Puerto Rico Health Insurance Administration

Vital
Health at your reach
GOBIERNO DE PUERTO RICO

BENEFICIARY MANUAL

PSM 1979 PLAN DE SALUD MENONITA

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

Dear Enrollee:

Greetings from the Puerto Rico Health Insurance Administration (ASES by Spanish acronym).

Welcome to Vital, the Government Health (Plan, Vital). We appreciate the opportunity to manage your comprehensive health care needs.

It's important to for you know that with Plan Vital, you can choose the Insurer Company, and provider network including doctors, laboratories, therapists and other health providers. In addition, you will have access to medical and hospital services island wide.

This guide will keep you informed regarding benefit coverage and services offered by the Plan Vital, including medical, hospital, dental, mental health and pharmacy services. This manual also informs about your rights and responsibilities as a beneficiary, the grievances and appeals procedures among other interest topics. We encourage you to read carefully. Keep this manual in a safe and easily accessible place so you have the information available.

If you have trouble reading this guide, you can request it in a different format like large print, Braille (writing and reading system for people with visual impairment) or audio CD, for free to your Insurer Company.

Your Insurer can answer any questions you have about your health care, ID card, benefits and healthcare providers.

It is important for ASES to have your address, personal information up dated. If your information has changed, contact the Medicaid Program Call Center at 787-641-4224, (TTY) 787-625-6355 (Audio-impaired Service). Remember to attend eligibility appointments to keep your eligibility to the Plan Vital.

You can also contact the Call Center of the Vital Health Insurance of the Government of Puerto Rico free of charge at 1-800-981-2737, 1-833-253-7721, (TTY) 787-474-3389 (Audio-impaired services).

Today, your health is in your hands!

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WHO CAN I CALL FOR HELP?

If you are having an emergency, call 911

PSM 1979 PLAN DE SALUD MENONITA	**Beneficiary Services** Toll-free: 1-866-600-4753 TTY (hearing impaired): 1-844-726-3345 **TeleCuidado Menonita** (Medical Advice Line) Toll free: 1-844-736-3345 TTY (hearing impaired) 1-844-716-3345 **www.MenonitaVital.com**
Estado Libre Asociado de Puerto Rico Departamento de Salud	**Medicaid Program Call Center** **787-641-4224** **www.medicaid.pr.gov**
assmca Estado Libre Asociado de Puerto Rico Administración de Servicios de Salud Mental y Contra la Adicción	**ASSMCA (Linea PAS)** **Mental Health Service Line** **1-800-981-0023**
Oficina del Procurador del Paciente Gobierno de Puerto Rico	**Patient Advocate Office** **Toll-free 1-800-981-0031** **TTY 787-710-7057**
ASES ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO	**Puerto Rico Health Insurance Administration (ASES)** **VITAL** **Toll-free 1-800-981-2737** **TTY 787-474-3389** www.planvitalpr.com

WHAT INFORMATION CAN I FIND ONLINE?

For the Plan de Salud Menonita (PSM) Provider directory, orientation and education materials and an electronic copy of this guide visit our web page: www.MenonitaVital.com

For information on the Plan Vital access: http://www.planvitalpr.com
For information about Medicaid programs: www.medicaid.pr.gov/
For more information on patient protections: www.opp.pr.gov/

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 the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

DO YOU NEED HELP TALKING WITH PSM OR READING WHAT THEY SEND YOU?

This guide, and all written materials are available to you in Spanish and English. **As requested, *this document may be available in alternate formats such as large print, audio or Braille, at no cost to you.***

If you speak another language, we will coordinate to provide an interpreter free of charge to help you understand.

Call the PSM Beneficiary Service Line for this or any assistance:
1-866-600-4753 / 1-844-726-3345 TTY (hearing impaired)

PART 1: GETTING STARTED

HOW DO I SIGN UP FOR VITAL?

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

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. If you do not do this, the newborn cannot get services under VITAL. 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 BENEFITS?

To keep your VITAL 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 benefits stop. These letters will remind you that you have to go to your local Medicaid Office to maintain your eligibility in VITAL.

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, 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 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 1-833-253-7721 (toll free) or 1-888-984-0128 TTY (hearing impaired), Monday through Friday, 8 a.m. to 6 p.m.

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 45 days to change Insurers. You can also change your Insurer once a year during the “open enrollment period”, which is from November 1 to December 15, 2019.

• For change of insurer you can access : http://www.planvitalpr.com , 24 hours a day, 7 days a week or by calling the Vital call center at 1-833-253-7721 from Monday to Friday from 8:00 am at 6:00 p.m.

• If you are satisfied with your Insurer, you do not have to perform any process and will continue to receive your health services, as usual.

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 enrollment counselor at 1-833-253-7721. 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
- 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

You will not lose your membership with your Insurer if:

- You have changes in your health
- You are using more health care services

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

HOW DO I REPORT CHANGES?

VITAL 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 coverage and benefits in the mail. If they don't have your current address, you could lose your VITAL benefits. To report a change, call your Insurer or visit your local Medicaid Office.

YOUR ID CARD

Everyone in VITAL has an ID card. This is an example of the **ID Card** with **Plan de Salud Menonita (PSM):**

State Population

Federal Population (Medicaid/ CHIP)

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 Service Line and the free 24/7 VITAL 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. Our service representatives can help you. Call or the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

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 PSM a new card. You can visit the PSM Service Centers or the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (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 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 free of charge the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). If you do not choose PCP, 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.

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 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. Check the **PSM Provider Directory (**www.MenonitaVital.com**)** to see if your doctors' offices are open. Most Primary Medical Groups also have clinics that are open late. For information about your doctors' hours call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

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. If you call **TeleCuidado Menonita** (Medical Advice Service Line) before you go to the emergency room, you will not have to pay when you go to the

emergency room.

TeleCuidado Menonita (Medical Advice Line)
Toll free: 1-844-736-3345/ TTY (hearing impaired) 1-844-716-3345

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
- Arthritis
- Headache, unless it is very bad and like you've never had before

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. Remember to call PSM Medical Advice Service Line at any time: TeleCuidado Menonita 1-844-736-3345/ TTY (hearing impaired) 1-844-716-3345. Your PCP can help you get emergency care if you need it.

You can also call VITAL call center for advice: **1-800-981-2737**. The phone numbers of VITAL and TeleCuidado Menonita are on the back of your ID Card. You can call 24 hours a day, 7 days a week.

CAN I CHANGE MY PCP?

Yes, you can change your PCP at least once (1) a year. There are other 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, you must call your Insurer to corroborate whether the change may be performed. 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 and tell them you want to change your PCP. You can also make the change by visiting your Insurer's Service Center.

You could 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 the PSM Beneficiary Service Line at 1-866-600-4753 (toll free) or 1-844-726-3345 TTY (Hearing impaired). The phone call is free.

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 the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). This phone call is free of charge.

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 PSM website at www.MenonitaVital.com. Your Primary Medical Group and your Insurer's Service Centers also have a copy of the lists.
For more information about how VITAL 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 PSM Beneficiary Service Line at 1-866-600-4753 (toll free) or 1-844-726-3345 TTY (hearing impaired). The phone call is free.
2. Call VITAL call center at 1-800-981-2737
3. Go to PSM 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 the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (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 toll free or 787-474-3389 TTY . The phone calls are free.

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. You can call your Municipality.

If you need the help of a care manager to help you with transportation, and you do not have one, you can call PSM Beneficiary Service Line at 1-866-600-4753 (toll free) or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

PART 3: SERVICES VITAL PAYS FOR

GENERAL INFORMATION

VITAL offers services to keep you healthy. VITAL 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 beneficiary, you have a variety of health care benefits and services available to you. Not everyone in VITAL 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 covers. Some services may have limits. For information call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

- 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 21 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

VITAL with Plan de Salud Menonita also covers Chiropractor Services.

DENTAL SERVICES

VITAL offers dental services. You can see any dentist that accepts VITAL. You can find information about participating dentists in the PSM Provider Directory on PSM's website www.MenonitaVital.com .Your Primary Medical Group and the PSM Service Centers also have a copy of the list.

For questions about your dental benefits, call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES

VITAL 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 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 and providers, call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

PHARMACY SERVICES

VITAL 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 the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

Prescription medicines are free for children up to the age of 20 and for pregnant women that are Medicaid or CHIP beneficiaries. Other adults will need to pay for prescription drugs. For more information on payments for prescription medicines, look at Part 4 of this guide.

Your Formulary of Medications Covered (FMC) is the list of medicines VITAL covers. This list helps your doctor prescribe medicines for you. Brand-name and generic medicines are on the FMC. 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. You can find a full list of services that VITAL will not pay online at www.MenonitaVital.com. Or, you call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free. 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 uses 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 has copays. Your ID Card will tell you if you have copays and what they are. Copays depend on the type of VITAL you have. Your ID Card says what type of VITAL 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 Or, you call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

Services	CO-PAYS & COINSURANCE										
	Federal				CHIPS		Commonwealth				*ELA
	100F	110F	120F	130F	220C	230C	300E	310E	320E	330E	GPR4
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)											
Emergency Room (ER)	$0	$0	$0	$0	$0	$0	$2	$10	$15	$20	$20
Non-emergency Services Provided in a Hospital Emergency Room.(per visit)	$0	$4	$5	$8	$0	$0	$20	$20	$25	$30	$20
Non-emergency Services Provided in a Freestanding Emergency Room.(per visit)ergency	$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 TO											
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 Laboratories **	$0	50¢	$1	$1.50	$0	$0	$2	$2	$5	$5	20%
Clinical Laboratories **	$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	$6	40%
Therapy-Physical	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5
Therapy-Respiratory	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5
Therapy Occupational	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$5	$5
Vaccines	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Healthy Child Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DENTAL											
Preventive (Child)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Preventive (Adult)	$0	$1	$1.50	$2	$0	$0	$2	$2	$3	$5	$3
Restorative	$0	$1	$1.50	$2	$0	$0	$2	$2	$5	$6	$10
PHARMACY * **											
Peferred (Children 0-21)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5
Peferred (Adult) ***	$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 diagnostics 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

Beneficiaries 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
8. Scleroderma
9. Multiple Sclerosis (MS) and Amiotrophic 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 must make sure that you get access to the services. VITAL Special Coverage will begin when the beneficiary 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. For information call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

- 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
  - ✓ Children with special needs. Except:
    - Asthma and diabetes (Part of the Disease Management Program),
    - 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 Fax. (787) 881-5773 Fax. (787) 878-8288 Tel. (787) 879-3168	Antiguo Hosp. Distrito (Dr Cayetano Coll y Toste) Carretera 129 hacia Lares Arecibo, PR 00614
		PO Box 140370 Arecibo, PR 00614
BAYAMON	(787) 787-5151 Ext. 2224, 2475 (787) 787-5154 Fax. (787) 778-1209 (787) 787-4211	Antigua Casa de Salud- Hosp. Regional Bayamón Dr. Ramón Ruíz Arnau Ave. Laurel Santa Juanita Bayamón, PR 00956
CAGUAS	(787) 653-0550 Ext. 1142, 1150 Fax (787) 746-2898 (787) 744-8645	Hospital San Juan Bautista PO Box 8548 Caguas, PR 00726-8548
CLINICA SATELITE HUMACAO	(787) 285-5660	CDT de Humacao- Dr. Jorge Franceshi Calle Sergio Peña Almodóvar, Esq. Flor Gerena Humacao, Puerto Rico 00791
CAROLINA	(787)757-1800 Ext. 454, 459 Fax (787)765-5105	Hospital UPR Dr. Federico Trilla P. O. Box 6021 Carolina, PR 00984-6021/ Carretera 3, Km. 8.3
CLETS	(787)754-8118 (787)754-8128 (787)754-8127	P. O. Box 70184 San Juan, PR 00936-8523
		Calle José Celso Barbosa, Centro Médico de PR Bo. Monacillos, San Juan
FAJARDO	(787)801-1992 (787)801-1995	Calle San Rafael # 55 Fajardo, PR 00738

REGION	TELEPHONE/ FAX	ADDRESS
MAYAGEZ	(787)834-2115 (787)834- 2118	Centro Médico de Mayagüez Hospital Ramón Emeterio Betances Carr. # 2, Suite 6 Mayagüez, PR 00680
PONCE	(787)842-0948 (787)842-2000	Departamento de Salud- Región Ponce Antiguo Hosp. Distrito Ponce- Dr. José Gándara Carretara Estatal 14, Bo. Machuelo Ponce, PR 00731
CENTRAL OFFICE	(787)765-2929 Ext. 4026, 4027 Fax (787)274-5523	P.O. Box 70184 San Juan, PR 00936
		Antiguo Hospital Psiquiatría 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.

The Plan de Salud Menonita (PSM) Care Management Program (CM) facilitate access and coordination of services for all beneficiaries with high needs and special conditions. Beneficiaries with these conditions are chosen to be managed more closely by case managers.

If you are eligible for Care Management, care managers are available to do an evaluation, create and carry out a care plan for your care. Our team, Primary Care Physicians (PCP), pharmacists, social workers, and behavioral health and community professionals, will review your care plan with you at least once a year, if your health needs change, or if you ask for a review.

The PSM Care Management Program will support you with your high needs and special conditions and assist you in meeting your health goals. These services will help you receive the right care, at the right time, in the right place. You should have fewer gaps in service and better coordination between all your health care providers.
If you have questions and want to speak to someone you may do so by calling hours call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free. We look forward to continuing to serve you and helping you achieve your best possible health.

For any question related to your health conditions call Medical Advice Line- T**eleCuidado Menonita at** 1-844-736-3345 or 1-844-716-3345 TTY (hearing impaired). This phone call is free. **TeleCuidado Menonita** is available 24 hours a day, 7 days a week at as well as to the TTY line 1-844- 716-3345, 24 hours a day, 7 days a week.

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.

Plan de Salud Menonita (PSM) High Cost High Need Program (HCHN or HCHN Program) focuses on members with high risk and/or chronic conditions. Beneficiaries in the HCHN Program have the assistance from an individual intervention plan.
The PSM HCHN Program's purpose is to help Beneficiaries with chronic conditions to take care of their conditions, by receiving education and the medical care they need. The persons that bring the services to the Beneficiaries are: nurses, nutritionist, social workers, behavioral specialist under a guidance of the Medical Director and Pharmacists.

Participating Beneficiaries received guidance to assist them to stay healthy and decrease the Beneficiary's reliance on emergency or urgent care.

Eligible Beneficiaries are automatically enrolled in the program and receive the help they need. Participation, however, is voluntary and the Beneficiary has the right to decline or "opt out" of all or any part of the HCHN program. Beneficiaries who opt out may reenter the program at any time, simply by contacting the case manager or calling the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

PSM HAVE OTHER PROGRAMS TO HELP YOU BE HEALTHY.

Health Care Education and Wellness Program

Plan de Salud Menonita (PSM) offers a Health Care Education and Wellness Program (Wellness Program) focused on helping you stay healthy and happier. All the services in this program are planned to help you live a healthy life by preventing and dealing with chronic conditions. When our bodies feel right, our minds work right. PSM will show how to avoid risk factors such as: a healthy diet or unhealthy diet, lack of physical activity, smoking, obesity among others that can affect your health.

PSM Wellness Program includes:

- Health promotion and preventive programs
- Chronic Disease Management education program
- Health Education and Wellness materials

All services take into consideration your physical and behavioral health. Some of the health areas are:

- Annual health checkup
- Proper use of the services of VITAL, including the PSM Beneficiary Service Line available and how to navigate the managed care system
- Women's health test including: mammograms, pap smears, cervical screenings, and tests for sexually transmitted infections
- Maintain a healthy body weight, through good nutrition and exercise
- Annual dental exam
- Behavioral Health screening
- Medical and developmental needs of children and adolescents, including vaccinations
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
- Education regarding the diagnosis and treatment of high-risk conditions such as: Depression; Schizophrenia; Bipolar disorders; Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder; Substance abuse; and Anxiety disorders.
- Stress management, Anxiety
- Educational workshops on Diabetes, CKD, CHF, Prenatal and maternity care, etc.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The Plan de Salud Menonita (PSM) Early and Periodic Screening, Diagnostic and Treatment (**EPSDT**) Program is the child health component of Medicaid. EPSDT means:

- Early: Identifying problems early, starting at birth
- Periodic: Checking children's health at periodic, age-appropriate intervals.
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- Diagnosis: Performing diagnostic tests to follow up when a risk is identified
- Treatment: Control, correct or reduce health problems found.

This benefit covers evaluation and diagnostic services to uncover any physical and mental deficiencies in the beneficiaries with less than twenty-one (21) years of age. The care services are preventive. The PSM It also identifies health care, prevention, treatment, and other measures to correct or ameliorate any deficiencies and chronic conditions discovered.

Grow Healthy with Plan de Salud Menonita (PSM)

PSM created the **"Crece Saludable con PSM" (Grow Healthy with PSM)** Program to promote good health in the children beneficiaries of VITAL.

The "Crece Saludable con PSM" Program includes:

- Nutritional assessment
- Comprehensive health and developmental history including assessment of physical, behavioral and nutritional conditions
- Laboratory tests according to the age and health history, including Lead Toxicity Testing
- Comprehensive physical examination, including weight, height and growth charting
- Health education including anticipatory guidance. Developmental screening using a recognized, standardized developmental screening tool approved by ASES
- Immunizations according to age
- Developmental screening for social-emotional conditions
- Screening for vision and hearing
- Periodicals health evaluations
- Dental
- Fine/gross Motor screening
- Tuberculosis screening
- Perinatal depression for mothers of infants in the most appropriate clinical setting, at the pediatric, behavioral or OB/GYN visit

Pre-Natal and Maternal Wellness Program

The Pre-Natal and Maternal Wellness Program will bring services to the beneficiaries during their pregnancy. Since the beginning of the pregnancy this program will offer you support and guidance during this important part of your life.

The Pre-Natal and Maternal Wellness Program will help you:

- Enroll in PSM Pregnancy Registry
- Check-ups for potential risk factors
- Assist the pregnant woman in meeting her basic needs, such as eating healthy and exercise
- Provide education services to all pregnant beneficiaries and their families
- Educate and assist the beneficiaries on family planning

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.
- 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. The law says that ASES and your Insurer must protect your information. ASES and your Insurer can share your information for your care, to pay your health claims, and to run the program. But we can't share your information with others unless you tell us we can. If you want to know more about what information we have, how we can share it, or what to do if you don't want your health information shared with certain people, call your Insurer.

HIPAA is a law that protects your information and governs the way ASES and your Insurer can use your medical records and other healthcare information. Your protected health information under HIPAA includes any information that:

- Identifies you or can be used to identify you.
- Either comes from you or has been created or received by a health care provider, a health plan, or a healthcare clearinghouse.
- Has to do with your physical or mental health condition, providing health care to you, or paying for your health care.

The law says that ASES and your Insurer must protect your information and keep it confidential. ASES and your Insurer can share or disclose your information for your treatment or care, to pay your health claims, and to run the program. But we can't share your information with others unless you tell us we can, by signing an authorization or release form. If you give us your written permission, you may still decide later that you no longer want us to use or disclose your protected health information in that way. If you change your mind, you must tell us in writing. We will then stop using your protected health information in that way.

Your Insurer and ASES have internal procedures to protect your oral, written and electronic health information. If your Insurer shares your private health information with others without your consent, or if your Insurer uses or discloses that information for an unauthorized purpose, they can be subject to legal and monetary sanctions from ASES and other state and federal government agencies.

If you want to know more about what information we have, how we can share it, or what to do if you don't want your health information shared with certain people, call your Insurer.

If you think we violated your privacy rights, you may file a grievance. **You will not be punished for filing a grievance**.

You may file a grievance via written correspondence, telephone, fax, through the website or in-person to the following addresses and numbers:

Mail	Telephone	Fax	PSM Website
Attention: Vital PSM – Compliance Department PO Box 364668 San Juan, PR 00936	**Hot Line** **1-844-335-2864** PSM Beneficiary Service Line at **1-866-600-4753** or **1-844-726-3345 TTY** (hearing impaired). Available Monday through Friday from 7:00 AM to 7:00 PM	**Attention: Vital PSM – Compliance Department** **787-332-0930** **1-844-900-4523**	www.planmenonita.ethicspoint.com

Beneficiaries can also file a grievance by visiting one of our Service Offices. To have more information on our different locations, please call PSM Beneficiary Service Line at **1-866-600-4753** or **1-844-726-3345 TTY** (hearing impaired).

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

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 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. Some examples are:

- A person lies about facts to get or keep VITAL 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 Plan de Salud Menonita, the Patient's Advocate Office or ASES. We will keep your private information. However, as per your

request, you do not need to give us your information to notify a fraud or abuse. You will not lose your VITAL coverage if you report fraud or abuse.

Any person who makes a fraud or abuse notification will not receive reprisals nor discrimination with their VITAL coverage.

If you want more information, you can visit the ASES website at **www.planvitalpr.com/** . 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 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

You may tell us about any fraud or abuse situation via written correspondence, telephone, fax, through the website or in-person to the following addresses and numbers:

Mail	Telephone	Fax	PSM Website
Attention: Vital PSM – Compliance Department PO Box 364668 San Juan, PR 00936	**Hot Line** **1-844-335-2864** PSM Beneficiary Service Line at **1-866-600-4753** or **1-844-726-3345 TTY** (hearing impaired). Available Monday through Friday from 7:00 AM to 7:00 PM	**Attention: Vital PSM –** **Compliance Department** **787-332-0930** **1-844-900-4523**	www.planmenonita.ethicspoint.com

PART 7: COMPLAINTS AND APPEALS

NEED TO MAKE A COMPLAINT ABOUT YOUR CARE?

If you are not happy with the care that you are getting, call the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free. 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 decide something 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 the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.
- Visit any of the PSM Service Centers
- Mail your appeal to Plan de Salud Menonita, P.O. Box 364128, San Juan, P.R. 00936.
- Or visit PSM www.MenonitaVital.com

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 the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

You can also visit any of the PSM Service Center, or write a letter to Plan de Salud Menonita P.O. Box 364668, San Juan, P.R. 00936

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.

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 call center at:	1-800-981-2737 787-474-3389 TTY
Writing ASES at:	ASES PO Box 195661 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 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 the PSM Beneficiary Service Line at 1-866-600-4753 or 1-844-726-3345 TTY (hearing impaired). The phone call is free.

PART 8: HOW VITAL WORKS WITH OTHER HEALTH INSURANCE

HOW VITAL WORKS WITH MEDICARE

If you have Medicare, your VITAL 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 coverage works differently:

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

If you have Medicare Part A:

- VITAL will pay once you have reached the limit of what Medicare pays for.
- VITAL will not pay for your Part A deductibles.
- You will pay a copay for services depending on what type of VITAL you have. See the copay chart on page 20 for more information.

If you have Medicare Part A and Part B:

- VITAL will pay for your pharmacy and dental services.
- VITAL will not pay for your Part A deductibles.
- VITAL 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 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 is your second (secondary) insurance. After your providers bill your other insurance, they will bill VITAL.

If you have other health insurance, you must let your Insurer and Medicaid Program know. Call your Insurer and the Medicaid Program at 1-866-600-4753 (toll free) or 1-844-726-3345 TTY (free of charge) to let them know.

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

HOW VITAL 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 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 for other reasons. If you are eligible for VITAL 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. This is called “joint enrollment.”

If at any time you lose eligibility for VITAL, you can sign up for VITAL in the ELA Puro group. That way, you can continue getting your VITAL 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 benefits **before** you sign up for the other health insurance. Visit your local Medicaid office to cancel your VITAL 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 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. 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.

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

DEFINITIONS

Appeal: A request from the beneficiary for the review of a decision. It is a formal request made by the beneficiary, his authorized representative or provider, acting on behalf of the beneficiary with the consent of the beneficiary, to reconsider a decision in the case that the beneficiary does not agree, 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 Beneficiary exercise his/her right to receive services outside the network

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.

Beneficiary (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 Beneficiary.

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 instead of having to file a Grievance.

Coordinated Care: Is the service provided to Beneficiaries 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.

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.

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.

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

Grievance: A formal claim made by the Beneficiary in writing, by telephone or by visiting your Insurer or the Health Advocate Office, regarding an expression of dissatisfaction about any matter that is not an Adverse Benefits Determination.

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 Beneficiaries 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.

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 Beneficiaries. The PCP is responsible for determining services required by Beneficiaries, provides continuity of care, and provides Referrals for Beneficiaries 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 Beneficiary to use as the first option. Beneficiaries 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 a Beneficiary 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 Beneficiary 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.

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