

**MEMBER HANDBOOK Guidelines:  
FOR SPECIAL NEEDS BASICCARE (SNBC) MEDICAID ONLY**

**REQUIREMENTS FOR MEMBER HANDBOOK**

**Model Member Handbook**

- Managed care organizations (MCO) are required to use the most recent version of the standardized Model Member Handbook.
- The legend for the Model Member Handbook is:
  - Text shown as “<text>” is required language. This text represents variable data.
  - Text shown as “[text]” is optionally printed, depending on the italicized notes.
  - Text shown as “{text}” is never printed. This text is informational only.
  - Language in *italics* is instructions to the MCO. It is to be deleted in the MCO’s version.
- Permissible alterations include modifications as allowed in model instructions and as approved by DHS.
- The document can be formatted as desired specific to font style, margins and bullets, but must meet contractual and Managed Care Regulation requirements.
- Whenever a phone number is listed, the TTY must also be provided.
- MCO must insert a comprehensive written key in Section 7. Covered Services after the two introductory paragraphs and before the first covered service is listed. The key must describe the symbols used in the Member Handbook.
- MCOs may include the words (toll free) where ever a toll free phone number is listed.
- Send a copy of the final approved electronic version of the Member Handbook in an accessible format for a web environment to the DHS Contract Manager within two weeks of receiving DHS approval.
- Starting with the Table of Contents through the duration of the document, page numbers need to flow continuously in numeric order.
- The Member Handbook text must be in a 12 point type size or greater. Alternative formats must include large print version, which the Managed Care Regulation defines as font size no smaller than 18 point.

**MCO Member Handbook Submission Process**

- Review and edit the draft Member Handbook prior to submission to DHS. This includes correcting grammar, spelling, and other typographical errors, and ensuring accuracy of data. Errors may cause delays in the approval process.
- Submit the following to the DHS Contract Manager:
  - The Material Review Checklist.

- The Member Handbook (in a format ready for printing).
- The name and contact information of the person at the MCO to whom questions can be directed.
- A Flesch Scale Analysis Readability Score at or below 7th grade level for the Member Handbook.
- A signed attestation that the information contained in the Member Handbook is accurate as of the date of submission to DHS. The MCO must ensure in their attestation that the MCO has reviewed the information submitted in their Member Handbook. The narrative information must be accurate and must not contain false or misleading statements. The MCO must have a process to validate that the information provided is correct as stated in the contract, Managed Care Regulation, and the Member Handbook Guidelines. This must be signed by an officer within the MCO such as a CEO, CFO, or Vice President. The officer can delegate a person within the MCO to sign on their behalf. The letter of delegation must be on file with DHS. DHS is not able to verify and accept electronic signatures. The attestation must have a “wet” signature.
- Submit revised Member Handbook drafts as necessary until final approval from DHS is obtained.
- Send a PDF copy of the final approved version of the Member Handbook to the DHS Contract Manager.

#### **Process for Distribution of Final Approved Member Handbook**

- MCOs must comply with contract requirements related to electronic accessibility, including Sections 504 and 508 of the Rehabilitation Act.
- The MCO must provide the Member Handbook in an alternative format to its members upon request. Alternative format refers to auxiliary aids and services as defined in the contract and Managed Care Regulation.
- The MCO may provide the Member Handbook in an alternative format to the State and to counties within its service area according to contractual and Managed Care Regulation requirements. (Refer to current contract.)
- Send a PDF copy of any non-English Member Handbook to the Contract Manager and a signed attestation that the Non-English version contains the same information as the English version. If the MCO translates the Member Handbook into other languages, the entire Member Handbook must be translated.
- Send a copy of the final approved electronic version of the Member Handbook in an accessible format for a web environment to the DHS Contract Manager within two weeks of receiving DHS approval.



# Model

## Member Handbook

### SPECIAL NEEDS BASICCARE (SNBC) MEDICAID ONLY

January 1, 2021

This booklet contains important information about your health care services.

*<Insert MCO cover page for the 2021 Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook>*

*<Insert name of MCO, address, Member/Customer Services phone numbers including TTY, website, and hours of service>*

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

(Inside front cover on the left side or on the first page after the front cover)

*Place the following starting inside the front cover:*

*<Language Block>*

*<Discrimination and Complaint Notice CB-5>*

*< American Indian Statement>*

*<*

*<Insert Table of Contents with page numbers> [MCOs may include additional subheadings]*

### **Section 1: Telephone Numbers and Contact Information**

[Gives you contact information for our Plan and other organizations that can help you.]

### **Section 2: Important Information on Getting the Care You Need**

[Tells you important things you need to know about getting health care as a member of our Plan.]

- [Transition of care
- <Prior/Service> authorizations
- Covered and non-covered services
- Cost sharing
- Payments to providers
- Interpreter services
- Other health insurance
- Private information
- Restricted Recipient Program
- Cancellation]

### **Section 3: Member Bill of Rights**

[Tells you about your rights as a member of our Plan.]

### **Section 4: Member Responsibilities**

[Tells you about your responsibilities as a member of our Plan.]

### **Section 5: Your Health Plan <Member Identification (ID) Card>**

[Tells you about your health Plan <member ID card>, which you should show whenever you get health care services.]

### **Section 6: Cost Sharing**

[Tells you about the amounts (copays) you may need to pay for some services.]

### **Section 7: Covered Services**

[Tells you which health care services are covered and not covered for you as a member of our Plan. Also tells you about restrictions and limitations on covered services.]

### **Section 8: Services We Do Not Cover**

[Tells you about some additional health care services that are **not** covered for you as a member of our Plan.]

### **Section 9: Services That Are Not Covered Under the Plan But May Be Covered Through Another Source**

[Tells you about some health care services that are not covered by the Plan, but may be covered in some other way.]

### **Section 10: When to Call Your County Worker**

[Tells you what kind of information you need to share with your county worker.]

### **Section 11: Using the Plan Coverage with Other Insurance**

[Tells you how to get health care services if you have some other kind of insurance in addition to the Plan.]

### **Section 12: Subrogation or Other Claim**

[Tells about our right to collect payment from a third party if they are responsible for paying for your health care services.]

### **Section 13: Grievance, Appeal, and State Appeal (Fair Hearing with the state) Process**

[Tells you about your right to complain about the quality of care you get, how to appeal a decision we make, and how to request a state appeal (Fair Hearing with the state).]

### **Section 14: Definitions**

[Gives you some definitions of words that will help you better understand your health care and coverage.]

### **[Section 15: Additional Information]**

[Tells you about <insert applicable topic(s): Health Care Directives, provider payment methods, Women’s Health and Cancer Rights, protecting privacy, and Physician Incentive Plans>.]

*<When using acronyms, the MCO must provide the full description of the term that the acronym is describing. For example, Advanced Practice Nurse (APN).>*

### **Welcome to <insert name of MCO>**

We are pleased to welcome you as a member of <insert name of MCO’s SNBC Medicaid-Only product> (referred to as “Plan” or “the Plan”).

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

<Insert name of MCO> (referred to as “we,” “us,” or “our”) is part of Special Needs BasicCare (SNBC). The Minnesota Department of Human Services designed this voluntary program to provide health care for people with disabilities. It combines doctor, hospital, nursing home, dental, behavioral health, rehabilitative, and other health care into one coordinated care system. You will get most of your health services through the Plan’s network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which <doctor/qualified health care provider> to see.

You will be contacted by <Insert name of MCO>, to complete a health assessment by <Insert methods – mail, care coordinator>. The assessment will help us connect you to health care services or other services available to you as a member. Based on your answers, we may contact you for additional information. If you have questions about this assessment, please call <Member/Customer Services/your care coordinator>.

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

This Member Handbook includes:

- Contact information
- Information on how to get the care you need
- Your rights and responsibilities as a member of the Plan
- Information about cost sharing
- A listing of covered and non-covered health care services

- When to call your county worker
- Using the Plan coverage with other insurance or other sources of payment
- Information on what to do if you have a grievance (complaint) or want to appeal a Plan action, as defined in Section 13
- Definitions

The counties in the Plan service area are as follows: *<insert names of counties>*.

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

## Section 1. Telephone numbers and contact information

### How to contact our <Member/Customer Services>

If you have any questions or concerns, please call, [email], or write to <Member/Customer Services>. We will be happy to help you. <Member/Customer Services> hours of service are <insert business days and hours>.

CALL: <insert local and toll free phone numbers>

TTY: <insert TTY local and toll free phone numbers>

[FAX: <insert FAX number>]

WRITE: <insert address>

[VISIT: <insert if different from the “write” address>]

WEBSITE: <insert website address>

[EMAIL: <insert e-mail address>]

[MESSAGING THROUGH <MEMBER PORTAL> : <insert contact information>]

[MOBILE WEBSITE: <insert name of mobile application>]

**Our Plan contact information for certain services** [Plans may insert additional contact information as applicable in this area]

Appeals and Grievances <insert contact information> See Section 13 for more information.

Chiropractic Services <insert contact information>

Dental Services <insert contact information>

Durable Medical Equipment Coverage Criteria <insert contact information>

<Insert name of Health Questions Phone Line/Nurse Line in alpha order> <insert contact information>

Interpreter Services

American Sign Language (ASL) <insert contact information>

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

Spoken Language <*insert contact information*>

Mental Health and Behavioral Health Services <*insert contact information*>

Prescriptions <*insert contact information*>

Substance Use Disorder Services <*insert contact information*>

Transportation <*insert contact information*>

## 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 (toll free) (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 *<insert MCO name and MCO contact information>*. *More information about health care directives can be found: <insert MCO website information>* 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 *<insert MCO specific instructions and contact information.>* To report fraud or abuse directly to the State, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at 651-431-2650 or 800-657-3750 (toll free) or 711 (TTY); by fax at 651-431-7569; or by email at [DHS.SIRS@state.mn.us](mailto:DHS.SIRS@state.mn.us).

## Minnesota Department of Human Services

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

## Ombudsman for Public Managed Health Care Programs

The Ombudsman for Public Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving 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

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

with the state). Call 651-431-2660 (Twin Cities metro area) or 800-657-3729 (toll free non-metro) or 711 (TTY). Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m. *[Non-metro MCOs can choose to change the order of the numbers to list non-metro phone number first.]*

### Disability Hub MN™

Disability Hub MN™ is a free statewide resource network that helps you solve problems, navigate the system and plan for your future. Disability Hub MN™ knows the ins and outs of community resources and government programs, and has years of experience helping people fit them together. Call Disability Hub MN at 866-333-2466 (toll free) Monday through Friday from 8:30 a.m. to 5:00 p.m., or visit online at [disabilityhubmn.org](http://disabilityhubmn.org).

### Veterans Linkage Line™

The Veterans Linkage Line™ provides information and referrals to veterans and their families. The Minnesota Department of Veterans Affairs (MDVA) provides the LinkVet call center. During business hours, trained MDVA staff will provide information on veterans' benefits, health care, education, and reintegration.

#### Hours of Operation

Monday-Friday: 7 a.m. to 8 p.m., CST

Saturday: 9 a.m. to 2:30 p.m., CST

Sunday: 11 a.m. to 4:30 p.m., CST

Closed Holidays. Call 1-888-LinkVet (888-546-5838, toll free) or 711 (TTY).

### How to Contact the Medicare Program

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

- Call 1-800-MEDICARE (800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit [www.medicare.gov](http://www.medicare.gov). This is the official government website for Medicare information. This website gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can search under “Forms, Help & Resources” and print the “Medicare & You” booklet directly from your computer. Select “Phone Numbers and websites” to find helpful contacts for organizations in your state. 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.

## 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 print copy of this at any time. To verify current information, you can *[Insert all applicable statements: call the provider, call < Member/Customer 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 <MCO Name> you chose or were assigned to a <primary care provider (PCP)/primary care clinic (PCC) or care system> [and a dental clinic]. Your <primary care provider (PCP)/primary care clinic (PCC) or care system> [and dental clinic] 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 see specialists.] You may change your <primary care provider (PCP)/primary care clinic (PCC) or care system> [or dental clinic]. *<Explain the process for changing a provider/clinic/care system/dental provider.>*

**Or**

<MCO name> encourages you to choose a <primary care provider (PCP)/primary care clinic (PCC) or care system> [and dental clinic]. Your primary care clinic can provide most of the health care services you need, and will help coordinate your care. Please confirm with Member Services that your clinic is still a provider with our health plan. You can go to any primary care clinic that's listed in this directory or our online provider search at <MCO website>.]

*[MCOs with referral models, insert: Your primary care clinic or <doctor/qualified health care provider> will refer you to other [doctors or] qualified health care providers when needed.]*

*[MCOs with direct access model, insert: You do not need a referral to see 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, *[insert if applicable: referrals,]* <prior/service> authorizations, and to make an appointment. If you cannot go to your appointment, call your clinic right away.

[You may change your primary care provider or clinic. To find out how to do this, call <Member/Customer 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 were taking previously 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/Customer Services>.

**<Prior/Service> Authorizations [*insert if applicable: and referrals*]:**

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

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

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

- Routine dental care, routine vision care, chiropractic care, and obstetrics and gynecology services. You must get these services from providers in our network.
- Open access services: family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for acquired immune deficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related conditions are open access services. You can go to any <doctor/qualified health care provider>, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- For substance use disorder services, call the phone number listed in Section 1.
- For mental health services, call the phone number listed in Section 1.

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

For more information, call <Member/Customer Services> at the phone number listed in Section 1.]

[*MCOs with direct access models, insert:* 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/service> authorization from us to see 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/qualified health care provider>, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- Emergency and post-stabilization services

For more information, call <Member/Customer Services> at the phone number listed in Section 1.]

[*MCOs with direct access models, insert as applicable:* The Plan allows direct access to the providers in our network, but keeps the right to manage your care under certain circumstances, such as: [*List examples for which this applies.*]. We may do this by choosing the provider you use or the services you receive. [When we manage your care, our <nurse care manager> and network providers will coordinate your care.] For more information, call Member/Customer Services at the phone number in Section 1.]

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

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

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

[*MCOs with direct access models, insert:* If we are unable to find you a qualified Plan network provider, we must give you a standing <prior/service> authorization for you to see a qualified specialist for any of the following conditions:

- A chronic (ongoing) 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/service> authorization from us when needed, the bill may not be paid.** For more information, call <Member/Customer 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/qualified health care provider> certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

For more information, call <Member/Customer Services> at the phone number in Section 1.

At <MCO NAME>, 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 <phone number, hours of operation>. If you need language assistance to talk about these issues, <MCO NAME> can give you information in

your language through an interpreter. For sign language services, call <TTY number>. For other language assistance, call <phone number>.

### **Covered and non-covered services:**

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

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

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

We may cover additional or substitute services under some conditions.

### **Cost sharing:**

Cost sharing is an amount that health plan members may be responsible to pay to their providers for their medical services. It includes deductibles and copays. **You do not have cost sharing for services covered under our Plan.** If you disenroll from our plan, you may have cost sharing for certain services.

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

### **Payments to providers:**

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. If you paid for a service that you think we should have covered, call <Member/Customer Services>. [If you received a medical bill that should have been covered, *Plans must add additional language to describe how to submit a claim.*]

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

### **Cultural Competency:**

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/qualified health care provider>. We want to ensure you get care in a culturally competent 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/Customer Services> at the phone number in Section 1 to find out which interpreters you can use.

### **Other health insurance:**

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

insurance plan. If your other health or dental insurance changes, tell your county worker.

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

**Private information:**

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

**Restricted Recipient Program:**

The Restricted Recipient Program (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. <MCO Name> 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. <MCO Name> may designate other health services providers. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options, or consumer directed services.

You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your primary care provider and received by the <MCO Name> 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. See Section 13.

### **Disenrollment:**

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

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

- You are no longer eligible for Medical Assistance (Medicaid).
- You lose eligibility for SNBC because you are no longer disabled.

- You are eligible for Medicare but do not stay continuously enrolled in both Medicare Part A and Medicare Part B.
- You have cost effective health insurance.
- You have a spenddown and you do not pay it.
- You move out of our Plan service area.
- You turn age 65.
- You choose to leave the plan.

If you are no longer eligible for Medical Assistance (Medicaid), you may be eligible to purchase health coverage through MNsure. For information about MNsure, call 1-855-3MNSURE or 1-855-366-7873 (toll free), TTY, use your preferred relay services, or visit [www.MNsure.org](http://www.MNsure.org).

### 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 or harm you.

Participate with providers in making decisions about your health care.

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

Refuse care from specific providers.

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

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 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 care coordination. You also have the right to refuse care coordination. Voluntarily disenroll.

Get the following information from us, if you ask for it. Call <Member/Customer 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/qualified health care provider> before you become ill. This helps you and your <primary care doctor/qualified health care provider> understand your total health condition.

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

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

Work with your care coordinator to create your care plan. If you do not want care coordination or want to limit how much contact you get from a care coordinator or case manager, call your health plan to let them know.

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/Customer 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/Customer 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:

*<Insert member ID card diagram here – front and back. Mark it as sample card.>*

## Section 6. Cost Sharing

Cost sharing is an amount that health plan members may be responsible to pay to their providers for their medical services. It includes deductibles and copays. **You do not have cost sharing for services covered under our Plan.** If you disenroll from our plan, you may have cost sharing for certain services.

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

## Section 7. Covered Services

This section describes the major services that are covered under the Plan for Medical Assistance (Medicaid) members. It is not a complete list of covered services. If you need help understanding what services are covered, call <Member/Customer Services> at the phone number in Section 1. Some services have limitations. Some services require a [*insert if applicable*: referral or order or] <prior/service> authorization. A service marked with an asterisk (\*) means a [referral or order or] <prior/service> authorization is required [or may be required]. {*Insert asterisks next to services that require a referral, order, or <prior/service> authorization.*} [MCOs may add a footnote to each page with an asterisk and description: “\*Requires [or may require] a [referral or an order or a <prior/service> authorization.”] Make sure there is a [*insert if applicable*: referral or order or] <prior/service> authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Call <Member/Customer Services> at the phone number in Section 1 for more information.

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

[For each covered service, if MCO benefits differ from the fee for service information listed below, MCO must also list any limitations related to each benefit within the covered service section]

## **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. Request 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

### **[Care Coordination or other title as used by health plan]**

[MCO should describe how to access this service and list any additional benefits offered. The MCO should add information on care coordination specific to the MCO. MCOs may change the title of this service to match the title they use for this service and the person providing the service (i.e., “care navigator,” etc.). The MCO should add a definition to Section 14 to correspond to this section.]

**Covered Services:**

- Assisting you in arranging for, getting, and coordinating assessments, tests, and health care services such as dental, behavioral health, rehabilitative, and primary care.
- Developing and updating your care plan with you, based on your unique needs.
- Communicating with a variety of agencies and people.

**Child and Teen Checkups (C&TC)**

**Covered Services:**

- Child and Teen Checkups (C&TC) preventive health visits include:
  - growth measurements
  - health education
  - health history including nutrition
  - developmental screening
  - social-emotional or mental health screening
  - head-to-toe physical exam
  - immunizations
  - lab tests
  - vision checks
  - hearing checks
  - Oral health, including fluoride varnish application

**Notes:**

C&TC is a health care program of well-child visits for members under age 21. C&TC visits help keep kids healthy and can provide more support, if needed.

Each visit may include one-on-one time with the healthcare provider. This gives time for questions and discussion about health needs and goals and helps young adults learn to manage their own health.

Members under age 21 should contact their Primary Care Clinic to schedule C&TC well-child and preventive health visits.

### **Chiropractic Care**

#### **Covered Services:**

- One evaluation or exam per calendar year
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine - up to 24 visits per calendar year, limited to six per month. Visits exceeding 24 per calendar year or six per month require a <prior/service> 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 (for adults except pregnant women)**

#### **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 prophylaxis]; documentation must include notation of the specific oral health problem or complaint*)
- Teledentistry for diagnostic services (*limited to 3 telemedicine services per member per calendar week*)
- X-rays, limited to:
  - bitewing (*once per calendar year*)
  - single X-rays for diagnosis of problems
  - panoramic (*once every five years and as medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma; once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure*)
  - full mouth X-rays (*once every five years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery*)
- Preventive services:
  - cleaning (*up to four times per year if medically necessary*)
  - fluoride varnish (*once per calendar year*)
  - caries medicament application (*once per tooth per 6 months*)
- Restorative services:
  - fillings
  - sedative fillings for relief of pain
- Endodontics (root canals) (*on anterior teeth and premolars only and once per tooth per lifetime; retreatment is not covered*)
- Oral surgery (*limited to extractions, biopsies, and incision and drainage of abscesses*)
- Periodontics:
  - gross removal of plaque and tartar (full mouth debridement) (*once every five years*)
  - scaling and root planing (*once every two years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery*).

- *[scaling and root planing may also be covered in a clinic setting under certain circumstances\*] If optional language is added, please submit a list of circumstances.*
- Prosthodontics:
  - removable prostheses (dentures and partials) *(once every six years per dental arch); [partials always require a <Service/Prior> Authorization]*
  - relines, repairs, and rebases of removable prostheses (dentures and partials)
  - replacement of prostheses that are lost, stolen, or damaged beyond repair under certain circumstances
  - replacement of partial prostheses if the existing partial cannot be altered to meet dental needs
- Additional general dental services:
  - treatment for pain *(once per day)*
  - general anesthesia *(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\* If optional language is added, please include a list of circumstances in this sub-bullet.*
  - extended care facility or house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMDs), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) Hospices, Minnesota Extended Treatment Options (METO), nursing facilities, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital).
  - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
  - oral or IV sedation – only if 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:**

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 MCOs offers additional dental benefits, add this language and provide the list of additional benefits.*  
 [Additional dental benefits offered by <plan name> are only available if you go to a dental provider in <plan name>'s provider network.]

[Additional Dental Services:] *Provide a listing*

See Section 1 for Dental Services contact information.

**Dental Services (for children and pregnant women)****Covered Services:**

- Diagnostic services:
  - comprehensive exam *(cannot be performed on same date as a periodic or limited evaluation)*
  - periodic exam *(cannot be performed on same date as a limited or comprehensive evaluation)*
  - limited (problem-focused) exams *(Cannot be performed on same date as a periodic or comprehensive oral evaluation [or prophylaxis]; documentation must include notation of the specific oral health problem or complaint)*
  - Teledentistry for diagnostic services *(limited to 3 telemedicine services per member per calendar week)*
  - X-rays, limited to:
    - bitewing *(once per calendar year)*
    - single X-rays for diagnosis of problems *(as medically necessary)*

- panoramic (*once in a five-year period except when medically necessary to evaluate development and to detect anomalies, injuries and disease*)
- full mouth X-rays (*once in a five-year period*)
- Preventive services:
  - cleaning
  - fluoride varnish (*once every six months*)
  - sealants for children under age 21 (*one every five years per permanent molar*)
  - caries medicament application (*once per tooth per 6 months*)
- Restorative services:
  - fillings
  - sedative fillings for relief of pain
  - individual crowns (*must be made of prefabricated stainless steel or resin*)
- Endodontics (root canals) (*once per tooth per lifetime*)
- Periodontics:
  - gross removal of plaque and tartar (full mouth debridement)
  - scaling and root planing (*once every two years in a clinic setting with a <service /prior> authorization or when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery*).
    - [*scaling and root planing may also be covered in a clinic setting under certain circumstances\**] *If optional language is added, please include a list of circumstances in this sub-bullet.*
- Prosthodontics:
  - removable prosthesis (dentures and partials) (*once every six -years per dental arch; [partials always require a <Service/Prior> Authorization]*)
  - relines, repairs, and rebases of removable prosthesis (dentures and partials)
  - replacement of prosthesis that are lost, stolen, or damaged beyond repair under certain circumstances

- replacement of partial prosthesis if the existing partial cannot be altered to meet dental needs
- Oral surgery
- Orthodontics (*only when medically necessary for very limited conditions for members age 20 and younger*)
- Additional general dental services:
  - treatment for pain
  - general anesthesia
  - extended care facility or house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMDs), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) Hospices, Minnesota Extended Treatment Options (METO), nursing facilities, school or Head Start program, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital)
  - 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:**

If you begin orthodontia services, we will not require completion of the treatment plan in order to pay the provider for services received.

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

See Section 1 for Dental Services contact information.

**Diagnostic Services****Covered Services:**

- Lab tests and X-rays

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

- Other medical diagnostic tests ordered by your <doctor/qualified health care provider>

## **Doctor and Other Health Services**

### **Covered Services:**

- Doctor visits including:
  - care for pregnant women
  - family planning – **open access service**
  - lab tests and X-rays
  - physical exams
  - preventive exams
  - preventive office visits
  - specialists
  - telemedicine consultation
  - vaccines and drugs administered in a <doctor's/qualified health care provider's> office
  - visits for illness or injury
  - visits in the hospital or nursing home
- Acupuncture for pain and other specific conditions, by licensed acupuncturists or within the scope of practice by a licensed provider with acupuncture training or credentialing
- 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
- Community Medical Emergency Technician (CMET) services
  - post-hospital or post-nursing home discharge visits ordered by your primary care provider
  - safety evaluation visits ordered by Primary Care Provider or 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 see a provider in the Plan network.
- 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)

### **Early Intensive Developmental and Behavioral Intervention (EIDBI) Services**

*(for members under age 21)*

#### **Covered Services:**

- Comprehensive Multi-Disciplinary Evaluation (CMDE)
- EIDBI: Individual or Group
- Intervention Observation and Direction
- Family or Caregiver Training and Counseling: Individual or Group
- Individual Treatment Plan (ITP) Development (Initial)
  - Individual Treatment Plan (ITP) Development and Progress Monitoring
- Coordinated Care Conference (one per year without authorization)
- Travel time

### **Emergency Medical Services and Post-Stabilization Care**

#### **Covered Services:**

- Emergency room services
- Post-stabilization care

- Ambulance (air or ground includes transport on water)

### **Not Covered Services:**

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

### **Notes:**

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/ qualified health care provider>.

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

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

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

### **Eye Care Services**

#### **Covered Services:**

- Eye exams
- 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

### **Not Covered Services:**

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

### **Family Planning Services**

#### **Covered Services:**

- Family planning exam and medical treatment – **open access service**
- Family planning lab and diagnostic tests – **open access service**
- Family planning methods (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 see a provider in the Plan network. Note: This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS, and other HIV-related conditions – **open access service**
- Treatment for sexually transmitted diseases (STDs) - **open access service**
- Voluntary sterilization – **open access service**

**Note:** You must be age 21 or over and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.

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

### **Not Covered Services:**

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

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

**Covered Services:**

- Skilled nurse visit
- Rehabilitation therapies to restore function (for example, speech, physical, occupational, respiratory)
- Home health aide visit

**Hospice****Covered Services:**

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

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

**Notes:****Medicare Election**

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

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.

Members age 21 and under can still receive treatment for their terminal condition in addition to hospice services.

If you are interested in using hospice services, please call <Member/Customer 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
- Dialysis
- Emergency room services
- Post-stabilization care

**Housing Stabilization Services** (for members 18 years old and older)

**Covered Services:**

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

- Housing consultation services: service to develop a person-centered plan for people without Medical Assistance case management services
- Housing transition services: helps you plan for, find, and move into housing
- Housing sustaining services: helps you maintain housing
- Non-emergency medical transportation to receive Housing Stabilization Services (look at limitation language)

**Notes:**

You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. People who need Housing Stabilization Services can ask for an assessment or be supported by a provider or case manager. If a person has a targeted case manager or waiver case manager that case manager may support them to access services, or the person can contact a Housing Stabilization Services provider directly to help them receive Housing Stabilization Services.

Department of Human Services (DHS) staff will use the results of the assessment to determine whether the member meets the needs-based criteria to receive this service. DHS will send the member 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.

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

### **Medical Equipment and Supplies**

#### **Covered Services:**

- Prosthetics or orthotics
- Durable medical equipment (for example, wheelchairs, hospital beds, walkers, crutches, and wigs for people with alopecia areata). Contact

<Member/Customer 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 and 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 see your <doctor/qualified health care provider> 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 and Behavioral Health Services**

#### **Covered Services:**

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

- Certified Community Behavioral Health Clinic (CCBHC)
- Clinical Care Consultation
- Crisis response services including:
  - Screening
  - Assessment
  - Intervention
  - Stabilization including residential stabilization
  - Community intervention
- Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorders
- Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP)
- Inpatient 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
  - Family psychoeducation services (*for members under age 21*)
  - Mental health medication management
  - Neuropsychological services
  - Psychotherapy (patient and family, family, crisis, and group)
  - Psychological testing
- Physician Mental Health Services including:
  - Health and behavior assessment and 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 family peer specialists. (*for members under age 21*)
  - Certified Peer Specialist (CPS) support services in limited situations

- Children’s mental health residential treatment services (*for members under age 21*)
- Children’s Therapeutic Services and Supports (CTSS) including Children’s Day Treatment (*for members under age 21*)
- Family psychoeducation services (*for members under age 21*)
- Intensive Residential Treatment Services (IRTS)
- Intensive Treatment Foster Care Services (*for members under age 21*)
- Partial Hospitalization Program (PHP)
- Intensive Rehabilitative Mental Health Services (IRMHS) (*for members ages 18 through 20*)
- Treatment services at children’s residential mental health treatment facilities. Treatment services do not include coverage for room and board. Room and board may be covered by your county. Call your county for information.
- Psychiatric Residential Treatment Facility (PRTF) for members 21 and under
- Telemedicine

### **Not Covered Services:**

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

- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Treatment and room and board services at certain children’s residential mental health treatment facilities in bordering states

### **Notes:**

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

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

Use a Plan network provider for mental health services.

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

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

### **Nursing Home Services**

#### **Covered Services:**

- Nursing Home Room and Board – We are responsible for paying a total of 100 days of nursing home room and board. If you need continued nursing home care beyond the 100 days, the Minnesota Department of Human Services (DHS) will pay directly for your room and board. If DHS is currently paying for your room and board in the nursing home, DHS, not us, will continue to pay for your room and board.
- Nursing care
- Therapy services
- Drugs covered under Medical Assistance
- Medical supplies and equipment

#### **Not Covered Services:**

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

## **Obstetrics and Gynecology (OB/GYN) Services**

### **Covered Services:**

- Prenatal, delivery, and postpartum care
- Childbirth classes
- HIV counseling and testing for pregnant women – **open access service**
- Treatment for HIV-positive pregnant women
- Testing and treatment of sexually transmitted diseases (STDs) – **open access service**
- Pregnancy-related services received in connection with an abortion (*does not include abortion-related services*)
- Doula services by a certified doula supervised by either a physician, nurse practitioner, or certified nurse midwife and registered with the Minnesota Department of Health (MDH)
- Services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives

### **Not Covered Services:**

- Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) or 711 (TTY) for coverage information. Also see Section 9.
- Planned home births

### **Notes:**

You have “direct access” to OB-GYN providers [*Insert if applicable:* without a referral] for the following services: annual preventive health exam, including follow-up exams that your <doctor/qualified health care provider> says are

necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as **open access**, you can go to any <doctor/qualified health care provider> clinic, hospital, pharmacy, or family planning agency.

### **Out-of-Area Services**

#### **Covered Services:**

- A service you need when temporarily out of the Plan service area <MCO to insert instructions for how member is to obtain>
- 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/Customer 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**

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

**Covered Services:**

- Certain services you need that you cannot get through a Plan network provider
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- A second opinion for mental health and substance use disorder
- Open access services
- Pregnancy-related services received in connection with an *abortion (does not include abortion-related services)*
- A non-emergency medical service you need when temporarily out of the network or plan service area that is or was prescribed, recommended, or is currently provided by a network provider

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

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

**Not Covered Services:**

- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs or products to promote weight loss
- Drugs not clinically proven to be effective
- Experimental or investigational drugs
- 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 <MCO NAME>. 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 <MCO NAME>, some over-the-counter drugs are covered for you under your Medical Assistance (Medicaid) benefits. You can search for prescription drugs using our online search tool at <web address>. A list of covered drugs (formulary) is also posted on the website. You can also call <Member/Customer 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/Customer Services>.

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

- **Prior Authorization (PA):** <MCO NAME> requires you or your <doctor or health care provider> to get prior authorization for certain drugs. This means that you will need to get approval from <MCO NAME> before you fill your prescriptions. If you don't get approval, <MCO NAME> may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, <MCO NAME> limits the amount of the drug that <MCO NAME> will cover.
- **Preferred and Non-Preferred (P/NP):** For some groups of drugs, <MCO Name> 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 <MCO NAME> only when:
  1. Your prescriber informs <MCO NAME> in writing that the brand name version of the drug is medically necessary; OR
  2. <MCO NAME> 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 or Non-Preferred status, or has an age requirement by contacting <Customer/Member Services> or visiting our website at <MCO Website>. 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 <Customer/Member Services> or visiting our website at <MCO Website>.

If <MCO NAME> changes prior authorization requirements, quantity limits, or other restrictions on a drug you are currently taking, <MCO NAME> 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 <primary care doctor/qualified health care provider> shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your <doctor/qualified health care provider> is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.

We will cover an antipsychotic drug, even if it is not on our drug list, if your provider certifies this is best for you. There is no copay for 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.

**For most drugs, you can get only a *[Insert plan limit between 30 and 34]-day supply at one time.***

If <MCO name> 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 or your health care provider can ask <MCO NAME> 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.

*[Describe the formulary exception process, including authorization requirements.]*

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

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. *[MCO may add/clarify any exceptions to the specialty drug rule].*

*If an MCO uses an exclusive Specialty Drug Provider, use this language:*

If you are prescribed a drug that is on the <MCO NAME> Specialty Drug List, your prescriber will need to send the prescription of that specialty drug to <MCO NAME>'s Specialty Pharmacy.

Name of Specialty Pharmacy:

Phone and TTY:

Fax:

Hours of Operation:

[Insert Specialty Pharmacy website]

[You will also need to call the Specialty Pharmacy at <insert phone number> to set up an account. You will need to have your <MCO NAME> Member Identification (ID) card when you call the Specialty Pharmacy.] *or* [The Specialty Pharmacy will contact you to set up your account after you have authorized your prescriber to send the prescription to the Specialty pharmacy <and receive authorization from <MCO Name>>.]

*If an MCO uses multiple Specialty Drug providers, use this language:*

If you are prescribed a drug that is on the <MCO NAME> Specialty Drug List, your prescriber will need to send the prescription of that specialty drug to one of <MCO NAME>'s Specialty Pharmacies listed here.

Name of Specialty Pharmacy:

Phone and TTY:

Fax:

Hours of Operation:

[Insert Specialty Pharmacy website]

[You will also need to call the Specialty Pharmacy that receives your prescription to set up an account. You will need to have your <MCO NAME> Member ID card when you call the Specialty Pharmacy.] *or* [The Specialty Pharmacy will contact you to set up your account after you have authorized your prescriber to send the

prescription to the Specialty Pharmacy <and receive authorization from <MCO Name>>.]

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

#### **Covered Services:**

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

#### **Not Covered Services:**

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

**Rehabilitation****Covered Services:**

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

**Not Covered Services:**

- Vocational rehabilitation
- Health clubs and spas

**Substance Use Disorder Services (SUD)****Covered Services:**

- Screening, Assessment and 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:**

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

**Surgery****Covered Services:**

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

**Not Covered Services:**

- Cosmetic surgery

**Telemedicine Services**

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

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

## **Transplants**

### **Covered Services:**

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

### **Notes:**

The type of transplant must be: 1) listed in the Minnesota Department of Human Services Provider Manual; 2) a type covered by Medicare; or 3) 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).

*[MCOs may include additional information about their processes for transplant services if not contrary to contractual requirements.]*

### **Transportation to and from Medical Services**

#### **Covered Services:**

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

#### **Not Covered Services:**

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

#### **Notes:**

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

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

[MCOs may include additional information on to how access transportation services. *MCOs are not allowed to include information regarding a penalty for missed rides.*]

### **Urgent Care**

#### **Covered Services:**

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

#### **Not Covered Services:**

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

#### **Notes:**

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

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

## Section 8. Services we do not cover

If you get services or supplies that are not covered, you may have to pay for them yourself. Some “not covered” services and supplies are listed under each category in Section 7. Here is a list of other services and supplies that are not covered under the Plan. This is not a complete list. Call <Member/Customer 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

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

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 (MHCP) Member Helpdesk at 651-431-2670 or 800-657-3739 (toll free) or 711 (TTY).

- Abortion services
- Case management for members with developmental disabilities
- Child welfare targeted case management
- Day training and habilitation services
- HIV case management
- Home Care Nursing (HCN): To learn more about HCN services, contact a home care agency for an assessment. To find a home care agency in your area, call the MHCP Member Helpdesk number listed in the first paragraph.
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Job training and educational services
- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance (Medicaid)
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Moving Home Minnesota services
- Nursing home stays that exceed 100 days. See “Nursing Home Services” in Section 7.
- Personal Care Assistance (PCA). Community First Services and Supports (CFSS) will replace PCA services, upon federal approval. Contact your county of residence intake for long-term care services and supports to learn more about PCA services and to arrange for an assessment.
- Post-arrest Community-Based Services Coordination
- 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.

- Relocation service coordination.
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Room and board associated with treatment services at children’s residential mental health treatment facilities. Room and board may be covered by your county. Call your county for information.
- Services provided by federal institutions
- Services provided by a state regional treatment center, 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)
- Home and Community-Based Services waivers

## Section 10. When to call your county worker

Call your county worker to report these changes:

- Name changes
- Address changes including moving out of Minnesota

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

### **Section 11. Using the Plan coverage with other insurance**

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

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

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

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

If your other insurance changes, call your county worker.

## **Section 12. Subrogation or other claim**

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and state laws provide that Medical Assistance (Medicaid) benefits pay only if no other source of payment exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source

that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than federal and state laws allow.

### **Section 13. Grievance, appeal and state appeal (Fair Hearing with the state) process**

This section tells you about the grievance and appeal system including notices, grievances (complaints), health plan appeals, and state appeals (Fair 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 disagree with a decision we made. It tells you about your rights when using the grievance and appeal system.

Please call <Member/Customer 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> 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 <MCO name> 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/service> authorizations and appeals
- financial liability including copayments or other cost sharing
- any other action

### **Important Timelines for Appeals**

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

You must appeal to us **within 60 days** from the date of the DTR (notice of action). We can give you more time if you have a good reason for missing the deadline. You must file an appeal with us **before** you request a state appeal. If we take more than 30 days to decide your appeal and 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 is found in Section 1 under “Appeals and Grievances.”

If you call us with your appeal, it must be followed by a written appeal, unless you are requesting a fast resolution. We will help you complete a written appeal. We will ask you to sign and return the written appeal.

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 <Health Plan>. 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/Customer Services> at the phone number in Section 1 and tell us about the problem.

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

If your grievance is about our denial of 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/Customer 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 or if you or your provider requests extra time. We will tell you we are taking the extra time and why.

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

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

Call: 800-657-3916 (toll free) or (651) 201-5100  
711 (TTY)

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 give you a copy of the guidelines we used to make our decision, at no cost to you. You may need to put your request in writing.

If you need help with your grievance, 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 (Twin Cities metro area),  
toll-free 800-657-3729 (non-metro area) or 711 (TTY). Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m. *[Non-metro MCOs can choose to change the order of the numbers to list non-metro phone number first.]*

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.

Special Needs BasicCare (SNBC) Medicaid-Only Member Handbook  
Guidelines/Requirements, Effective for  
January 2021

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.

Child: Member under age 21.

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

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

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 and Copayment: A fixed amount you may pay as your share of the cost each time you get certain services, supplies, or prescription drugs. Co-pays are usually paid at the time services, supplies, or prescription drugs are provided. 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. See 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 members' social, cultural, and language 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/service> authorization from your PCP or PCC before getting services.

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

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

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

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

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

- be the services, supplies and prescription drugs other providers would usually order.

- help you get better or stay as well as you are.
- help stop your condition from getting worse.
- help prevent or find health problems.

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

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

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

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

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

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.

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 <Insert “physician” or “qualified health care provider”>, clinic, hospital, pharmacy, or family planning agency - even if not in our network - to get these services.

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

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

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

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

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

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

Plan: An organization that has a network of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators [plans should change “care coordinator” to the term used by the state and/or plan] to help you

Prepaid Medical Assistance Program (PMAP): A program in which the state contracts with health plans to cover and manage health care services for Medical Assistance (Medicaid) enrollees.

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

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

Prescriptions: Medicines and drugs ordered by a medical provider.

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

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

Primary Care Clinic: The primary care clinic (PCC) you choose for your routine care. This clinic will provide [*Insert if applicable*: or approve] most of your care. [The name of your clinic appears on your <member ID card>.]

*MCO must select Primary Care Physician OR Primary Care Provider*

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

Medicare health plans, you must see your primary care provider before you see any other health care provider.]

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

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

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

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 <physician/provider/clinic> that you may need to get before you see certain providers, such as specialists, for covered services. Your primary care <physician/provider/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/Customer 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.

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

Special Needs BasicCare (SNBC): A voluntary managed care program for people with disabilities. SNBC is for people who have Medical Assistance (Medicaid) and are ages 18-64. SNBC covers the basic Medical Assistance (Medicaid) health care services, except for personal care assistance and home care nursing.

[MCOs with referral models, insert: [Standing Referral]: Written consent from your Primary Care Clinic to see a specialist more than one time (for ongoing care).]

[MCOs with direct access models, insert: [Standing Authorization]: Written consent from us to see 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/service> authorizations and appeals
- any other action

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

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

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

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

## **[Section 15. Additional information]**

*[MCO may include Additional Health Benefits and Services information here but may not include information about incentives. Marketing statements should not include false or misleading information]*

- *If the Additional Health Benefits and Services are offered to all of the MCO's members who meet the criteria for the program.*
- *If the Additional Health Benefits and Services are specifically linked to a preventive service or expected health outcome and the link between the two is clearly stated on the marketing materials.*
- *If the Additional Health Benefits and Services are included in marketing materials beyond those materials given to members.*

*[MCOs may also include information on the following topics:*

- Health Care Directives
- Provider payment methodology (including physician incentive plans)  
*{MCOs must MCO must follow the language in accordance with 62J.72*

<https://www.revisor.mn.gov/statutes/cite/62J.72>

*Language for editing if an MCO chooses to include IHP payments in their disclosure of provider payment methods :}*

<<MCO Name> 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.>

- Federal Women's Health and Cancer Rights requirements
- Privacy notice
- NCQA Information *(MCOs must submit the NCQA standards along with member handbook as supporting documentation)*