Vital
Health at your reach
GOVERNMENT OF PUERTO RICO

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

# BENEFICIARY MANUAL

MMM
multihealth

¿Ayuda con su Plan de Salud del Gobierno?
ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO
Línea libre de cargos
1-800-981-2737
TTY 787-474-3389

GOBIERNO DE PUERTO RICO
Administración de Seguros de Salud

Hon. Ricardo A. Rosselló Nevárez
**Gobernador**

Sra. Angela M. Ávila Marrero
**Directora Ejecutiva**

10 de octubre de 2018

Estimado(a) beneficiario(a):

¡Bienvenido al nuevo Plan del Seguro de Salud del Gobierno, Vital! Desde el 1 de noviembre de 2018 usted tendrá más acceso a los servicios médicos y hospitalarios en todo Puerto Rico. Esta es la primera vez que, si lo desea, puede cambiarse de aseguradora.

**Antes del 1 de noviembre de 2018:**

Usted será asignado a una aseguradora donde mantendrá el médico primario que hoy visita.

**Desde el 1 de noviembre de 2018 hasta el 31 de enero de 2019:**

Acompañado a esta carta tiene una Certificación de Cubierta de Beneficios. La certificación de cubierta la puede utilizar desde el 1 de noviembre de 2018, para continuar recibiendo los servicios médicos, hospitalarios y de medicamentos, mientras le llega su nueva tarjeta del plan médico.

Usted puede realizar un cambio de aseguradora si así lo desea durante el periodo de Inscripción Abierta a partir del 1 de noviembre 2018 hasta el 31 de enero de 2019. Si prefiere quedarse con la aseguradora a la cual fue asignado no tiene que realizar ninguna gestión. Le recordamos que tiene derecho a realizar el cambio de aseguradora solamente una (1) vez al año, a menos que tenga justa causa para volverse a cambiar.

Antes de hacer un cambio, verifique que sus médicos de preferencia estén contratados por la aseguradora a la cual quiere cambiar.

Si quiere realizar un cambio de aseguradora puede llamar al Consejero de Inscripción a los siguientes números de teléfonos, libre de costos:

1-833-253-7721
(TTY) Español: 1-866-280-2050 (TTY) Inglés: 1-866-280-2053

Si prefiere realizar preguntas personalmente, puede acceder el calendario de actividades en nuestra página de internet www.planvitalpr.com y asistir a las orientaciones que tendremos en diferentes localidades.

***¡Salud en tus manos!***

Angela M. Ávila Marrero
Directora Ejecutiva

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## WHO CAN I CALL FOR HELP?

**If you are having an emergency, call 911.**

**Member Services Line** 1-844-336-3331, TTY 787-999-4411 (for the hearing impaired), Monday through Friday from 7:00AM to 7:00PM

**Medicaid Program Call Center 787-641-4224**

**ASSMCA (Linea PAS) Mental Health Service Line**
**1-800-981-0023**

**Patient Advocate Office**
**Toll-free 1-800-981-0031**
**TTY 787-710-7057**

**Puerto Rico Health Insurance Administration (ASES)**
**Vital Plan Toll-free 1-800-981-2737**

## WHAT INFORMATION CAN I FIND ONLINE?

For provider directory, Beneficiary handbook, orientation and education materials and an electronic copy of this guide:
**www.multihealth-vital.com**

For information about **Vital Plan**: http://www.ases.pr.gov

For information about Medicaid programs: http://www.medicaid.pr.gov

For more information on patient protections:
http://www2.pr.gov/Directorios/Pages/InfoAgencia.aspx?PRIFA=231

## YOUR RIGHT TO PRIVACY (HIPAA)

There are laws that protect your privacy. The Government of Puerto Rico, your Insurer, and your doctors can't tell others certain facts about you. Read more about your privacy rights in Part 6 of this guide.

## DO YOU NEED HELP UNDERSTANDING THIS GUIDE?

If the information provided in this guide is confusing or if you have any questions, call your Insurer for help at 1-844-336-3331, TTY 787-999-4411 (for the hearing impaired)

## DO YOU NEED HELP TALKING WITH YOUR INSURER OR READING WHAT THEY SEND YOU?

Your Insurer must make this guide and all written materials available to you in Spanish and English at a fourth (4th) grade reading level. You can also ask your Insurer to send this guide or any written materials in other languages or other formats like large print, audio CD or Braille. Materials in other languages or formats are free.

If you speak another language, your Insurer must provide an interpreter to help you understand. The interpreter is free.

- Call us at 1-844-336-3331, TTY 787-999-4411 (for the hearing impaired) for help.
- In writing to PO BOX 72010, SAN JUAN, PR 00936-7710
- Visit our web site www.multihealth-vital.com
- By email servicioalbeneficiariopsg@mmmhc.com

# PART 1: GETTING STARTED

## HOW DO I SIGN UP FOR VITAL PLAN?

Anyone who wants to see if they can sign up for **Vital Plan** can visit their local Medicaid Office. They will look at the person's information and tell them if they are eligible for **Vital Plan**.

To find out where your Medicaid Office is, call the Medicaid Program call center at 787-641-4224. The call is free. Or visit www.medicaid.pr.gov

## WHAT IF I HAVE A NEWBORN?

If you have a newborn, visit your Medicaid Office and give them a copy of the newborn's birth certificate to enroll the newborn in **Vital Plan**. If you do not do this, the newborn cannot get services under **Vital Plan**. When you have a newborn, you also might be able to get other benefits, so it is important to visit the Medicaid Office so they can check.

## HOW DO I KEEP MY VITAL PLAN BENEFITS?

To keep your **Vital Plan** benefits, you have to go to all your Medicaid appointments. Your Insurer will send you a letter 90 days, 60 days and 30 days before the day when your **Vital Plan** benefits stop. These letters will remind you that you have to go to your local Medicaid Office to maintain your eligibility in **Vital Plan**. If you miss your recertification appointment, your coverage under **Vital Plan** will be cancelled by the Medicaid Program and you will need to apply again

If you miss your appointment, call the Medicaid Program Call Center at 787-641-4224 or visit your local Medicaid Office to ask for a new appointment.

## HOW DO I CHOOSE AN INSURER?

Once you sign up for **Vital Plan**, you can choose your Insurer. Your Insurer will work with you and your doctors to keep you healthy.

There is an enrollment counselor available in Medicaid offices and on the phone who can help you choose an Insurer. The enrollment counselor does not work for any Insurer or any providers. They are neutral. They can give you information about **Vital Plan** and your benefits. They can tell you about the choices available to you and help answer your questions. They can't choose for you. They can help you:

- Choose a new Insurer or change Insurers;
- If you change your Insurer, they can also help you change your Primary Care Physician (PCP) or Primary Medical Group (see more information in Part 2 of this guide).

You can contact the Enrollment Counselor for support:

- By phone at 787-641-4224, Monday through Friday, 8 am to 6 pm
- In the Medicaid offices

There are Enrollment Counselor staff in each of the Medicaid Offices. The offices are open Monday through Friday from 7:30am to 4:00pm. Your Insurer can tell you the Medicaid Office that is closest to you.

If you do not choose an Insurer, one will be chosen for you.

## CAN I CHANGE MY INSURER?

Yes, you can ask to change your Insurer. Once you have chosen an Insurer or one has been chosen for you, you have 90 days to change Insurers. You can also change your Insurer once a year during the "open enrollment period", which is from November 1 to January 31.

If you want to change your Insurer, call the Enrollment counselor at 787-641-4224 or visit your local Medicaid Office.

You can also ask to change your Insurer at any time if you have certain reasons, like:

- You are not able to access services or providers.
- You cannot get all related services you need at one time from the doctors, healthcare professionals and service facilities that work with your Insurer.
- You get poor-quality care.
- You ask for a service that your Insurer does not cover because of moral or religious reasons.
- Your Insurer does not have doctors that are experienced in dealing with your health care needs.

If you want to change your insurer for one of these reasons, you can ask for this change from the Insurer, the enrollment counselor or ASES. ASES will decide if you can change or if you have to wait until Open Enrollment. If you do not like the decision ASES makes, you can ask them to reconsider. If the decision is still not to your liking, you can ask for a hearing.

## CAN MY MEMBERSHIP WITH MY INSURER STOP?

Yes, your membership with your Insurer will stop if you:

- Lose eligibility for **Vital Plan**.
- Move outside of Puerto Rico.
- Go to prison.
- Give your ID card to someone else to use.
- Move to a long-term care nursing facility or intermediate care facility for the developmentally disabled.
- If you request a voluntary termination of coverage
- If a termination is requested by your insurer
- In any of these situations you will lose Access to services under **Vital Plan**

You will not lose your membership with your Insurer if:

- You have changes in your health.
- You are using more health care services
- If you complete your recertification process on time. The new eligibility period is generally 12 months but may vary at the sole discretion of the Medicaid Program

You also might want to stop your membership with your Insurer if you no longer need your **Vital Plan** benefits. If this happens, let your Medicaid Office and your Insurer know.

## HOW DO I REPORT CHANGES?

**Vital Plan** and your Insurer are committed to helping you. To support your needs, we need your help.

Please remember to let your Medicaid Office and Insurer know of any changes that may affect your membership or benefits. Some examples include:

- You are pregnant.
- You have a newborn.
- You have changes in your family group (for example, you get married, someone in your family dies, and someone in your family reaches age 21).
- You move or your phone number changes.
- You or one of your children has other health insurance.
- You have a special medical condition.
- You move outside of Puerto Rico
- Your income changes (for example, you lose your job or get a new job)

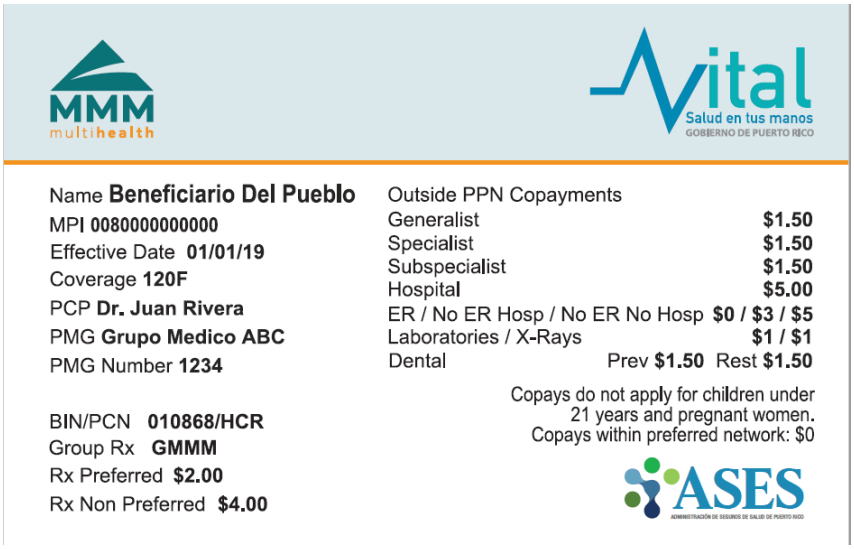
To report a change, call the Medicaid Program call center at 787-641-4224 or visit your local Medicaid Office.

It is important to make sure your contact information is up to date with your local Medicaid Office. This is important because Medicaid and your Insurer send you important information about your **Vital Plan** coverage and benefits in the mail. If they don't have your current address, you could lose your **Vital Plan** benefits. To report a change, call your Insurer or visit your local Medicaid Office.

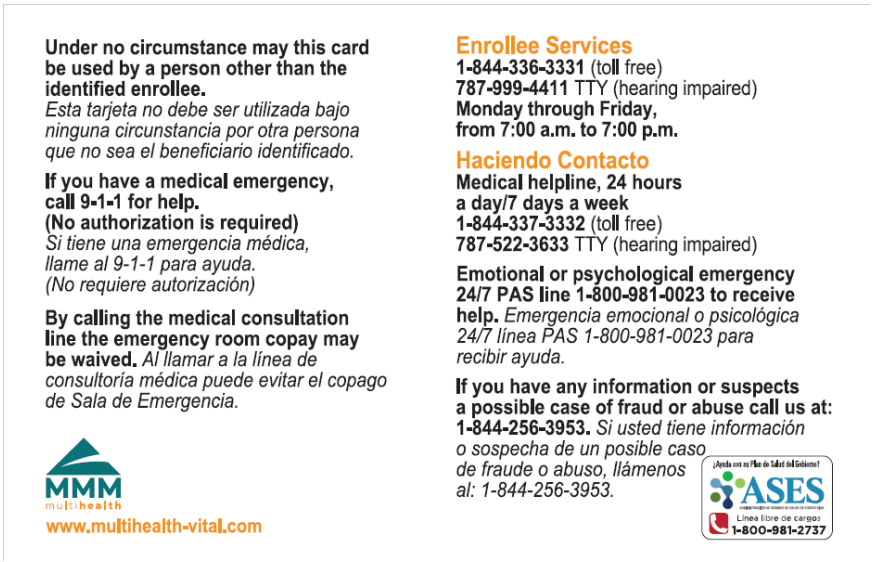
## YOUR ID CARD

Everyone in **Vital Plan** has an ID card. This is an example of what it looks like:

**[ Front ]**




**[ Back]**



Each insured person in your family will have his/her own ID card, even if he/she is a newborn. Your ID card has important information like:

- Your ID number (MPI)
- How to access emergency services
- Any money you will pay for health services
- Your Insurer's free phone number (on the back of your card)
- The phone number for the free **Vital Plan** Service Line and the free 24/7 **Vital Plan** Medical Advice Line (on the back of your card).

If you need to use your health benefits before you get your ID card, use your MA-10 form given to you by your Medicaid Office.

Remember to:

- Always carry your ID card with you.
- Keep your card in a safe place so you don't lose it.
- Take your ID card when you go to the doctor or to the emergency room.
- Be sure they give you your ID card back.

Your ID card is only for you. Don't let anyone else use your card. If your card is lost or stolen, you can ask your Insurer for a new card. You can visit your Insurer's Service Centers or call them at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired). The phone call is free.

# PART 2: YOUR PRIMARY CARE PHYSICIAN AND OTHER DOCTORS

When you sign up with your Insurer, you must choose a doctor or "primary care physician" (PCP). This is the main person you will see for most of your health care. This includes checkups, treatment for colds and flu, health concerns and health screenings. Your PCP can find and treat health problems early. He or she will have your medical records. Your PCP can see your whole health care picture. Your PCP keeps track of all of the care you get.

There are different types of doctors who are PCPs, like:

- General Practitioners
- Family Physicians
- Pediatricians
- Gynecologists/Obstetricians
- Internists

You must choose a PCP for each insured member in your family. Your family members can have different PCPs.

If you are a woman over age 12, you can also choose a gynecologist to be your PCP. If you are pregnant, your PCP could be your obstetrician during your pregnancy. When your pregnancy ends you will go back to your regular doctor, but your gynecologist will still take care of your gynecological needs. You may choose a pediatrician or a family physician for your newborn or one will be chosen for you.

To choose your PCP, call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired). If you do not choose one, then one will be chosen for you.

A Primary Medical Group is a group of doctors that help arrange your health care services and work with your Insurer to make sure you get the care you need. Your ID card shows the name of your PCP and your Primary Medical Group number.

## HOW CAN I SEE MY PCP?

If you need an appointment, call your PCP. It is free to make appointments with them. It is important that you keep your appointments with your PCP. If you cannot make it for any reason, call the PCP's office right away to let them know.

If your PCP is new for you, you should get to know him/her. Call to get an appointment as soon as you can. This is even more important if you've been getting care or

treatment from a different doctor. We want to make sure that you keep getting the care you need. If you feel OK, you should call to get a checkup with your PCP.

**Preferential Turns:** The policy of requiring Network Providers to give priority in treating Enrollees from the island municipalities of Vieques and Culebra, so that they may be seen by a Provider within a reasonable time after arriving at the Provider's office. This priority treatment is necessary because of the remote locations of these municipalities, and the greater travel time required for their residents to seek medical attention.

Before you go to your first appointment:

1. Ask your past doctor to give you your medical records. This will not cost you anything. Bring your medical records to your new PCP at your first visit. They will help your new PCP learn about your health.
2. Call your PCP to schedule your appointment.
3. Have your ID card ready when you call.
4. Say you are a **Vital Plan** member and give them your ID number.
5. Write down your appointment date and time. If you're a new patient, the provider may ask you to come early. Write down the time they ask you to be there.
6. Make a list of questions you want to ask your doctor. List any health problems you have.
7. If you need a ride to the appointment and have no other way to get there, call your Insurer or your local Municipality. They can help you get a ride.

On the day of your appointment:

1. Bring a list of all your medicines and your questions with you so your doctor will know how to help you.
2. Be on time for your visit. If you cannot keep your appointment, call your PCP to get a new time.
3. Take your ID card with you. Your PCP may make a copy of it.

## WHAT IF IT'S AN EMERGENCY AND I NEED CARE AFTER MY PCP'S OFFICE CLOSES?

Most PCPs have regular office hours. Your Insurer's Provider Directory will tell you when your doctors' offices are open. Most Primary Medical Groups also have clinics that are open late. But, you can call your Insurer service line anytime.

You can get emergency health care any time you need it. Always carry your ID card with you. In case of an emergency, doctors will know you have **Vital Plan**. If you call your Insurer's Medical Advice Service Line before you go to the emergency room, you

will not have to pay when you go to the emergency room.
Your Insurer's Medical Advice Service Line number is 1-844-337-3332 (toll free) or TTY 787-522-3633 (for the hearing impaired).

Emergencies are times when there could be serious danger or damage to your health if you don't get medical care right away.

**Emergencies might be things like:**

- Shortness of breath, not able to talk
- A bad cut, broken bone, or a burn
- Bleeding that cannot be stopped
- Strong chest pain that does not go away
- Strong stomach pain that doesn't stop
- Seizures that cause someone to pass out
- Not able to move your legs or arms
- A person who will not wake up
- Drug overdose

**These are usually not emergencies:**

- Sore throat
- Cold or flu
- Lower back pain
- Earache
- Stomachache
- Small, superficial, cuts
- Bruise
- Headache, unless it is very bad and like you've never had before
- Arthritis

If you think you have an emergency, go to the nearest hospital Emergency Room (ER). If you can't get to the ER, call 911.

**If you need emergency care, you don't have to get an OK from anyone before you get emergency care.**

If you are not sure if it's an emergency, call your PCP. You can call your Insurer's Medical Advice Service Line at any time. Your PCP can help you get emergency care if you need it.

You can also call **Vital Plan** call center for advice. Their phone number is on the back of your ID card. You can call 24 hours a day, 7 days a week.

Additional Information, including the Provider Guidelines and Information on the structure and operations of the GHP and Physician Incentive Plans, shall be made available to Enrollees and Potential Enrollees upon request

## CAN I CHANGE MY PCP?

Yes, you can change your PCP. There are many reasons why you may need to change your PCP. For example, you may want to see one whose office is closer to you. To change your PCP:

1. Find a new PCP in your Insurer's Provider Directory.
2. Call the new PCP to make sure that they are in your Insurer's network. Be sure to ask if they are taking new patients.
3. If the new PCP is in your Insurer's network and taking new patients, call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired). and tell them you want to change your PCP. You can also make the change by visiting your Insurer's Service Center.

You can also change to a new Primary Medical Group if the PCP you want to see is in a different Primary Medical Group.

Most of the time, after the first 90 days of signing up with your Insurer, you can change your Primary Medical Group at any time for some reasons, like if:

- Your PCP can't give you the care or treatment you need because of ethical (moral) or religious reasons.
- Your PCP can't give you all the services you need at the same time, and not getting services at the same time is risky for your health.
- You get bad quality care.
- You can't access the services you need.
- Your PCP doesn't have experience to take care of your health care needs.

For orientation and to make the change, call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired).

Another reason why your PCP or Primary Medical Group could change is if your PCP or Primary Medical Group stops working with your Insurer. If this happens, your Insurer will send you a letter letting you know your new PCP or Primary Medical Group. If you want to change your PCP or Primary Medical Group, call your Insurer at 1-844-336-3331 (toll free) or 787-999-4411 (TTY).

## WHAT HAPPENS AFTER I ASK FOR THE CHANGE?

Once you make the change with your Insurer, it will take some time for the change to be effective. If you make the change in the first 5 days of a month, it will be effective in the next month. For example, if you make the change on January 5, it will be effective on February 1. But if you make the change after the first 5 days of the month, it will be effective the month after next. For example, if you make the change on January 6, it will be effective March 1.

You should keep seeing your old PCP until the change is effective. You cannot start seeing your new PCP until the effective date.

## WHAT ABOUT OTHER DOCTORS OR PROVIDERS I NEED TO SEE?

Besides your PCP, you may also need to see other doctors and health care providers, like specialists. A specialist is a doctor who gives care for a certain illness or part of the body. One kind of specialist is a cardiologist, who is a heart doctor. Another kind of specialist is an oncologist, who treats cancer. There are many kinds of specialists.

Besides specialists, you may also need to go to other healthcare professionals and healthcare facilities to get care, like laboratories, x-ray facilities, or hospitals. The doctors, other health care professionals and service facilities that work with your Insurer and your Primary Medical Group are called the Preferred Provider Network.

The other doctors, other health care professionals and service facilities that work with your Insurer are called the General Network. When you sign up with your Insurer, they will mail you a Provider Directory for the Preferred Provider Network and the General Network. These lists are also on your Insurer's website at www.multihealth-vital.com Your Primary Medical Group and your Insurer's Service Centers also have a copy of the lists.

For more information about how **Vital Plan** works if you have Medicare, look at Part 8 of this guide.

**Preferred Provider Network**

The doctors, other health care professionals and services facilities who work with your Primary Medical Group are called the Preferred Provider Network.

There are benefits to seeing the doctors, other health care professionals and service facilities in the Preferred Provider Network:

- You can visit any of the doctors and service facilities in the Preferred Provider Network for free.
- If you visit the doctors, healthcare professionals and service facilities in your Preferred Provider Network, you don't need to go to your PCP first to get a referral.
- If you get any of the following services within the Preferred Provider Network, you don't need your PCP to sign off:
  - Prescription medicine
  - Laboratory tests
  - X-rays

To get more information about your Preferred Provider Network, you can:

1. Call your Insurer at 1-844-336-333 (toll free), TTY 787-999-4411 (for the hearing impaired).
2. Call **Vital Plan** call center at 1-800-981-2737.
3. Go to your Insurer's Service Centers.
4. Call your Primary Medical Group.

### General Network

The general network is the health care professionals and services facilities that work with your Insurer and that support the Primary Medical Groups. If the doctor or provider you need to see isn't in your Preferred Provider Network, they might be in your Insurer's General Network. You can see any doctor or provider in your Insurer's General Network as long as you go to your PCP first to get a referral. If you need a referral, your PCP must give you one during your visit or within 24 hours after you ask for one.

Your PCP will coordinate your visits to doctors or providers in the General Network.

You might need to pay money for these visits. Look at Part 4 of this guide for more information about payments.

If you get any of the following by a provider in the General Network, your PCP will have to sign off:

- Prescription medicine
- Laboratory tests
- X-rays

### Out-of-Network

A doctor or other provider who does not work with your Insurer is called an Out-of-Network provider. If you need to see a doctor or other provider who is out-of-network, your PCP must get an OK from your Insurer first. This OK is called a prior authorization. Your Insurer must give the prior authorization within 72 hours of getting the request. If you need the prior authorization faster because of your health care needs, your Insurer must give the prior authorization within 24 hours.

If you need services from an out-of-network community health clinic, you will first need a referral from your PCP. You can get care at an out-of-network community health clinic for free.

**If you feel that your Insurer or your doctors are not following these rules, you can call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing**

**impaired) and tell them that you need to make a complaint. You can also call the Patient Advocate Office at 1-800-981-0031 or ASES at 1-800-981-2737.**

## HELP WITH GETTING TO YOUR HEALTH CARE VISITS

If you don't have a way to get to your health care visits, your Insurer and your Municipality can help with transportation. Each Municipality has some ways to help you get to your visits. Call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired) or call your local Municipality for help.

Your Insurer and some providers also offer transportation for some members through care management. If you need the help of a care manager and you do not have one, call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired) Part 5 of this guide has more information on care management.

# PART 3: SERVICES VITAL PLAN PAYS FOR

## GENERAL INFORMATION

**Vital Plan** offers services to keep you healthy. **Vital Plan** works with Insurers, who coordinate with you and your doctors to help you access services you need.

You can start getting services as soon as your Medicaid Office tells that you are eligible for the Government Health Program. You don't have to wait.

As a **Vital Plan** enrollee, you have a variety of health care benefits and services available to you. Not everyone in **Vital Plan** has the same benefits. The benefits that are covered for you depend on the group you're in. Your ID card will tell you what coverage you can get.

Listed below are the services that **Vital Plan** covers. Some services may have limits. Call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired) if you want more information.

- Routine doctor office visits, checkups, and sick visits
- Well-baby visits, well-child visits, and immunizations
- Tests and studies, laboratory work, and X-rays
- Preventive services, including mammogram, colonoscopy, and well visits for adults
- OB/GYN exams and annual Pap tests
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including periodic preventive health screenings and other necessary diagnostic and treatment services for members ages 20 and under
- Nutritional evaluations and tests
- Vision and hearing test
- Prenatal and postpartum care
- Family planning
- Health certificates
- Dental services
- Physical therapy
- Occupational therapy
- Speech therapy
- Physician home visits

- Pharmacy
- Care management and care coordination services
- Emergency services
- Post-stabilization services
- Mental health services
- Visits to specialists
- Community health clinic services
- Hospital: inpatient and/or outpatient care
- Mental health hospitalization and partial hospitalization
- Ambulatory service center services
- Surgery: inpatient and/or outpatient
- Ambulance services
- Outpatient rehabilitation services
- Syringes for the administration of medicines at home
- Health Certificate covered by **Vital Plan**, any other certificate is excluded
- Health Certificate that includes diagnosis of sexually transmitted diseases (VDRL) and Tuberculosis. The Puerto Rico Department of Health charges a nominal fee up to $5.00 for the emission of the certificate. This is not a copayment for receiving services.
- Any Health Certificated related to the eligibility of the Medicaid & CHIP program (e.g. prescription history) will be provided to the beneficiary free of charge.
- Any Health Certificate required by programs such as Head Start, WIC and Child Care will be provided to the beneficiary free of charge.
- Any applicable copayment for procedures or laboratories for the emission of a Health Certificate will be the sole responsibility of the beneficiary.
- Annual Physical exam and follow up to Diabetic patients as per the treatment guide for such patients and the protocols of the Department of Health.

- The Contractor shall cover Post-Stabilization Services obtained from any Provider, regardless of whether the Provider is in the General Network or PPN, that are administered to maintain the Enrollee's stabilized condition for one (1) hour while awaiting response on a Prior Authorization request. The attending Emergency Room physician or other treating Provider shall be responsible for determining whether the Enrollee is sufficiently stabilized for transfer or discharge. That determination will be binding for the Contractor with respect to its responsibility for coverage and payment.

- For the list of hospitals and providers network consult your copy of the Provider Directory or visit our webpage at www.multihealth-vital.com

## DENTAL SERVICES

**Vital Plan** offers dental services. You can see any dentist that accepts **Vital Plan**. You can find information about participating dentists in your Insurer's Provider Directory. When you sign up with your Insurer, they will mail you a Provider Directory. The list is also on your Insurer's website at www.multiheath-vital.com Your Primary Medical Group and your Insurer's Service Centers also have a copy of the list.

For questions about your dental benefits, call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired).

## MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES

**Vital Plan** offers mental health, alcohol and substances abuse services. You do not have to see your PCP first to see a doctor or other provider for mental health, alcohol or substances abuse services. You can ask for these services whenever you feel like you need them.

**Vital Plan** wants to make it easy for you to get physical and mental health, alcohol, and substance abuse services in the same place. This is called integrated care.

Your Primary Medical Group is one place you can go to get mental health, alcohol or drug abuse services. Your Primary Medical Group must have a psychologist and/or a social worker available at least from 4 to 16 hours per week during regular business hours.

If you get mental health, alcohol or drug abuse services at another place (like a mental health clinic or a psychiatric hospital), they must have services from a PCP in the office at least part of the time to care for your physical health needs.

If you need help finding mental health, alcohol and substance abuse services, call your Insurer at 1-844-336-3331(toll free), TTY 787-999-4411 (for the hearing impaired).

## PHARMACY SERVICES

**Vital Plan** covers prescription medicines. If you need medicine, your provider will write you a prescription to take to a participating pharmacy. You can choose any pharmacy that works with your Insurer. You can find a list of participating pharmacies in your Insurer's Provider Directory. Or you can call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired).

Prescription medicines are free for children up to the age of 20 and for pregnant women for the Federal and Chip population. Other adults will need to pay for prescription drugs. The State and ELA population will pay the copayments and / or coinsurance as detailed in the Copayment & Coinsurance Table. For more information on payments for prescription medicines, look at Part 4 of this guide.

Your Covered Drugs Formulary (CDF) is the list of medicines **Vital Plan** covers. This list helps your doctor prescribe medicines for you. Brand-name and generic medicines are on the CDF. A generic version of a medicine is the first choice. If a generic version of a medicine is available, your doctor has to prescribe the generic version.

If you have a chronic condition, your doctor can write a prescription for a 90-day supply of some medicines. This way, you only have to pay for the medicine once instead of paying three times (1 payment per month).

## NON-COVERED SERVICES

Here is a general list of some services that are not covered by **Vital Plan**. You can find a full list of services that **Vital Plan** will not pay for online at www.multihealth-vital.com Or, you can call your Insurer at 1-844-336-3331(toll free), TTY 787-999-4411 (for the hearing impaired) for a full list.

Some non-covered services are:

1. Services for non-covered illnesses or trauma.
2. Services for automobile accidents covered by the Administration of Compensation for Automobile Accidents (ACAA, for its acronym in Spanish).
3. Accidents on the job that are covered by the State Insurance Fund Corporation.
4. Services covered by another insurance or entity with primary responsibility (third party liability).
5. Specialized nursing services for the comfort of the Patient when they are not medically necessary.
6. Hospitalizations for services that can be rendered on an outpatient basis.
7. Hospitalization of a Patient for diagnostic services only.
8. Expenses for services or materials for the Patient's comfort such as telephone, television, admission kits, etc.
9. Services rendered by Patient's relative (parents, children, siblings, grandparents, grandchildren, spouse, etc.).
10. Organ and tissue transplants, except skin, bone and corneal transplants.

11. Weight control Treatments (obesity or weight increase for aesthetic reasons).
12. Sports medicine, music therapy and natural medicine.
13. Cosmetic surgery to correct physical appearance defects.
14. Services, diagnostic tests ordered or provided by naturopaths, and iridologists.
15. Health Certificates except for (i) venereal disease research laboratory tests, (ii) tuberculosis tests and (iii) any certification related to the eligibility for the Medicaid program.
16. Mammoplasty or plastic reconstruction of breast for aesthetic purposes only.
17. Outpatient use of fetal monitor.
18. Services, Treatment or hospitalization as a result of induced, non-therapeutic abortions or their complications.
19. Medications delivered by a provider that does not have a pharmacy license, with the exception of medications that are traditionally administered in a doctor's office such as an injection.
20. Epidural anesthesia services.
21. Educational tests, educational services.
22. Peritoneal dialysis or hemodialysis services (Covered under the Special Coverage).
23. New or experimental procedures not approved by ASES to be included in the Basic Coverage.
24. Custody, rest and convalescence once the disease is under control or in irreversible terminal cases (hospice care for members under 21 is part of basic coverage).
25. Services covered under the Special Coverage.
26. Services received outside the territorial limit of the Commonwealth of Puerto Rico, except for emergency services for Medicaid or CHIP beneficiaries.
27. Judicial order for evaluations for legal purposes.
28. Counseling services or referrals based on moral or religious objections of the Insurer are excluded.
29. Travel expenses, even when ordered by the PCP, are excluded.
30. Eyeglasses, contact lenses and hearing aids (for members over age 21).
31. Acupuncture services.
32. Procedures for sex changes, including hospitalizations and complications.
33. Treatment for infertility and/or related to conception by artificial means including tuboplasty, vasovasectomy, and any other procedure to restore the ability to procreate.

# PART 4: WILL I HAVE TO PAY TO GET HEALTH CARE SERVICES?

Sometimes you will have to pay to get health care services. Preventive care is care that helps you stay well, like checkups, shots, pregnancy care, and childbirth. This kind of care is always free. You don't have copays for preventive care.

For other care like hospital stays or sick child visits, you may have to pay part of the cost. Copays are what you pay for each health care service you get.

Not everyone in **Vital Plan** has copays. Your ID card will tell you if you have copays and what they are. Copays depend on the type of **Vital Plan** you have. Your ID card says what type of **Vital Plan** you have.

None of your doctors or providers can refuse to give you medically necessary services because you don't pay your copays. But, your Insurer and your providers can take steps to collect any copays you owe.

You should only have to pay your copay for your care. You should not be billed for the rest of the cost of your care. If you are billed for the rest of the cost, you can appeal. Look at Part 7 of this guide to find out what to do if you get a bill for your care.

## COPAY CHARTS

Do you have to pay copays for a PCP, Specialist, ER visit, hospital stay, or other type of service? Not sure? Check the chart below, look at your ID card or call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired).

- No copayments can be charged to the Federal and CHIP population for the treatment of any Emergency Medical Condition or Psychiatric Emergency;
- No Co-Payments shall be charged for Medicaid and CHIP children under eighteen (21) years under any circumstances;
- The State and ELA population will pay the copayments and / or coinsurance as detailed in the Copayment & Coinsurance Table.
- By using **Vital Plan** Medical Consultation Line the Enrollee may avoid a Co-Payment for such services

| COPAYMENTS & COINSURANCE – efective July 1, 2016 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | | | | CHIPs | | State | | | | *ELA |
| SERVICES | 100 | 110 | 120 | 130 | 220 | 230 | 300 | 310 | 320 | 330 | 400 |
| **HOSPITAL** | | | | | | | | | | | |
| Admissions | $0 | $4 | $5 | $8 | $0 | $0 | $15 | $15 | $15 | $20 | $50 |
| Nursery | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **EMERGENCY ROOM** | | | | | | | | | | | |
| ER Room visits | $0 | $0 | $0 | $0 | $0 | $0 | $2 | $10 | $15 | $15 | $20 |
| Non Emergency services provided in ER Room (per visit ) | $0 | $4 | $5 | $8 | $0 | $0 | $20 | $20 | $25 | $30 | $20 |
| Non Emergency services provided in an independent ER Room (per visit) | $0 | $2 | $3 | $4 | $0 | $0 | $20 | $20 | $25 | $30 | $20 |
| Trauma | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **AMBULATORY VISITS** | | | | | | | | | | | |
| Primary Care Physician (PCP) | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $5 | $5 | $3 |
| Specialist | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $5 | $5 | $7 |
| Sub Specialist | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $5 | $5 | $10 |
| Pre natal Services | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **OTHER SERVICES** | | | | | | | | | | | |
| High-Tech Labs** | $0 | 50¢ | $1 | $1.50 | $0 | $0 | $2 | $2 | $5 | $5 | 20% |
| Clínical Labs | $0 | 50¢ | $1 | $1.50 | $0 | $0 | $2 | $2 | $5 | $5 | 20% |
| X Rays** | $0 | 50¢ | $1 | $1.50 | $0 | $0 | $2 | $2 | $5 | $5 | 20% |
| Special Diagnostic Tests | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $5 | $5 | 40% |
| Physical Therapy | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $5 | $5 | $5 |
| Respiratory Therapy | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $5 | $5 | $5 |
| Occupational Therapy | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $5 | $5 | $5 |
| Vaccines | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Well Baby Care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **DENTAL** | | | | | | | | | | | |
| Preventive (Children) | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Preventive (Adults) | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $3 | $5 | $3 |
| Restaurative | $0 | $1 | $1.50 | $2 | $0 | $0 | $2 | $2 | $5 | $6 | $10 |
| **PHARMACY *** ** | | | | | | | | | | | |
| Preferred (Children 0-21) | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $5 |
| Preferred (Adults)**** | $0 | $1 | $2 | $3 | N/A | N/A | $3 | $3 | $5 | $5 | $5 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Non-Preferred (Children 0-21) | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $10 |
| Non-Preferred (Adult) **** | $0 | $3 | $4 | $6 | N/A | N/A | $8 | $8 | $10 | $10 | $10 |

* Copays apply to diagnostic tests only. Copays do not apply to tests required as part of a preventive service.
** Copays apply to each medicine included in the same prescription pad.

# PART 5: SPECIAL PROGRAMS

## SPECIAL COVERAGE

Enrollees with special health care needs can get Special Coverage that will provide services for the care they need. The special health care needs are:

1. Aplastic Anemia
2. Rheumatoid Arthritis
3. Autism
4. Cancer
5. Skin Cancer such as Invasive Melanoma or squamous cells with evidence of metastasis.
6. Skin Cancer - Carcinoma IN SITU
7. Chronic Renal Disease (Levels 3-5)
8. Scleroderma
9. Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS)
10. Cystic Fibrosis
11. Hemophilia
12. Leprosy
13. Systemic Lupus Erythematosus(SLE)
14. Children with Special Health Needs
15. Obstetric
16. Tuberculosis (Tb)
17. HIV/AIDS
18. Adults with phenylketonuria (PKU)
19. Pulmonary Hypertension

Your PCP or your Primary Medical Group can give you more information on which people qualify for the special coverage. If you qualify for Special Coverage, they can also help you sign up for it.

People with Special Coverage can choose any provider that works with your Preferred Provider Network or your Insurer's General Network. People with Special Coverage can get prescription medications, tests and other services through the Special Coverage without a referral or needing their PCP to sign off.

Your Insurer will let you know if you are qualified and will, if you are,

make sure that you get access to the services. **Vital Plan** Special Coverage will begin when the enrollee reaches the limits of the Special Coverage for any other health plan.

The benefits under Special Coverage include the list below. Some services may have limits. Contact your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired) if you want more information.

- Coronary disease services and intensive care
- Maxillary surgery
- Neurosurgical and cardiovascular procedures
- Peritoneal dialysis and related services
- Clinical services and laboratory tests
- Neonatal intensive care unit services
- Chemotherapy, radiology and related services
- Gastrointestinal conditions, allergies and nutritional evaluation for autistic patients
- Procedures and diagnostic tests, when medically necessary
- Physical therapy
- General Anesthesia
- Hyperbaric chamber
- Immunosuppressive medicines and laboratory tests for patients who have received transplants
- Treatment for specific conditions after diagnosis:
  - ✓ Positive HIV Factor and Acquired Immunodeficiency Syndrome (AIDS) – Ambulatory and hospitalization services are included. You do not need a Referral or Prior-Authorization from your Insurer or your PCP for visits and treatment at the Immunology Regional Clinics of the Health Department;
  - ✓ Tuberculosis;
  - ✓ Leprosy;
  - ✓ Lupus;
  - ✓ Cystic fibrosis;
  - ✓ Cancer;
  - ✓ Hemophilia;
  - ✓ Aplastics Anemia;
  - ✓ Reumatoid Artritis ;
  - ✓ Autism;
  - ✓ OBG Obstetricians;
  - ✓ Post Organ Transplantation; and

- ✓ Children with special needs. Except:
  - Asthma and diabetes
  - Psychiatric disorders, and
  - Catastrophic diseases for persons with Intellectual disabilities
- Scleroderma
- Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS)
- Services for the Treatment of conditions resulting from self-inflicted damage or as a result of a felony committed by a beneficiary or negligence.
- Chronic renal disease
- Medications required for the ambulatory Treatment of Tuberculosis and Leprosy

## SPECIAL COVERAGE FOR HIV-AIDS

If you have HIV or AIDS, your PCP must ask your Insurer to give you Special Coverage. Once your Insurer adds you to Special Coverage, they will mail you a letter letting you know that you can get services under Special Coverage. The letter will let you know when the Special Coverage starts and when it will stop.

Once you have the letter, you can get all services and treatments for your condition like prescription medicines, laboratory tests, x-rays and other services without your PCP needing to sign off.

You must get your prescription medicines for HIV/AIDS at the Department of Health's Centers for Prevention and Treatment of Communicable Diseases. Here they are:

### Centers for the Prevention and Treatment of Communicable Diseases (CPTET, for its acronym in Spanish)

| *REGION* | *TELEPHONE/FAX* | *ADDRESS* |
|---|---|---|
| **ARECIBO** | **(787) 878-7895**<br>**Fax. (787) 881-5773**<br>**Fax. (787) 878-8288**<br>**Tel. (787) 879-3168** | **Antiguo Hosp. Distrito (Dr Cayetano Coll y Toste)**<br>**Carretera 129 hacia Lares**<br>**Arecibo, PR 00614**<br><br>**PO Box 140370**<br>**Arecibo, PR 00614** |
| **BAYAMON** | **(787) 787-5151**<br>**Ext. 2224, 2475**<br>**(787) 787-5154** | **Antigua Casa de Salud**<br>**Hosp. Regional Bayamón**<br>**Dr. Ramón Ruíz Arnau,** |

| | | |
|---|---|---|
| | Fax. (787) 778-1209<br>(787) 787-4211 | Ave. Laurel Santa Juanita<br>Bayamón, PR 00956 |
| CAGUAS<br><br>CLINICA SATELITE<br><br>HUMACAO | (787) 653-0550<br>Ext. 1142, 1150<br>Fax (787) 746-2898; 744-8645<br><br>(787) 285-5660 | Hosp. San Juan Bautista<br>PO Box 8548<br>Caguas, PR 00726-8548<br><br>CDT de Humacao, Dr. Jorge Franceshi<br>Calle Sergio Peña Almodovar Esq. Flor Gerena<br>Humacao, Puerto Rico 00791 |
| CAROLINA | (787)757-1800<br>Ext. 454, 459<br>Fax (787)765-5105 | Hospital UPR Dr. Federico Trilla<br>P. O. Box 6021<br>Carolina, PR 00984-6021<br>Carretera 3, Km. 8.3 |
| CLETS | (787)754-8118<br>(787)754-8128<br>(787)754-8127 | P. O. Box 70184<br>San Juan, PR 00936-8523<br><br>Calle José Celso Barbosa<br>Centro Médico de PR<br>Bo. Monacillos, San Juan |
| FAJARDO | (787)801-1992<br>(787)801-1995 | Calle San Rafael # 55<br>Fajardo, PR 00738 |
| MAYAGUEZ | (787)834-2115<br>(787)834- 2118 | Centro Médico de Mayagüez<br>Hospital Ramón Emeterio Betances<br>Carr.# 2 Suite 6<br>Mayagüez, PR 00680 |
| PONCE | (787)842-0948<br>(787)842-2000 | Departamento de Salud<br>Región Ponce<br>Antiguo Hosp. Distrito Ponce<br>Dr. José Gándara<br>Carretara Estatal 14<br>Bo. Machuelo<br>Ponce, PR 00731 |
| CENTRAL<br><br>OFFICE | (787)765-2929<br>Ext. 4026, 4027<br>Fax (787)274-5523 | P.O. Box 70184<br>San Juan, PR 00936<br><br>Ant. Hosp. Psiquiatría<br>Pabellón 1, primer piso, 4ta. Puerta - Terrenos de Centro Médico, Río Piedras |

## CARE MANAGEMENT

Some people with high needs and special conditions can receive Care Management. If you are eligible for Care Management, nurses, social workers and nutritionists are available to help you create a plan for your care. Your team will review your care plan with you at least once a year, if your health needs change, or if you ask for a review.

You can ask for help through this program by calling your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired). Your doctor, your family, your hospital can also ask for you.

For more information call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired).

## HIGH COST HIGH NEEDS PROGRAM

If you have certain conditions, you may benefit from your Insurer's High Cost High Needs program to help you get all the care you need. This program is free.

If your PCP tells you that you have:

- Cancer
- End-Stage Renal Disease (ESRD)
- Multiple Sclerosis
- Rheumatoid Arthritis
- Diabetes
- Asthma
- Severe Heart Failure
- Hypertension
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Substance Use Disorders
- Serious Mental Illness (SMI)
- Hemophilia
- Autism

Your Insurer will offer you extra help with getting care. Your Insurer may want to send someone to your home to talk to you about your needs and learn which, doctors, tests or other help is needed. Talking to the Insurer about your needs will help them understand the best ways to help you.

MMM MH's Care Management Program facilitates that certain HCHN Enrollees with medically and socially complex health care needs will be managed by specialized multidisciplinary clinics. These specialized and multidisciplinary clinics are designed to provide integrated support for HCHN enrollees with multiple complex conditions; including social and psychological. Through a collaborative team approach, a multidisciplinary team will provide guidance, support and treatment for Enrollees within the framework of these clinics. Identified enrollees will have comprehensive multi-needs assessment performed which will result in an Individualized Care Plan (ICP). Team collaborators may include Physicians, Services Coordinator, Nurses, Social Worker, Health Educator, Nutritionist, Pharm D, embedded Case Managers, Chronic Care Specialties, and a Mental Health Liaison as identified in the ICP.

Enrollees with High Cost High Needs are those who have long-term or complicated physical, mental, emotional, behavioral or developmental disorders. Such Enrollees may need health and related services beyond those needed by the general population and require ongoing treatment and or monitoring. Initial identification of High Cost High Needs Enrollees will be completed by ASES. In addition, screening tools and guidelines will be used to identify Enrollees as soon as possible after becoming a MMM MH Enrollee. Enrollees may be also be identified through their Primary Care Physician, Treating Specialists or by your Insurer.

If you are identified as a High Cost High Need Enrollee, you will be assigned to a Case Manager. He or she will be your partner in helping you get the health care you need, subject to the **Vital Plan** coverage, exclusions and limitations. Your Case Manager will contact you by phone to complete an assessment and develop and individual care plan in collaboration with your doctors. This plan will be based on your identified medical and behavioral health care needs. Based on your risk level and needs, you may be enrolled in Care Management, Complex Case Management or Intensive Case Management. With the help of your Primary Care Physician, you (or your Caregiver) and your Case Manager will establish goals to help improve your overall health and well-being with specific interventions to help you meet those goals and objectives.

Your Care Manager will:
-Work with you and your providers to prepare a Care Plan
-Help schedule appointments with your PCP, specialists, and other providers, when needed
-Help you to understand your conditions and how to manage them.
-Connect you to resources in the community that can help you.
- Help you understand your current treatment as well as treatment options

You may also receive Case Manager home visits to further identify your needs and/or provide information and education.

As a participant in a program, your Care Plan will be evaluated regularly, but no less than yearly, to determine your progress. The plan will also be modified when immediate needs are identified. When you accomplish your care plan goals and objectives are met, you may be discharged or referred to a lower level of case or care management, as needed.

**Prenatal Program**

MMM Multihealth has developed the OB Registry and Prenatal Program for enrollees who are pregnant. As part of this program, Enrollees are oriented on how they can access the services designed for expecting mothers, with particular focus on needs assessments, the establishment of treatment plans with specific treatment objectives, coordination of care with OBGYN specialists and other subspecialists, communication and monitoring.

The goal of the Prenatal Program is to support Enrollee's appropriate care choices, provide advice on better self-management practices, and encourage positive health behaviors and adherence to care standards including regular physician visits, disease-appropriate testing, and medication adherence. It also allows Enrollees to access appropriate level of care, including referrals, based on results from an individualized assessment, medical recommendations and the establishment of a care plan. To facilitate the latter process, MMM MH has established a Prenatal Program Team which is in charge of the following:

- Assess enrollees' risk factors
- Develop treatment plans with care objectives; including OBGYNs and subspecialists
- Provide the necessary support to assist Enrollees meet their health care needs during pregnancy
- Follow progress on expected outcomes, coordination and referrals to the appropriate level of care as needed
- Monitor and revise the tailored care plan to identify needs for the expecting Enrollee.

**Ensure healthy outcomes for the mother and the infant.**

Wellness Program

Wellness and prevention are fundamental parts of MMM Multi Health approach to coordinated and integrated health care, especially after considering the impact of chronic health conditions in Puerto Rico. MMM Multi Health has developed services based on prevention and wellness principles. These wellness services allow Enrollees to have access to the following:

- Annual health checkups
- Women's health and screening
- Healthy body weight, through good nutrition and exercise
- Annual dental exam
- Appropriate use of the **Vital Plan** Program, including Service Line
- Medical and developmental need for children and adolescents
- Immunizations
- Behavioral health screening, services and management (depression, schizophrenia, bipolar disorder, ADD & ADHD, substance abuse, anxiety disorders)

The benefits of the aforementioned wellness approach are well known for enrollees, especially within the new model of services: improved clinical outcomes, better utilization of resources, and increased satisfaction. Wellness activities and events are developed according to age group, gender, social and the health needs of Enrollees, in accordance ASES. It seeks to provide education and easy to understand information to improve the health of Enrollees in **Vital Plan**.

Scope

- On a monthly basis the MMM Multi Health, LLC Wellness team will provide seminars, workshops, educational sessions and face to face interventions on health and wellness subject and risk behaviors that affect our eligible MMM Multi Health, LLC beneficiaries in traditional and nontraditional setting that includes

health care facilities, schools, and community (private and public) settings. Each setting provides opportunities to reach people using existing social structures. Using nontraditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

# PART 6: FOR YOUR PROTECTION

## YOUR RIGHTS

You have the right to:

- Be treated with respect and in a dignified way.
- Get written information from your Insurer in English and Spanish and translated into any other language. You also have the right to get written information in an alternative format. Afterwards, you have the right to get all future written information in that same format or language, unless you tell your Insurer otherwise.
- Get information about your Insurer, health care facilities, health care professionals, health services covered, and how to access services.
- Choose a Primary Medical Group, your PCP, and other doctors and providers within your Preferred Provider Network.
- Choose a dentist and a pharmacy among your Insurer's network.
- Contact your doctors when you want to and in private
- Get medically necessary care that is right for you, when you need it. This includes getting emergency services, 24 hours a day, 7 days a week.
- Be told in an easy-to-understand way about your care and all of the different kinds of treatment that could work for you, no matter what they cost or even if they aren't covered.
- Help to make decisions about your health care. You can turn down care.
- Ask for a second opinion for a diagnosis or treatment plan.
- Make an Advanced Directive. Look at Part 6 of this guide for more information.
- Get care without fear of physical restraint or seclusion used for bullying, discipline, convenience or revenge.
- Ask for and get information about your medical records as the federal and state laws say. You can see your medical records, get copies of your medical records, and ask to correct your medical records if they are wrong.
- File a complaint or an appeal about your Insurer or your care. Look at Part 6 of this guide for more information. The complaint can be filed in your Insurer's office or in the Patience Advocate office.
- Get services without being treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability. You have a right to file a complaint if you think you have been treated unfairly. If you complain or appeal, you have the right to keep getting care without fear of bad treatment from your Insurer, providers, or **Vital Plan**.

- Choose an Authorized Representative to be involved in making decisions.
- Provide informed consent.
- Only have to pay the amounts for services listed in Part 4 of this guide. You can't be charged more than those amounts.
- Be free from harassment by your Insurer or its Network Providers with respect to contractual disputes between the Insurer and its Providers;

## YOUR RIGHT TO PRIVACY (HIPAA)

Your health information is private and confidential. The law says that ASES and your Insurer must protect the privacy of your protected health information. ASES and your Insurer can share your protected health information for your care, to pay your health claims, and to run the program. But we can't share your protected health information with others unless you tell us we can or as permitted by law. The Insurer publicizes provisions governing the confidential nature of the information about you, the legal sanctions imposed for the improper use and disclosure of your information and provides copies of these provisions to you and to other persons and/or agencies to whom your information is disclosed (42 CFR 431.304).

If you want to know more about what information we have, how and to whom we can share it, what are your rights and our legal obligations with respect to your protected health information, call your Insurer for more information. Also, you can visit Insurer website to obtain Insurer Notice of Privacy Practices that describes how your health information about you may be used and disclosed and how you can get access to your information.

## YOUR RESPONSIBILITIES

You have the responsibility to:

- Understand the information in your guide and other papers that your Insurer sends you.
- Give your doctor your health records and let them know about any changes in your health so that they can take care of you.
- Follow your doctor's instructions. If you can't follow your doctor's instructions, let them know.
- Let your doctor know if you don't understand something.
- Help to make decisions about your health care.
- Communicate your Advance Directive so your doctors know how you want to be treated if you are too sick to say so.
- Treat your health care provider and your Insurer's staff with respect and dignity.

- Let your Insurer know if you have another insurance company that should pay your medical care.
- Let ASES know if you find out about a case of fraud and abuse in **Vital Plan**.

## ADVANCE DIRECTIVES

Advance Directives are your written wishes about what you want to happen, if you get too sick to be able to say. The written document that states your Advance Directives is called a living will. You can use either word: advance directive or living will.

Your doctor can give you information on how to make an Advance Directive. If you are in the hospital, the hospital staff can also give you information on Advance Directives. You can also call the Senior Citizens Advocate Office at 787-721-6121. They have free information about Advanced Directives.

A Durable Power of Attorney is a paper that lets you name another person to make medical decisions for you. This person can only make decisions if you are too sick to make your own. He or she can say your wishes for you if you can't speak for yourself. Your illness can be temporary.

You do not have to fill out these papers for an Advance Directive or Durable Power of Attorney. It is your choice. You may want to talk to a lawyer or friend before you fill out these papers.

To make all of these papers legal, you need to have a lawyer watch you sign the form. Instead of a lawyer, you could also have your doctor plus two additional witnesses watch you sign the form. The two additional witnesses have to be of legal age and they can't be related to you by blood or marriage.

Once the papers are signed by everyone, it is your rule about what you want to happen to you if you get too sick to be able to say. It stays like this unless you change your mind.

These papers will only be used if you get too sick to be able to say what you want to happen. As long as you can still think for yourself, you can decide about your health care yourself.

Give a copy of the papers to your PCP and to your family members so they know what you want to happen to you if you are too sick to say.

If you feel that your Insurer or your doctors aren't complying with your wishes, or if you have any complaints, you have the right to call the **Vital Plan** call center at 1-800-981-2737 or the Puerto Rico Patient Advocate Office at 1-800-981-0031. The phone call is free.

## FRAUD AND ABUSE

Unfortunately, there could be a time when you see fraud or abuse related to **Vital Plan**. Some examples are:

- A person lies about facts to get or keep **Vital Plan** coverage
- A doctor bills you or makes you pay cash for covered services
- A person uses someone else's ID card
- A doctor bills for services that you did not get
- A person sells or gives medications to someone else

If you find out about fraud or abuse, you must tell us about it. You can call your Insurer, the Patient's Advocate Office or ASES. You do not need to tell us your name and we will keep your information private. You will not lose your **Vital Plan** coverage if you report fraud or abuse.

If you want more information, you can visit the ASES website at www.asespr.org. On the website there is a form that you can use to make your report. Your Insurer's website also has more information.

You can also help prevent fraud and abuse. Here are some things you can do:

- Don't give your ID card to anyone else.
- Learn about your **Vital Plan** benefits.
- Keep records of your doctor's visits, laboratory tests and medications. Make sure you don't get repeat services.
- Make sure your information is right on a form before you sign it.
- Request and review the quarterly summary of the services you receive. You may request the summary of services directly from your Insurer.
- Request and review the quarterly summary of the services you receive. You may request the summary of services directly from your Insurer.

  One of the laws related to Fraud, Waste and Abuse in healthcare is the False Claim Act. This law prohibits any individual or organization to knowingly submit a claim he or she knows (or should know) is false. Examples of violations of the False Claims Act are:

  - A provider who submits a bill for services that were not rendered
  - A provider that bills for a different service than the one that actually provided

The False Claims Act includes a “qui tam” or whistleblower provision. This provision essentially allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government.

Another law related to fraud, waste and abuse is the Stark Law or Self-Referral Prohibition Statute. This law prohibits physicians from referring Medicaid patients for certain health services to an entity in which the physician or the physician’s immediate family has a financial relationship. For example, a doctor can not refer a patient to a clinical laboratory of which he is the owner.

## NEED TO MAKE A COMPLAINT ABOUT YOUR CARE?

If you are not happy with the care that you are getting, call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired). Tell them that you need to make a complaint. You can also visit your Insurer's Service Centers. You can make a complaint at any time.

Your doctor, a family member, or your representative can make a complaint for you if you authorize them to do so.

You also have the right to call the Patient Advocate Office to make a complaint. Their number is 1-800-981-0031. You can also make a complaint to ASES. Their number is 1-800-981-2737.

No one can do anything bad to you if you make a complaint.

Your Insurer has 72 hours to fix your complaint. If they can't fix your complaint quickly, it will become a "grievance". In this case, your Insurer has up to 90 days to fix it, but they have to decide faster if it's important to your health. The Insurer must tell you how the complaint was fixed.

## WHAT HAPPENS IF MY COMPLAINT ISN'T FIXED?

If your Insurer does not fix your complaint, you can ask for a hearing. A hearing is where you can tell a judge about the issue.

## WHAT IS AN APPEAL?

If your doctors or your Insurer make a decision about your care that you don't agree with, you can file an appeal. When you appeal, you're asking your Insurer to take another look at a mistake you think was made.

If your Insurer denies, reduces, limits, suspends, or ends your health care services, they will send you a letter in the mail. The letter will have information like:

- What decision your Insurer made
- Why they made the decision
- How to file an appeal

If you don't agree with the decision, you can file an appeal. **You have 60 days from the date of the letter to file an appeal.** Your doctor or your representative can file the appeal for you if you authorize them to do so.

There are many ways to file an appeal. You can:

- Call your Insurer at 1-844-336-3331(toll free), TTY 787-999-4411 (for the hearing impaired)
- Visit any of your Insurer's service centers
- Mail your Insurer your appeal at MMM Multi Health, G&A DEPT, PO BOX 72010, San Juan PR 00936
- By Fax at 1-844-990-1990

By Email at AGPLANVITAL@mmmhc.com

**www.multihealth-vital.com/eng/appeals.html**

## WHAT WILL HAPPEN WHEN MY INSURER GETS THE APPEAL?

Your appeal will be reviewed by a team of experts that have not been involved with the issue of your appeal. Your Insurer will make a decision within 30 days. If you have an emergency and your Insurer agrees that you do, you can ask for an expedited or fast appeal. You, your doctor, or your representative can ask for a fast appeal by calling your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired) or visiting any of your Insurer's service centers, or writing a letter to your Insurer at MMM Multi Health, G&A DEPT, PO BOX 72010, San Juan PR 00936-7710

If your Insurer agrees to give you a fast appeal, they will decide your case within 72 hours. If your Insurer does not agree to give you a fast appeal, they will call you within 2 days to let you know they will decide your case within 30 days.

If your Insurer can't make a decision within 30 days, they can ask for up to 14 more days. If they ask for more time, they have to let you know why. If you do not agree to give your Insurer more time, you can file a complaint.

ASES may choose to make available to Providers any appeals rights to challenge the failure of your insurer to cover a service.

Once your Insurer makes a decision, they will send you a letter within 2 business days. The letter will tell you what they decided and that you have the right to ask for a hearing if you do not agree with the decision.

## WHAT CAN I DO IF I DON'T AGREE WITH THE DECISION?

If you are not happy with your Insurer's decision about a complaint or an appeal, you can ask for a hearing. A hearing is where you can tell an Official Examiner about the mistake you think your Insurer made. You have 120 days from the date of your Insurer's decision to ask for an Administrative Hearing with ASES.

You can get more information about hearings or request a hearing by:

| | |
|---|---|
| Calling the **Vital Plan** call center at: | 1-800-981-2737 |
| Writing ASES at: | ASES<br>PO Box 195661<br>San Juan, PR 00919-5661 |
| Sending ASES a fax to: | 787-474-3347 |

Before the hearing, you and your representative can ask to look at the papers and records that your Insurer will use. Your Insurer must give you access to those papers and records for free.

During the hearing, you can give facts and proof about your health and medical care. An Official Examiner will listen to everyone's side. At the hearing, you can talk for yourself or you can bring someone else to talk for you like a friend or a lawyer.

The Official Examiner will decide your case within 90 days. If you need a fast decision, the Official Examiner will decide your case within 72 hours.

If you do not agree with the Official Examiner's decision, you can file an appeal with the Court of Appeals of Puerto Rico. More information about how to file an appeal will be in the papers you get after the hearing.

## CAN I KEEP GETTING SERVICES DURING MY APPEAL OR HEARING?

If you are already getting services, you may be able to keep getting services during your appeal or hearing. To keep getting services, all of these things must be true:

- You file the appeal within 60 days of the date on the letter from your Insurer.
- You ask to keep getting services by the date your care will stop or change or within 10 days of the date on the letter from your Insurer (whichever date is later).

- You say in your appeal that you want to keep getting services during the appeal.
- The appeal is for the kind and amount of care you've been getting that has been stopped or changed.
- You have a doctor's order for the services (if one is needed).
- The services are something that **Vital Plan** still covers.

If you keep getting services during your appeal or hearing and you lose, you might have to pay your Insurer back for the services you got during the appeal or hearing process.

To ask to keep getting services during your appeal or hearing, call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired).

# PART 8: HOW VITAL PLAN WORKS WITH OTHER HEALTH INSURANCE

## HOW VITAL PLAN WORKS WITH MEDICARE

If you have Medicare, your **Vital Plan** coverage works in a different way. Medicare is health insurance for people who are age 65 and older, and for some people of any age who Social Security says are disabled. People with end stage renal disease can have Medicare too.

These are the different parts of Medicare:

- **Part A** is for hospital stays, skilled nursing facility care, home health care, and hospice care.
- **Part B** is for your doctor's services and outpatient care.
- **Part D** is for prescription medicines.

There are also other ways to have Medicare. These are called Medicare Health Plans (these plans are sometimes called Medicare Part C). These plans put all of the parts A, B, and D together for you in one plan.

To learn more about Medicare, call them at 1-800-633-4227. It's a free call.

If you have Medicare, your **Vital Plan** coverage works differently:

- Your Medicare is your first (primary) insurance. Hospitals, doctors and other health care providers will bill Medicare first.
- Your **Vital Plan** is your second (secondary) insurance. After your providers bill Medicare, they will also bill **Vital Plan**.

If you have Medicare Part A:

- **Vital Plan** will pay once you have reached the limit of what Medicare pays for.
- **Vital Plan** will not pay for your Part A deductibles.
- You will pay a copay for services depending on what type of **Vital Plan** you have. See the copay chart on page 25 for more information.

If you have Medicare Part A and Part B:

- **Vital Plan** will pay for your pharmacy and dental services.
- **Vital Plan** will not pay for your Part A deductibles.
- **Vital Plan** will pay for your Part B Deductibles and Copayments.

If you have Medicare Part C:

- You have the option to choose a Platino plan, which will cover services your Medicare health plan doesn't cover.

## HOW VITAL PLAN WORKS WITH OTHER INSURANCE

If you have other health insurance, your other insurance is your first (primary) insurance. Hospitals, doctors and other health care providers will bill your other insurance first. Your **Vital Plan** is your second (secondary) insurance. After your providers bill your other insurance, they will bill **Vital Plan**.

If you have other health insurance, you must let your Insurer and Medicaid Program know. Call your Insurer at 1-844-336-3331 (toll free), TTY 787-999-4411 (for the hearing impaired) and the Medicaid Program at 787-641-4224 to let them know.

When you go to your health care visits, bring your **Vital Plan** ID card and your ID cards for your other insurance.

## HOW VITAL PLAN WORKS IF YOU ARE A PUBLIC EMPLOYEE OR RETIREE

If you are a public employee or a retiree from the Government of Puerto Rico, you can choose **Vital Plan** as your health insurance. Your employer will pay ASES and you will pay the difference, if any.

You can also visit your local Medicaid Office to see if you are eligible for **Vital Plan** for other reasons. If you are eligible for **Vital Plan** for other reasons, you will not have to pay the difference, if any. If you and your husband (or wife) are public employees or retirees from the Government of Puerto Rico, you can apply together for **Vital Plan**. This is called "joint enrollment."

If at any time you lose eligibility for **Vital Plan**, you can sign up for **Vital Plan** in the ELA Puro group. That way, you can continue getting your **Vital Plan** benefits until you can get insurance through your job. You do not have to continue as ELA Puro. It is your choice!

If you get other health insurance from your job, you have to cancel your **Vital Plan** benefits **before** you sign up for the other health insurance. Visit your local Medicaid office to cancel your **Vital Plan** benefits. The change will be effective the first day of the next month after you cancel your benefits. If you do not cancel your benefits, you will have to pay for part of the cost of the premium for the new insurance you affiliate with.

## HOW VITAL PLAN WORKS IF YOU ARE A MEMBER OF THE POLICE DEPARTMENT OF PUERTO RICO

The members of the Police Department of Puerto Rico, their spouses and children may also enroll in **Vital Plan**. The Police Department of Puerto Rico will pay.

If you are a member of the Police Department of Puerto Rico, you must visit your local Medicaid Office to sign up for **Vital Plan**.

If a member of the Police Department of Puerto Rico dies, his/her widow can continue to get **Vital Plan** benefits until he/she remarries. Children can continue to get **Vital Plan** benefits up to the age of 26.

# DEFINITIONS

**Appeal:** A request from the enrollee for the review of a decision. It is a formal request made by the enrollee, his authorized representative or provider, acting on behalf of the enrollee with the consent of the enrollee, to reconsider a decision in the case that the provider does not agree.

**Authorization:** A written document through which a person freely and voluntarily authorizes another person or provider to represent, him/her for medical or treatment purposes or to initiate an action such as a grievance. It may also be used to end a previous authorization.

**Benefits:** The health care services covered under **Vital Plan**.

**CHIP:** *Children Health Insurance Program*, a federal program that provides medical services to low-income children age 21 and under, through Insurers qualified to offer coverage under this program.

**Commonwealth Population:** Individuals, regardless of age, who meet State eligibility standards established by the Puerto Rico Medicaid Program but do not qualify for Medicaid or CHIP.

**Complaint:** An expression of dissatisfaction about any issue that is not an Adverse Benefit Determination that is resolved at the point of contact.

**Coordinated Care:** Is the service provided to Enrollees by doctors who are part of the preferred network of providers in your Primary Medical Group. The PCP is the leading provider of services and is responsible to periodically evaluate your health and coordinate all medical services you need.

**Copayment**: Money you need to pay at the time of service.

**Covered Services:** Services and benefits included in **Vital Plan**.

**ELA Puro:** An option available to public employees so they can maintain medical coverage when they lose eligibility in the Medicaid Program and the enrollment for other Insurers contracted under Law 95 has ended. This coverage is the same as the coverage of **Vital Plan**.

**Emergency Medical Condition:** A medical problem so serious that you must seek care right away to avoid severe harm.

**Emergency Services:** Treatment of an emergency medical condition to keep it from getting worse.

**Enrollee:** A person who after being certified as eligible under the Medicaid program has completed the enrollment process with the Insurer and for whom the Insurer has issued the ID card that identifies the person as a **Vital Plan** Enrollee.

**Enrollment Counselor:** An individual or entity that performs choice counseling, or enrollment activities, or both.

**Grievance:** A formal claim made by the Enrollee in writing, by telephone or by visiting your Insurer or the Health Advocate Office, requesting a solution be granted when a service has been denied or allowed on a limited basis. A service; reduction, suspension or termination of a previously authorized service; total or partial denial of payment for a service; not having received services in a timely manner; when your Insurer has not acted on a situation according to the established terms, refusal of your Insurer to let the Enrollee exercise his/her right to receive services outside the network

**HIPAA (Health Insurance Portability and Accountability Act):** The law that includes regulations for establishing safe electronic health records that will protect the privacy of a person's medical information and prevent the misuse of this information.

**High Cost High Needs Program:** A specialized program of coordinated care for Enrollees with specific conditions that require additional management due to the cost or elevated needs associated with the condition.

**Hospital:** A facility that provides medical-surgical services to patients.

**Insurer**: The company contracted with ASES to provide your medical services under **Vital Plan**.

**Medical Record:** Detailed collection of data and information on the treatment and care the Patient receives from a health professional.

**Medically Necessary**: Services related to (i) the prevention, diagnosis, and Treatment of health impairments; (ii) the ability to achieve age-appropriate growth and development; or (iii) the ability to attain, maintain, or regain functional capacity. Additionally, Medically Necessary services must be:

- Appropriate and consistent with the diagnosis of the treating provider and not getting could adversely affect your medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for your convenience or the convenience of the Provider or Hospital; and
- Not primarily custodial care (for example, foster care).

In order for a service to be Medically Necessary, there must be no other effective and more conservative or substantially less costly Treatment, service, or setting available.

**Medicaid:** Program that provides health insurance for people with low or no income and limited resources, according to federal regulations.

**Primary Care Physician (PCP):** A licensed medical doctor (MD) who is a provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required primary care to Enrollees. The PCP is responsible for determining services required by Enrollees, provides continuity of care, and provides Referrals for Enrollees when Medically Necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

**Patient:** Person receiving Treatment for his mental and physical health.

**Prescription:** Original written order issued by a duly licensed health professional, ordering the dispensing of a product, or formula.

**Preferred Provider Network:** Health professionals duly licensed to practice medicine in Puerto Rico contracted by your Insurer for the Enrollee to use as the first option. Enrollees can access these providers without Referral or co-payments if they belong to their Primary Medical Group.

**Primary Medical Group:** Health professionals grouped to contract with your Insurer to provide health services under a Coordinated Care model.

**Prior-Authorization:** Permission your Insurer grants in writing to you, at the request of the PCP, Specialist or sub-specialist, to obtain a specialized service.

**Referral:** Written authorization a PCP gives to an Enrollee to receive services from a Specialist, sub-specialist or facility outside the preferred network of the Primary Medical Group.

**Specialist:** A health professional licensed to practice medicine and surgery in Puerto Rico that provides specialized medical and complementary services to the primary physicians. This category includes: cardiologists, endocrinologists, neurologists, surgeons, radiologists, psychiatrists, ophthalmologists, nephrologists, urologists, physiatrists, orthopedists, and other physicians not included in the definition of PCP.

**Second Opinion:** Additional consultation the Enrollee makes to another physician with the same medical specialty to receive or confirm that the initially recommended medical procedure is the Treatment indicated for his condition.

**Treatment:** To provide, coordinate or manage health care and related services offered by health care providers.