2020 Member Handbook

1-833-404-1061
TTY: 711

IowaTotalCare.com

012020

Nondiscrimination Language

Iowa Total Care complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Iowa Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Iowa Total Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Iowa Total Care at our toll-free number 1-833-404-1061 (TTY: 711).

If you believe that Iowa Total Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Iowa Total Care Grievance Coordinator
1080 Jordan Creek Parkway, Suite 100 South
West Des Moines, IA 50266
1-833-404-1061 (TTY: 711)
Email: AppealsGrievances@IowaTotalCare.com
Fax: 1-833-809-3868

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, Iowa Total Care is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/index.html

Language Assistance

Medicaid Member Services: 1-833-404-1061 (TTY 711)

English: Language assistance services, auxiliary aids and services, larger font, oral translation, and other alternative formats are available to you at no cost. To obtain this, please call the number above.

Español (Spanish): Servicios de asistencia de idiomas, ayudas y servicios auxiliares, traducción oral y escrita en letra más grande y otros formatos alternativos están disponibles para usted sin ningún costo. Para obtener esto, llame al número de arriba.

中文 (Chinese): 可以免费为您提供语言协助服务、辅助用具和服务、较大的字体、口译以及其他格式。如有需要请拨打上述电话号码。

Tiếng Việt (Vietnamese): Các dịch vụ trợ giúp về ngôn ngữ, các trợ cụ và dịch vụ phụ thuộc, phông chữ khổ lớn, thông dịch bằng lời nói, và các dạng thức thay thế khác hiện có cho quý vị miễn phí. Để có được những dịch vụ này, xin gọi số điện thoại nêu trên.

Srpsko-Hrvatski (Serbo-Croatian): Nna raspolaganju su vam besplatne jezičke podrške, dodatna pomoć i usluge, krupniji font, usmeni prevod kao i drugi alternativni formati. Da biste sve ovo dobili, molimo vas da nas nazovete na gornji broj.

Deutsch (German): Sprachunterstützung, Hilfen und Dienste für Hörbehinderte und Gehörlose, eine größere Schriftart, eine mündliche Übersetzung sowie weitere alternative Formate werden Ihnen kostenlos zur Verfügung gestellt. Um eines dieser Serviceangebote zu nutzen, wählen Sie die o. a. Rufnummer.

العربية (**Arabic**):

البديلة الأشكال من وغيرها وشفهياً كبيرة بأحرف الإضافية والمساعدات والاعانات اللغوية المساعدة خدمات لك تتوفر مجانا. الخدمات هذه على للحصول ،أعلاه بالرقم اتصل.

ລາວ (Lao): ບໍລິການໃຫ້ຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍລິການ ແລະ ຄວາມຊ່ວຍເຫຼືອຕ່າງໆ, ແລະ ຮູບແບບທາງເລືອກອື່ນໆ ມີໃຫ້ເຈົ້າ ຟຣີ. ຫາກຕ້ອງການຮັບຂໍ້ມູນ ກະລຸນາໂທໄປທີ່ໝາຍເລກຂ້າງເທິງ..

한국어 (Korean): 언어 지원 서비스, 보조 지원 및 서비스, 대형 활자본, 통역, 기타 대체 형식을 무료로 이용하실 수 있습니다. 이를 위해 위의 전화번호로 연락해 십시오.

हिंदी (Hindi):
आप या जिसकी आप मदद कर रहे हैं उनके के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए

Français (French) : Des services gratuits d'assistance linguistique, ainsi que des services d'assistance complémentaires, des polices de caractères plus grosses, de la traduction orale et d'autres formats sont à votre disposition. Pour y accéder, appelez le numéro ci-dessus.

Pennsylvanian Deitsh (Pennsylvanian Dutch): Du kansht hilf greeya mitt dee shprohch, adda annah hilf un services in diffahndi vayya un es kosht dich nix. Fa hilf greeya adda may ausfinna, kawl da phone number do ovvah droh.

ไทย (Thai): บริการความช่วยเหลือด้านภาษา อุปกรณ์และบริการเสริม แบบอักษรขนาดใหญ่ขึ้น การแปลด้วยปากเปล่า
รวมทั้งรูปแบบทางเลือกอื่น ๆ มีให้คุณใช้ได้โดยไม่เสียค่าใช้จ่าย หากต้องการใช้บริการนี้ กรุณาโทรศัพท์ติดต่อที่หมายเลขข้างต้น

Italiano (Italian): Sono disponibili servizi di assistenza linguistica, ausili e servizi accessori, testo in caratteri grandi, traduzione orale e altri formati alternativi. Per ottenerli, chiamare il numero di telefono riportato sopra.

Русский язык (Russian): Услуги по переводу, вспомогательные средства и услуги, материалы, напечатанные более крупным шрифтом, услуги устного перевода, а также материалы в других, альтернативных, форматах предоставляются Вам совершенно бесплатно. Чтобы получить их, позвоните по указанному выше номеру телефона.

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WELCOME

Thank you for choosing Iowa Total Care as your health plan!

Iowa Total Care works with the Iowa Department of Human Services (DHS). We provide health services for the Iowa Medicaid program. With your doctor, we help manage your care and health. Our job is to make sure you get the services you need to stay healthy.

What is the Iowa Medicaid program?

The Iowa Medicaid program provides physical health services, behavioral health services, Long Term Services and Supports (LTSS), select vision services, Non-Emergency Medical Transportation (NEMT), and community benefits.

Who is Iowa Total Care?

Iowa Total Care is a Medicaid Managed Care Organization (MCO). A member is anyone who gets services from the MCO. The purpose of an MCO is to give members access to all of the health services they need through one company.

As an MCO, Iowa Total Care will help coordinate your individual health care needs. By doing this, our goal is to improve health outcomes for every Iowa resident we have the privilege to serve. Contact us to request information such as:

- Benefits, eligibility, claims or participating providers
- How we work with your other health plans (if you have one)
- How we pay our providers
- Results of member surveys

If you want to tell us ways to improve or recommend changes in our policies, procedures or services, call Iowa Total Care Member Services. The toll-free phone number is 1-833-404-1061 (TTY: 711).

Iowa Total Care in the Community

Iowa Total Care is committed to our community. We participate in many events around Iowa throughout the year. Visit our *Medicaid News and Events* webpage on our website at www.iowatotalcare.com to find out more about these events.

About Your Member Handbook

THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE. IT SHALL NOT BE TAKEN TO BE PROOF OF INSURANCE COVERAGE BETWEEN Iowa Total Care AND THE MEMBER.

The Member Handbook is a detailed guide to Iowa Total Care and your health care benefits. The Member Handbook explains your rights, your benefits, and your responsibilities as a member of Iowa Total Care. Please read this booklet carefully. It gives you information on your benefits and services such as:

- What is covered/not covered by Iowa Total Care
- How to get the care you need
- How to get your prescriptions filled
- How to choose your Primary Care Provider (PCP)
- Eligibility requirements
- Your rights and responsibilities
- What to do if you are unhappy about your health plan or coverage
- When to use Urgent Care instead of the Emergency Room
- Materials you will receive from Iowa Total Care

Services mentioned are funded in part with the state of Iowa.

Iowa Total Care does not deny services based on moral or religious objections.

Call Member Services to receive a paper copy or an additional copy of the Member Handbook at no cost to you. Paper copies of the handbook will be mailed within 5 business days. The toll-free phone number is 1-833-404-1061 (TTY: 711). You may also visit our website at www.iowatotalcare.com to view the Member Handbook.
Please take time to look over your handbook. Keep it handy in case you need it.

Important Contact Information

Iowa Total Care

- Phone: Toll-Free: 1-833-404-1061 (TTY: 711)
  Call this number for all Member Services needs, such as:
  - Nurses (available 24/7)
  - Vision
  - Non-Emergency Medical Transportation (NEMT)
  - Medical Management
  - Connection Plus
  - Care Management Physical and Behavioral Health
  - Waiver and Facility Based Services
  - Ombudsmen
- Hours of Operation: Monday through Friday 7:30 a.m. – 6:00 p.m. CST
- Website: www.iowatotalcare.com
- Address:
  1080 Jordan Creek Parkway, Suite 100 South
  West Des Moines, IA 50266

Iowa Medicaid Member Services Call Center

- Toll Free: 1-800-338-8366; In the Des Moines area: 515-256-4606
- Email: IMEMemberServices@dhs.state.ia.us

- Hours of operation: Monday through Friday 8 a.m. to 5 p.m. CST

For telephone accessibility assistance if you are deaf, hard-of-hearing, blind, or have difficulty speaking, call Relay Iowa TTY at 1-800-735-2942.

Website: www.IAHealthLink.gov

Hawki Member Services

Toll-Free: 1-800-257-8563

Hours of operation: Monday through Friday 8 a.m. to 5 p.m. CST

Iowa DHS Income Maintenance Customer Service Center

- 1-877-347-5678

Child and Dependent Adult Abuse

- If you suspect that a child is being abused, Iowa law requires you to report this. Call the Abuse Hotline at 1-800-362-2178.

- If you suspect abuse or neglect of an adult in the community, call the Abuse Hotline at 1-800-362-2178. Phone lines are staffed 24 hours a day, 7 days a week. In an emergency, call your local police force or call 911.

How To Submit A Claim For Covered Services

Providers will typically submit claims on your behalf, but sometimes you may have to submit claims yourself for covered services. This is usually if:

- Your provider is not contracted with us
- You have an out-of-area emergency

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid. We can adjust your deductible, copayment or cost sharing to reimburse you.

To request reimbursement for a covered service, you need a copy of the detailed claim from the provider. You also need to submit an explanation of why you paid for the covered services along with the member reimbursement claim form posted on the health plan website under “Member Resources”. Send this to us at the following address:

Iowa Total Care
Attn: Claims Department
PO Box 8030
Farmington, MO 63640

Your ID Cards

All members receive a *Medical Assistance Eligibility Card* (form 470-1911).

- Keep your card until you get a new one.
- Always carry your card with you and don't let anyone else use it.
- Show your card to the provider every time you get care.
- If you lose your Medicaid card, call Iowa Medicaid Member Services Toll free at 1-800-338-8366.
- If you go off of Iowa Medicaid and come back on, a new card will not be issued. Please contact Iowa Medicaid Member Services to request a new Medicaid card.

Managed Care Organization Card

When you enroll, Iowa Total Care will mail you an Iowa Total Care member ID card. Bring your ID card to all appointments.

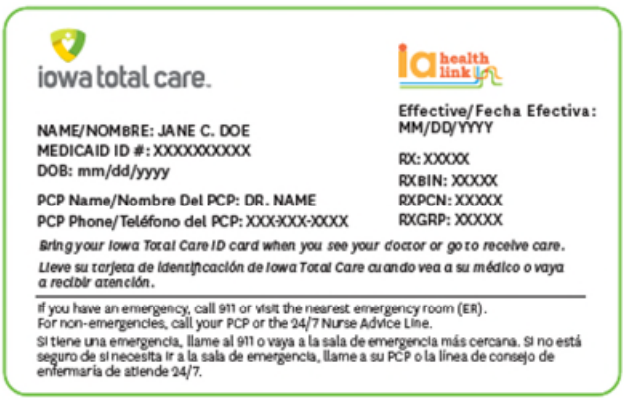
Your **Iowa Total Care/Hawki** ID card will look like this:

Front

Back

Your **Iowa Total Care/IA Health Link** ID card will look like this:

Front



Back

We will mail you your permanent ID card after you have chosen a Primary Care Provider (PCP). Your member ID card is proof you are an Iowa Total Care member. Show this ID card every time you need care. This includes:

- Medical appointments
- Urgent care
- Vision appointments
- Behavioral health appointments
- Emergency visits
- Picking up prescriptions from the pharmacy

You must also keep your state-issued Medicaid ID card with you to receive Medicaid benefits not provided by Iowa Total Care.

Anytime you receive a new member ID card from us, please destroy your old one. If you lose your Iowa Total Care member ID card, or did not receive one, we can replace the card. You can also view your ID card on the Iowa Total Care mobile app until your new card is received. To replace the card please visit the Secure Member Portal to ask for a new one or call Member Services. The toll-free phone number is 1-833-404-1061 (TTY: 711). We will send you a new ID card within 7 business days.

You can print a paper copy of your Iowa Total Care member ID card from the Secure Member Portal on our website www.iowatotalcare.com.

Keep your cards with you and safe at all times. Make sure they are not stolen or used by someone else. Iowa Total Care coverage is for you only. It is up to you to protect your member ID card. No one else can use your member ID card. It is against the law to give or sell your member ID card to anyone. If another person uses your card, you may be disenrolled from Iowa Total Care and the state could charge you with a crime.

ACCESSIBILITY

Accessibility to Information

Iowa Total care is committed to making sure you understand your benefits. If you have trouble reading what we send you or communicating with us, we can help.

To get a large print, braille or audio CD version of this handbook or any other written material, contact Iowa Total Care Member Services at our toll-free number 1-833-404-1061**,** TTY 711 for assistance.

For members who don't speak English, we offer help in many different languages. Call Member Services to get any of these services at no cost to you:

- Over-the-phone interpreter services
- Interpretation at your doctor visits, within 24 hours' notice
- This member handbook or any other written materials in your preferred language

For members who are deaf or hard of hearing:

- To call us using a TTY relay service, call 711.
- We'll set up and pay for you to have a person who knows sign language help you during your doctor visits, with 24 hours' notice.

Accessibility to Services

Iowa Total Care is committed to ensuring that all providers and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. If you have difficulty getting an appointment with a provider, or accessing services because of a disability, contact Iowa Total Care Member Services at our toll-free number 1-833-404-1061 (TTY: 711) for assistance.

ELIGIBILITY

What Happens If I Move?

If you move, please contact the Iowa Department of Human Services (DHS Income Maintenance Customer Call Center at 1-877-347-5678 and contact Iowa Total Care. Hawki members should contact Hawki Member Services at 1-800-257-8563 and Iowa Total Care.

If You are No Longer Eligible for Medicaid or Hawki

Iowa Total Care is here to help with any concerns with eligibility for Medicaid or Hawki. For any questions, please call Iowa Total Care Member Services at our toll-free number 1-833-404-1061.

Renewal and Changes in Your coverage

Major life changes can affect your eligibility with Iowa Total Care. It is important to let DHS and Iowa Total Care know when you have these life changes. If you have a major life change, please call the DHS Call Center at 877-347-5678 and Iowa Total Care at our toll-free number 1-833-404-1061. Some examples of major life changes are:

- Changing your name
- A change in your health insurance
- If you add or lose other insurance coverage.
- If you are added to or removed from someone else's insurance.
- Changing jobs
- Your ability or disability changes
- Your family changes. This might mean your family got bigger because of a birth or a marriage. Or your family got smaller. This may be because a family member passed or moved away.
- Changes in your income or assets
- You become pregnant. Call Iowa Total Care if you are pregnant. We have special help for you and your baby. Contact Iowa Total Care Member Services at our toll-free number 1-833-404-1061 (TTY: 711).

Coverage for most Medicaid programs must be renewed every 12 months. When your renewal date is coming up, DHS will send you a letter letting you know to renew. If you do not renew by the deadline, you may lose your Medicaid coverage.

IA HEALTH LINK

Most members who get health coverage from Iowa Medicaid are enrolled in the IA Health Link managed care program. A Managed Care Organization, or MCO, is a health plan that coordinates your care. Iowa Total Care is your MCO. The benefits you receive from Iowa Total Care depend on the type of Medicaid coverage you have.

Iowa Total Care is offered statewide. We have a network of providers across the state of Iowa who you may see for care. We will also coordinate your care to help you stay healthy.

- A list of members excluded from the IA Health Link program can be found at www.iahealthlink.gov .

Program of All-Inclusive Care for the Elderly (PACE) program

If you are a member enrolled with PACE, you will need to be determined eligible under a new Medicaid coverage group in order to transition to an IA Health Link Managed Care program. Please contact your PACE provider for assistance in applying for a new coverage group before making any changes to your plan. Your PACE provider will assist you with disenrolling with PACE and enrolling with the IA Health Link Managed Care program if you are found to be eligible for another Medicaid coverage group.

American Indian or Alaskan Native (AI/AN) members may also choose to enroll in the managed care program. If you are a member who identifies as American Indian or Alaskan Native, contact Iowa Medicaid Member Services at 1-800-338-8366 to learn about enrolling in the IA Health Link Managed Care program.

IOWA HEALTH AND WELLNESS PLAN

The Iowa Health and Wellness Plan program provides a variety of medical benefits and services at low or no cost to Iowans between the ages of 19 and 64. All Iowa Health and Wellness Plan members are covered for the same types of health benefits. Eligibility is based on household income. To learn more about the benefits and services you may be able to get, refer to the **Covered Benefits and Services** section of this document.

Healthy Behaviors for Iowa Health and Wellness Plan Members

Members in the Iowa Health and Wellness Plan can receive free healthcare if they choose to take specific steps to protect their health and complete what are known as Healthy Behaviors. The Healthy Behaviors program is a way for all Iowa Health and Wellness Plan members to work with health care providers to be healthy and stay healthy. To participate in the Healthy Behaviors Program and avoid paying a monthly contribution after the first year of coverage, each year Iowa Health and Wellness Plan members must:

1. **Get an annual Wellness Exam or Physical by visiting your provider OR Get a Dental Exam by visiting your dentist** AND
2. **Complete a Health Risk Assessment (HRA)**. The Health Risk Assessment consists of a few questions about your general health. IA Health Link members should contact Iowa Total Care to complete their HRA. **Iowa Total Care's toll-free number is 1-833-404-1061**

What is a Dental Exam?

In a dental exam, your dentist will go over your dental health. You may receive a cleaning or basic X-rays.

What is a Health Risk Assessment (HRA)?

A Health Risk Assessment is a 15-40 minute survey that asks questions about your health and your experience in getting health services.

Monthly Contributions for Iowa Health and Wellness Plan Members

- All Iowa Health and Wellness Plan members will receive health coverage under the Iowa Health and Wellness Plan in their first year of eligibility.
- Members **must** complete their Healthy Behaviors in their first year, and every year after, to continue to receive free health services for the following year.
- Members who **do not** complete their Healthy Behaviors every year may be required to pay a small monthly contribution that depends on their family income.
- Monthly contributions are either $5 or $10 depending on family income.

- Members who **do not** complete their Healthy Behaviors and do not pay their monthly bill after 90 days, depending on their income, **may be disenrolled** from the Iowa Health and Wellness Plan.

Financial Hardship for Iowa Health and Wellness Plan Members

If an Iowa Health and Wellness Plan member is unable to pay their contribution, they may check the hardship box on their monthly statement and return the payment coupon OR call IME Member Services at 1-800-338-8366.

Important: Claiming financial hardship will apply to that current month's amount due only. The member will still be responsible for amounts due from past months. Members will also be responsible for amounts due in future months unless they claim hardship in those months. Any payment that is more than 90 days past due will be subject to recovery or depending on their income, may be disenrolled.

Notice: Dental Wellness Plan members also have Healthy Behaviors to complete for dental coverage. See the Dental Benefits Plan section for more information.

HAWKI

The Children's Health Insurance Program (CHIP) is offered through the Healthy and Well Kids in Iowa program, also known as Hawki. Iowa's Hawki health coverage is offered to children who have no other health insurance. Eligibility is based on household income. Members are under 19 years of age. No family pays more than $40 per month. Some families pay nothing at all. To learn more about the benefits and services you may be able to get, refer to the **Covered Benefits and Services** section of this document.

COVERED BENEFITS AND SERVICES

As a member of the Iowa Total Care program you will receive a variety of medical benefits and services. Some services may require prior approval. Please work with your health care provider to determine if the specific service you need is covered. You may contact Iowa Total Care to find providers you can see for your medical care described below by calling our toll-free number at 1-833-404-1061 (TTY 711).

Services **prior authorization may be required*	**IA Health Link**	**Iowa Health and Wellness Plan (IHAWP)**	**Hawki**
	Covered	**Covered**	**Covered**
Preventive Services			
Affordable Care Act (ACA) preventive services	√	√	√
Routine check-ups	√	√ limitations may apply	√
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	√ up to age 21	√ up to age 21	
Immunizations	√	√ limitations may apply	√ limitations may apply
Professional Office Services			
Primary Care Provider	√	√	√
Office visit	√	√	√
Allergy testing	√	√	√
Allergy serum and injections	√	√	√
Certified nurse midwife services	√	√	√
Chiropractor	√ limitations may apply	√ limitations may apply	√ limitations may apply
Contraceptive devices	√	√	√
Family planning and family planning related services	√	√	√

Gynecological exam	√	√ limited to one visit per year	√
Injections	√ limitations may apply	√ limitations may apply	√ limitations may apply
Laboratory tests	√	√	√
Child care medical services	√ up to age 21 under EPSDT		
Newborn child - office visits	√	√	√
Podiatry	√ Routine foot care is not covered unless it is part of a Member's overall treatment related to certain health care conditions.	√ Routine foot care is not covered unless it is part of a Member's overall treatment related to certain health care conditions.	√
Routine eye exam *One routine vision exam per calendar year.*	√	√	√
Routine hearing exam *One routine hearing exam per calendar year.*	√	√	√
Specialist office visit	√ PCP referral may be required	√ PCP referral may be required	√ PCP referral may be required
Inpatient Hospital Services			
Preapproval of inpatient admissions	√ Required for non-emergent admissions	√ Required for non-emergent admissions	√ Required for non-emergent admissions
Room and board	√	√	√
Inpatient Physician services	√ includes anesthesia	√ includes anesthesia	√

Inpatient supplies	√	√	√
Inpatient surgery	√	√	√
Bariatric surgery for morbid obesity	√		√ limitations may apply
Breast reconstruction, following breast cancer and mastectomy	√	√	√ limitations may apply
Organ/bone marrow transplants	√ limitations apply	√ limitations apply	√ limitations apply
Outpatient Hospital Services			
Abortions	√ Certain circumstances must apply	√ Certain circumstances must apply	√ Certain circumstances must apply
Ambulatory surgical center	√ includes anesthesia	√ includes anesthesia	√ includes anesthesia
Chemotherapy	√	√	√
Dialysis	√	√	√
Outpatient diagnostic lab, radiology	√	√	√
Emergency Care			
Ambulance	√	√	√
Urgent care center	√	√	√
Hospital emergency room	√	√ $8.00 per visit for non-emergent medical services	√ emergency services for non-emergent conditions are subject to a $25 copay if the family pays a premium for the Hawki program
Non-Emergency Medical Transportation (NEMT)	√		

Behavioral Health Services			
Assertive Community Treatment (ACT)	√	√ Covered if member has been determined to be medically exempt.	
Behavioral Health Intervention Services (BHIS), including applied behavior analysis	√	√ residential treatment is covered if member has been determined to be medically exempt.	
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, and residential substance use treatment)	√ (MCO Members only)	√ Covered if member has been determined to be medically exempt.	
Inpatient mental health and substance abuse treatment	√	√ Limitations may apply	√
Office visit	√	√	√
Outpatient mental health and substance abuse	√	√	√
Psychiatric Medical Institutions for Children (PMIC)	√	√ For 19 to 20 year olds. Limitations may apply	
Crisis Response and Subacute Mental Health Services	√	√ Covered if member has been determined to be medically exempt.	√

Outpatient Therapy Services			
Cardiac rehabilitation	√	√	√
Occupational therapy	√	√ Limited to 60 visits per year	√
Oxygen therapy	√	√ Limited to 60 visits in a 12-month period	√
Physical therapy	√	√ Limited to 60 visits per year	√
Pulmonary therapy	√	√ Limited to 60 visits per year	√
Respiratory therapy	√	√ Limited to 60 visits per year	√
Speech therapy	√	√ Limited to 60 visits per year	√
Radiology Services			
Mammography	√	√	√
Routine radiology screening and diagnostic services	√	√	√

Sleep study testing	√	√ sleep apnea diagnostic services only	√
Laboratory Services			
Colorectal cancer screening	√	√	√
Diagnostic genetic testing	√	√	√
Pap smears	√	√	√
Pathology tests	√	√	√
Routine laboratory screening and diagnostic services	√	√	√
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) testing	√	√	√
Durable Medical Equipment (DME)			
Medical equipment and supplies	√	√	√
Diabetes equipment and supplies	√	√ limitations may apply	√
Eye glasses	√ limitations may apply	√ for ages 19 to 20, limitations may apply	√ limitations may apply
Hearing aids	√	√ for ages 19 to 20, limitations may apply	√ limitations may apply
Orthotics	√ limitations may apply		√ limitations may apply

Long Term Services Supports (LTSS) – Community Based			
Care Management – HCBS Waiver and HCBS Habitation populations only	√		
Section 1915(C) Home- and Community-Based Services (HCBS)	√		
Section 1915(I) Habilitation Services	√	√ medically exempt only	
Long Term Services and Support (LTSS) – Institutional			
ICF/ID (Intermediate Care Facility for individuals with Intellectual Disabilities)	√ limitations apply		
Nursing Facility (NF)	√		
Nursing Facility for the Mentally Ill (NF/MI)	√		
Skilled Nursing Facility (SNF)	√	√ limitations apply, limited to 120 day stays	
Skilled Nursing Facility Out of State (Skilled preapproval)	√ limitations apply		
Community-based Neurobehavioral Rehabilitation Services	√	√ medically exempt only	
Hospice			
Hospice	√	√ limitations apply	√

Chronic condition health homes	√	√ medically exempt only	
Integrated Health Homes	√	√ medically exempt only	
Home Health			
Private duty nursing/Personal cares per EPSDT authority	√ up to age 21 under EPSDT	√ up to age 21 under EPSDT	
Vision Services			
Exams (every 12 months): Additional coverage for exams are covered following eye surgeries or for monitoring of certain medical conditions may be covered.	√	√	√
Eyewear:	√ Eyeglasses (frames and lenses) are covered as follows: Under 1 year of age: 3 pair every 12 months Age 1 – 3: 4 pair every 12 months Age 4 – 7: 1 pair every 12 months Age 8 and over: 1 pair every 24 months	√ Eyeglasses (frames and lenses) are covered as follows: Age 19-21: 1 pair every 24 months	√ $100 each year towards frames and contact lenses

Repairs: Under 21: Covered for lost or damaged glasses. Over 21: Lost or damaged glasses beyond repair are covered once every 12 months.	√	√ Age 19-20: Coverage for lost or damaged glasses	

Excluded Services
Services Not Covered

Iowa Total Care does not pay for the following services:

- Services or items used for cosmetic purposes only
- Acupuncture
- Infertility Services
- Dental Services

This is not a complete list of excluded services. If you want to know if a service is covered, please call Iowa Total Care at 1-833-404-1061 (TTY: 711).

Prior Authorizations

Some services and benefits require prior approval. This means your provider must ask Iowa Total Care to approve those services or benefits before you get them. We may not cover the service or drug if you don't get approval.

If there are services that were approved before your coverage starts with Iowa Total Care, those services will still be approved for the first 90 days you're enrolled in Iowa Total Care, whether an in-network or out-of-network provider asked for the approval. After the first 90 days you're enrolled with Iowa Total Care, if you wish to keep getting services from an out-of-network provider, or if the services require prior approval, the provider must ask us to approve them before you can get these services.
These services do not require prior approval:

- Emergency services
- Post-stabilization care (after you get out of the hospital)
- Urgent care
- Family planning services
- Routine provider visits with in-network providers (some tests or procedures may require prior approval)
- Certain behavioral health and substance use disorder services (Ask your provider if prior approval is needed.)

If you have questions about an approval request, call Member Services at 1-833-404-1061 (TTY: 711).

Transportation Benefits

Iowa Total Care covers Non-Emergency Medical Transportation (NEMT) for IA Health Link members. This includes medically necessary covered services, such as doctor appointments, dialysis, and counseling appointments. Iowa Total Care works with Access2Care to provide transportation.

Schedule your ride at least three (3) working days before your appointment. You can schedule rides up to 60 days before your appointment. Sometimes urgent medical trips can be requested with less than a three days' notice. Access2Care may check with your provider to make sure your appointment is urgent.

To Schedule Transportation
Call 1-833-404-1061, Option 2 for transportation services. When scheduling a ride, you will be asked for:

- your full name, address and telephone number.
- your Medicaid identification number.
- the date and location of your medical appointment.
- the type of appointment.
- the reason for your transportation request.
- the type of assistance or mobility aid(s), as needed.

Dental Benefits

Iowa Total Care only covers dental procedures done in a hospital setting. Dental services are available to Iowa Medicaid members age 18 and younger through the Iowa Medicaid Fee-for-Service (FFS) program. Most Iowa Medicaid members, age 19 and older, are enrolled in the Dental Wellness Plan. Hawki members receive their dental benefits through Delta Dental of Iowa.

These services are not part of those provided by your MCO, however your dental visit may help qualify you for Healthy Behavior Awards through Iowa Total Care. During your dental visit your dentist will go over your dental health. You may receive a dental cleaning or basic x-ray's as well. For questions about your dental benefits, call Iowa Medicaid Member Services at 1-800-338-8366.

Healthy Behaviors for Dental Wellness Plan Members

All Dental Wellness Plan members have full dental benefits during the first year. You must complete Healthy Behaviors during this year to keep your Full Benefits in the next year. Healthy Behaviors include completion of both:

1. Oral Health Self-Assessment AND
2. Preventive Service

What Happens If I Don't Complete My Healthy Behaviors? Depending on your income, you may have to pay a monthly premium after the first year if you don't complete Healthy Behaviors. Complete Healthy Behaviors each year to waive your monthly premiums for the next year. If you have a monthly premium after your first year and do not make payments, you will only have emergency dental benefits.

How Much Will I Have To Pay? Monthly premiums for the Dental Wellness Plan are no more than $3 per month. If you are unable to pay, you may check the hardship box on your monthly statement and return the payment coupon OR call Iowa Medicaid Member Services at 1-800-338-8366.

Notice: Iowa Health and Wellness Plan members also have Healthy Behaviors to complete for medical coverage. Find information on these Healthy Behaviors in the 'Iowa Health and Wellness Plan' section of this handbook.

GOING TO THE DOCTOR

To get many kinds of care, you can just choose an in-network provider and make an appointment. You do not need approval from Iowa Total Care or a referral from your provider for these services:

- Visits to a Primary Care Provider (PCP), pediatrician or family doctor
- Visits to specialist doctors (some specialists need a referral from your PCP. Visit www.iowatotalcare.com for full details.)
- Urgent care
- Obstetrics & Gynecology (OB/GYN) care.
    - Make an appointment as soon as you think you are pregnant.
    - Female members will have direct access to an in-network OB/GYN, or other women's health specialist for routine OB/GYN services regardless of whether your PCP (general practitioner, family practitioner or internist) provides such women's health services, including routine gynecological exams.
- Behavioral health services (mental health and substance use services)
- Routine vision services

We can help you find or choose a provider. Call Member Services at our toll-free number 1-833-404-1061 (TTY: 711). Or you can find a provider online at www.iowatotalcare.com.

Picking Your Primary Care Provider (PCP)

When you become an Iowa Total Care member, you must choose a PCP within 10 calendar days from your initial enrollment. If you do not choose one, we will assign you one.

If you did not choose a PCP, we will notify you of your assigned PCP when you receive your Iowa Total Care member ID card. This mailing will include your assigned PCP's name, location, and office telephone number, as well as offering you an opportunity to select a different PCP, if you are not satisfied with the Plan-assigned PCP.

Your PCP will be your main doctor. They can help coordinate all of your health needs. You can choose any PCP in our network. You can change your PCP any time. Your PCP can be a:

- Family or General Practitioner
- Internal Medicine
- Pediatrician
- Advanced Registered Nurse Practitioner (ARNP)
- Obstetrician or Gynecologist (OB/GYN)
- Physician Assistant (under the supervision of a Physician)

- Attending specialist (for members requiring specialty care for their acute or chronic conditions, or condition related to a disability)
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Indian Tribe, Tribal Organization or Urban Indian Organization

If you would like to know more about a PCP, you can call Member Services at our toll free-number 1-833-404-1061 (TTY: 711). They can tell you what language the provider speaks, if they are in the network, and where they are located. If you would like to change your PCP, we will help you.

There are two ways to change your PCP:

1. Use the Secure Member Portal on our website www.iowatotalcare.com.

2. Call Member Services at our toll-free number 1-833-404-1061 (TTY: 711) to help you. After you tell us who your new PCP is, we will send you a new Iowa Total Care member ID card with your new PCP's name and telephone number on it.

Specialists

You may need to see a specialist. Iowa Total Care does not need a referral from your PCP to cover the service. The specialist may still need a referral from your PCP. This helps them give you the right treatment. They will tell you if they need a referral. Members can also receive a second opinion at no cost to the member. If you would like help finding an in-network provider, please call Member Services at our toll-free number 1-833-404-1061.

Some of the services that need a referral from your PCP are:

- Diagnostic tests (X-ray & lab)
- Scheduled outpatient hospital services
- Planned inpatient admission
- Renal dialysis (kidney disease)
- Out-of-network providers need Iowa Total Care approval (with exception to Family Planning services)
- Durable Medical Equipment (DME)
- Home health care

Going to Your PCP

After you choose your PCP, make an appointment with them. This will give you both a chance to get to know each other. Your PCP can give you medical care, advice and information about your health.

Call your PCP's office to make an appointment. Remember to bring your Iowa Total Care member ID card and Iowa Medicaid ID card. Hawki members should bring their Hawki ID card. If you need help getting an appointment with your PCP, call Iowa Total Care Member Services at our toll-free number 1-833-404-1061 (TTY: 711) and Iowa Total Care will assist.

Important: You have unlimited visits to your PCP. There is no cost to you. Make appointments with them when you feel sick. You should also have a wellness check-up every year.

Members have the right to ask for a second opinion at no cost to the member about the diagnosis or the options for surgery or other treatment of a health condition. You can get a second opinion from a network provider or a non-network provider if a network provider is not available. Please call Member Services at our toll-free number 1-833-404-1061.

Procedures for obtaining out-of-network services and special benefit provisions (for example, co-payments, limits or rejections of claims):

If there are services that were approved before your coverage starts with Iowa Total Care, those services will still be approved for the first 30 days you're enrolled in Iowa Total Care, whether an in-network or **out-of-network provider** asked for the approval.

After the first 30 days you're enrolled with Iowa Total Care, if you wish to keep getting services from an out-of-network provider, or if the services require prior approval, the provider must ask us to approve them before you can get these services.

Benefit Provisions:
Emergency services – doesn't matter if in or out of network
If not an actual emergency an $8 Co-Pay applies
If seeing a Specialist Out of Network and do NOT get prior Authorization, the Claim is denied
If seeing a Specialist Out of Network with a prior Authorization, the Claim is paid at a reduced benefit (80%)

You may have to pay for out-of-network services if you do not get prior authorization. If you have questions, call Member Services at our toll-free number 1-833-404-1061 (TTY: 711).

Notice of significant change about your PCP

Your PCP's office may move, close or leave the Iowa Total Care network. If this happens, we will notify you within 15 days. We can help you pick a new PCP and send you a new ID card within five business days after you pick a new PCP. Please call Member Services at our toll-free number 1-833-404-1061.

PHARMACY

When you need a prescription, your doctor will contact your pharmacy or give you a written prescription to take to your pharmacy. The pharmacy can fill your prescription, but if the prescription is not listed on the Iowa Preferred Drug List (PDL) it may not be covered.

All Iowa Total Care members must use a pharmacy in our network. **To find a pharmacy, call Iowa Total Care Member Services. The toll-free phone number is 1-833-404-1061 (TTY: 711) or you can look for a pharmacy on our website at www.iowatotalcare.com.** Show your Iowa Total Care ID card to the pharmacy when you pick up medication. Do not wait until you are out of a medication to request a refill. Call your doctor or pharmacy a few days before you run out.

Preferred Drug List (PDL)
Your pharmacy benefit has a Preferred Drug List. The PDL shows the drugs covered by Medicaid.

The PDL is a list of drugs recommended by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that have been identified as being therapeutically equivalent within a drug class, and that provide cost benefits to the Medicaid program. **You can find the link to the Iowa Medicaid PDL on our website at www.iowatotalcare.com under the Pharmacy section.**

To request a printed copy of the PDL, call Member Services at our toll-free number 1-833-404-1061 (TTY: 711). **Some prescriptions will require prior authorization.** Your provider may have to send us a request for approval for certain drugs on the PDL. Your provider may have to send information on why a certain drug is medically necessary.

The PDL includes the limits for each drug on the list. If your drug is not on the drug list, call Member Services at 1-833-404-1061 (TTY: 711) to ask if your drug is covered. If your drug is not covered, you can ask your doctor to prescribe a similar drug that is covered. If your doctor feels you need to have the drug that is not covered, your doctor can ask us to make an exception.

Most medications are covered up to a 31-day supply with the exception of some contraceptives. Some contraceptives are covered up to a 90-day supply. Should the medication require a prior authorization, you may receive 72-hour emergency supply of the medication while the prior authorization is being reviewed. Refer to the Iowa Medicaid PDL or call Iowa Total Care Member Services at our toll-free number 1-833-404-1061 (TTY:711)

Copays
Iowa Total Care does not charge members any copayments for pharmaceuticals; however, you may be responsible for a copay for other services. Please see your Iowa Total Care ID card for your current copayments.

Prescriptions

Iowa Total Care does cover these types of medication:

- Prescription drugs and some Over-the-Counter (OTC) items approved by the U.S. Food and Drug Administration (FDA)
- Self-injectable drugs (including insulin)
- Drugs to help you quit smoking

Iowa Total Care does not cover:

- Drugs that do not have Federal Drug Administration (FDA) approval or compendia indications
- Experimental or investigational drugs
- Drugs to help you get pregnant
- Drugs used for weight loss, cosmetic or hair growth
- Drugs used to treat erectile problems
- Drug Efficacy Study Implementation (DESI) drugs – The FDA has very little proof that the drugs will help. Also, the reason for their medical need has not been proven.
- Drugs for relief of cough and cold, except listed nonprescription drugs

Iowa Total Care offers mail order prescriptions to our members. To request a mail order prescription please contact Iowa Total Care Member Services at our toll-free number 1-833-404-1061 (TTY: 711).

Over-the-Counter (OTC) Medicines

Iowa Total Care members have access to some OTC medications with a written prescription from an authorized prescriber. The covered list of OTC medications is located on the Iowa Medicaid PDL. You can access the OTC list through a link located on the www.iowatotalcare.com or contact Iowa Total Care Member Services at our toll-free number 1-833-404-1061 (TTY: 711). Some over the counter medications may require a prior authorization.

EMERGENCY AND URGENT CARE

Emergencies
Emergency care is covered by Iowa Total Care in the United States and does not require a prior authorization. You can use any hospital or other setting for emergency care. An emergency is when not getting medical attention could risk your health, or during pregnancy, the health of an unborn child. An emergency can include an accident, injury or sudden illness.

Go to the emergency room for:

- Broken bone(s)
- Gun or knife wound(s)
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Severe chest pain or heart attack
- Drug overdose
- You feel you are a danger to yourself or others
- Poisoning
- Bad burn(s)
- Shock (you may sweat, feel thirsty or dizzy or have pale skin)
- Convulsions or seizures
- Trouble breathing
- Suddenly unable to see, move or speak

Do NOT go to the emergency room for:

- Flu, cold, sore throat or earache
- A sprain or strain
- A cut or scrape that does not need stitches
- To get more medicine or have a prescription refilled
- Diaper rash

Emergency rooms are for emergencies. If you can, call your PCP first. If your condition is severe, call 911 or go to the nearest hospital. You do not need approval.

If you are not sure if it is an emergency, call your doctor. Your doctor will tell you what to do. If your doctor's office is closed there should be a message telling you how to get help. You can also call our 24/7 Nurse Advice Line. The toll-free phone number is 1-833-404-1061 (TTY: 711).

You can go to a hospital that is not in the Iowa Total Care network. You can use any hospital emergency room in the United States. Show the provider your Iowa Total Care member ID card.

Call your PCP and Iowa Total Care after you go to the emergency room. Call within 48 hours of your emergency. This help us make sure you get the follow-up care you need.

The toll-free phone number is 1-833-404-1061 (TTY: Relay 711).

Non-Emergency Care in the Emergency Room
You should not go to the emergency room for a medical illness where immediate care is not needed. This is called non-emergency care. The emergency room staff will decide if your medical illness is an emergency by conducting appropriate medical screening. If the emergency room staff decides your medical illness is not an emergency, they must let you know. Before the emergency room staff provides care for the medical illness, that is not an emergency, they must tell you where you can go to get care.

* There is an **$8 copay for IHAWP members and $25 for Hawki premium members for using the emergency room for non-emergency services**.

Out-of-Network Emergency Services

Out-of-network emergency services do not need approval from Iowa Total Care. All other services from an out-of-network provider need prior authorization. We will check to see if there is an in-network provider who can help you. If not, we will help you find an out-of-network provider.

IMPORTANT: You may have to pay for out-of-network services if you do not get prior authorization. If you have questions, call Member Services. The toll-free phone number is 1-833-404-1061 (TTY: 711).

Post Stabilization Services

Post stabilization services are services you need after an emergency. These services help get your health back to normal. These services are important and help make sure you do not have another emergency. Post stabilization services are covered and subject to prior authorization requirements.

Emergency Transportation

Iowa Total Care covers emergency ambulance transportation. They will take you to the nearest hospital. Ambulance transportation from one health care facility to another is only covered when it is:

- Medically necessary
- Arranged for and approved by an in-network provider

If you have an emergency and you need help getting to the emergency room, call 911.

Urgent Care

Urgent care is NOT emergency care. You should use urgent care when you have an injury or illness that is not life threatening but needs to be treated within 48 hours. Use urgent care when you cannot wait for an appointment with your doctor. Only go to the emergency room if your provider tells you to or if you have a life-threatening emergency. When you need urgent care, follow these steps:

- **Call your PCP.** The name and phone number are on your Iowa Total Care member ID card. An after-hours number is listed. Your doctor may help you and give you directions over the phone.
- **If you cannot reach your PCP, call our 24/7 Nurse Advice Line.** The toll-free phone number is 1-833-404-1061 (TTY: 711). You will talk to a nurse. Have your Iowa Total Care member ID card with you. They will ask you for your number. The nurse will help you over the phone. If you need to see a doctor they will help you find care.
- **If you have a mental illness or addiction crisis, do not wait to get help.** Call our Behavioral Health Crisis Line at our toll-free number 1-833-404-1061 (TTY: 711).
- Iowa Total Care also has a behavioral health crisis line that is free to you. That toll-free number is 1-833-404-1061, then press *. They can help with depression, substance use and other behavioral health needs.

If your provider tells you to go to the nearest emergency room go right away. Take your Iowa Total Care member ID card and Iowa Medicaid ID card with you.

Hospital Services

Hospital services are those services provided in the hospital setting. These services may be considered observation, inpatient or outpatient services. Please speak with your provider about these services as they are subject to authorization requirements. Emergency services never require authorization. If you are experiencing a true medical emergency, go to the nearest hospital.

Routine Care

Medical care, which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment is considered a routine care event. You should call your PCP to schedule routine care. If you go to the emergency room for these type of services, you may be required to pay a copayment for the services you get there.

Family Planning

Iowa Total Care covers family planning services for males and females of childbearing age. You do not need a referral or authorization to see the practitioner of your choice in or out-of-network. There is no out of pocket cost (copay) for these services and or supplies.

MEMBER COSTS

Copays

Some Iowa Total Care Members are subject to a **Copayment (copay)**, for certain services (see Emergency Care Co-payments below), which are tracked by Iowa Total Care (Aggregate Share of Cost). This will be indicated on your member ID card. Member co-payments are capped at 5% of household income.

Paying Copays

- You must make copays directly to provider at the time of service.
- You are always responsible for paying a provider's full charges for non-covered services.

At any time, you can ask us how much you and your household have paid in copays. There are several ways to request your copay totals:

- Contact Iowa Total Care Member Services by calling our toll-free number at 1-833-404-1061
- Request through your online account on the Member Secure Portal
- Request this information from your care coordinator

If you do not agree with the copay totals we tell you, you have the right to appeal.

If you paid a copay that you should not have been charged for, you have the right to be paid back by the provider who collected the copay.

Exemptions

These types of members are always exempt from paying copays:

- Children under the age of 21
- Pregnant women
- Individuals receiving hospice care
- Federally-recognized American Indians/Alaska Natives
- Children in Foster Care
- Breast and Cervical Cancer Care Program (BCCCP)
- Disabled children under Family Opportunity Act

Note: You will be charged a copay if you decide to get care at the emergency room, and your medical illness is not an emergency.

Emergency Care Co-payments

An eight dollar ($8) copayment for Iowa Total Care Plan Members and a twenty-five dollar ($25) copayment for Hawki Members will be applied for use of a hospital Emergency Department (ED) to treat non-emergent conditions. A copayment shall not be imposed on Hawki Members whose family income is less than 182 percent of the federal poverty level.

Before providing non-emergency services and imposing co-payments, the hospital providing care must:

1. Conduct an appropriate medical screening to determine that the Member does not need emergency services
2. Inform the Member of the amount of his or her co-payment obligation for non-emergency services provided in the hospital ED
3. Provide the Member with the name and location of an available and accessible alternative non-emergency services provider
4. Determine that the alternative provider can provide services to the Member in a timely manner with the imposition of a lesser or no co-payment
5. Provide a referral to coordinate scheduling for treatment by the alternative provider

If the Member has been advised of the available alternative provider and of the amount of the co-payment, and chooses to continue to receive treatment for a non-emergency condition at the hospital ED, the hospital will assess the co-payment.

Emergency services rendered for emergent conditions are exempt from any copayment

Member Liability/Client Participation

The other type of cost sharing is when a member must pay a portion of their monthly expense. This is referred to as **Patient Liability.**

Client Participation

Client participation is the amount of income the Member must pay before Medicaid reimbursement for services is available. Members may be subject to client participation such as the following: (i) Members in an institutional setting and (ii) 1915(c) HCBS Waiver Member. The Iowa Department of Human Services (DHS) has the responsibility of determining the Member liability amount.

Explanation of Benefits

If you receive a service from a provider and we don't pay for that service, you may receive a notice from us called an Explanation of Benefits (EOB). **This is not a bill.** The EOB will tell you:

- The date you received the service
- The type of service
- The reason we cannot pay for the service

If you receive an EOB:

- **You don't need to call or do anything at that time.**
- You aren't liable for payment.
- It tells you how you can appeal this decision.

VALUE-ADDED SERVICES

We offer these Value-Added Services to our members. If you have any questions about these services, call Iowa Total Care Member Services toll-free at 1-833-404-1061.

My Health Pays
This program rewards members who engage in healthy behaviors with predetermined nominal dollar amounts. Members who complete plan determined healthy behaviors will receive a reloadable Visa card. This Visa card can only be used at participating retailers, such as Walmart and for additional options such as transportation, utilities, phone bills, education costs, child care and rent. This card does not allow for the purchase of tobacco, firearms, or alcohol. In addition to this, members may utilize this card for medical cost share. Should a member incur a copay for a non-emergent emergency department visit, they may use the card to pay for this copay.

Mobile App
To make information easily accessible to members, Iowa Total Care offers a Mobile App that includes interactive tools and functions, such as Health Risk Screening, Care Gap Alerts, Health Library, one touch calling, Mobile Find-a-Provider, Mobile ID Card, and personal health trackers, designed to be a comprehensive and integrated mobile “one stop shop.”

The Flu Program
The Flu Program is our annual flu prevention campaign that provides targeted outreach to you as a member. The program provides information about preventing transmission of the influenza virus by encouraging you to get the seasonal flu vaccines, taking everyday precautions to prevent illness, and what to do if a member (or family member) becomes ill. Additionally, you are able to obtain your flu vaccine at participating pharmacies subject to the age or other restrictions of the pharmacy.

Start Smart for Your Baby (Start Smart)
Start Smart promotes education and communication between pregnant members and our case managers to ensure a healthy pregnancy and first year of life for their babies. Start Smart offers a range of care management techniques, including health screenings, educational literature and MP3 players with educational podcasts designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease which can result from high-risk pregnancies. The program provides educational materials as well as incentives for going to prenatal, postpartum, and well-child visits. Other services provided include:

> **Start Smart Mobile.** An interactive and personalized application for new and expecting mothers. Start Smart Mobile will provide support for Iowa Total Care’s pregnant members from the first positive pregnancy test through the post-partum and early newborn period. The mobile application helps families stay on track with key prevention milestones, set personalized reminders, identify and take action on health issues, and tap into Iowa Total Care’s other programs, such as, Care Management via phone and a 24/7 nurse advice line. Start Smart Mobile content is

personalized based on expecting mother's due date and provides daily advice and informational photos and videos by weekly pregnancy stage. Start Smart Mobile features a broad range of interactive tracking tools, self-service functions, alerts, educational videos, and resources. Using Start Smart Mobile, Members are able to access care and support quickly and efficiently, engage with self-service tools (i.e., gaps-in-care, set custom reminders and alerts), check their My Health Pays rewards balance, and interact with additional features (i.e., baby gift registry and name picker, local parenting classes, family planning tools and information to enroll their newborn in health coverage). Includes free gifts for qualified moms.

Start Smart® Baby Shower Program. Baby Showers are conducted in a classroom environment in different locations across the state to educate pregnant members about prenatal and postpartum care for themselves and their newborn. The classes cover the basics of prenatal care, including nutrition, the risk of smoking and benefits of smoking cessation, the progress of a fetus throughout pregnancy, the importance of regular follow-up with medical providers, common health issues that occur during pregnancy, and a review of the Start Smart® and MemberConnections programs.

MemberConnections® Community Health Worker (CHW) Program.
MemberConnections® Community Health Workers (CHWs) allow us to provide a high touch, personal level of interaction with our members that builds strong relationships and trust. CHWs are hired from within the communities we serve to help ensure that our outreach is culturally competent and conducted by people who know the needs of the people in the community. CHWs receive comprehensive training, including CHW certification, and become an important part of our Member Services and Care Coordination staff, which benefits our members and increases our effectiveness. CHWs make home visits to high-risk members we cannot reach by phone, and will assist with member outreach, coordinate social services, and attend community events to provide health education and outreach.

ConnectionsPlus®
Iowa Total Care offers the ConnectionsPlus® Program, which provides pre-programmed cell phones to our eligible high-risk members who lack reliable phone access, through SafeLink or through the plan if you do not qualify for a SafeLink phone. For example, if there are multiple members in the household. This program provides 24-hour access for our members, allowing them to make calls to and receive calls from their providers, case managers (including behavioral health case managers), peer supports (for members with behavioral health conditions), health plan personnel, our nurse advice line, and 911. The overall purpose of the program is to prevent events such as inappropriate ER use or hospital admissions through improved access to healthcare information and treating providers. High-risk members receive a cell phone (at no expense to the member) that has pre-programmed direct dial to important phone numbers. Members are educated on how to monitor their health and calling quickly for advice rather than waiting until the next appointment. The cell phones are also used so that case managers can send the member a text message with health information targeted to the individual member's condition. In rural areas, this program helps members more easily connect with their provider.

WELLNESS CARE

Healthy Celebration Days

This benefit helps ensure that Iowa Total Care members receive needed preventive health check-ups. At these events, Iowa Total Care will partner with provider offices across the state to identify members who have missed certain preventive care visits. Iowa Total Care staff will then make contact with the member to encourage them to make an appointment for the needed service on a certain day set aside by the practice and assist with arranging transportation, interpretive services or other accommodations as needed.

Additional Value-Added Services include:

- No co-pays, except for ER visits.
- Telephone coaching sessions and educational print materials.

Your health is important to us. Good health begins with enough sleep, healthy food and healthy behaviors. One of these behaviors is to see your doctor annually (children more frequently) and to follow the advice of your doctor.

Wellness Care for Adults

You should schedule yearly checkups with your PCP to safeguard your health. These checkups can include a physical exam, blood tests, and the shots you need. If there is a health problem, it can be discovered and treated early. How often you get a screening is based on your age and risk factors. Talk to your doctor about what's right for you.

Wellness Care for Children

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is preventive care for IA Health Link children under the age of 21. These are also called well-child checkups. Doctor visits when your child is well helps make sure they are growing, healthy, and safe. These services are provided at no cost to you. How often your child gets a screening is based on his/her age and risk factors. Talk to your doctor about what's right for your child. Many schools, activities, and other organizations require a "sports physical." This is a limited exam. Tell your provider if you need this exam. They can complete the forms you need during your child's well- child checkup.

We have many programs and tools to help keep you and your family healthy, including:

- Health coaching
- Care management services
- Pregnancy care and parenting classes
- Well-care reminders

Your provider may suggest one of these programs for you. If you want to know more about these programs please call Member Services.

CARE FOR PREGNANT MEMBERS

Women may see any OB/GYN for pregnancy care without being sent by their PCP (maternity-prenatal, delivery and postpartum).

- If you think you may be pregnant, see your PCP or an OB/GYN right away. It is important to start prenatal care as soon as you become pregnant.
- See your PCP or OB/GYN throughout your pregnancy.
- Make sure you go to all your visits when your PCP or OB/GYN tells you to.
- Make sure you go to your provider after you have your baby for follow-up care (between 21 and 56 days after your baby is born).

There are things you can do to help have a safe pregnancy. Talk to your doctor about medical problems you have, like diabetes and high blood pressure. Do not use tobacco, alcohol or drugs now or while you are pregnant.

You should see your doctor before you are pregnant if you have had the following problems:

- Three or more miscarriages
- Premature birth (born before 38 weeks of pregnancy)
- Stillbirth

When you are pregnant, keep the following in mind:

- Go to the doctor (OB/GYN) as soon as you think you are pregnant. It is important for you and your baby's health to see a doctor as early as possible.
- If you have had problems or a high-risk pregnancy in the past, you may need extra care. Choose a doctor you can see during your entire pregnancy. It is even better to see your doctor before you get pregnant. The doctor can help you get your body ready for pregnancy.
- You should choose a pediatrician for your baby before it is born. If you do not choose a pediatrician, Iowa Total Care will choose one for you.

It is important to have healthy lifestyle habits while you are pregnant. This includes exercising, eating balanced meals, not smoking, and sleeping 8-10 hours a night. These things can help you and your baby stay healthy.

A Note about Folic Acid

Folic acid is very important for your baby's health. Getting enough folic acid can help prevent serious birth defects. Folic acid is a B vitamin. It is found mostly in leafy green vegetables like kale and spinach. It is also found in enriched grains. Some foods with folic acid in them include:

- Orange juice
- Green vegetables
- Beans
- Peas
- Fortified breakfast cereals
- Enriched rice
- Whole wheat bread

It is difficult to get enough folic acid from food alone. Ask your doctor about taking prenatal vitamins. These will have the extra folic acid your baby needs. Your baby needs this right away. This is one reason to see your doctor as soon as you think you could be pregnant.

Start Smart for Your Baby®

Start Smart for Your Baby (Start Smart) is a program just for pregnant women and mothers with a newborn. It helps make sure you and your baby are healthy during your pregnancy and after you deliver.

When you sign up, we will give you information that can help you. We will talk to you on the phone and send you things in the mail. Our Start Smart staff can answer questions and give you support if you are having a problem. We can even arrange for a home visit if you need more help. We have a website just for this program. It is www.startsmartforyourbaby.com.

Smoking Cessation

If you are pregnant and smoke, we can help you stop smoking. We have a free smoking cessation program for pregnant women. The program has trained health care workers who are ready to help you one-on-one.

They will provide the education, counseling and support you need to help you quit smoking. Through regular phone calls, you and your health coach develop a plan to make changes to help you stop smoking.

CARE MANAGEMENT

We offer one-on-one help for members with a specific health concern. Care Management gives support to members who need extra help to be as healthy as possible. These services can be:

- Education about lifestyle changes
- Home care
- Community resources

Our staff will reach out to you within 30 calendar days of your enrollment. The staff member will ask you some questions about your health and health care needs. It is important that we speak to be sure you get or continue to get the services you need. This will help us determine if you have needs we can help you with. If you need help, we will visit with you and talk about your needs and how we can help. We will work together on a care plan specifically for you. We may even be able to help you with things such as food, shelter, and community resources you may not know about.

Should You Be in Care Management?

Care Management could be helpful to you if you:

- Have a life long illness like asthma or diabetes
- Have or are at risk for a serious condition
- Have a behavioral health need
- Have a developmental or physical disability
- Have some other special health care need
- Have nursing facility level of care needs
- Need Home and Community Based Services
- Are using the Self-Directed Community Benefit Services

What Is a Care Manager?

A Care Manager is a personal wellness coach. They work closely with you to plan your health goals. They help you figure out the steps to achieve your goals.
Our Care Coordination/Care Management teams include:

- Registered Nurses (RN)
- Licensed Social Workers (LSW)
- Behavioral Health Clinicians (counselor or social worker)
- Community Health Services Representatives

Your Care Manager will work with you and your providers to help you get the care you need. Together, you will develop your individualized plan of care. Sometimes they can arrange treatment that is not typical for most people. They may work with our Medical Director to authorize additional care when:

- There is a serious condition and treatment will probably take a long time
- There are alternative services that can be used instead of covered services that are more expensive
- More services than usual are necessary

We will work with you individually to establish a person-centered service plan and allow you to participate in arranging and directing your own care, if you wish to do so. We will stop or adjust the plan if it is no longer appropriate or it doesn't work. You would get a letter notifying you of a change at least 10 calendar days before a plan is stopped. For more information about Care Management or making changes to currently assigned care management program, you can call Member Services and ask to speak with a Care Management staff. We will help you find the right resources for your needs.

Chronic Care Management

We offer chronic care management services. Our care managers help doctors, specialists, and the member work together for the best care. These care managers teach the member about their condition. They help the member make a plan to improve their health.
Members with these conditions may benefit from chronic care management:

- Asthma
- Coronary Artery Disease
- COPD
- Heart Failure
- Tobacco Abuse

Our care managers will listen to the member concerns. They will help the member get the things they need. They will talk to the member about:

- Understanding your condition
- Making a plan of care
- How to take your medicine
- What screening tests to get
- When to call your doctor or other provider

The goal of chronic care management is to help the member understand and take control of their health. Better control means better health. For more information, call Member Services.

BEHAVIORAL HEALTH

Behavioral health refers to mental health and substance use (alcohol and drug) treatment. Sometimes talking to a friend or family member can help you work out a problem. When that is not enough, call your doctor or Iowa Total Care. We can give you support. We can talk to your providers/doctors and help you find mental health and substance use providers to help you.

You do not need a referral from your doctor. You can go to any provider in our network for services. Providers will help you figure out what services might best meet your needs.

To learn more about specific covered benefits contact Iowa Total Care at our toll-free number 1-833-404-1061.

How do I know if I/my child needs help?

- Can't cope with daily life
- Feels very sad, stressed or worried
- Not sleeping or eating well
- Thinks about hurting themselves or others
- Bothered by strange thoughts, like hearing or seeing things other people don't
- Drinking alcohol or using other substances
- Having problems at school
- The school or daycare thinks that your child should see a doctor about mental health or substance use problems, including Attention Deficit Hyperactivity Disorder (ADHD)
- Unable to concentrate
- Feels hopeless

If you have a behavioral health concern we can help you find a provider. We want you to have a provider who will be a good match for you. It is important for you to have someone to talk to so you can work on solving problems.

What do I do in a behavioral health emergency?

In a life-threatening emergency, call 911 or you can go to the nearest emergency room. You do not have to wait for an emergency to get help. Iowa Total Care has a crisis support line. The toll-free phone number is 1-833-404-1061.They will help you at any time for free. They can help with depression, mental illness, substance use and other behavioral health needs.

If you would like to speak to an Iowa Total Care, Care Manager, you may call Member Services at our toll-free number 1-833-404-1061 for assistance finding a provider in your area.

Are there any online behavioral health services?

Iowa Total Care, offers online, consumer directed behavioral health resources through www.myStrength.com, a website that offers a range of personalized e-Learning programs to help overcome depression, anxiety or overuse of drugs or alcohol supported by tools, weekly exercises and daily inspiration in a safe and confidential environment. The website offers members in need the ability to take responsibility for their healthcare and learn more about their diagnoses, track their symptoms, and offers motivational ideas and information. We also encourage caregivers to enroll and utilize MyStrength for support for themselves or to better understand the behavioral health diagnosis of the child. MyStrength is also accessible through a member's smart phone.

LONG TERM SERVICES AND SUPPORTS

Iowa Total Care coverage includes services for members who require services and supports at a level that is provided in facility-based settings such as a nursing home or an intermediate care facility. This is referred to as Long-Term Care (LTC). When the same type of care is provided to you in your home and/or community (Home and Community Based Services or HCBS), in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID), or in a Nursing Facility or Skilled Nursing Facility it is called Long Term Services and Supports (LTSS).

The Role of Community Based Case Managers

The Community Based Case Managers (CBCM) main role is to support members and help them access LTSS and other services. The CBCM is responsible to lead the Person-Centered Service Plan (PCSP) process. The CBCM will identify, coordinate, and assist the member in accessing all needed services including covered and non-covered services, medical, social, housing, educational, and other necessary services and supports. The CBCM is responsible for locating and coordinating providers, specialists, or other services needed for service delivery. This includes coordination between physical, behavioral, and support services. The CBCM will work with the member to complete activities necessary to maintain LTSS eligibility. The CBCM will keep the member informed during the process of facilitating, locating, and monitoring services and support. Service alternatives and other options will be taken into consideration, such as Consumer Choices Option (CCO), and other LTSS services. To contact a CBCM, please call Iowa Total Care at 833-404-1061.

Home- and Community- Based Services

Home- and Community- Based Services (HCBS) are designed for people with disabilities, chronic mental illness and older Iowans who need help with the normal activities of daily living, like eating, bathing, dressing, or using the bathroom. HCBS can help people maintain their quality of life while staying in their home instead of moving to an institutional setting, such as a nursing home.

If you need help with daily living tasks, call your Community Based Case Manager (CBCM). If you do not have a CBCM, please contact Iowa Total Care. If you are not currently receiving HCBS, Iowa Total Care will help you with the process to access those services. An assessment is needed to determine if you need the level of care provided in a nursing facility, skilled nursing facility, hospital, or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID). If the assessment shows you need those services, and you are Medicaid eligible, you may be able to receive nursing home services or choose to receive services in your home.

To receive HCBS, you must meet the specific requirements of one of Iowa's eight HCBS programs:

AIDS/HIV Waiver
AIDS/HIV Waiver services may be available to people who:

- Are diagnosed by a physician as having AIDS or HIV infection
- Are determined to need ICF or hospital level of care

Based on your assessed needs, covered services may include:
AIDS/HIV Waiver Services

- Adult day care
- Consumer-Directed Attendant Care (CDAC)
- Counseling services
- Home-delivered meals
- Home health aide
- Homemaker services
- Nursing care
- Respite
- Consumer choices option

Brain Injury Waiver
Brain Injury (BI) Waiver services may be available to people who are:

- Determined to have a brain injury diagnosis, as defined under the Iowa Administrative Code
- Determined to need Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) level of care
- At least 1 month of age

Based on your assessed needs, covered services may include:
Brain Injury Waiver Services

- Adult day care
- Behavioral programming
- Consumer-Directed Attendant Care (CDAC)
- Family counseling and training
- Home and vehicle modifications
- Interim medical monitoring and treatment
- Personal Emergency Response System (PERS)
- Prevocational services
- Respite
- Specialized medical equipment
- Supported Community Living (SCL)
- Supported employment
- Transportation
- Consumer Choices Option (CCO)

Children's Mental Health Waiver
Children's Mental Health (CMH) Waiver services may be available to people who:

- Are aged from birth to age 18
- Have a diagnosis of Serious Emotional Disturbance (SED) as verified by a psychiatrist, psychologist or mental health professional within the past 12 months
- Are determined to need hospital level of care

Based on your assessed needs, covered services may include:
Children's Mental Health Waiver Services

- Environmental modifications, adaptive devices and therapeutic resources
- In-home family therapy
- Family and community supports
- Respite

Elderly Waiver
Elderly Waiver services may be available to people who are:

- Age 65 or older
- Determined to need Intermediate Care Facility (ICF) or skilled level of care

Based on your assessed needs, covered services may include:
Elderly Waiver Services

- Adult day care
- Assistive devices
- Assisted living
- Chore services
- Consumer-Directed Attendant Care (CDAC)
- Emergency response system
- Home and vehicle modifications
- Home-delivered meals
- Home health aide
- Homemaker services
- Mental health outreach
- Nursing care
- Nutritional counseling
- Respite
- Senior companions
- Transportation
- Consumer Choices Option (CCO)

Habilitation
Habilitation services may be available to people who experience functional limitations typically associated with chronic mental illness.

Based on your assessed needs, covered services may include:
Habilitation Waiver Services

- Home-based habilitation (hourly and daily services)
- Day habilitation
- Prevocational
- Supported employment

Health and Disability Waiver
Health and Disability (HD) Waiver services may be available to people who:

- Are under age 65 and blind or determined disabled by receipt of Social Security disability benefits or through the Iowa Department of Human Services' disability decision process
- Are ineligible for SSI if over age 21; members receiving HD Waiver services when reaching age 21 may continue to be eligible, regardless of SSI eligibility until they reach age 25
- Meet all nonfinancial requirements for Medicaid
- Are determined to need Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) level of care

Based on your assessed needs, covered services may include:
Health and Disability Waiver Services

- Adult day care
- Consumer-Directed Attendant Care (CDAC)
- Counseling services
- Home and vehicle modifications
- Home-delivered meals
- Home health aide
- Homemaker services
- Interim medical monitoring and treatment
- Nursing services
- Nutritional counseling
- Personal Emergency Response System (PERS)
- Respite
- Consumer Choices Option (CCO)

Intellectual Disability Waiver
Intellectual Disability (ID) Waiver services may be available to people who:

- Have a diagnosis of intellectual disability as decided by a psychologist or psychiatrist
- Are determined to need Intermediate Care Facility for the Intellectually Disabled (ICF/ID) level of care

Based on your assessed needs, covered services may include:
Intellectual Disability Waiver Services

- Adult day care
- Consumer-Directed Attendant Care (CDAC)
- Day habilitation
- Home and vehicle modifications
- Home health aide
- Interim medical monitoring and treatment
- Nursing
- Personal Emergency Response System (PERS)
- Prevocational services
- Respite
- Supported Community Living (SCL)
- Residential Based Supported Community Living (RBSCL)
- Supported Employment Transportation
- Consumer Choices Option (CCO)

Physical Disability Waiver
Physical Disability (PD) Waiver services may be available to people who:

- Have a physical disability
- Are ages 18 to 64
- Are determined blind or disabled by receipt of Social Security disability benefits or through the Iowa Department of Human Services' disability determination process

Based on your assessed needs, covered services may include:
Physical Disability Waiver Services

- Consumer-Directed Attendant Care (CDAC)
- Home and vehicle modification
- Personal Emergency Response System (PERS)
- Specialized medical equipment
- Transportation
- Consumer Choices Option (CCO)

For more information about each of the HCBS programs please visit
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs

CONSUMER CHOICES OPTION

Self-Direction

Self-Direction, also called Consumer Choices Option (CCO), means that you choose your personal caregiver(s). CCO is available under the Home- and Community- Based Services (HCBS) waivers, with the exception of the Children's Mental Health (CMH) Waiver. CCO gives you control over a targeted amount of Medicaid dollars so that you can develop a plan to meet your needs by directly hiring employees and/or purchasing other goods and services. CCO offers more choice, control and flexibility over your services and also includes more responsibility. This will allow more direction and flexibility with your Home- and Community-Based Services to enable you to stay in your home and community.

The CCO program allows you to have control over when your services are provided, how they are provided and who will be hired to provide your services to you. This gives you the ability to make choices, select and employ staff, and control the quality of your services. If you would like assistance to help manage your employees and/or budget, you can choose to delegate the tasks to someone else you trust to manage this for you. Your Community Based Case Manager can work with you to delegate your budget authority.

CCO may be right for you if you answer yes to these questions:

- Do you want more control over how waiver Medicaid dollars are spent on your needs?
- Do you want to be the employer of the people that provide support to you?
- Do you want to be responsible for recruiting, hiring and firing your workers and service providers?
- Do you want to be responsible for training, managing and supervising your workers and service providers?
- Do you want the flexibility to be able to purchase goods or services in order to meet your needs?

If you would like to choose this option, you simply let your CBCM know you are interested. You will work with your Community Based Case Manager to determine the services available for self-direction and develop a Person Centered Service Plan (PCSP). You will choose an Independent Support Broker (ISB) who will help you develop your individual budget, organize your services, and help you recruit employees.

You will also work with a Financial Management Service that will help manage your tasks as an employer. They will complete background checks on your employees and will use your budget to pay your workers on your behalf.

You will be responsible for hiring and training your employees. Your caregivers must be able to pass a background check and be 18 years or older. You say how your care is given. Your caregiver works for you. You will sign the timesheets and monitor how the

services are provided. The caregiver may do things like help you with dressing, cleaning, fixing meals or other care needs identified in your assessment.

Your CBCM will complete a self-assessment tool with you to determine if you are eligible to self-direct your services. Please ask your Community Based Case Manager (CBCM) for more details.

The following Services can be chosen for self-direction:

1. AIDS/HIV Waiver
    a. Consumer Directed Attendant Care (CDAC)-Unskilled Services
    b. Home and Vehicle Modification
    c. Home Delivered Meals
    d. Homemaker Services
    e. Basic Individual Respite
2. Brain Injury Waiver
    a. Consumer Directed Attendant Care (CDAC)-Unskilled Services
    b. Home and Vehicle Modification
    c. Prevocational Services
    d. Basic Individual Respite
    e. Specialized Medical Equipment
    f. Supported Community Living
    g. Supported Employment
    h. Transportation
3. Elderly Waiver
    a. Assistive Devices
    b. Chore Services
    c. Consumer Directed Attendant Care (CDAC)-Unskilled Services
    d. Home and Vehicle Modification
    e. Home Delivered Meals
    f. Homemaker Services
    g. Basic Individual Respite
    h. Senior Companion
    i. Transportation
4. Health and Disability Waiver
    a. Consumer Directed Attendant Care (CDAC)-Unskilled Services
    b. Home and Vehicle Modification
    c. Home Delivered Meals
    d. Basic Individual Respite
5. Intellectual Disability Waiver
    a. Consumer Directed Attendant Care (CDAC)-Unskilled Services
    b. Day Habilitation
    c. Home and Vehicle Modification
    d. Prevocational Services
    e. Basic Individual Respite
    f. Supported Community Living
    g. Supported Employment
    h. Transportation

6. Physical Disability Waiver
    a. Consumer Directed Attendant Care (CDAC)-Unskilled Services
    b. Home and Vehicle Modification
    c. Specialized Medical Equipment
    d. Transportation

If you feel the CCO is right for you, talk with your CBCM to learn more.

You may choose to stop directing your own care at any time. Your CBCM can help you with the process to stop self-directing your services.

You may choose to stop directing your own care at any time. Just talk with your CBCM. More information about the CCO is online at **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option**.

CONSUMER DIRECTED ATTENDANT CARE (CDAC)

Medicaid Home and Community Based Services (HCBS) Waiver programs offer the opportunity for you to have help in your own home or your community. One option is Consumer-Directed Attendant Care, or CDAC, which can give you the help you need to stay in your own home. CDAC services must be direct, hands-on services. CDAC services cannot provide for your personal supervision or for someone to stay with you overnight.
There are two kinds of CDAC services, unskilled and skilled.

Unskilled services include help with normal daily life activities such as dressing, bathing, meals, bedtime, taking medicine, making appointments, handling money, communicating with others, doctor visits, errands, and housekeeping.

Skilled services are medical services that require a licensed nurse or therapist to supervise the person who does these things for you. These include monitoring medications, post-surgical nursing care, injections, recording vital signs, tube feedings, catheter care, colostomy care, therapeutic diets and intravenous therapy.

You are the employer of your CDAC. You will need to make an employee agreement outlining the duties your CDAC provider will perform. Your CDAC provider can be a person that you know or someone from an agency. Remember, this person will be in your home helping you do things needed to keep you in your home. It is important that you feel comfortable with him or her. Your Community Based Case Manager (CBCM) can help you determine how much funding is available to you under your HCBS Waiver for CDAC services. This will help you plan work schedules and provider salaries.

How to get CDAC services.

To receive CDAC, you must already be receiving HCBS waiver services. If you request CDAC as a service, you will have a meeting with your CBCM and other people you want to include. Your CBCM must agree that CDAC services are right for you so that you are healthy and safe.

For more information on finding the right provider, work contracts, salaries, record-keeping, backup plans, personnel issues, reporting abuse and more, visit https://dhs.iowa.gov/ime/members/medicaid-a-to-z/cdac.

HEALTH HOME PROGRAMS

A Health Home is an approach to care coordination for individuals with multiple chronic conditions, including mental health and substance use disorders. The health home provides a team-based clinical approach that includes the member, their medical providers, and family members (when appropriate). The Health Home model builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of our members with multiple chronic illnesses.

Health Homes focus on providing the following six core services for our members:

1. Comprehensive Care Management.

2. Care Coordination.

3. Health Promotion.

4. Comprehensive Transitional Care.

5. Individual and Family Support.

6. Referral to Community and Social Support Services.

For IA Health Link members, there are two Health Home programs, Chronic Condition Health Home and Integrated Health Home.

Chronic Condition Health Home.

Members of any age with two chronic health conditions, or who are at risk for developing a second condition are eligible for Chronic Conditions Health Homes. Chronic health conditions include:

- Mental health condition
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- Body Mass Index over 25
- Hypertension
- Body Mass Index (BMI) over 85th percentile for pediatric population

Integrated Health Home.

Members are eligible for Integrated Health Homes if they have been diagnosed with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).

SMI is defined as:

- Psychotic disorders
- Schizophrenia
- Schizoaffective disorder
- Major depression
- Bipolar disorder
- Delusional disorder
- Obsessive Compulsive Disorder

SED is a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders published by the American Psychiatric Association or its most recent International Classification of Diseases equivalent that result in functional impairment. SED may co-occur with substance use disorders, learning disorders, or intellectual disorders that may be a focus of clinical attention.

For additional information on eligibility, participation or making changes to a currently assigned Health Home or Integrated Health Home programs, please talk with your Primary Care Provider (PCP) or Community Based Case Manager (CBCM) to learn more.

YOUR RIGHTS AND RESPONSIBILITIES

Member Rights

As a member you have certain rights. Iowa Total Care wants to always respect your rights. We expect our providers to respect your rights.

- Be treated with respect and dignity
- To take part in the community and work, live and learn as you are able
- To receive Health Care service
- Know that your medical records and discussions with your providers will be private and confidential.
- Receive information on all available treatment options.
- Have access to creating and using an Advance Directive.
- Be able to receive Covered Services in a fair manner.
- Be able to make decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion as stated in federal regulations.
- Have access to his or her medical records and be able to request corrections.
- Be able to choose a representative to help with making care decisions.
- Be able to provide informed consent.
- Be able to express grievances and appeal the care provided by Iowa Total Care.
- Be able to choose from available contract providers that follow Iowa Total Care's prior authorization requirements.
- Be able to receive information about Iowa Total Care including covered services, contract providers and how to access them.
- Be able to request co-payment totals paid. If there is a disagreement about the totals, you are able to appeal this information.
- Be free from harassment by Iowa Total Care or its contract providers.
- Have an open discussion with your provider about your treatment options, regardless of cost or benefit coverage.
- Be able to take an active part in understanding physical and behavioral health problems, and setting treatment goals with your provider.
- Be able to make recommendations regarding Iowa Total Care's member rights and responsibilities.
- Be able to exercise your rights and doing so will not affect the way Iowa Total Care or Iowa Total Care providers treat you.
- To request a change in Care Managers

Member Responsibilities

As a member you have certain responsibilities. Treatment can work better if you do these things. Your responsibilities are:

- Notify Iowa Medicaid if:
  - Your family size changes
  - You move out of the state or have other address changes
  - You get or have health coverage under another policy, other third party, or there are changes to that coverage
- Work on improving your own health
- Tell Iowa Total Care when you go to the emergency room.
- Talk to your provider about preauthorization of services they recommend.
- Be aware of cost-sharing responsibilities. Make payments that you are responsible for.
- Inform Iowa Total Care if your member ID card is lost or stolen.
- Show your Iowa Total Care member ID card when getting health care services.
- Know Iowa Total Care procedures, coverage rules and restrictions the best that you can.
- Contact Iowa Total Care when you need information or have questions.
- Give providers and Iowa Total Care accurate and complete medical information so you can be provided appropriate care.
- Follow prescribed treatment plans and instructions. Or tell your provider the reason(s) treatment cannot be followed as soon as possible.
- Ask your providers questions to help you understand treatment. Learn about the possible risks, benefits, and costs of treatment alternatives. Make care decisions after you have thought about all of these things.
- Be actively involved in your treatment. Understand your health problems and be a part of making treatment goals with your provider as much as you can.
- Follow the grievance process if you have concerns about your care.

Community Based Case Management Choice

At Iowa Total Care, we do our best to assign a Community Based Case Manager (CBCM) that lives in the same community as you. This means your CBCM will have knowledge about your local services and supports that are available to you. We understand that sometimes there can be conflicts between members and CBCMs and that you may want to request a different CBCM. Your Community Based Case Manager should be a person to you feel comfortable with. If you feel you need a change in CBCMs, please call our

Member Services. They will connect you with a CBCM Manager in your area. The Manager will discuss the reason you would like to change CBCMs with you. If a change is needed, Iowa Total Care will make every effort to transition you to another CBCM in your area.

Member Satisfaction

You can help Iowa Total Care improve the way our health plan works. Through our Stakeholder Advisory Board, we give members like you the chance to share your thoughts and ideas with us. The Board shares health education with our members. It discusses ways to focus on preventative health.

At these meetings, you can talk about the services you get. You can tell us how we are doing. You can share your ideas on policy changes. You may ask questions or share any concerns.

Would you like to join our Member Advisory Board? Just call Member Services. The toll-free phone number is 1-833-404-1061 (TTY: 711). They can give you information about joining the Member Advisory Board.

Cultural Competency

It is important to Iowa Total Care that we provide services that are mindful of each member's culture. This means you receive services that are respectful of your social and cultural needs. It is important to us that our providers are also aware and respectful of these needs.

We give providers training and tools to help them. We support providers by:

- Accessing language services for our members who cannot communicate because of a language barrier. This includes interpreter services in non-English languages, sign language, and TTY services. There is no cost for these services.
- Race and ethnicity have an influence on health and treatment decisions. Providers should understand these issues.
- Providers who help members are given training on cultural competency and accessing language services.

Quality Improvement Program

Iowa Total Care is committed to providing quality health care for you and your family. Our goal is to improve your health. We want to help you with any illness or disability. We want to help you get safe, reliable, and quality health care from our programs.

Our programs follow standards of the National Committee on Quality Assurance (NCQA) and include:

- Reviewing of doctors and providers when they become part of our network.
- Making sure members have access to all types of health care services.
- Giving members support and education about general health care and specific diseases.
- Sending members reminders to get tests once a year like adult physicals or breast cancer screenings.
- Looking into any member concerns regarding care received.

Iowa Total Care believes your ideas can help make services better. We send out a member survey each year. The survey asks questions about your experience with the health care and services. We hope you will take the time to send us your answers.

Do you have questions about our Quality Improvement Program or our Provider incentive plans? Please contact Member Services or visit our website at www.iowatotalcare.com.

Advance Directives

All Iowa Total Care adult members have a right to make Advance Directives. An Advance Directive protects your rights for medical care. It helps to plan for future treatment decisions ahead of time. It tells people what you want if you would not be able to make your own decisions. Your doctor can talk with you about these options before you have an emergency. Then if you do have a medical emergency and cannot communicate what you need, your doctors will already know what to do.

Examples of Common Types of Advance Directives include:

- **A Living Will.** Tells a doctor what kind of medical care you want to receive (or not receive). This lets you decide ahead of time which treatments you would want or not want to prolong your life. Treatments could include:
  - Feeding tubes
  - Breathing machines
  - Organ transplants
  - Treatments to make you comfortable

  A living will is only used when you are near the end of life with no hope to recover.
- **A Healthcare Power of Attorney.** Names someone who is allowed to make health care decisions for you. This is only used if you are no longer able to communicate what you want.
- **A "Do Not Resuscitate" (DNR) Order.** Tells health care providers not to give Cardiopulmonary Resuscitation (CPR) if your heart and/or breathing stops. A DNR order is only about CPR. It does not provide instructions about other treatments.

OTHER INSURANCE AND BILLS

If you have Medicare

If you have Medicare and Medicaid coverage, your Medicare coverage is considered your primary insurance. Your Medicaid coverage through Iowa Total Care is secondary. Medicare will cover services from participating physicians, hospitals and other network providers. Medical services are based on the guidelines of that program. Your doctor will bill Medicare first for services covered by both programs and Medicaid will be billed second for any cost-sharing. Your Medicaid benefits will not change your primary insurance benefits. Be sure to show both your Medicare and Medicaid ID cards each time you go to a doctor's visit. If you have any questions in regard to your coverage please call Iowa Total Care at our toll-free number 1-833-404-1061.

GRIEVANCES AND APPEALS

You, or someone you choose to help you may file an appeal or grievance by phone or in writing. Iowa Total Care can help you complete forms to file a grievance or an appeal. If you need help, please call Member Services at our toll-free number 1-833-404-1061 TDD/TTY 711. We have people to help you Monday through Friday, 7:30 a.m.— 6:00 p.m. CST. Translation services are also available if needed. Iowa Total Care will not treat you differently for filing an appeal or grievance.

Grievances
A grievance may be about anything you are unhappy with while getting services as a member of Iowa Total Care. Some examples are:

- Unclear or wrong information from staff
- Poor quality of care
- Rudeness from a provider or employee
- Failing to respect your member rights
- You disagree with the decision to extend an appeal timeframe
- Unpaid medical bills
- Any other access to care issues

How to File a Grievance

You can file a grievance at any time by: Calling Member Services at our toll free number 1-833-404-1061 (TTY: 711)

- Sending a fax to 1-833-809-3868
- Give it to us in person or by mail at:

Iowa Total Care
Attn: Grievances
1080 Jordan Creek Parkway
Suite 100 South West
Des Moines, IA 50266

Be sure to include:

- Your first and last name
- Your Medicaid ID number
- Your address and telephone number

- What made you unhappy
- What you would like to have happen

There is a grievance form that you can use on our website at: www.iowatotalcare.com.

If you want someone to file the grievance for you, we need your written permission. We have a form you can use to give someone else this permission. You can find this on our website at www.iowatotalcare.com. You can also call member services and ask for the form. The form is titled "Authorized Representative Designation." Parents or guardians of members that are minors do not need to fill out this form.

What to Expect After You File a Grievance

We will send you a letter within 3 business days after you file a grievance to let you know we received it.

If you have information to help us with your grievance, please send it to us by fax or mail.

You can request copies of the documents we used to resolve your grievance free of charge.

We will send a resolution letter to you within 30 calendar days. If additional information is needed to resolve your grievance, a 14 calendar day extension may be requested by Iowa Total Care. We will only request an extension if it is in your best interest. If additional time is needed, we will let you know by phone and in writing at least 2 days before the 30 calendar days are up. You may file a grievance if you disagree with the extension. Members can also request an extension if you they need additional time to support your their grievance. If you want an extension, please contact Iowa Total Care Member Services.

Appeals

An appeal is a request for Iowa Total Care to review a decision we made about a service that was denied, reduced, or limited. Examples of this would be a decision that:

- Denies requested care or services
- Approves a smaller amount of a service than you asked for
- Ends a service or care that was approved before

These decisions are called "Adverse Benefit Determinations".

You will get a letter in the mail that will tell you why that decision was made. If you do not agree with a decision, you have 60 calendar days from the date on the letter you received to ask for an appeal. You can ask to file the appeal by phone or in writing. If you do the appeal by phone, you will also need to file a written request.

How to File an Appeal

You can file an appeal up to 60 calendar days from the date on the letter that states what decision was made.

If you need help filing an appeal, please call Iowa Total Care Member Services. Iowa Total Care will help you complete the steps for filing an appeal.

Appeals may be filed by

- Calling Member Services. The toll-free phone number is 1-833-404-1061 (TTY: 711)
- Sending a fax, the fax number is 1-833-809-3868
- Give it to us in person or by mail:

Iowa Total Care
Attn: Appeals
1080 Jordan Creek Parkway
Suite 100 South
West Des Moines, IA 50266

Be sure to include:

- Your first and last name
- Your Medicaid ID number
- Your address and telephone number
- The reason for the appeal

There is an appeal form that you can use located on our website at www.iowatotalcare.com. This form will also be included with the letter you received.

You or someone you choose can help you file an appeal. If you want someone else to file the appeal we need your permission in writing. We have a form you can use to give someone else permission to file the appeal. You can get this form from Iowa Total Care Member Services or on our website at www.iowatotalcare.com. The form is titled "Authorized Representative Designation." This form will also be included with the letter you received. Parents or guardians of members that are minors do not need to fill out this form.

What to Expect After You Request an Appeal

We will send you a letter within 3 business days to let you know we received your appeal.

For appeals requested over the phone, a written request must also be sent to Iowa Total Care, or we cannot complete the appeal

If you have information to help us resolve your appeal, please send it to us. You can send that information in by fax or mail.

You can request copies of the documents used to resolve the appeal free of charge.

We will send a resolution letter within 30 calendar days of receiving your appeal. If additional information is needed to resolve your appeal, a 14 calendar day extension may be requested by Iowa Total Care. We will only request an extension if it is in your best interest. If we need more time, we will let you know by phone and in writing at least 2 days before the 30 calendar days are up. You may file a grievance if you disagree with the extension. Members can also request an extension if they need additional time to prepare your appeal. If you want an extension, please contact Iowa Total Care Member Services.

You may request an expedited appeal to be completed in 72 hours if it is a situation that may cause you physical or mental harm. If the request does not need to be completed in 72 hours, we will complete it in the standard 30 days.

We will not treat you differently for filing an appeal.

State Fair Hearings

If you are not happy with the outcome of your appeal, you can request a State Fair Hearing. Members must complete an appeal with Iowa Total Care before they can ask for a State Fair Hearing. You will get a letter with the appeal decision on it. From the date on the letter, you have 120 calendar days to request a State Fair Hearing. You can request that services be continued during a State Fair hearing. If the State Fair Hearing finds our decision is right, you may have to pay for the services you received during the appeal and State Fair Hearing processes. You may choose for someone else to request a State Fair Hearing for you.

Requests can be made to the Department of Human Services for a State Fair Hearing. Requests can be filed in person, by telephone or in writing. To file in writing, submit requests to:

Department of Human Services
Appeals Section, 5th Floor
1305 E. Walnut
Des Moines, IA 50319-0114

If you need assistance or want to file by phone you can ask the Iowa Department of Human Services (DHS) office. You can contact the DHS Appeals Section at (515) 281-3094.

Continuing to Receive Services

You can ask for services to continue while we review the appeal and during the State Fair Hearing process. You need to request that services be continued within 10 calendar days of the date on the letter you received about your service denial, reduction, or limitation.

IMPORTANT: If the appeal or State Fair Hearing finds our decision was right, you may have to pay for the service that was continued during the appeal and State Fair Hearing.

Ombudsman

If you get long term care in a facility or under one of the seven (7) Home and Community Based Services (HCBS) waivers, the Managed Care Ombudsman can help you:

- With education and information
- With a problem you cannot solve by talking with Iowa Total Care Member Services
- If you feel you are not getting the care you need
- If you feel your rights are not respected
- With complaint resolution or filing a grievance
- File an appeal, or State Fair Hearing request

You may contact the Managed Care Ombudsman by mail, phone, fax, or email at:

Office of the State Long-Term Care Ombudsman
Attn: Managed Care Ombudsman
Jessie M. Parker Building
510 E 12th Street, Suite 2
Des Moines, IA 50313-9025
Phone: 515-725-3333 or toll free at 1-866-236-1430
Fax: 515-725-3313
Email: ManagedCareOmbudsman@iowa.gov

If you are a member who is not receiving the long term care services the Managed Care Ombudsman covers, you may contact the State of Iowa, Ombudsman Office, for assistance by mail, phone, fax, or email at:

State of Iowa, Ombudsman Office
Ola Babcock Miller Building
1112 E Grand Avenue
Des Moines, IA 50319
Phone: 515-281-3592 or toll free at 1-888-426-6283
Fax: 515-242-6007
Email: ombudsman@legis.iowa.gov

ESTATE RECOVERY

Estate recovery legal reference: 441 IAC 75.28(7)

If you received Medicaid benefits, which includes capitation fees paid to an MCO, the state of Iowa has the right to ask for money back from your estate after your death. Members affected by the estate recovery are those who:

- Are 55 years of age or older, regardless of where they are living; or
- Are under age 55 and:
    - Reside in a nursing facility, an intermediate care facility for persons with an intellectually disability, or a mental health institute, and
    - Cannot reasonably be expected to be discharged and return home.

For more information, call Iowa Medicaid Member Services at 1-800-338-8366 or 515-256-4606 (when calling within the Des Moines area) (TTY 1-800-735-2942) Monday through Friday from 8 a.m. to 5 p.m.

MAKING A LIVING WILL

All Iowa Total Care adult members have a right to make Advance Directives. An Advance Directive protects your rights for medical care. It helps to plan for future treatment decisions ahead of time. It tells people what you want if you would not be able to make your own decisions. Your doctor can help discuss these options before you have an emergency. Then if you do have a medical emergency and cannot communicate what you need, your doctors will already know what to do.

Examples of Common Types of Advance Directives include:

- **A Living Will.** This tells a doctor what kind of medical care you want to receive (or not receive). This lets you decide ahead of time which treatments you would want or not want to prolong your life. Treatments could include:
    - Feeding tubes
    - Breathing machines
    - Organ transplants
    - Treatments to make you comfortable

    A living will is only used when you are near the end of life with no hope to recover.

- **A Healthcare Power of Attorney.** This names someone who is allowed to make health care decisions for you. This is only used if you are no longer able to communicate what you want.
- **A "Do Not Resuscitate" (DNR) Order.** This tells health care providers not to give Cardiopulmonary Resuscitation (CPR) if your heart and/or breathing stops. A DNR order is only about CPR. It does not provide instructions about other treatments.

FRAUD, WASTE AND ABUSE

Iowa Total Care is committed to preventing, identifying and reporting all instances of suspected fraud, waste, and abuse. Fraud, waste and abuse means that any member, any provider, or another person is misusing the Iowa Medicaid program or Iowa Total Care resources.

It is against the law for a doctor, dentist, pharmacist, other healthcare provider or an individual Medicaid recipient to receive Medicaid benefits based on false information.

Some examples of fraud, waste and abuse are:

- Billing or charging you for services that were not provided.
- Offering you free services, medical equipment or supplies in exchange for your Medicaid number.
- Providing you treatment or services you don't need.
- Someone using another person's Medicaid or Iowa Total Care identification card.

If you suspect anyone is committing fraud, waste and abuse, including healthcare providers, contact Iowa Total Care's Hotline at 1-866-685-8664. You can remain anonymous.

You can also report suspected Medicaid fraud to the Iowa Department of Human Services, by calling 1-800-831-1394.

NOTICE OF PRIVACY PRACTICES

Iowa Total Care
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
***PLEASE REVIEW IT CAREFULLY*.**

Effective 03.01.2018

For help to translate or understand this, please call our toll-free number 1-833-404-1061 (TTY: 711).
Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-833-404-1061. (TTY: 711).

Covered Entities Duties:

Iowa Total Care is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Iowa Total Care is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Iowa Total Care reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Iowa Total Care will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website, www.iowatotalcare.com.

Internal Protections of Oral, Written and Electronic PHI:

Iowa Total Care protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- **Treatment** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.

- **Payment** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
    - processing claims
    - determining eligibility or coverage for claims
    - issuing premium billings
    - reviewing services for medical necessity
    - performing utilization review of claims

- **HealthCare Operations** - We may use and disclose your PHI to perform our healthcare operations. These activities may include:
    - providing Member Services
    - responding to complaints and appeals
    - providing case management and care coordination
    - conducting medical review of claims and other quality assessment
    - improvement activities

- **Group Health Plan/Plan Sponsor Disclosures** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- **Fundraising Activities** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- **Underwriting Purposes** – We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

- **Appointment Reminders/Treatment Alternatives** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

- **As Required by Law** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

- **Public Health Activities** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.

- **Victims of Abuse and Neglect** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

- **Judicial and Administrative Proceedings** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
    - an order of a court
    - administrative tribunal
    - subpoena
    - summons
    - warrant
    - discovery request
    - similar legal requests

- **Law Enforcement** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
    - court order
    - court-ordered warrant
    - subpoena
    - summons issued by a judicial officer
    - grand jury subpoena

  We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- **Coroners, Medical Examiners and Funeral Directors** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- **Organ, Eye and Tissue Donation** - may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
    - cadaveric organs
    - eyes
    - tissues

- **Threats to Health and Safety** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- **Specialized Government Functions** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
    - to authorized federal officials for national security
    - to intelligence activities
    - the Department of State for medical suitability determinations
    - for protective services of the President or other authorized persons

- **Threats to Health and Safety** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- **Specialized Government Functions** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
    - to authorized federal officials for national security
    - to intelligence activities
    - the Department of State for medical suitability determinations
    - for protective services of the President or other authorized persons

- **Workers' Compensation** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- **Emergency Situations** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

- **Inmates -** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

- **Research** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposed with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of you psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.

- ***Right to Request Restrictions -*** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications -*** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason is for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.

- ***Right to Access and Received Copy of your PHI -*** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- ***Right to Amend your PHI -*** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including

people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Right to Receive an Accounting of Disclosures -*** You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

- ***Right to File a Complaint -*** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.com .

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice -*** You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Iowa Total Care
Attn: Privacy Official
1080 Jordan Creek Parkway, Suite 100 South
West Des Moines, IA 50266
1-833-404-1061 (TTY: 711)

OTHER PLAN DETAILS

Member Survey

Iowa Total Care is interested in hearing what our members think about our plan. Based on our survey results, we will try to improve and build Iowa Total Care around our member's needs.

Once a year, you will receive a survey from our certified vendor to ask you what you think about us and our services. We strongly recommend that our members take advantage of this opportunity. This is your chance to inform us on what we did well and what we could work on. We look forward to hearing from you!

Nondiscrimination Policy

Iowa Total Care does not and shall not discriminate on the basis of race, color, religion, gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status. As a member, you have the right to file a grievance or appeal with Iowa Total Care if you believe you have been the victim of discrimination.

How to disenroll from Iowa Total Care

You can change your health plan with good cause for reasons such as:

- You move out of the service area
- Your provider is not in the MCO's network.
- You need related services to be performed at the same time. Not all related services are available within your MCO's provider network. Your primary care provider or another provider determined that receiving the services separately would subject you to unnecessary risk.
- Lack of access to providers experienced in dealing with your health care needs.
- Your provider has been terminated or no longer participates with your MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by your MCO.
- The MCO plan does not cover the services you need due to moral or religious objections.

If you believe you have a good-cause reason to change to a new health plan, you may call Iowa Medicaid Member Services at 1-800-338-8366 Monday through Friday from 8 a.m. to 5 p.m.

State-initiated disenrollment may occur based on changes in conditions, including:

- You are no longer eligible for Medicaid
- You move to another state
- The agency decides that participating in the Health Insurance Premium Payment Program (HIPP) is more cost-effective than enrollment in the contract
- Death

What is Utilization Management

We want to make sure you get the right care and services. Our utilization management process is designed to make sure you get the treatment you need.

We will approve all covered benefits that are medically necessary. Our Utilization Management (UM) Department checks to see if the service needed is a covered benefit. If it is a covered benefit, the UM nurses will review it to see if the service requested meets medical necessity criteria. They do this by reviewing the medical notes and talking with your doctor. Iowa Total Care does not reward practitioners, providers, or employees who perform utilization reviews, including those of the delegated entities. Utilization Management's (UM) decision making is based only on appropriateness of care, services and existence of coverage. Iowa Total Care does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Iowa Total Care reviews services to ensure the care you receive is the best way to help improve your health condition. Utilization review includes:

What is Utilization Review?

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Preservice or prior authorization review

Iowa Total Care may need to approve medical services before you receive them. This process is known as prior authorization. Prior authorization means that we have pre-approved a medical service.

To see if a service requires prior authorization, check with your PCP, the ordering provider, or Iowa Total Care Member Services. When we receive your prior authorization request, our nurses and doctors will review it. If prior authorization is not received on a medical service when required, you may be responsible for all charges.

Concurrent review

Concurrent utilization review evaluates your services or treatment plans (like an inpatient stay or hospital admission) as they happen. This process determines when treatment may no longer be medically necessary. It includes discharge planning to ensure you receive services you need after your discharge from the hospital.

Retrospective review

Retrospective review takes place after a service has already been provided. Iowa Total Care may perform a retrospective review to make sure the information provided at the time of authorization was correct and complete. We may also evaluate services you received due to special circumstances (for example, if we didn't receive an authorization request or notification because of an emergency).

Adverse determinations and appeals

An adverse determination occurs when a service is not considered medically necessary, appropriate, or because it is experimental or investigational. You will receive written notification to let you know if we have made an adverse determination. In the notice, you will receive detailed information about why the decision was made, as well as the process and time frame you should follow for submitting appeals.

New Technology

Health technology is always changing and we want to grow with it. If we think a new medical advancement can benefit our members, we evaluate it for coverage. These advancements include:

- New technology
- New medical procedures
- New drugs
- New devices
- New application of existing technology

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit our members. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether we should change any of our benefits to include the new technology.

If the CPC doesn't review a request for coverage of new technology, our Medical Director will review the request and make a one-time determination. The CPC may then review the new technology request at a future meeting.

The organization distributes a statement to all members and to all practitioners, providers, and employees who make UM decisions, affirming the following:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

GLOSSARY OF TERMS

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or member's authorized representative may request an appeal following a decision made by Iowa Total Care.

Iowa Total Care actions that a member may choose to appeal:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or in part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of Iowa Total Care to act within required time frames.
- For a resident of a rural area with only one MCO, the denial of services outside the network.

Members may file an appeal directly with Iowa Total Care. If the member is not happy with the outcome of the appeal, they may file an appeal with the Department of Human Services (DHS). Or they may ask for a state fair hearing.

Care Management: Care Management helps you manage your complex health care needs. It may include helping you get other social services, too.

Chronic Condition: Chronic Condition is a persistent health condition or one with long-lasting effects. The term chronic is often applied when the disease lasts for more than three months.

Chronic Condition Health Home: Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions. A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

Client Participation: Client Participation is what a Medicaid member pays for Long-Term Services and Supports (LTSS) services such as nursing home or home supports.

Community -Based Case Management (CBCM): Community -Based Case Management (CBCM) helps Long-Term Services and Supports (LTSS) members manage complex health care needs. It includes planning, facilitating and advocating to meet the member's needs. It promotes high-quality care and cost-effective outcomes. Community-Based Case Managers (CBCMs) make sure that the member's care plan is carried out. They make updates to the care plan as needed.

Consumer-Directed Attendant Care (CDAC): Consumer-Directed Attendant Care (CDAC) helps people do things that they normally would for themselves if they were able.

CDAC services include:

- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

Copayment (Copay): Some medical services have a copayment, which is your share of the cost. If there is a copayment, you will pay it to the provider. The provider will tell you how much it is.

Durable Medical Equipment (DME): Durable Medical Equipment (DME) is reusable medical equipment for use in the home. It is rented or owned by the member and ordered by a provider.

Emergency Medical Condition: An Emergency Medical Condition is any condition that you believe endangers your life or would cause permanent disability if not treated immediately.

If you have a serious or disabling emergency, you do not need to call your provider or Iowa Total Care.

Go directly to the nearest hospital emergency room or call an ambulance.
The following are examples of emergencies:

- A Serious Accident
- Stroke
- Severe Shortness of Breath
- Poisoning
- Severe Bleeding
- Heart Attack
- Severe Burns

Emergency Medical Transportation: Emergency Medical Transportation provides stabilization care and transportation to the nearest emergency facility.

Emergency Room Care: Emergency Room Care is provided for Emergency Medical Conditions.

Emergency Services: Emergency Services are provided when you have an Emergency Medical Condition.

Excluded Services: Excluded services are services that Medicaid does not cover. The member may have to pay for these services.

Good Cause: You may request to change your MCO during your 12 months of closed enrollment. A request for this change, called disenrollment, will require a Good Cause reason.

Some examples of Good Cause for disenrollment include:

- You move out of the service area
- Your provider is not in the MCO's network.
- You need related services to be performed at the same time. Not all related services are available within your MCO's provider network. Your primary care provider or another provider determined that receiving the services separately would subject you to unnecessary risk.
- Lack of access to providers experienced in dealing with your health care needs.
- Your provider has been terminated or no longer participates with your MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by your MCO.
- The MCO plan does not cover the services you need due to moral or religious objections.

Grievance: You have the right to file a grievance with Iowa Total Care. A Grievance is an expression of dissatisfaction about any matter other than a decision. You, your representative or provider who is acting on your behalf and has your written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred.

Examples include, but are not limited to:

- You are unhappy with the quality of your care.
- The doctor who you want to see is not an Iowa Total Care doctor.
- You are not able to receive culturally competent care.
- You got a bill from a provider for a service that should be covered by Iowa Total Care.
- Rights and dignity.
- Any other access to care issues.

Habilitation Services: Habilitation Services are HCBS services for members with chronic mental illness.

Health Care Coordinator: A Health Care Coordinator is a person who helps manage the health of members with chronic health conditions.

Health Insurance: A type of insurance coverage that pays for medical and surgical expenses incurred by the insured.

Health Risk Assessment: A Health Risk Assessment (HRA) is a short survey with questions about your health.

Home- and Community-Based Services (HCBS): Home- and Community-Based Services (HCBS) provide supports to keep Long-Term Services and Supports (LTSS) members in their homes and communities.

Home Health: Home Health is a program that provides services in the home. These services include visits by nurses, home health aides and therapists.

Hospice Services: Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.

Hospital Inpatient Care: Hospital Inpatient Care, or Hospitalization, is care in a hospital that requires admission as an inpatient. This usually requires an overnight stay. These can include serious illness, surgery or having a baby. (An overnight stay for observation could be outpatient care.)

Hospital Outpatient Care: Hospital Outpatient Care is when a member gets hospital services without being admitted as an inpatient. These may include:

- Emergency services.
- Observation services.
- Outpatient surgery.
- Lab tests.
- X-rays.

Integrated Health Home: An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

Long -Term Services and Supports (LTSS): Long-Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.

Long-Term Care Services:

- Home and Community-Based Services (HCBS).
- Intermediate Care Facilities for Persons with Intellectual Disabilities.
- Nursing Facilities and Skilled Nursing Facilities.

Medically Necessary: Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

Network: Iowa Total Care has a network of providers across Iowa who you may see for care. You don't need to call us before seeing one of these providers. Before getting services from your providers, please show them your Iowa Total Care ID card to ensure they are in our network. There may be times when you need to get services outside of our network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to you than if provided in-network.

Non-Participating Provider: A Non-Participating Provider is a provider who does not have a contract with Iowa Total Care to provide services to you. Before receiving services from non-participating providers, please contact Iowa Total Care Member Services toll-free at 1-833-404-1067 to assist you.

Over-the-Counter Medications (OTC): Iowa Total Care covers many over-the counter (OTC) medications that are on the state's covered list. A provider must write you a prescription for the OTC medication you need.

Participating Provider: A Participating Provider has a contract with Iowa Total Care to provide services to you.

Physician Services: Physician Services are necessary medical services performed by doctors, physician assistants and nurse practitioners. They must be licensed to practice.

Plan: Iowa Total Care is your health plan, or Plan, which pays for and coordinates your health care services.

Premium: A Premium is the amount you pay for your health insurance every month. Most IA Health Link members are not required to pay a premium. Some Iowa Health and Wellness Plan members and some Hawki members must pay monthly premiums depending on their income.

Prescription Drug Coverage: Iowa Total Care provides payment for all or part of the cost of medications identified as covered on the Iowa Medicaid Preferred Drug List, for eligible members of Iowa Medicaid. This is known as prescription drug coverage.

Prescription Drug: Is a medication that is available only with written instructions from a licensed prescriber and dispensed by either the prescriber or a licensed pharmacist.

Preferred Drug: Preferred drugs are those that Iowa Medicaid has determined are the best value for treating most people with a certain condition. Preferred drugs with conditions are also a good value, but your doctor/provider may need to provide some additional information before coverage is given. Non-preferred medications are medications that require additional steps before coverage can be considered. Your doctor/provider may have you try one or more preferred drugs before requesting coverage for a non-preferred medication.

Primary Care Physician: A Primary Care Physician directly provides or coordinates your health care services. A Primary Care Physician is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals.

Primary Care Provider: A Primary Care Provider (PCP) is either a physician, a physician assistant or nurse practitioner, who directly provides or coordinates your health care services. A PCP is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals.

Prior-Authorization: Some services or prescriptions require approval from Iowa Total Care for them to be covered. This must be done before you get that service or fill that prescription.

Provider: A Provider is a health care professional who offers medical services and support.

Referral: A referral means that your primary care provider must give you approval to see someone that is not your primary care provider. If you don't get approval we may not cover the services. There are certain specialists in which you do not need a referral, such as women's health specialists.

Rehabilitation Services and Devices: Rehabilitation Services and Devices help you keep, get back, or improve skills for daily living after you were sick, hurt, or disabled. This may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation.

Service Plan: A Service Plan is a plan of services for HCBS waiver members. Your service plan is based on your needs and goals. It is created by you and your interdisciplinary team to meet HCBS waiver criteria.

Skilled Nursing Care: Nursing facilities provide 24-hour care for members who need nursing or Skilled Nursing Care. Medicaid helps with the cost of care in nursing facilities. You must be medically and financially eligible. If your care needs require that licensed nursing staff be available in the facility 24 hours a day to provide direct care or make decisions regarding your care, then a skilled level of care is assigned.

Specialist: Specialists are health care professionals who are highly trained to treat certain conditions.

Urgent Care: Urgent care is when you are not in a life-threatening or a permanent disability situation and have time to call your MCO or provider. If you have an urgent care situation, you should call your provider or MCO to get instructions.

The following are some examples of urgent care:

- Fever
- Earaches
- Upper Respiratory Infection
- Stomach Pain
- Sore Throat
- Minor Cuts and Lacerations