



BENEFICIARY MANUAL

Puerto Rico Health Insurance Administration



PLAN DE SALUD
MENONITA



Dear Enrollee:

We present to you the Enrollee Handbook that explains the services and benefits you have through the Vital Health Plan. We invite you to read it to learn in detail about the medical, hospital and drug benefits you are entitled to through the Vital Plan.

If you require a copy with larger letters or braille, for visually impaired people, in another language or audio CD, you can request a free copy from your health plan.

Your plan can help you answer any questions you have about your health care, ID card, benefit coverage, and contracted health care provider network.

It is important that we have your personal information up to date and your address. If your information has changed, you should contact the Medicaid Program at the call center at 787-641-4224. Remember to attend eligibility appointments so you can maintain Vital health plan benefits.

You can also contact the Government Health Plan free of charge at 1-800-981-2737, 1-833-253-7721, (TTY) 787-474-3389 and 1-888-984-0128.

At ASES, we are committed to serving you as you deserve.

Cordially,

**Edna Y. Marín Ramos, MA
Executive Director**

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WHO CAN I CALL FOR HELP?

If you are having an emergency, call 911.

If you need physical and/or mental health counseling, you can contact **TeleCuidado Menonita**, PSM Medical Counseling Line at 1-844-736-3345, twenty-four (24) hours a day, seven (7) days a week; TTY/TDD users should call 1-844-716-3345.

Plan de Salud Menonita Beneficiary Service Line 1-866-600-4753; TTY/TDD users should call 1-844-716-3345 Monday through Friday from 7:00 a.m. to 7:00 p.m.

	<p>Beneficiary Services Toll-free: 1-866-600-4753 TTY (hearing impaired): 1-844-726-3345 TeleCuidado Menonita (Medical Counseling Line) Toll free: 1-844-736-3345 TTY (hearing impaired) 1-844-716-3345 www.MenonitaVital.com</p>
	<p>Medicaid Program Call Center 787-641-4224 www.medicaid.pr.gov</p>
	<p>ASSMCA (Linea PAS) Mental Health Service Line 1-800-981-0023</p>
	<p>Patient Advocate Office Toll-free 1-800-981-0031 TTY 787-710-7057</p>
	<p>Puerto Rico Health Insurance Administration (ASES) VITAL Toll-free 1-800-981-2737 TTY 787-474-3389 www.planvitalpr.com</p>

WHAT INFORMATION CAN I FIND ONLINE?

For the 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 plan, and your doctors can't tell others certain facts about you. Read more about your privacy rights in Part 6 of this guide.

Your plan has provisions governing the confidential nature of information about Vital Plan enrollees, including legal penalties imposed for misuse and improper disclosures. You may request a copy of these provisions from your PSM Beneficiary Service Centers.

DO YOU NEED HELP UNDERSTANDING THIS GUIDE?

If the information provided in this guide is confusing or if you have any questions, call PSM Beneficiary Service Line at 1-866-600-4753, TTY/TDD users should call 1-844-726-3345.

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

PSM should have this guide and all materials available written in Spanish and English. You may also ask PSM to submit this guide, or any material written in other languages or other formats such as large print, audio CD, or Braille. Materials in other languages or formats are free.

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

**Call your plan at 1-866-600-4753,
TTY/TDD users should call 1-844-726-3345.**

PART 1: GETTING STARTED

HOW DO I SIGN UP FOR VITAL?

Anyone who wants to know if they qualify to enroll in Plan Vital can visit their local Medicaid Office. They will evaluate the information and tell you if you are eligible for the Vital Plan.

To find out where your Medicaid Office is, call the Medicaid Program Call Center at 787-641-4224. The call is free. You can also visit the www.medicaid.pr.gov website.

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 Plan Vital. If you do not do this, the newborn cannot get services under Plan Vital. When you have a newborn, you also might be able to access other benefits, so it is important to visit the Medicaid Office, so they can offer you additional information.

HOW DO I KEEP MY VITAL PLAN BENEFITS?

To keep your Vital Plan benefits, you must go to all your Medicaid appointments. Your plan will send you a letter 90 days, 60 days, and 30 days before the day when your Plan Vital benefits expire. These letters will remind you that you must go to your local Medicaid Office to maintain your eligibility active in Plan 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 A PLAN?

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

The Enrollment Counselor does not work for any Managed Care Organization (MCO) or any providers. They are neutral. They can give you information about Vital Plan and its 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 Managed Care Organization or MCO (insurance company) or change to a different MCO.
- If you change your plan, 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 Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY/TDD users should call 1-888-984-0128.
- Visiting the Medicaid Offices

If you do not choose a plan, one will be chosen for you.

CAN I CHANGE MY MCO (Insurance company)?

Yes, you can request to change your current MCO. Once you have chosen an MCO (insurance company) or one has been chosen for you, you will have 90 days to request a change to get enrolled under another MCO. You can also change your MCO once a year, during the “Open Enrollment Period,” that occurs from November 1st. to December 15.

If you want to change your MCO, call the Enrollment Counselor at 1-833-253-7721 Monday to Friday from 8:00 a.m. to 6:00 p.m. or visit your local Medicaid Office. TTY/TDD users should call 1-888-984-0128.

You can also ask to change from your current MCO at any time, if you have certain reasons as:

- 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 plan.
- You are receiving poor-quality of care
- You ask for a service that your MCO does not cover because of moral or religious reasons.
- Your MCO does not have doctors that are experienced in dealing with your health care needs.

If you want to change your MCO for one of these reasons, you may request a change of MCO to the Enrollment Counselor. ASES will decide if you can change or if you must wait until the Open Enrollment Period. 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 an administrative hearing.

CAN MY MEMBERSHIP WITH MY MCO STOP?

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

- Lose eligibility for Plan Vital
- Move outside of Puerto Rico
- Are sent to prison
- Let someone else to use your Plan Vital member card
- Move to a long-term care nursing facility or intermediate care facility for the developmentally disabled.

You will not lose your membership with your MCO if:

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

You also might want to stop your membership with your MCO if you no longer need your Plan Vital (Medicaid) benefits. If this happens, let your Medicaid Office and your MCO know about it.

HOW DO I REPORT CHANGES?

Plan Vital and PSM are committed to helping you. To support your needs, we need your help. Please remember to let your Medicaid Office and your MCO 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 that you make sure your contact information is up to date with your local Medicaid Office. This is important because Medicaid and your MCO send you important information about your Vital Plan coverage and benefits by mail. If they don't have your current address, you could lose your Vital Plan benefits. To report a change, call your plan at 1-866-600-4753 or visit your local Medicaid Office; TTY/TDD users should call at 1-844-726-3345.

YOUR PLAN VITAL MEMBERSHIP CARD

Everyone in Plan Vital has a member card. This is an example of how it will look:

State Population

PLAN DE SALUD MENONITA

JUAN DEL PUEBLO
0080012345678
Efectividad: 01/11/2018
Cubierta: 300 E
PCP: JUAN DEL PUEBLO
PMG: #123- JUAN DEL CAMPO

BENEFICIOS FARMACIA
BIN/PCN: 123456/ ABARCA
Grupo RX: 098765
Rx Preferida:
Rx No Preferida:

COPAGOS RED NO PREFERIDA
Generalista: \$2
Especialista: \$2
Subespecialista: \$2
Hospital: \$15
ER: \$2 /No ER Hosp: \$20 /No ER No Hosp: \$20
Lab: \$2 /X-Ray: \$2
Dental Prev: \$2 /Rest: \$2

Copagos Red Preferida: \$0

ASES
Asesoramiento y Servicio al Cliente de Salud en tus manos

Esta tarjeta no debe ser utilizada bajo ninguna circunstancia por otra persona que no sea el beneficiario identificado.
Under no circumstance may this card be used by a person other than the identified enrollee.

Si tiene una emergencia médica, llame al 9-1-1 para ayuda. (No requiere autorización)
If you have a medical emergency, call 9-1-1 for help. (No authorization is required)

Servicio al Beneficiario
1-866-600-4753 (libre de cargos)
1-844-726-3345 TTY (audiopmedidos)

TeleCuidado Menonita
Línea de Consultoría Médica:
24 horas al día, 7 días a la semana
1-844-736-3345 (libre de cargos)
1-844-716-3345 TTY (audiopmedidos)

*Podría tener \$0 copago al llamar antes de visitar una sala de emergencia.
You may have \$0 copayments by calling before visiting an emergency room.

Para recibir ayuda con una emergencia emocional o psicológica 24 horas / 7 días: **Línea PAS 1-800-961-0023**

Si tiene información o sospecha de posible fraude o abuso, por favor llame:
If you have any information or suspicion of a possible case of fraud or abuse, please call:
1-844-335-2864

PLAN DE SALUD MENONITA
www.MenonitaVital.com

ASES
Asesoramiento y Servicio al Cliente de Salud en tus manos

Federal Population (Medicaid/ CHIP)

PLAN DE SALUD MENONITA

JUAN DEL PUEBLO
0080012345678
Efectividad: 01/11/2018
Cubierta: 230 C
PCP: JUAN DEL PUEBLO
PMG: #123- JUAN DEL CAMPO

BENEFICIOS FARMACIA
BIN/PCN: 123456/ ABARCA
Grupo RX: 098765
Rx Preferida:
Rx No Preferida:

COPAGOS RED NO PREFERIDA
Generalista: \$0
Especialista: \$0
Subespecialista: \$0
Hospital: \$0
ER: \$0 /No ER Hosp: \$0 /No ER No Hosp: \$0
Lab: \$0 /X-Ray: \$0
Dental Prev: \$0 /Rest: \$0

Copagos Red Preferida: \$0
\$0 Copagos a niños menores de 21 años y mujeres embarazadas

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Asesoramiento y Servicio al Cliente de Salud en tus manos

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PLAN DE SALUD MENONITA
www.MenonitaVital.com

ASES
Asesoramiento y Servicio al Cliente de Salud en tus manos

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

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

If you need to use your health benefits before you get your member card, use your Notice of Decision formulary given to you by your Medicaid Office.

Remember to:

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

Your Member Card is only for you. **Don't let anyone else use your card.** If your card is lost or stolen, you can ask PSM for a new card. You can visit the PSM Service Centers or call at 1-866-600-4753. TTY/TDD users should call 1-844-726-3345. The phone call is free.

PART 2: YOUR PRIMARYCARE PHYSICIAN AND OTHER DOCTORS

When you sign up with your plan, 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; TTY/TDD users should call at 1-844-726-3345. If you do not choose a PCP, then one will be chosen for you.

A Primary Medical Group is a group of doctors that help coordinate your health care services and work with your plan 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 to 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 previous PCP to give you your original medical records. This is free of charge. Bring your original medical records to your new PCP on your first visit. This will help your new PCP learn about your health.
2. Call your PCP to schedule your appointment.
3. Have your Member Card ready, when you call your PCP.
4. Say you are a Plan Vital member and give them your MPI 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 plan or your Municipality. They can help you get a ride.

On the day of your appointment:

1. Bring a list of all your drugs 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 CLOSSES?

Most PCPs have regular office hours. PSM Provider Directory (www.MenonitaVital.com) will tell you when your doctors' offices are open. Most Primary Medical Groups also have clinics that have an extended schedule, but you can call your plan's Medical Counseling Line at any time.

You can get emergency health care any time you need it. Always carry your Plan Vital Member Card with you. In case of an emergency, doctors will know you have Plan Vital. If you call **TeleCuidado Menonita** (PSM Medical Counseling Line) before you go to the emergency room, you will not have to pay a copay.

Emergencies are times when there could be 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 authorization from anyone before you get emergency care.

If you are not sure if it's an emergency, call your PCP. You can call PSM Medical Counseling Service Line at any time: TeleCuidado Menonita 1-844-736-3345. TTY users 1-844-716-3345. Your PCP can help you get emergency care if you need it.

You can also call Plan Vital call center for advice. The phone number is on the back of your ID Card. You can call twenty-four (24) hours a day, seven (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 plan to corroborate whether the change may be performed.

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 plan, 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, TTY/TDD users should call at 1-844-726-3345.

Another reason why your PCP or Primary Medical Group could change is if your PCP or Primary Medical Group stops working with your plan. If this happens, your plan 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, TTY/TDD users should call 1-844-726-3345.

WHAT HAPPENS AFTER I ASK FOR THE CHANGE?

Once you make the change with your plan, 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 plan 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 plan are called the General Network. When you sign up with your plan, they will mail you a Provider Directory for the Preferred Provider Network and the General Network. These lists are also on PSM website www.MenonitaVital.com. Your Primary Medical Group and your plan'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 drugs
 - 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), TTY/TDD users should call at 1-844-726-3345.
2. Call Vital Plan call center at 1-800-981-2737, TTY/TDD users should call at 787-474-3389.
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 MCO Name 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 plan's General Network. You can see any doctor or provider in your plan's General Network if 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 drugs
- Laboratory tests
- X-rays

Out-of-Network

A doctor or other provider who does not work with your plan 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 plan first.

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 plan or your doctors are not following these rules, you can call the PSM Beneficiary Service Line at 1-866-600-4753, TTY/TDD users should call at 1-844-726-3345, 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 plan and your Municipality can help with transportation. Each Municipality has some ways to help you get to your visits. Call your plan at 1-866-600-4753, TTY/TDD users should call at 1-844-726-3345 or call your Municipality for help.

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), TTY/TDD users should call at 1-844-726-3345. Part 5 of this guide has more information on care management.

PART 3: SERVICES VITAL PAYS FOR

GENERAL INFORMATION

Plan Vital offers services to keep you healthy. Plan Vital works with MCO's 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 says that you are eligible for Plan Vital. You don't have to wait.

As a Plan Vital beneficiary, you have a variety of health care benefits and services available to you. Not everyone in Plan Vital has the same benefits. The benefits that are covered for you depend on the group you're in. Your Plan Vital Member Card will indicate what type of coverage you qualify for.

Listed below are the basic services covered by Plan Vital. Some services may have limits. For more information call the PSM Beneficiary Service Line at 1-866-600-4753, TTY/TDD users should call at 1-844-726-3345.

- 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 vaccines, 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

DENTAL SERVICES

Plan Vital offers dental services. You can see any dentist that accepts Plan Vital. You can find information about participating dentists in PSM's Provider Directory. You can access the list of providers by visiting PSM's website www.MenonitaVital.com under the Provider Directory section. Your Primary Medical Group and 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, TTY/TDD users should call at 1-844-726-3345.

MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES

Plan 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.

Plan 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 PSM Beneficiary Service Line at 1-866-600-4753, TTY/TDD users should call at 1-844-726-3345.

PHARMACY SERVICES

Plan Vital covers prescription drugs. 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 insurance company. You can find a list of participating pharmacies in PSM's Provider Directory, or you can call the PSM Beneficiary Service Line at 1-866-600-4753, TTY/TDD users should call at 1-844-726-3345.

Prescription drugs 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 drugs, look at Part 4 of this guide.

Your Formulary of Medications Covered (FMC) is the list of drugs Vital Plan covers. This list helps your doctor prescribe drugs for you. Brand-name and generic drugs are on the FMC. A generic version of a drug is the first choice. If a generic version of a drug is available, your doctor must prescribe the generic version.

If you have a chronic condition, your doctor can write a prescription for a 90-day supply of some drugs. This way, you only must pay for the drug once instead of paying three times (1 payment per month). You can access the Vital Plan Covered Drug Formulary at the following electronic address: <https://www.asespr.org/beneficiarios/medicamentos/>

NON-COVERED SERVICES

Here is a general list of some services that are not covered by Plan Vital. You can find a full list of services that Plan Vital will not pay online at www.MenonitaVital.com, or you can call the PSM Beneficiary Service Line at 1-866-600-4753, TTY/TDD users should call at 1-844-726-3345. 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).
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 the patient's relatives (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, except for 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 plan 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 change, 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 Plan Vital has copays. Your Plan Vital membership card will indicate if you have copays and what they are. Copays depend on the type of coverage you qualified under Plan Vital. Your Plan Vital member card indicates what type of coverage you have.

None of your doctors or providers can refuse to give you medically necessary services because you don't pay your copays. However, your MCO 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.

COPAYS 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 Member Card or call plan PSM Beneficiary Service Line at 1-866-600-4753, TTY/TDD users should call at 1-844-726-3345.

BENEFIT PACKAGES, CO-PAYS & CO-INSURANCE – effective in January 2023*

BENEFIT PACKAGES & SERVICES FOR MENTAL HEALTH (MH), SUBSTANCE USE DISORDER (SUD), MEDICAL/SURGICAL (M/S)	Federal				CHIPs		Commonwealth				*ELA
	100	110	120	130	220	230	300	310	320	330	400
HOSPITALIZATION SERVICES											
Admissions	\$0	\$0	\$0	\$0	\$0	\$0	\$15	\$15	\$15	\$20	\$50
Nursery	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Behavioral health hospitalizations	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Detoxification Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient behavioral Health Services in an Institution for Mental Disease (IMD)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
BEHAVIORAL HEALTH SERVICES											
Evaluation, screening, and treatment of individual, couples, families, and groups	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient services with psychiatrist, psychologist, and social workers	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Hospital services for substances and alcohol abuse disorders	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient services for substance and alcohol abuse disorders	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Intensive outpatient services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Emergency or crisis intervention services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Long-lasting injected medicine clinics	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Escort/professional assistance and ambulance services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prevention and secondary-education services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Treatment of attention deficit disorder	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Substance abuse treatment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Opiate addiction treatment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Partial hospitalization	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Electroconvulsive Therapy (EC)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Psychological / Neuropsychological testing	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
PREVENTIVE HEALTH SERVICE:											
Well baby care	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Immunizations	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Hearing Exams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Evaluation and nutritional screening	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Laboratory and Clinical Tests	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$6	20%

BENEFIT PACKAGES & SERVICES FOR MENTAL HEALTH (MH), SUBSTANCE USE DISORDER (SUD), MEDICAL/SURGICAL (M/S)	Federal				CHIPs		Commonwealth				*ELA
	100	110	120	130	220	230	300	310	320	330	400
Nutritional, oral, and physical health education	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Reproductive health/family planning	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Annual physical exam for diabetics	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Health certificates	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DIAGNOSTIC TEST SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$6	40%
OUTPATIENT REHABILITATION SERVICES											
Physical therapy	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$5
Occupational therapy	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$5
Speech therapy	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$5
EMERGENCY ROOM (ER)											
Emergency Room (ER) Visit	\$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)	\$0	\$2	\$3	\$4	\$0	\$0	\$20	\$20	\$25	\$30	\$20
Trauma	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
MEDICAL AND SURGICAL SERVICES											
EPSDT/early and periodic screening, diag, treatment <21	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary care physicians' visits including nursing services	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$3
Specialist treatment	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$7
Sub-specialist treatment	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$10
Physician home visits	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$10
Respiratory therapy	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$5
Anesthesia services (except of epidural)	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	\$5
Radiology services	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Pathology services	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Surgery	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Outpatient surgery facility services	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Nursing services	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Sterilization	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Prosthetics	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Ostomy equipment	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Blood transfusion and blood plasma services	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%

BENEFIT PACKAGES & SERVICES FOR MENTAL HEALTH (MH), SUBSTANCE USE DISORDER (SUD), MEDICAL/SURGICAL (M/S)	Federal				CHIPS		Commonwealth				*ELA
	100	110	120	130	220	230	300	310	320	330	400
Services to patients with Level 1 or Level 2 chronic renal disease	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Skin, bone, and corneal transplants	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Veklury (remdesivir) for COVID-18	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Breast reconstruction after mastectomy	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Surgical procedures to treat morbid obesity	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Mechanical respirators and ventilators	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Durable Medical Equipment****	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Emergency Transportation Services	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Maternity and Pre-natal services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
OTHER SERVICES											
High-Tech Laboratories**	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$5	20%
Special Diagnostic Tests**	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$6	40%
DENTAL SERVICES											
Preventive (Child)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Preventive (Adult)	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$3	\$5	\$3
Restorative	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$2	\$5	\$6	\$10
PHARMACY SERVICES											
Preferred (Children 0-21)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$5
Preferred (Adult)****	\$0	\$1	\$2	\$3	\$0	\$0	\$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	\$0	\$0	\$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.

**** All Durable Medical Equipment (DME) is not covered; however, DME may be covered on a case-by-case basis under an exceptions process.

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 - Carcinoma IN SITU
6. Skin Cancer such as Invasive Melanoma or squamous cells with evidence of metastasis.
7. Chronic Renal Disease
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 (NNES)
15. Obstetric
16. Tuberculosis (Tb)
17. HIV/AIDS
18. Adults with phenylketonuria (PKU)
19. Pulmonary Hypertension
20. Post-Transplant (Excludes cornea, bone, and skin transplant)
21. Chronic Hepatitis C (HCV)
22. Congestive Heart Failure (CHF): Class III & Class IV, NYHA
23. Primary Ciliary Diskinesia (PCD), or Immotile Ciliary Syndrome, or Kartagener Syndrome

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 plan's General Network. People with Special Coverage can get prescription drugs, tests, and other services through the Special Coverage without a referral or needing their PCP to sign off.

Your MCO will let you know if you are qualified and, will if you are qualified, they must make sure that you get access to the services. Plan 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 PSM Beneficiary Service Line at 1-866-600-4753, TTY/TDD users should call at 1-844-726-3345.

- 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 drugs 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 plan or your PCP for visits and treatment at the Immunology Regional Clinics of the Health Department
 - ✓ Tuberculosis
 - ✓ Leprosy
 - ✓ Lupus
 - ✓ Cystic fibrosis
 - ✓ Cancer
 - ✓ Hemophilia
 - ✓ Aplastic Anemia
 - ✓ Rheumatoid Arthritis
 - ✓ Autism
 - ✓ OBGyn 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 because of a felony committed by a beneficiary or negligence
- Chronic renal disease
- Drugs required for the ambulatory treatment of Tuberculosis and Leprosy
- Hepatitis C treatment with the drug included in the Plan Vital Drug Formulary.

SPECIAL COVERAGE FOR HIV-AIDS

If you have HIV or AIDS, your PCP must ask your plan to give you Special Coverage. Once your plan 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 drugs, laboratory tests, x-rays and other services without your PCP needing to sign off.

You must get your prescription drugs for HIV/AIDS at the following Department of Health's Centers for Prevention and Treatment of Communicable Diseases:

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 CLINICA SATELITE	(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 Franceschi Calle Sergio Peña Almodóvar, Esq. Flor Gerena Humacao, Puerto Rico 00791
CAROLINA CLETS	(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
	(787)754-8118 (787)754-8128 (787)754-8127	P. O. Box 70184 San Juan, PR 00936-8523

REGION	TELEPHONE/ FAX	ADDRESS
CLETS SAN JUAN		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
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 Carretera 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.

You can ask for help through this program by calling PSM Beneficiary Service Line at 1-866-600-4753; TTY/TDD users should call 1-844-726-3345. Your doctor, your family, your hospital may also ask about the program. For any health-related questions, please call **TeleCuidado Menonita** at 1-844-736-3345 o 1-844-716-3345 TTY (for hearing impaired). This call is free of charge. **TeleCuidado Menonita** is available 24 hours a day, 7 days a week.

TRANSITION OF CARE

Through the Care Management Program, our team of professionals can help you continue receiving the health care you need in the following situations:

- You are coming from another plan and your doctors are not part of the Plan's network of doctors and providers.
- Your doctor is no longer part of our Plan's network of doctors and providers.
- You are hospitalized.
- You move residence and/or municipality.
- Your child reaches the legal age of majority. The care and services you need from your doctor are different.

- You change your Primary Physician (PCP) or Primary Medical Group (PMG).
- You change to another Plan.

We want to help you have a smooth transition and ensure that your health care is not interrupted. This is why it is important that you tell us right away if you have any of these situations and will need to continue receiving certain services.

Our Case Managers will help you access and coordinate the health care services you need. They will also give you the information you need to make sure this transition happens.

In some situations, we will allow you to stay with an out-of-network doctor or provider for up to 90 days. Sometimes we will help you find a doctor or provider in our network who can give you the services you need. We may also work with your previous doctor or provider to add him/her to our network.

You can ask for help through this program by calling the PSM Beneficiary Service Line at 1-866-600-4753; TTY/TDD users should call 1-844-726-4753. Your doctor, your family, your hospital may also ask about the program and the transition of care. For more information about your health conditions, call the PSM TeleCuidado Menonita Medical Counseling Line 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.

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 (MCO Name) 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 plan otherwise.
- Get information about your plan, 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 plan's networks.
- 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 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 plan or your care. Look at Part 7 of this guide for more information. The complaint can be filed in your plan's Service Office or in the Patient 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 plan, providers, or Vital Plan.
- Choose an Authorized Representative to be involved in making decisions.
- Provide informed consent.
- Only must pay the amounts for services listed in Part 4 of this guide. You cannot be charged more than those amounts.
- Be free from harassment by your MCO or its Network Providers with respect to contractual disputes between the plan and its providers.

YOUR RIGHT TO PRIVACY (HIPAA)

Your health information is private. The law says that ASES and your (MCO Name) must protect your information. ASES and your (MCO Name) 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 PSM Beneficiary Service line at 1-866-600-4753; TTY/TDD users should call 1-844-726-3345.

YOUR RESPONSIBILITIES

You have the responsibility to:

- Understand the information in your guide and other papers that your plan 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 healthcare.
- 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 plan's staff with respect and dignity.
- Let your plan 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 Plan 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 on medical treatment.

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 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 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 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 must 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. If 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 plan or your doctors aren't complying with your wishes, or if you have any complaints, you have the right to call the Plan 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.

FRAUDE 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 Member card
- A doctor bills for services that you did not get
- A person sells or gives drugs to someone else

If you find out about fraud or abuse, you must tell us about it. You can call your plan, the Patient's Advocate Office or ASES. You do not need to tell us your name, we will keep your information private. You will not lose your Plan Vital cover if you report Fraud or Abuse. If you want more information, you can visit the ASES website at www.planvitalpr.com/. On the website there is a formulary that you can use to make your report. Plan de Salud Menonita website www.MenonitaVital.com also has more information.

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

- Don't give your Plan Vital Member Card to anyone else
- Learn about your Vital Plan benefits
- Keep records of your doctor's visits, laboratory tests and drugs. Make sure you don't get repeat services
- Make sure your information is right on a formulary 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 plan

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 PSM Beneficiary Service Line at 1-866-600-4753; TTY/TDD users should call 1-844-726-3345. Tell them that you need to make a complaint. You can also visit your plan'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 MCO has 72 hours to fix your complaint. If they cannot fix your complaint quickly, it will become a “grievance.” In this case, your plan has up to 90 days to fix it, but they must decide faster if it’s important to your health. Your plan must tell you how the complaint was fixed.

WHAT HAPPENS IF MY COMPLAINT ISN’T FIXED?

If your plan does not fix your complaint, you can ask for an administrative hearing, where you can tell a judge about the issue.

WHAT IS AN APPEAL?

If your doctors or your plan decide something about your care that you don’t agree with, you can file an appeal. When you appeal, you’re asking your plan to take another look at a mistake you think was made.

If your plan 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 plan 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 PSM Beneficiary Service Line at 1-866-600-4753; TTY/TDD users should call 1-844-726-3345.
- Visit any of PSM Service Centers
- Mail your appeal to your plan at:

Plan de Salud Menonita
Grievances and Appeals Department
P.O. Box 364128,
San Juan, P.R. 00936

WHAT WILL HAPPEN WHEN MY MCO 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 plan will decide within 30 days. If you have an emergency and your plan 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 PSM Beneficiary Service Line at 1-866-600-4753; TTY/TDD users should call 1-844-726-3345, or visiting any of PSM Service Centers, or writing a letter to:

Plan de Salud Menonita
Grievances and Appeals Department
P.O. Box 364128
San Juan, P.R. 00936

If your plan agrees to give you a fast appeal, they will decide your case within 72 hours. If your plan 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 plan cannot decide within 30 days, they can ask for up to 14 more days. If they ask for more time, they must let you know why. If you do not agree to give your plan more time, you can file a complaint.

Once your plan decides, 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 plan's decision about a complaint or an appeal, you can ask for an administrative hearing. An administrative hearing is where you can tell an Official Examiner about the mistake you think your plan made. You have 120 days from the date of your plan's decision to ask for an Administrative Hearing with ASES.

Calling the Plan Vital call center at: **1-800-981-2737**
TTY 787-474-3389

Writing ASES at: **ASES**
PO Box 195661
San Juan, PR 00919-5661

Sending ASES a fax at: **787-474-3346**

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

During the administrative hearing, you can give facts and proof about your health and medical care. An Official Examiner will listen to everyone's side. At the administrative 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 administrative 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 these things must be true:

- You file the appeal within 60 days of the date on the letter from your plan.
- 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 plan (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 Plan Vital still covers.

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

To ask to keep getting services during your appeal or administrative hearing, call your PSM Beneficiary Service Line at 1-866-600-4753; TTY/TDD users should call 1-844-726-3345.

PART 8: HOW VITAL WORKS WITH OTHER HEALTH INSURANCE

HOW VITAL PLAN WORKS WITH MEDICARE

If you have Medicare, your Plan 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 drugs.

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 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 Plan Vital is your second (secondary) insurance. After your providers bill Medicare, they will also bill Plan Vital.

If you have Medicare Part A:

- Plan Vital will pay once you have reached the limit of what Medicare pays for.
- Plan Vital will not pay for your Part A deductibles.
- You will pay a copay for services depending on what type of Plan Vital you have. See the copay chart on page 19 for more information.

If you have Medicare Part A and Part B:

- Plan Vital will pay for your pharmacy and dental services.
- Plan Vital will not pay for your Part A deductibles.
- Plan 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 does not 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 plan and Medicaid Program know. Call your plan and the Medicaid Program at PSM Beneficiary Service Line at 1-866-600-4753; TTY/TDD users should call 1-844-726-3345 to let them know.

When you go to your health care visits, bring your Plan Vital Member card and your member cards of 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 Plan 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 Plan Vital for other reasons. If you are eligible for Plan 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 Plan. This is called “joint enrollment.”

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

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

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 Plan Vital.

Beneficiary (Enrollee): A person who after being certified as eligible under the Medicaid program has completed the enrollment process with the plan and for whom the plan has issued the Member card that identifies the person as a Plan Vital Beneficiary.

CHIP: *Children Health Insurance Program*, a federal program that provides medical services to low-income children aged 21 and under, through plans 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 Plan 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 plans contracted under Law 95 has ended. This coverage is the same as the coverage of Plan 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 plan 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.

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

Insurer (plan): The company contracted with ASES to provide your medical services under Plan 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).

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 plan 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 plan to provide health services under a Coordinated Care model.

Prior-Authorization: Permission your plan 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.

¿Ayuda con su Plan de Salud del Gobierno?



ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO



Línea libre de cargos
1-800-981-2737
TTY 787-474-3389