/surgical benefits.

HOW WE PROTECT YOUR PRIVACY

Our privacy rules protect your personal health information. We obey federal and state laws that protect your information, whether on paper, the Internet, by phone, written, electronic or orally. In most cases, we need your approval before we can share your personal medical information. This includes health records, claims data and anything else that identifies you.

You have the right to choose “yes” or “no” when we ask to share your information. If you approve our request, we will describe what we will share. We will tell you how it will be used and how long your consent lasts.

By law, there are cases when we do not need your approval before we share personal information. For example, we can share data with:

- Blue Plus employees or contractors who handle applications and claims.
- Providers – if they need to confirm your benefits or if we need to review their work. (We have strict privacy rules with all providers.)
- Health researchers or people doing health plan studies. When we take part in research studies that use your information, we write to you to explain the study. Then you can choose if you want to share information. Please note: Researchers can only see data that does not identify you.

If you can’t sign the form to approve sharing your information, Blue Plus will ask your legally

authorized representative (parent, guardian or conservator who holds your power of attorney) to sign. Proof of identity is required.

You can request in writing a copy of your personal health information. However, if your doctor believes that your records are sensitive, we may not share them with you. If you think your privacy rights were violated, or you disagree with a decision regarding your personal health information, you can:

- Call the Member Services number on the back of your member ID card.
- Write to the Blue Plus address on the back of your member ID card.
- Write to the Minnesota Department of Health:
  Minnesota Department of Health
  Managed Care Systems
  P.O. Box 64882
  St. Paul, MN 55164-0882

To learn more about our privacy procedures, go to **bluecrossmn.com** (click on "Legal & Privacy"at the bottom) or call Member Services.

QUALITY IMPROVEMENT

You deserve high quality medical and behavioral health care. Our Quality Improvement (QI) program reviews the services that you get from our doctors, hospitals and other health care services. This ensures that you receive care that is good quality, helpful and right for you. Your health is important to us, and we believe quality work yields quality results. We make information about our Quality Improvement program available every year on our website and in writing to members upon request. We work hard to make sure you have access to great care.

We do this by:

- Having programs and services to help improve your quality of health care
- Providing learning tools on pregnancy and newborn care for all pregnant members and new moms
- Finding local programs in your community that help you get these services if you need them
- Hosting learning events to answer your questions and concerns and help you make the most of your health care
- Following state and federal guidelines
- Looking at our quality results to find new ways to provide better care

Want to know more about our how our Quality Improvement program works? Call us at **1-800-711-9862**, TTY **711** (This call is free). Ask us to mail you a copy of our program flier. We can also tell you more about the ways we make sure you get quality health care services.

You can review the quality and cost of care as well. This can help you make the best decisions about your care. Visit these sites online to help you find out more:
The Leapfrog Group — **leapfroggroup.org**
Hospital Compare — **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare**

Hospital Inpatient Quality Reporting Program — **cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html**

Your opinion is important to us. You will receive a member satisfaction survey each year to tell us how we're doing. Your answers are anonymous. This information is used to improve our services and your care. If we helped you, please tell us in the survey.

You can also be part of our Community Member Advisory Committee (CMAC). As part of this group, you can tell us your views and ideas to help us understand what our members need. It will also help us to find out how we can improve the quality and cost of health care. For more information about CMAC, call Member Services at **1-800-711-9862, TTY 711**, Monday through Friday, 8 a.m. to 5 p.m. Central Time. This call is free.

Additional rights and responsibilities

Get information about the health plan, its services, its doctors and other providers, and member rights and responsibilities.

Get information about treatments, your treatment choices, and how treatments will help or harm you, regardless of cost or benefit coverage.

Follow plans and instructions for care that you have agreed to with your doctor.

We want you to know your rights and responsibilities as a Blue Plus member. We will tell you about them when you enroll and once a year after that. If you have questions about your rights, responsibilities, or how to request information, call Member Services at **1-800-711-9862, TTY 711** (this call is free).

Important information on getting the care you need

Members have access to a Provider Directory that lists the address, phone number, and special training of Plan network providers. You may ask for a printed copy of the Provider Directory at any time by calling Member Services at **1-800-711-9862, TTY 711** (this call is free), or by visiting our website at **bluecrossmn.com/publicprograms**.

Emergency and urgent care when you are out of town

If you need urgent or emergency care when you are out of town, go to the nearest hospital emergency room or call **911**. See the sections above for more information about urgent and emergency care. For after-hours care, call your PCP. If you cannot reach your PCP, call **1-800-711-9862** (This call is free), TTY **711**. You can also call 24/7 NurseLine at **1-800-711-9862** (This call is free), TTY **711**.

If you need routine care, like a checkup or prescription refill when you're out of town, call your PCP or 24/7 NurseLine.

New types of care

Blue Plus medical directors and network providers are always looking at new medical treatments and studies. They do this to see if:

- These new treatments should be covered benefits

- The government has agreed the treatment is safe and effective
- The results are as good as or better than covered benefit treatments in use now

Additional covered services

See Section 7 for a complete list of covered services. They also include:

- Evaluating new technology for inclusion

Additional benefits

See the table of contents for a complete list of subjects covered. Please call **1-800-711-9862**, TTY **711** to learn more about how to obtain care after normal business hours. This call is free.

IF YOU ARE SICK OR HURT, WHERE DO YOU GO?

You do not need a referral to see Plan network specialists, or for behavioral health services, and hospital services who are in network. However, your primary care clinic can provide most of the health care services you need and will help coordinate your care.

After-hours care/when your PCP's office is closed

After-hours care is when you have an urgent health issue that you want to discuss with a health practitioner, but your provider's office is closed. If you need after-hours care, call your provider to hear what to do when the office is closed. Provider offices have answering machines or answering services to help with after-hours health issues. You may also call 24/7 NurseLine at **1-800-711-9862, TTY 711**. This is a free call.

Urgent care

An urgent medical condition is not an emergency but needs medical care within 24 hours. It is not the same as a true emergency. Call your PCP or PCC if your condition is urgent and you need medical help within 24 hours. If you can't reach your PCP or PCC, call 24/7 NurseLine (toll free), even on holidays, at **1-800-711-9862, TTY 711**. This call is free.

Emergency care

An emergency is a medical condition with such severe symptoms that you reasonably believe not getting medical attention right away may be life threatening or cause serious damage to you or your unborn child. If you have an emergency, call 911 or go to the nearest ER.

Call your PCP or PCC within 24 hours after you go to the ER or if you've checked into the hospital. Your PCP will set up a visit with you for follow-up care.

How to find additional information about your benefits and access to medical services

You can visit **bluecrossmn.com/publicprograms** to find information on benefits or medical services you may need, such as:

- A member handbook that includes your benefits and how to access your benefits and providers
- A provider directory that includes the provider's specialty, address and phone number, professional qualifications, medical school attended, residency completion, and board certification
- How to file a grievance or appeal
- What to do if you get a bill
- How to obtain language assistance or a copy of the member handbook or other member materials in a language other than English