Member Handbook

1-833-404-1061

TTY: 711

IowaTotalCare.com

OP-M-1853

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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 400 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 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, 1-800-537-7697 (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 con el idioma, ayudas y servicios auxiliares, letra más grande, interpretación y otros formatos alternos están a su disposición sin costo alguno. Para obtener estos servicios, llame al número que se proporciona arriba.

中國人 (Chinese): 您可以免費獲得語言協助服務、輔助設備和服務、更大的字體、口譯和其他替代格式。如需獲得這些服務，請撥打上面的號碼。

Tiếng Việt **(Vietnamese):** Các dịch vụ hỗ trợ ngôn ngữ, dịch vụ và công cụ phụ trợ, phông chữ lớn hơn, thông dịch, và các định dạng thay thế khác được cung cấp miễn phí cho bạn. Để nhận dịch vụ này, vui lòng gọi số điện thoại ở trên.

Serbo-Croatian (Serbo-Croatian): Usluge jezične pomoći, pomoćni alati i usluge, veći font, usmeni prijevod i ostali alternativni oblici dostupni su vam besplatno. Za dobivanje istog, nazovite gore navedeni broj.

Deutsch (German): Sprachassistenzdienste, Hilfsmittel und -dienste, größere Schrift, mündliche Übersetzungen und andere alternative Formate stehen Ihnen kostenlos zur Verfügung. Hierzu rufen Sie bitte die oben genannte Nummer an.

عربى (Arabic): تتوفر خدمات المساعدة اللغوية والمساعدات والخدمات الإضافية وتكبير حجم الخط والترجمة الشفوية والتنسيقات البديلة الأخرى لك مجانًا. للحصول على هذه الخدمات، يُرجى الاتصال بالرقم الوارد أعلاه.

ลาว (Lao): ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການ, ການຂຽນເປັນຕົວໜັງສືຂະໜາດໃຫຍ່, ການແປປາກເປົ່າ, ແລະ ຮູບແບບທີ່ເປັນທາງເລືອກອື່ນ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ເພື່ອໃຫ້ໄດ້ຮັບການບໍລິການນີ້, ກະລຸນາໂທຫາໝາຍເລກໂທລະສັບຂ້າງເທິງ.

Medicaid Plan: Toll-Free **1-833-404-1061** (TTY: **711**)

한국어 (Korean): 언어 지원 서비스, 보조 지원 및 서비스, 큰 글꼴, 통역, 기타 대체 형식이 무료로 이용 가능합니다. 이를 이용하시려면, 위의 번호로 전화하십시오.

हिन्दी (Hindi): भाषा सहायता सेवाएं, अतिरिक्त साधन और सेवाएं, बड़े अक्षर, मौखिक अनुवाद, और अन्य वैकल्पिक प्रारूप आपके लिए निःशुल्क उपलब्ध हैं। इसे हासिल करने के लिए, कृपया ऊपर दिए गए नंबर पर कॉल करें।

Français (French): Des services d'assistance linguistique, des services et des aides complémentaires, une police de caractères agrandie, une traduction orale et d'autres formats vous sont accessibles gratuitement. Pour en bénéficier, veuillez appeler le numéro indiqué ci-dessus.

Pennsylvanian Dutch (Pennsylvania Dutch): Hilf mitt di shproch, anri sadda hilf un deenshta, graysah print, laut shvetza translaydes, un anri veyya un formats kansht du greeya unni kosht. Fa dess greeya, please roof da nummah uf es do ovva droh is.

ไทย (Thai): เรามีบริการช่วยเหลือด้านภาษา ความช่วยเหลือและบริการเพิ่มเติม บริการแบบอักษรขนาดใหญ่ การแปลด้วยวาจา และรูปแบบทางเลือกอื่น ๆ ให้คุณใช้บริการได้ฟรี หากต้องการใช้บริการนี้ โปรดโทรติดต่อไปที่หมายเลขด้านบน

Tagalog (Tagalog): Mga serbisyong pantulong sa wika, karagdagang pantulong at mga serbisyo, mas malaking font, binibigkas na pagsasalin, at iba pang alternatibong format na makukuha mo nang libre. Para makuha ito, pakitawagan ang numero sa itaas.

ကညီ (Karen): တၢ်မၤစၢၤကျိာ် အတၢ်မၤစၢၤတၢ်မၤ, တၢ်တိစၢၤမၤစၢၤတၢ်လၢ ပှၤနၢ်တဟူတၢ်အဂီၢ်ဒီး တၢ်မၤစၢၤ တၢ်မၤတဖဉ်, လံာ်မံာ်ဖျၢဉ် လၢအဒိဉ်ထိဉ်တဖဉ်, တၢ်တံၤကျိးထံတၢ်, ဒီးတၢ်ရဲဉ်လီၤ အကၠၢ်အဂီၤလၢ အဂၤတဖဉ်လၢ အိဉ်လၢနဂီၢ်လၢတအိဉ်ဒီး တၢ်လာ်ဘူဉ်လာ်စ့ၤနီတမံၤဘဉ်နၣ်လီၤ. လၢနကမၤန့ၢ် တၢ်အံၤအဂီၢ်, ဝံသးစူၤ ကိးလီတဲစီနိဉ်ဂံၢ်လၢထးတကၠၢ်.

Medicaid Plan: Toll-Free **1-833-404-1061** (TTY: **711**)

русский (Russian): Услуги переводчика, вспомогательные средства и услуги, более крупный шрифт, услуги устного перевода и прочие альтернативные средства помощи предоставляются бесплатно. Чтобы воспользоваться этими услугами, позвоните по номеру выше.

For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, call 711.

Llame al 1-800-735-2942, a Relay Iowa TTY (teléfono de texto para personas con problemas de audición, del habla y ceguera) si necesita asistencia telefónicamente.

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MEMBER HANDBOOK

Table of Contents

WELCOME

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

Iowa Total Care works with the Iowa Department of Health and Human Services (HHS). 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 the health services they need through one company.

As an MCO, Iowa Total Care will help coordinate your individual healthcare 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: 1-833-404-1061 (TTY: 711).

Iowa Total Care in the Community

Iowa Total Care is committed to our community. We offer support and programs statewide to all Iowans. Visit **www.iowatotalcare.com** to learn more.

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 healthcare 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 five business days. The toll-free phone number is 1-833-404-1061 (TTY: 711). You may also visit **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 Member Services

- Phone: 1-833-404-1061 (TTY: 711).
- Call this number for all member services, such as:
    - Nurses (available 24/7).
    - Vision.
    - Non-emergency medical transportation (NEMT).
    - Medical management.
    - ConnectionsPlus.
    - Care management.
    - Physical and behavioral health.
    - Waiver and facility-based services.
    - Ombudsmen.
    - To request an interpreter.
- Hours of operation: Monday through Friday, 7:30 a.m.–6 p.m. CT.
- Website: **www.iowatotalcare.com**.
- Address:
  1080 Jordan Creek Parkway, Suite 400 South
  West Des Moines, IA 50266

24/7 Nurse Advice Line

- Phone: 1-833-404-1061 (TTY: 711).
- 24/7 Nurse Advice Line is available 24 hours a day, every day.
- Website: **www.iowatotalcare.com**.

Non-Emergency Medical Transportation (NEMT): Access2Care

- Phone: 1-833-404-1061 (TTY: 711).
- Available to Iowa Health Link members.
- Hours of operation: Monday through Friday, 7:30 a.m.–6 p.m. CT.
- Website: **www.iowatotalcare.com**.

Vision: Envolve Vision

- Phone: 1-833-404-1061 (TTY: 711).
- Hours of operation: Monday through Friday, 7:30 a.m.–6 p.m. CT.
- Website: **www.iowatotalcare.com**.

State Contact Information

Iowa Medicaid (IM) Member Services Call Center or Enrollment Broker

- Phone 1-800-338-8366 (toll-free); 1-515-256-4606 (in the Des Moines area).
- Call this number for MCO choice counseling and enrollment for Iowa Health Link members. IM Member Services can also help with premium payments and financial hardship requests for Iowa Health and Wellness Plan members.
- 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.
- Hours of operation: Monday through Friday, 8 a.m.–5 p.m. CT.
- You can also email IM Member Services at: **IMEMemberServices@dhs.state.ia.us**.
- Website: **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link**.

Hawki Customer Service

- Phone: 1-800-257-8563 (toll-free).
- Call this number for MCO choice counseling and enrollment for **Hawki** members. **Hawki** Customer Service can also help with premium payments and questions.
- Hours of operation: Monday through Friday, 7 a.m.–7 p.m. CT.

Iowa Department of Health and Human Services (HHS) Contact Center

- Phone: 1-855-889-7985.
- Hours of operation: Monday through Friday, 7 a.m.–6 p.m. CT.
- Call this number if you are new to Medicaid and have application questions.

Iowa Department of Health and Human Services (HHS) Income Maintenance Customer Service Center or Enrollment Broker

- Phone: 1-877-347-5678.
- Hours of operation: Monday through Friday, 7 a.m.–6 p.m. CT.
- Call this number to report changes for continued Medicaid eligibility, such as when employment starts and ends.
- Find your local HHS office: **hhs.iowa.gov/about/hhs-office-locations**

Child and Dependent Adult Abuse

- If you suspect a child or dependent adult is being abused, call the Abuse Hotline at 1-800-362-2178, 24 hours a day, seven days a week.
- If the child or dependent adult is in immediate danger, call 911.

Your ID Cards

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

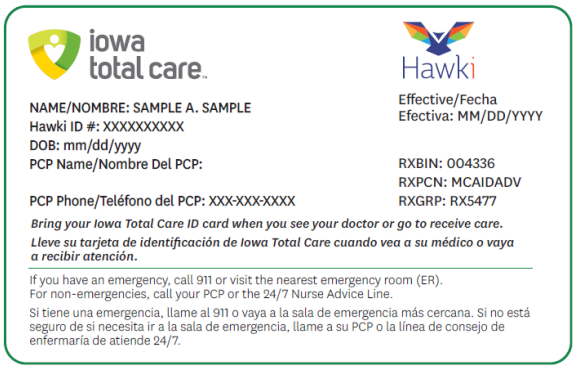
- Keep your card until you get a new one.
- Always carry your card with you and don't let anyone else use it.
- Show your card to the provider every time you get care.
- If you lose your Medicaid card, call Iowa Medicaid Member Services: 1-800-338-8366.
- If you go off of Iowa Medicaid and come back 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:

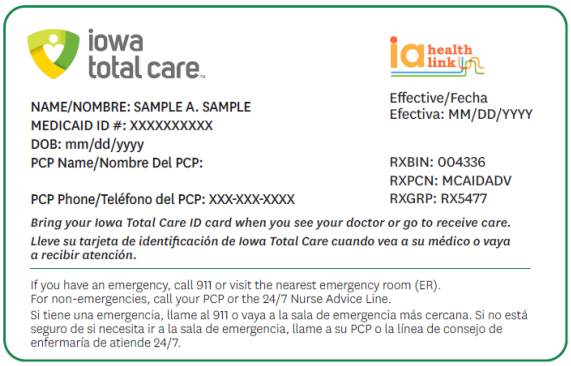
Front



Back

Your **Iowa Total Care/Iowa 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 our secure member portal (**member.iowatotalcare.com**) to ask for a new one or call Member Services: 1-833-404-1061 (TTY: 711). We will send you a new ID card within seven business days.

You can print a paper copy of your Iowa Total Care member ID card from our secure member portal: **member.iowatotalcare.com**.

Always keep your cards with you and safe. 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

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 for assistance: 1-833-404-1061 (TTY: 711).

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.
- This member handbook or any other written materials in your preferred language.
- Additional information, including our language services request form, is available on our Language Services webpage: **www.iowatotalcare.com/members/medicaid/language-services.html**

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.

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 for assistance: 1-833-404-1061 (TTY: 711).

ELIGIBILITY

If You Move

If you move, please contact the Iowa Department of Health and Human Services (HHS) Income Maintenance Customer Call Center at 1-877-347-5678 and Iowa Total Care at 1-833-404-1061 (TTY: 711). Hawki members should contact Hawki Member Services at 1-800-257-8563 and Iowa Total Care at 1-833-404-1061 (TTY: 711).

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: 1-833-404-1061 (TTY: 711).

Renewal & Changes in Your Coverage

Renewal

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

Keep your health coverage! Renew benefits each year with these simple steps.

Step 1: Watch your mail.
You'll receive a renewal form from Iowa HHS.

- Look for your form up to 45 days before your coverage will end.
- Moved? Make sure HHS has your current address. Call 1-877-347-5678 if your address has changed.

Step 2: Complete the renewal form.
Complete the renewal form when you receive it.

- Fill out all the information on each page.
- Be sure to sign the signature page.

Step 3: Return the renewal form.
Return the form to HHS by the due date.

- Use the prepaid, self-addressed envelope you received with your form.

Don't have the envelope? You can mail the renewal form to the image center listed on the renewal form or return it to any HHS office.

Not sure what you need to do? We can help. Call Iowa Total Care Member Services at 1-833-404-1061 (TTY: 711) or call the HHS Contact Center at 1-855-889-7985.

Changes in Your Coverage

Major life changes can affect your eligibility with Iowa Total Care. It is important to let HHS and Iowa Total Care know when you have these life changes. If you have a major life change, please call the HHS Call Center at 1-877-347-5678 and Iowa Total Care at 1-833-404-1061 (TTY: 711). 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 for more information: 1-833-404-1061 (TTY: 711).

Change in Benefits

Sometimes, Iowa Total Care may have to change the way we work, your covered services or our network providers and hospitals. HHS may also change the covered services that we arrange for you. If this happens, we will send you a letter telling you about changes to your plan benefits.

Notice of Significant Change About Your Primary Care Provider (PCP)

Your PCP's office may move, close, or leave our plan. If this happens, we will tell you within 14 days of the change. We can help you pick a new PCP and send you a new ID card within five working days after you pick a new PCP. Call Member Services at 1-833-404-1061 (TTY: 711).

IOWA HEALTH LINK

Most members who get health coverage from Iowa Medicaid are enrolled in the Iowa 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 Iowa Health Link program can be found on the Iowa Department of Health and Human Services website:
hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/faq

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 to transition to an Iowa 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 Iowa 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 Iowa Health Link Managed Care program.

IOWA HEALTH AND WELLNESS PLAN

The Iowa Health and Wellness Plan (IHAWP) program provides health coverage at low or no cost to Iowans. Members are between the ages of 19 and 64. 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 complete what are known as Healthy Behaviors. To participate in the Healthy Behaviors Program and avoid monthly payments after the first year, 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 screening (HRS)**. The health risk screening consists of a few questions about your general health. Iowa Health Link members should contact Iowa Total Care to complete their HRS. **Iowa Total Care's toll-free number is 1-833-404-1061 (TTY: 711)**.

Monthly Contributions for Iowa Health and Wellness Plan Members

- Members will receive Members will receive free* 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 a member's 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.

*There are very few, or no, costs for the first year and very few costs after that. A small monthly payment may be required based on income. There is an $8 co-pay for using the emergency room for non-emergency services.

Wellness Exam

In a wellness exam, your health care provider will do things like check your blood pressure and pulse, listen to your lungs with a stethoscope, recommend preventative screenings or take a blood sample to check your cholesterol.

Dental Exam

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

Health Risk Screening (HRS)

In addition to your wellness exam -OR- dental exam, you must also complete a health risk screening. This screening should be completed within 90 days of enrollment, and annually every enrollment year. Set aside 15–40 minutes to complete a survey that asks questions about your health and your experience in getting health services.

To complete your HRS, visit our secure member portal (**member.iowatotalcare.com**) or contact Iowa Total Care Member Services at 1-833-404-1061 (TTY: 711).

Financial Hardship

If you are unable to pay your contribution, 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.

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

*Notice: Dental Wellness Plan members also have 'Healthy Behaviors' to complete for dental coverage. Find information on these in the '**Dental Benefits Plan**' section of this handbook.*

HAWKI

The Healthy and Well Kids in Iowa (Hawki) Program offers health insurance to children who have no other health insurance. Members are under 19 years of age. Eligibility is based on household income. No family pays more than $40 per month. Some families pay nothing at all.

To learn more about the benefits and services Hawki members may be able to receive, refer to the **Covered Benefits and Services** section of this handbook.

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 healthcare 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 1-833-404-1061 (TTY: 711).

Services **prior authorization may be required*	**Iowa Health Link**	**Iowa Health and Wellness Plan (IHAWP)**	**Hawki**
Preventive Services			
Affordable Care Act (ACA) preventive services	Covered	Covered	Covered
Routine check-ups	Covered	Covered; limitations may apply.	Covered
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Covered; up to age 21.	Covered; up to age 21.	
Immunizations	Covered	Covered; limitations may apply.	Covered; limitations may apply.
Professional Office Services			
Primary care provider (PCP)	Covered	Covered	Covered
Office visit	Covered	Covered	Covered
Allergy testing	Covered	Covered	Covered
Allergy serum and injections	Covered	Covered	Covered
Certified nurse midwife services	Covered	Covered	Covered
Chiropractor	Covered; limitations may apply.	Covered; limitations may apply.	Covered; limitations may apply.
Contraceptive devices	Covered	Covered	Covered
Family planning and family planning-related services	Covered	Covered	Covered
Gynecological exam	Covered	Covered; limited to one visit per year.	Covered
Injections	Covered; limitations may apply.	Covered; limitations may apply.	Covered; limitations may apply.
Laboratory tests	Covered	Covered	Covered

Services **prior authorization may be required*	**Iowa Health Link**	**Iowa Health and Wellness Plan (IHAWP)**	**Hawki**
Medical daycare services	Covered; up to age 21 under EPSDT.		
Newborn child: office visits	Covered	Covered	Covered
Podiatry	Covered; routine foot care is not covered unless it is part of a member's overall treatment related to certain healthcare conditions.	Covered; routine foot care is not covered unless it is part of a member's overall treatment related to certain healthcare conditions.	Covered
Routine eye exam *One routine vision exam per calendar year.*	Covered	Covered	Covered
Routine hearing exam *One routine hearing exam per calendar year.*	Covered	Covered	Covered
Specialist office visit	Covered; PCP referral may be required.	Covered; PCP referral may be required.	Covered; PCP referral may be required.
Inpatient Hospital Services			
Preapproval of inpatient admissions	Covered; required for non-emergent admissions.	Covered; required for non-emergent admissions.	Covered; required for non-emergent admissions.
Room and board	Covered	Covered	Covered
Inpatient physician services	Covered; includes anesthesia.	Covered; includes anesthesia.	Covered
Inpatient supplies	Covered	Covered	Covered
Inpatient surgery	Covered	Covered	Covered
Bariatric surgery for morbid obesity	Covered		Covered; limitations may apply.
Breast reconstruction, following breast cancer and mastectomy	Covered	Covered	Covered; limitations may apply.
Organ/bone marrow transplants	Covered; limitations apply.	Covered; limitations apply.	Covered; limitations may apply.
Inpatient supplies	Covered	Covered	Covered

Services *prior authorization may be required	Iowa Health Link	Iowa Health and Wellness Plan (IHAWP)	Hawki
Outpatient Hospital Services			
Abortions	Covered; certain circumstances must apply.	Covered; certain circumstances must apply.	Covered; certain circumstances must apply.
Ambulatory surgical center	Covered; includes anesthesia.	Covered; includes anesthesia.	Covered; includes anesthesia.
Chemotherapy	Covered	Covered	Covered
Dialysis	Covered	Covered	Covered
Outpatient diagnostic lab, radiology	Covered	Covered	Covered
Emergency Care			
Ambulance	Covered	Covered	Covered
Urgent care center	Covered	Covered	Covered
Hospital emergency room	Covered	Covered; $8 per visit for non-emergent medical services.	Covered; emergency services for non-emergent conditions are subject to a $25 copay if the family pays a premium for the Hawki program.
Behavioral Health Services			
Assertive community treatment (ACT)	Covered	Covered; if member has been determined to be medically exempt.	
Behavioral health intervention services (BHIS), including applied behavior analysis	Covered	Covered; 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	Covered; MCO members only.	Covered; if member has been determined to be medically exempt.	

Services *prior authorization may be required	Iowa Health Link	Iowa Health and Wellness Plan (IHAWP)	Hawki
Inpatient mental health and substance abuse treatment	Covered	Covered; limitations may apply.	Covered
Office visit	Covered	Covered	Covered
Outpatient mental health and substance abuse	Covered	Covered	Covered
Psychiatric medical institutions for children (PMIC)	Covered	Covered; for ages 19 to 20; limitations may apply.	
Crisis response and subacute mental health services	Covered	Covered; if member has been determined to be medically exempt.	Covered
Outpatient Therapy Services			
Cardiac rehabilitation	Covered	Covered	Covered
Occupational therapy	Covered	Covered; limited to 60 visits per year.	Covered
Physical therapy	Covered	Covered; limited to 60 visits per year.	Covered
Pulmonary therapy	Covered	Covered	Covered
Respiratory therapy	Covered	Covered	Covered
Speech therapy	Covered	Covered; limited to 60 visits per year.	Covered
Radiology Services			
Mammography	Covered	Covered	Covered
Routine radiology screening and diagnostic services	Covered	Covered	Covered
Sleep study testing	Covered	Covered; sleep apnea diagnostic services only.	Covered
Laboratory Services			
Colorectal cancer screening	Covered	Covered	Covered
Diagnostic genetic testing	Covered	Covered	Covered

Services *prior authorization may be required	Iowa Health Link	Iowa Health and Wellness Plan (IHAWP)	Hawki
Pap smears	Covered	Covered	Covered
Pathology tests	Covered	Covered	Covered
Routine laboratory screening and diagnostic services	Covered	Covered	Covered
Sexually transmitted infection (STI) and sexually transmitted disease (STD) testing	Covered	Covered	Covered
Durable Medical Equipment (DME)			
Medical equipment and supplies	Covered	Covered	Covered
Diabetes equipment and supplies	Covered	Covered; limitations may apply.	Covered
Eyeglasses	Covered; limitations may apply.	Covered; for ages 19 to 20, limitations may apply.	Covered; limitations may apply.
Hearing aids	Covered	Covered; for ages 19 to 20, limitations may apply.	Covered; limitations may apply.
Orthotics	Covered; limitations may apply.		Covered; limitations may apply.
Long-Term Services and Supports (LTSS): Community-Based			
Section 1915(C) home- and community-based services (HCBS)	Covered		
Section 1915(I) habilitation services	Covered	Covered; if member has been determined to be medically exempt.	
Integrated Health Homes	Covered	Covered; if member has been determined to be medically exempt.	

Services *prior authorization may be required	Iowa Health Link	Iowa Health and Wellness Plan (IHAWP)	Hawki
Long-Term Services and Supports (LTSS): Institutional			
ICF/ID Intermediate care facility for individuals with intellectual disabilities	Covered; limitations apply.		
ICF/MC Intermediate care facility for medically complex	Covered; limitations apply.		
Nursing facility (NF)	Covered		
Nursing facility for the mentally ill (NF/MI)	Covered		
Skilled nursing facility (SNF)	Covered	Covered; limitations apply, limited to 120-day stays.	
Skilled nursing facility: Out of state (Skilled preapproval)	Covered; limitations apply.		
Community-based neurobehavioral rehabilitation services	Covered	Covered; medically exempt only.	
Hospice			
Hospice	Covered	Covered; limitations apply.	
Home Health			
Private duty nursing/ Personal care services per EPSDT authority	Covered; up to age 21 under EPSDT.	Covered; up to age 21 under EPSDT.	
Home health aide	Covered	Covered	Covered
Skilled nursing	Covered	Covered	Covered
Occupational therapy (OT)	Covered	Covered	Covered
Physical therapy (PT)	Covered	Covered	Covered
Speech-language pathology	Covered	Covered	Covered
Vision Services			
Exams	Covered One complete preventive eye exam every 12 months.	Covered One complete preventive eye exam every 12 months.	Covered One complete preventive eye exam every 12 months.

Services **prior authorization may be required*	**Iowa Health Link**	**Iowa Health and Wellness Plan (IHAWP)**	**Hawki**
Eyewear	Covered Ages 1 and under: up to three pairs of eyeglasses every 12 months, up to 16 gas permeable contact lenses every 12 months. Ages 1–3: up to four pairs of eyeglasses every 12 months, up to eight gas permeable contact lenses every 12 months. Ages 4–7: One pair of eyeglasses every 12 months, up to six gas permeable contact lenses every 12 months. Ages 8 and over: One pair of eyeglasses every 24 months, two gas permeable contact lenses every 24 months.	Covered Age 19 and 20 only: One pair of eyeglasses (frames and lenses) every 24 months.	Covered $100 retail allowance toward eyeglasses and contact lenses every 12 months.
Repairs	Covered Ages 20 and under: replacement for eyeglasses lost or damaged beyond repair is not limited. Age 21 and over: replacement for eyeglasses lost or damaged beyond repair is limited to once every 12 months.	Covered Ages 19 and 20 only: replacement for eyeglasses lost or damaged beyond repair is not limited.	Not covered

Services *prior authorization may be required*	Iowa Health Link	Iowa Health and Wellness Plan (IHAWP)	Hawki
Transportation Services			
Non-emergency medical transportation (NEMT): Includes taxi, paratransit, and stretcher van services, as well as bus pass and mileage reimbursement. Pick-up and drop-off services and mileage reimbursement is allowed from member's home, work, or school prior to and from a trip to a doctor's appointment or pharmacy.	Covered	Covered; only if a member on this plan is medically exempt.	
Waiver transportation program: Applies to members on the Intellectual Disability, Elderly, Brain Injury or Physical Disability Waiver Programs.	Covered; case managers may request additional transportation benefits beyond NEMT. They must be added into the member's service plan and approval is based on need.		

Transportation Benefits

Iowa Total Care covers non-emergency medical transportation (NEMT) for Iowa Health Link members. This includes medically necessary covered services, such as doctor appointments, dialysis, and counseling appointments. Iowa Total Care works with Access2Care (A2C) to provide transportation.

Schedule your ride at least two working days before your appointment. You can schedule rides up to 30 days before your appointment. Urgent medical trips can be requested with less than two days' notice. Access2Care may check with your provider to make sure your appointment is urgent.

To Schedule Transportation

To schedule a ride, contact Iowa Total Care Member Services to reach Access2Care, our transportation partner:

- Call 1-833-404-1061 (TTY: 711).
- <After selecting your preferred language, say "Member" or press 1 for member services.
- Next, say "Transportation" or press 4 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.

You are to be dropped off at your appointment location within 15 minutes of the scheduled appointment time.

To *cancel* transportation services, call 1-833-404-1061 (TTY: 711). Be sure to also notify them if your appointment date or time changes.

To Schedule Return Trip After Appointment

Call 1-833-404-1061 (TTY: 711) to reach the Access2Care (A2C) Care Coordination Line. A2C will:

- confirm your pickup location.
- contact the transportation company and inform them you are ready to be picked up.

You are to be picked up within 60 minutes of appointment completion.

Note: Nursing homes are responsible for NEMT trips within a 30-mile radius of the nursing home. If you are a nursing home resident and need to see a doctor less than 30 miles from your location, your nursing home is to provide transportation.

Dental Benefits

Iowa Total Care only covers dental procedures done in a hospital setting.

Medicaid Dental Benefit: Dental services are available to Iowa Medicaid members ages 18 and younger through the Iowa Medicaid Fee-for-Service (FFS) program. These services are not part of those provided by Iowa Total Care. For questions about your dental benefits, call Iowa Medicaid Member Services at 1-800-338-8366.

Hawki Dental: Dental services are available to Hawki members through a dental carrier. The services are not part of those provided by Iowa Total Care. For questions about your dental benefits, call Hawki Customer Service at 1-800-257-8563.

Dental Wellness Plan: The Dental Wellness Plan provides dental coverage for adult Iowa Medicaid members ages 19 and older. The services are not part of those provided by Iowa Total Care. Dental coverage is provided by a dental carrier. For questions about your dental benefits, call Iowa Medicaid Member Services at 1-800-338-8366 or visit **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/dental-wellness-plan**.

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.

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.

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 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.

These services do not require prior approval:

- Emergency services.
- Diagnostic tests (x-ray & lab).
- Scheduled outpatient hospital services.
- Planned inpatient admission.
- Post-stabilization care (after you get out of the hospital).
- Urgent care.
- Out-of-network providers need Iowa Total Care approval (with the exception of 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).

Electronic Visit Verification (EVV)

Electronic visit verification (EVV) is a way to verify where and when direct care services for a member occur. Home health services, including skilled nursing visits and home health aides, are required to be recorded using an EVV system. Waiver personal care service providers must also use EVV to document the time and location of service(s) they provide. Waiver services that are required to use EVV include CDAC agencies, individual CDAC providers, homemaker agencies and CCO employees that provide CDAC or homemaker.

EVV is a Federal requirement under the 21st Century Cures Act. The 21st Century Cures Act requires that EVV systems collect and verify the following:

1. Type of service performed.
2. Beneficiary receiving the service.
3. Caregiver providing the service.
4. Date of the service.
5. Location of the service.
6. Time the service begins.
7. Time the service ends.

Currently, personal care service providers are using EVV whether they are a traditional Medicaid provider or a Consumer Choices Option (CCO) employee. Assisted living facilities and residential care facilities are able to opt out of using EVV if they complete an attestation. Home health services will be required to use EVV by January 1, 2024.

CareBridge is the company that facilitates EVV in Iowa. CareBridge EVV records the services that members receive and then sends a claim for billing to Iowa Total Care. Iowa Total Care directly pays the providers based on the claim that CareBridge submits. There is no charge to members or caregivers for using the CareBridge EVV platform. Providers and their employees can use the CareBridge mobile app on their mobile phone or tablet to check in and out of their visits in a member's home. If the provider does not have an electronic device, they can call into CareBridge on a phone using the Interactive Voice Response system.

Member Portal and Interactive Voice Response (IVR)
You will have access to the Member Portal or call the Member IVR number at 1-515-800-2537 to make sure that your visit details are correct in the system. CareBridge has training information to help you get started.

If you have any questions regarding EVV, please contact your assigned community-based case manager or care manager, if you have one. If you are not assigned a community-based case manager or care manager, please contact Member Services at 1-833-404-1061 (TTY: 711).

GOING TO THE DOCTOR

When you need to see a doctor, be sure to see one that is a part of the Iowa Total Care network. You do not need approval from Iowa Total Care or a referral from your in-network doctor 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 1-833-404-1061 (TTY: 711). Or you can find a provider with our online tool: **providersearch.iowatotalcare.com**.

Picking Your Primary Care Provider (PCP)

When you become an Iowa Total Care member, you must choose a family doctor. This doctor is called a primary care provider (PCP). 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 and rural health clinics.
- American Indian/Alaskan Native (AI/AN) tribe, tribal organization, or urban AI/AN organization.

If you would like to know more about a PCP, call Iowa Total Care Member Services: 1-833-404-1061 (TTY: 711). They can tell you what language the provider speaks, if they are in the network, where they are located, and their location accessibility accommodations.

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: **member.iowatotalcare.com**.
2. Call Iowa Total Care Member Services to help you: 1-833-404-1061 (TTY: 711). 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.

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 1-833-404-1061 (TTY: 711), and we 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.

How To Make An Appointment

Making Appointments With Your PCP

- For routine appointments, call your PCP's number listed on the front of your Iowa Total Care ID Card, during normal business hours.
- For emergencies, follow the process documented in the **Emergency and Urgent Care** section of this document.
- Let the scheduling representative know you would like to make an appointment with your PCP (for example, a checkup or a follow-up visit).
- Transportation to your appointment may be available. For details, refer to the **Transportation Benefits** section of this document.
    - To schedule a ride, contact Iowa Total Care Member Services: 1-833-404-1061 (TTY: 711).
    - <After selecting your preferred language, say "Member" or press 1 for member services.
    - Next, say "Transportation" or press 4 for transportation services.>

Making Appointments With Specialists

- If you need services your PCP cannot provide, your PCP may help schedule your appointment with a specialist or you may contact the specialist directly. Referrals are not required to see a specialist.
- Most specialists are Iowa Total Care providers. Be sure to talk to your provider to understand how referrals work.

Canceling An Appointment With Any Provider

- In the event you are unable to keep an appointment, call the provider's office at least 24 hours before the scheduled appointment. Use the same number you used to make the appointment.
- Let the scheduling representative know you need to cancel or reschedule your appointment with the provider's name, on the date, and at the time you were initially scheduled.
- To cancel transportation services, call Member Services to reach Access2Care (A2C): 1-833-404-1061 (TTY: 711).
- Not canceling your appointments or not showing up for scheduled appointments may lead to your provider asking you to be reassigned to another provider.

Second Opinion

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 1-833-404-1061 (TTY: 711).

Specialists

Iowa Total Care does not need a referral from your PCP to cover your service with a specialist, but the specialist may still want 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 1-833-404-1061 (TTY: 711).

Procedures for Obtaining Out-of-Network Services and Special Benefit Provisions (for example, copayments, 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 copay 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: 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 for assistance: 1-833-404-1061 (TTY: 711).

PHARMACY

Prescriptions

When you need a prescription, your doctor will send it electronically 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: 1-833-404-1061 (TTY: 711) or you can look for a pharmacy on 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.

Over-the-Counter (OTC) Medicines

Iowa Total Care members have access to some OTC medications with an electronically-submitted prescription from an authorized prescriber.

The covered list of OTC medications is located on the Iowa Medicaid PDL: **www.iowamedicaidpdl.com/preferred_drug_lists**, in the Nonprescription Drugs section.

Or contact Iowa Total Care Member Services: 1-833-404-1061 (TTY: 711). Some OTC medications may require a prior authorization.

Preferred Drug List (PDL)

Your pharmacy benefit has a Preferred Drug List. The PDL shows the drugs covered by Medicaid and is composed of drugs recommended by the Iowa Medicaid Pharmaceutical and Therapeutics Committee. **You can find the link to the Iowa Medicaid PDL at www.iowatotalcare.com under the Pharmacy section.**

To request a printed copy of the PDL, call Member Services: 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. Should the medication require a prior authorization, for some medications you may receive a 72-hour emergency supply of the medication while the prior authorization is being reviewed.

Some prescriptions also have a quantity limit. If your provider has determined that you need to take more of a medicine than is allowed on the quantity limit,

that will also require a prior authorization.

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.

For questions, please refer to the Iowa Medicaid PDL or call Iowa Total Care Member Services: 1-833-404-1061 (TTY: 711).

Medicines work best when you take them the way your doctor prescribed. Part of that is making sure you get them refilled on time. To fill your prescriptions:

- Ask your provider to send your prescriptions to the pharmacy of your choice.
- Show your Iowa Total Care member ID card to the pharmacy.
- If you use a new pharmacy, tell the pharmacist about all of the medicines you're taking including over-the-counter (OTC) medicines, too.

It's good to use the same pharmacy each time. This way, your pharmacist:

- Will know all the medicines you are taking.
- Can watch for problems that may occur.

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.

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 FDA approval or compendia indications.
- Experimental or investigational drugs.
- Drugs to help you get pregnant.
- Drugs used for weight loss, cosmetic use, 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 non-prescription drugs.

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

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 primary care provider (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: 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 helps us make sure you get the follow-up care you need. Our toll-free phone number is 1-833-404-1061 (TTY: 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: 1-833-404-1061 (TTY: 711).

Emergency Transportation

Iowa Total Care covers emergency ambulance transportation. They will take you to the nearest hospital. Ambulance transportation from one healthcare 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). Then press *. They can help with depression; substance use and other behavioral health needs. You can also call or text 988, the National Suicide & Crisis Lifeline. It offers free, confidential access to trained counselors 24/7.

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 types of services, you may be required to pay a copayment for the services you get there.

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.

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

Copayments

A copayment is a set dollar amount you pay when you get certain services or treatment. It is your share of the cost for a covered healthcare service.

The only services where a copayment may apply is for use of a hospital emergency room (ER) to treat non-emergent conditions.

- Iowa Health and Wellness Plan members will be charged an $8 copayment for each visit to the emergency room that is not considered an emergency.
- Hawki members will be charged a $25 copayment for each visit to the emergency room that is not considered an emergency. A copayment shall not be charged to Hawki members who are not required to pay a premium.

Before providing non-emergency services and imposing copayments, 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 ER.
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 no copayment.
5. Provide a referral to coordinate scheduling for treatment by the alternative provider.

If the member is advised of the available alternative provider and of the amount of the copayment, and chooses to receive treatment for a non-emergency condition at the hospital ER, the hospital will assess the copayment.

Emergency services for emergent conditions are exempt from any copayment.

Paying Copayments

- 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: 1-833-404-1061 (TTY: 711).
- Request through your online account on the secure member 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.*

Member Liability/Client Participation

The other type of cost sharing is when a member must pay for a portion of their monthly services. This is referred to as **client participation**. If you have are assigned a client participation, your provider will bill you up to this amount for the services you receive.

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 in an institutional setting or under 1915(c) home- and community-based services. The Iowa Department of Health and Human Services (HHS) has the responsibility of determining the member liability amount.

A nursing facility or immediate care facility for the intellectually disabled (ICF/ID) can discharge members due to non-payment of the client participation. In this instance, Iowa Total Care will work to find an alternative facility willing to serve the member. However, the client participation will apply at the new facility because it is a condition of the member's eligibility for Medicaid services.

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 are not liable for payment.
- It tells you how you can appeal this decision.

REWARDS PROGRAM

Iowa Total Care has a program that gives our members rewards for completing healthy behaviors. Once you complete a healthy activity, you will receive your My Health Pays® Visa Prepaid Card*. Each time you complete a qualifying healthy activity, we are notified, and your reward dollars are added to your existing card.

Rewards can range from $10 to up to $50. Visit the Rewards Program page on **www.iowatotalcare.com** or call Member Services at 1-833-404-1061 (TTY: 711) for more details and a current list of healthy activities.

How do I get my rewards card?
The first time you do something on the list, a card will be mailed to you. The card is usually mailed within 90 days. It will have your first reward on it. When you complete other healthy behaviors from the list, more reward dollars will be added. Keep your card after you use it. Your rewards will be added to the same card.

For questions about rewards impacting your Medicaid eligibility or client participation, please contact your Medicaid Maintenance Worker.

What qualifies as a healthy activity?
Visit **www.iowatotalcare.com** or call Member Services for a list of healthy activities that qualify for rewards, such as:

- Completing a health risk screening within 90 days of an initial enrollment, then once per enrollment year.
- Completing a Notification of Pregnancy form within the first trimester of pregnancy.
- Annual breast cancer screening (age restrictions apply).
- Getting a well care visit (age restrictions apply).
- Getting the flu vaccine (age restrictions apply).
- Attending a Stakeholder Advisory Board meeting.

*This My Health Pays® Visa Prepaid Card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted.

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: 1-833-404-1061 (TTY: 711).

Service	Description	How It Works	My Health Pays Reward?
Start Smart for Your Baby® (Start Smart) **Who is eligible?** Iowa Total Care members who are pregnant or just had a baby.	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. The program provides educational materials as well as incentives for going to prenatal, postpartum, and well-child visits.	To enroll in this program, just complete and return the Notification of Pregnancy form, which can be found: • In your welcome kit. • Online at **iowatotalcare.com**, under the Member Resources section. Your doctor can also complete and submit the form on your behalf.	Rewards can range from $15 to $40, depending on the stage in which you complete and submit the Notification of Pregnancy form and/or attend your prenatal doctor visit.
Start Smart for Your Baby® Shower Program **Who is eligible?** Iowa Total Care members who are pregnant.	Baby showers are conducted in a classroom environment with the purpose of educating pregnant members about prenatal and postpartum care for themselves and their newborn. 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.	Eligible members are invited to attend a baby show held in their area.	No rewards are provided for attending the baby shower; however, Iowa Total Care may partner with vendors to provide items you and your baby may need.

Service	Description	How It Works	My Health Pays Reward?
The Flu Program	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 educating on what to do if a member (or family member) becomes ill.	The Flu Program is our annual flu prevention campaign that provides targeted outreach to you as a member. Additionally, you are able to obtain your flu vaccine at participating pharmacies, subject to age or other restrictions of the pharmacy. To find a pharmacy or doctor near you, review "Flu Shots" under the Benefits & Services section on **iowatotalcare.com** or call Member Services at 1-833-404-1061 (TTY: 711).	Receive $10* in My Health Pays® rewards when you get a flu vaccine during flu season.** **Applies to ages 18 and up.* *** Flu season is September – April.*
Diabetes In-Home Test Kit **Who is eligible?** Members between the ages of 18–75 who have been diagnosed with diabetes.	We have partnered with <Visiting Physicians Association> (VPA) to provide an in-home Diabetes Monitoring Test – HgbA1C kit at no cost to you. The results from the screening kit will help you better manage your health.	Eligible members can call Member Services to request a kit. Iowa Total Care will mail an in-home test kit to your home. Kit will contain instruction on how to complete the test and where to mail it. Results will then be mailed to you and your primary doctor.	Receive $15 in My Health Pays® rewards for completing the in-home test. You may earn this amount twice per calendar year.

Service	Description	How It Works	My Health Pays Reward?
Member Connections® Community Outreach Program **Who is eligible?** Iowa Total Care high-risk members with multiple chronic health conditions.	This program allows us to provide a high touch, personal level of interaction with our members that builds strong relationships and trust. Member Connections Representatives (MCRs) 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. MCRs receive comprehensive training, including Community Health Outreach Worker certification, and become an important part of our Member Connections and Care Coordination staff.	MCRs 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.	MCRs can help ensure high-risk members receive the care they need to manage their health conditions: • Annual screenings & checkups $15 to $30.

Service	Description	How It Works	My Health Pays Reward?
Connections Plus® **Who is eligible?** Iowa Total Care high-risk members with multiple chronic health conditions who are enrolled in care management.	Iowa Total Care offers the Connections Plus Program, which loans free 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. 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.	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.	N/A
Mobile App **Who is eligible?** All Iowa Total Care members, or the parent or guardian of the Iowa Total Care member.	To make information easily accessible to you, Iowa Total Care offers a mobile app that includes interactive tools and functions, such as Health Risk Screenings, Care Gap Alerts, Health Library, one-touch calling, mobile Find-a-Provider, mobile ID Card, and personal health trackers. It is designed to be a comprehensive and integrated mobile "one-stop shop."	Search for Iowa Total Care in the App Store or Google Play to download the mobile app.	N/A

Service	Description	How It Works	My Health Pays Reward?
Video Chat with a Doctor **Who is eligible?** All Iowa Total Care members, or the parent or guardian on behalf of the Iowa Total Care member.	We have partnered with Teladoc to give 24/7* access to medical care. It's an easy way to get services from a doctor, have a face-to-face, and talk to a doctor about non-emergency issues. Get medical advice and referrals too. **Behavioral health services are available every day from 7 a.m. to 9 p.m. CT*.	Search for Teladoc in the App Store or Google Play.	N/A
Healthy Celebration Days **Who is eligible?** All Iowa Total Care members.	This benefit helps ensure that you 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 contact you to encourage you 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.	Annual screenings & checkups ($15 to $20 in My Health Pays® rewards).
Findhelp.org **Who is eligible?** Anyone interested in researching local community resources.	Iowa Total Care's online community resource tool that puts valuable community resources at your fingertips. You can find programs and services for: • Food. • Financial assistance. • Shelter. • And more!	Accessible to the public and has resources available in Spanish. A link to Findhelp.org can be found on **iowatotalcare.com**, under the Helpful Links section.	N/A

Service	Description	How It Works	My Health Pays Reward?
Long-Term Services and Supports (LTSS) Transition Coordination Fund **Who is eligible?** Members transitioning home from select settings; see How It Works. The member must not otherwise be eligible for other funds (e.g., Money Follows the Person grant program, community resources, county funds).	Members are eligible for: • Up to $750 if they have a home they are returning to, or • Up to $1,500 if they will need a home. Funds may be used for items including utility set-up, housing (rent and/or deposit), household items (linens, bedding, towels), food, cleaning supplies and more.	This fund is available for members transitioning home from the following settings: • Intermediate Care Facility for the Intellectually Disabled (ICF/ID), • Nursing Facility (NF) • Psychiatric Medical Institution for Children (PMIC), • Community Neuro Rehabilitation Services (CNRS), • Residential Care Facilities (RCF) • Mental Health Institute (MHI), or an • Out-of-State (OOS) placement. All requests must be initiated by Case Management and approved by Iowa Total Care directors prior to discharge.	N/A

WELLNESS CARE

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 once per calendar year with your primary care provider (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 Iowa Health Link children under the age of 21. These are also called well-child checkups. Doctor visits when your child is well help 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: 1-833-404-1061 (TTY: 711).

CARE FOR PREGNANT MEMBERS

Start Smart for Your Baby® is Iowa Total Care's program for all pregnant members. Women may see any obstetrician or gynecologist (OB/GYN) for pregnancy care without being sent by their primary care provider (PCP). This care is called prenatal care. It can help you have a healthy baby. Even if you already had a baby (postpartum), postnatal care is important. The postpartum (or postnatal) period begins immediately after childbirth. With our Start Smart for Your Baby® program, members receive health information and rewards for getting prenatal and postpartum care.

- If you think you may be pregnant, see your PCP or an OB/GYN right away. You do not need a referral from your PCP to see an OB/GYN doctor. It is important to start prenatal care as soon as you become pregnant. Call Member Services if you need help finding an OB/GYN in the Iowa Total Care network: 1-833-404-1061 (TTY: 711).
- When you find out you are pregnant, please complete the Notification of Pregnancy form available on our secure member portal: **member.iowatotalcare.com**. Also, contact the Iowa Department of Health and Human Services Income Maintenance Customer Service Center at 1-877-347-5678 to report this change for Medicaid. When you call, please provide them with your confirmed due date.
- 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 (on or between seven to 84 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.
- Preterm birth, also known as premature birth, is the birth of the baby at fewer than 37 weeks gestational age.
- 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.

When You Become Pregnant

When you first find out you are pregnant, you should complete the Notification of Pregnancy form available on our secure member portal: **member.iowatotalcare.com**. Upon completion and submission, we will send you a Start Smart for Your Baby® package. It will include:

- A letter welcoming you to the Start Smart for Your Baby® program.
- A book entitled *A Mother's Guide to Pregnancy* with information on what to expect during pregnancy and after delivery.
- A supply checklist to ensure you are ready for when your baby arrives.
- A Start Smart for Your Baby® brochure to help explain the program.

After You Have Your Baby

Iowa Total Care will send you a newborn welcome mailing. It will include:

- A letter welcoming your new little one and introducing ways to take care of your baby.
- A book entitled *A Mother's Guide to Life After Delivery*, with information on changes your body may go through.
- List of vaccines and well-child visits, information about each one and a schedule.

The Neonatal Intensive Care Unit (NICU)

If your baby is admitted to the neonatal intensive care unit (NICU), we offer the Start Smart for Your Baby® NICU program. Parents receive education and support, including tips on how to get through the tough times and things they can do to help their baby while in NICU. Call Iowa Total Care Member Services for more information: 1-833-404-1061 (TTY: 711).

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 healthcare 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 healthcare 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 lifelong 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 healthcare 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 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.
- Chronic obstructive pulmonary disease (COPD).
- Heart failure.
- Tobacco abuse.

Our care managers will listen to the member's 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: 1-833-404-1061 (TTY: 711).

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: 1-833-404-1061 (TTY: 711).

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 free crisis support line: 1-833-404-1061 (TTY: 711). 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, call Member Services for assistance finding a provider in your area: 1-833-404-1061 (TTY: 711).

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 smartphone.

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 (ICF). 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), 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).

Home- and Community-Based Services (HCBS)

Home- and community-based services (HCBS) programs 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 are not currently receiving HCBS, Iowa Total Care will help you with the process to access those services. An assessment is needed to determine your level of need for your level of need for services. If the assessment shows you need those services, and you are eligible for Medicaid, you may be able to receive nursing home services or choose to receive services in your home.

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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 (CCO).

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 ICF, SNF, or ICF/ID level of care.
- At least one 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:

- Age from birth to age 18.
- Have a diagnosis of serious emotional disturbance (SED) as verified by a licensed mental health professional within the past 12 months.
- Are determined to need hospital level of care.
- These services are managed by the Integrated Health Home team.

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 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:

- Are 16 years of age or older, have a serious mental illness or serious emotional disorder, with a functional impairment.
- Must be eligible for Medicaid and have a household income that does not exceed 150% of the Federal Poverty Level.
- Meet a needs-based evaluation, have one risk factor, and meet at least two of five criteria showing need for assistance.

This service can be managed by a CBCM or an Integrated Health Home team.

Based on your assessed needs, covered services may include:

Habilitation Services

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

Health and Disability Waiver

Health and Disability 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 Health and Human Services' disability decision process.
- Are ineligible for SSI if over age 21; members receiving HD Waiver services upon 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 ICF, SNF, or 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 Waiver services may be available to people who:

- Have a diagnosis of intellectual disability as determined by a psychologist or psychiatrist.
- Are determined to need ICF/IDICF/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: If you receive daily supported community living under the Intellectual Disability Waiver, your transportation will be provided unless otherwise specified in your person-centered plan.
- Consumer Choices Option (CCO).

Physical Disability Waiver

Physical Disability 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 Health and 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:
hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/hcbs

Case Management

Case Management Services are provided to eligible members who are accessing HCBS services. Case management services may be provided by an Iowa Total Care community-based case manager (CBCM) or integrated health home (IHH). Case management services will assist with:

- Coordinating and monitoring your health care needs.
- Coordinating and monitoring your services provided by physical, behavioral, and supportive service providers.
- Linking, coordinating, and monitoring Medicaid and non-Medicaid services.
- Linking, coordinating, and monitoring services and resources available in your community.
- Facilitating communication with members and their informal support(s) during the process of referring, coordinating, and monitoring necessary services and supports.
- Coordinating your transportation benefit, through available HCBS services or Access2Care.
- We also have complex care management for eligible members with unique health and wellness needs. We may reach out to you to discuss the program with you.

Service Coordination Program

Members accessing HCBS services will have a service coordination program, also called a person-centered service plan (PCSP). This is completed by the CBCM with the members. The PCSP is a plan consisting of services and supports that will meet the needs of the member to live as independently as possible in the community.

- The PCSP is developed and finalized at an interdisciplinary team meeting with participants chosen by the member.
- The PCSP is individualized to the member and is based on the member's current assessment.
- The PCSP includes member goals, services, needs, desired outcomes, emergency plan, risk factors, and rights restrictions.

Transportation for Waiver Services

If you are on a waiver that includes the transportation benefit, your case manager will:

- Work with you and your care team to determine the number of trips or mileage to be authorized.
- Submit the authorization to Access2Care to enable trips to be scheduled.
- Coordinate with you and your care team to arrange the waiver transportation with the provider of your choice through Access2Care for recurring and one-time trips and provide education on how to cancel scheduled waiver trips.

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, except for the Children's Mental Health (CMH) Waiver. CCO gives you control over your 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 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 (CBCM) can work with you to choose a delegate 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 CBCM 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 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. Your caregiver works for you and is supervised by 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 CBCM for more details.

The following services can be chosen for self-direction:

1. AIDS/HIV Waiver
    a. Consumer-directed attendant care (CDAC): Non-skilled 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): Non-skilled 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): Non-skilled 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): Non-skilled services.
    b. Home and vehicle modification.
    c. Home delivered meals.
    d. Basic individual respite.

5. Intellectual Disability Waiver
    a. Consumer-directed attendant care (CDAC): Non-skilled 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): Non-skilled services.
    b. Home and vehicle modification.
    c. Specialized medical equipment.
    d. Transportation.

Please note that some services may be subject to electronic visit verification (EVV), a tracking system that verifies when a person receives a Medicaid-funded personal care service. Currently, this applies to consumer-directed attendant care (CDAC) and homemaker services. You will be required to sign off on the employee's EVV service record before the employee will be paid for services they provide to you. For questions regarding EVV services and your role, please contact your assigned CBCM.

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. Just talk with your CBCM. More information about the CCO is online:
hhs.iowa.gov/programs/welcome-iowa-medicaid/member-services/cco

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 that you cannot perform for yourself. CDAC services cannot provide for your personal supervision or for someone to stay with you overnight.

There are two kinds of CDAC services: non-skilled and skilled.

Non-skilled 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 fill out a CDAC Agreement form with your CBCM and the person you are hiring to provide the CDAC services. The CDAC Agreement outlines the duties your CDAC provider will perform, how often they complete the duties, and what their rate will be. Your CDAC provider can be a person that you know or aa CDAC provider agency. Remember, this person will be in your home helping you do the things needed to keep you in your home. It is important that you feel comfortable with him or her. Your 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.

Electronic visit verification (EVV). CDAC services are required to be verified through EVV for CDAC agencies or individual CDAC providers unless you live in an assisted living or residential care facility. This verification should be done by your provider on the date of service to help ensure timely payment. For questions regarding this process or your role in EVV, please contact your assigned CBCM.

How to Get CDAC Services

To receive CDAC, you must already be approved for one of the HCBS Waiver programs that has CDAC as an available service. If you request to use CDAC as a service, you will have a meeting with your CBCM and the provider of your choice. 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, CDAC agreements, rates, record keeping, backup plans, personnel issues, reporting abuse and more, visit: **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/cdac**.

HEALTH HOMES PROGRAM

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 on community supports and resources and enhances coordination and integration of primary and behavioral health care to better meet the needs of members with multiple chronic illnesses.

Health homes focus on providing the following six core services for 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.

Iowa Health Link members may enroll in an Integrated Health Home.

Integrated Health Home

Members are eligible for Integrated Health Home (IHH) services, if they have been diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED) and have a functional impairment assessment completed by a licensed mental health professional.

SMI is defined as an adult that has a persistent or chronic mental health, behavioral, or emotional disorder specified within the most current *Diagnostic and Statistical Manual (DSM) of Mental Disorders* published by the American Psychiatric Association, or its most recent International Classification of Diseases equivalent that results in functional impairment that substantially interferes with or limits one or more life activities, including functioning in a family, school, employment, or community.

A **SED** is defined as a child with a diagnosable mental, behavioral or emotional disorder specified within the most current *Diagnostic and Statistical Manual (DSM) of Mental Disorders* published by the American Psychiatric Association or its most recent International Classification of Diseases equivalent that results in functional impairment that substantially interferes with or limits the child's role of functioning in family, school, or community activities.

- For children three years of age or younger, the *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood Revised* (DC:03R) may be used as a diagnostic tool.
- For children four years of age or older, the *Diagnostic Interview Schedule for Children* (DISC) may be used as an alternative to the most current DSM.

SMI and SED may co-occur with substance use disorder, developmental, neurodevelopmental, or intellectual disability but those diagnoses may not be clinical focus for health home services.

Functional Impairment (FI) means the loss of functional capacity that is episodic, recurrent, or continuous and that substantially interferes with or limits the achievement of or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills and substantially interferes with or limits the individual's functional capacity with family, employment, school or community. FI must be identified by an assessment completed by aa licensed mental health professional. This does not include difficulties resulting from temporary and expected responses to stressful events in a person's environment.

For additional information on eligibility, participation or making changes to a currently assigned Integrated Health Home programs, please talk with your CBCM, care coordinator, or local Integrated Health Home 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, dignity, and privacy.
- To take part in the community and work, live and learn to the fullest extent possible.
- To receive healthcare services as stated in Federal regulations.
- Know that your medical records and discussions with your providers will be private and confidential.
- Receive information on all available treatment options and alternatives, including treatment in the least restrictive setting, presented in a manner appropriate to the member's condition and ability to understand.
- 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 healthcare, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as stated in federal regulations.
- Have access to your 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.
- A right to express a concern or appeal about Iowa Total Care or the care that it provides.
- To receive a response in a reasonable period of time.
- 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 receive information about Iowa Total Care, its services, providers and members rights and responsibilities.
- Be able to request copayment 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.
- A right to get information on care options in a way that you can understand, regardless of cost or 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, Iowa Total Care providers or Iowa Medicaid treat you.
- To request a change in community-based case managers (CBCMs).
- A right to seek second opinions.
- A right to get help with care coordination from the PCP's office.
- A right to choose your health professional and long-term supports and services providers to the extent possible and appropriate, as per 42 CFR §438.6(m).
- A right to get healthcare services that are similar in amount and scope to those given under Medicaid Fee-For-Service. This includes the right to get healthcare services that will achieve the purpose for which the services are given.
- A right to get services that are fitting and are not denied or reduced due to:
  - Diagnosis.
  - Type of illness.
  - Medical condition.
- A right to be given information in a manner and format you can understand, as defined in the Provider Agreement and the Member Handbook. This includes:
  - Enrollment notices.
  - Informational materials.
  - Instructional materials.
- A right to get free oral interpretation services for all non-English languages.
- A right to be notified that interpretation services are available and how to access them.
- A right to request Iowa Total Care's adopted practice guidelines.
- A right to get adequate and timely information on Iowa Total Care's Provider Incentive Plan, upon request.

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.
  - Your phone number 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.

- Treat providers and staff with dignity and respect.
- 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 healthcare services.
- To choose a primary care provider (PCP).
- To keep appointments and follow-up appointments.
- To access preventive care services.
- To live healthy lifestyles and avoid behaviors known to be harmful.
- 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.
- To follow care prescribed by the provider or to let the provider know why treatment cannot by 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.
- To make your PCP aware of all other providers who are treating you. This is to ensure communication and coordination in care. This also includes behavioral health providers.
- Be actively involved in your treatment. Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- 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 the 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 CBCM should be a person you feel comfortable with. If you feel you need a change in CBCM, please call 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 Stakeholder 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 Stakeholder 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 healthcare 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 healthcare 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 healthcare services.
- Giving members support and education about general healthcare 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 healthcare and services. We hope you will take the time to send us your answers.

Do you have questions about our Quality Improvement Program? Please contact Member Services at 1-833-404-1061 (TTY: 711) or visit **www.iowatotalcare.com**.

As part of our quality initiatives, Iowa Total Care has a team helping members in need of food, housing, and more. Contact Member Services: 1-833-404-1061 (TTY: 711). Ask to speak to a Housing and Resource Specialist.

OTHER INSURANCE AND BILLS

If You Have Medicare or Other Insurance Coverage

If you have Medicare or other health insurance in addition to Medicaid coverage, this coverage is considered your primary insurance. Your Medicaid coverage through Iowa Total Care is secondary. These other coverages will pay for services from participating physicians, hospitals, and other network providers. Medical services are based on the guidelines of that program. Your doctor will bill Medicare or other insurance 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/other insurance coverage 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 Member Services: 1-833-404-1061 (TTY: 711).

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 (TTY: 711). We have people to help you Monday through Friday, 7:30 a.m. to 6 p.m. CT. 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 receiving 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:

- Phone: Iowa Total Care Member Services at 1-833-404-1061 (TTY: 711).
- Fax: 1-833-809-3868, Attn: Grievances.
- Mail:

  Iowa Total Care
  Attn: Grievances
  1080 Jordan Creek Parkway, Suite 400 South
  West Des Moines, IA 50266
- Email: **appealsgrievances@iowatotalcare.com**.

If you submit your grievance in writing, 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.

You may also use the grievance form available on **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. The form is titled "Release of Information" (ROI). You can find it on **www.iowatotalcare.com**. You can also call member services and ask for the form. 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 three 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, an extension of 14 calendar days 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 two 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 need additional time to support your 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:

- Denied requested care or services.
- Approved 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.

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:

- Phone: Iowa Total Care Member Services: 1-833-404-1061 (TTY: 711).
- Fax: 1-833-809-3868, Attn: Appeals.
- Mail:

  Iowa Total Care Attn: Appeals
  1080 Jordan Creek Parkway, Suite 400 South
  West Des Moines, IA 50266
- Email: **appealsgrievances@iowatotalcare.com.**

If you submit your appeal in writing, be sure to include:

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

You may also use the appeal form available at **www.iowatotalcare.com**.

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. The form is titled "Authorized Representative Designation." You can get this form from Iowa Total Care Member Services or on **www.iowatotalcare.com**. 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.

You have the right to submit additional information to support your appeal prior to the appeal being reviewed. The timeframe to submit this information to Iowa Total Care is limited. You will be notified of the due date for the information. If we do not receive it, the appeal will be continued without it.

What to Expect After You Request an Appeal

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

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

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, an extension of 14 calendar days 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 two 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.

Requests can be made to the Iowa Department of Health and 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:

Iowa Department of Health and Human Services
Appeals Section, 5th Floor
1305 East Walnut Street
Des Moines, IA 50319-0114

If you need assistance or want to file by phone, you can ask the Iowa Department of Health and Human Services (HHS) office. You can contact the HHS Appeals Section at 1-515-281-3094.

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 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 East 12th Street, Suite 2
Des Moines, IA 50313-9025
Phone: 1-866-236-1430 (toll-free); 1-515-725-3333 (in the Des Moines area)
Fax: 1-515-725-3313
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 Office of Ombudsman for assistance by mail, phone, fax, or email at:

State of Iowa Office of Ombudsman
Ola Babcock Miller Building
1112 East Grand Avenue
Des Moines, IA 50319
Phone: 1-888-426-6283 (toll-free); 1-515-281-3592 (in the Des Moines area)
Fax: 1-515-242-6007
Email: **ombudsman@legis.iowa.gov**

ESTATE RECOVERY

Estate recovery legal reference: 441 IAC 75.28(7)

The cost of medical assistance is subject to recovery. The recovery includes the full amount of capitation payments made to a managed care plan, including medical and dental, even if the plan did not pay for any services. Members affected by the estate recovery policy 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 (TTY: 1-800-735-2942) or 1-515-256-4606 when calling within the Des Moines area. Monday through Friday from 8 a.m. to 5 p.m.

You may also learn more from Iowa Medicaid: **hhs.iowa.gov/programs/welcome-iowa-medicaid/member-services/estate-recovery.**

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 are not 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. A living will is only used when you are near the end of life with no hope to recover. Treatments could include:
    - Feeding tubes.
    - Breathing machines.
    - Organ transplants.
    - Treatments to make you comfortable.

- **A Healthcare Power of Attorney.** This names someone who is allowed to make healthcare decisions for you. This is only used if you are unable, in the judgement of your doctor, to make healthcare decisions.

- **A "Do Not Resuscitate" (DNR) Order.** This tells healthcare 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 Health and Human Services by calling 1-877-347-5678.

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 05/05/2023

For help to translate or understand this, please call 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 Entity's 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 or through a separate mailing.

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, and reviewing services for medical necessity.
- **Healthcare Operations** – We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.

  In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:
  - Quality assessment and improvement activities.
  - Reviewing the competence or qualifications of healthcare professionals.
  - Case management and care coordination.
  - Detecting or preventing healthcare fraud and abuse.
- **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 disclose 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 disclose 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 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 response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.
- **Law Enforcement** – We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime.
- **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** – We 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, and 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 concerns, intelligence activities, The Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.
- **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 interest. 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 purposes 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 your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment, or healthcare operation functions.

You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

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 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 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 Receive a 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. We will also tell you 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-year 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: **1-800-537-7697**) or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints**.

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 listed 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.

Race, Ethnicity and Language Information

Iowa Total Care keeps your race, ethnicity, and language (REL) data private. Ways we protect your data:

- Keep papers in locked areas.
- Keep electronic data behind locked doors.
- Keep electronic data password protected.

We may use your REL data for our work. Our work may include:

- Checking for health care unfairness.
- Planning actions to improve unfairness.
- Creating member materials.
- Updating providers about language needs.

We will never use your REL data:

- To gain business.
- To make decisions about your health care coverage.
- Or give your REL data to anyone without your approval.

Contact Information

Questions About This Notice – 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 by using the contact information listed below.

Iowa Total Care
Attn: Privacy Official
1080 Jordan Creek Parkway, Suite 400 South
West Des Moines, IA 50266
1-833-404-1061 (TTY: 711)

ACCESS TO YOUR DIGITAL RECORDS

New Options for Managing Your Digital Health Records

On July 1, 2021, a new federal rule named the Interoperability and Patient Access Rule (CMS 915 F) made it easier for members to get their health records when they need it most. You now have full access to your health records on your mobile device which lets you manage your health better and know what resources are open to you.

Imagine:

- You go to a new doctor because you don't feel well and that doctor can pull up your health history from the past five years.
- You use an up-to-date provider directory to find a provider or specialist.
- That provider or specialist can use your health history to diagnose you and make sure you get the best care.
- You go to your computer to see if a claim is paid, denied, or still being processed.
- If you want, you take your health history with you as you switch health plans.*

**In 2022, members can start to request that their health records go with them as they switch health plans.*

THE NEW RULE MAKES IT EASY TO FIND INFORMATION** ON:

- claims (paid and denied).
- pharmacy drug coverage.
- specific parts of your clinical information.
- healthcare providers.

***You can get information for dates of service on or after January 1, 2016.*

For more information, review the Interoperability and Patient Access information under the Member Resources section on **www.iowatotalcare.com** or login to our secure member portal to visit your member account: **member.iowatotalcare.com**.

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 (PCP) 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 healthcare 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.
- For members that use long-term services and supports (LTSS),), the member would have to change their residential, institutional or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with Iowa Total Care and, as a result, would experience a disruption in their residence or employment.

If you believe you have a good-cause reason to change to a new health plan, call Iowa Total Care Member Services at 1-833-404-1061 (TTY: 711) Monday through Friday from 7:30 a.m. to 6 p.m. CT.

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. 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.

What is Utilization Review?

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

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. We will bring these new benefit opportunities to our state partners to consider whether we should change any of our benefits to include the new technology.

If a request is made for aa new technology that is not a covered benefit, our Medical Director will review the request and make a one-time determination to make an Exception to Policy request to the Director of Iowa Department of Health and Human Services.

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 action. 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 timeframes.
- 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 Iowa Department of Health and Human Services (HHS). Or they may ask for a State Fair Hearing.

Care management: Care management helps you manage your complex healthcare 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.

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 healthcare 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.

- Iowa Health and Wellness Plan members will be charged an $8 copayment for each visit to the emergency room that is not considered an emergency.
- Hawki members will be charged a $25 copayment for each visit to the emergency room that is not considered an emergency.
- All other Iowa Medicaid members* will be charged a $3 copayment for each visit to the emergency room.

**Children under the age of 21 and pregnant women will not be charged a copayment for any services.*

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.

Electronic visit verification (EVV): Electronic visit verification (EVV) is a way to verify where and when direct care services for a member occur. Home Health services, including skilled nursing visits and home health aides, are required to be recorded using an EVV system. Waiver personal care service providers must also use EVV to document the time and location they provide services. Waiver services that are required to use EVV include CDAC agencies, individual CDAC providers and homemaker agencies.

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:

- 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 (PCP) 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 healthcare 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.
- For members that use long-term services and supports (LTSS), the member would have to change their residential, institutional or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with Iowa Total Care and, as a result, would experience a disruption in their residence or employment.

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.

Healthy Behaviors Program: Members in the Iowa Health and Wellness Plan can get free* healthcare if they complete what are known as Healthy Behaviors. To participate in the Healthy Behaviors program and avoid monthly payments after the first year, each year Iowa Health and Wellness Plan members must:

1. Get a wellness exam -OR- get a dental exam
   AND
2. Get a health risk assessment.

*There are very few, or no, costs for the first year and very few costs after that. A small monthly payment may be required based on income. There is an $8 copay for using the emergency room for non-emergency services.

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 care: 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).

Level of care: Members asking for HCBS waivers or facility care must meet level of care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of care is determined by an assessment approved by Iowa Department of Health and Human Services.

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 your providers, please your providers, please show them your Iowa Total Care ID card.

Over-the-counter medications (OTC): Iowa Total Care covers many 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 healthcare services.

Premium: A premium is the amount you pay for your health insurance every month. Most Iowa 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 drugs: A medication that is available only with written instructions from a licensed prescriber and dispensed by either the prescriber or a licensed pharmacist.

Preferred drugs: 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.

Prevocational services: Prevocational services are services where the member can gain skills that lead to paid employment.

Primary care physician: A primary care physician directly provides or coordinates your healthcare 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 healthcare 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 healthcare 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.

Serious emotional disturbance (SED): Serious emotional disturbance (SED) is a mental, behavioral, or emotional disturbance. An SED impacts children. An SED may last a long time and interferes with family, school, or community activities.

SED does not include:

- Neurodevelopmental disorders.
- Substance-related disorders.
- Other conditions that may be a focus of clinical attention unless they co-occur with another (SED).

Service plan: A service plan is a plan of care for members accessing HCBS waiver and habilitation services. 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.

Skilled nursing facility level of care: Skilled nursing facility level of care describes the type and amount of skilled nursing care a nursing facility resident needs.

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

Supported employment: Supported employment means ongoing job supports for people with disabilities. The goal is to help the person keep a job at or above minimum wage.

Treatment plan: A documented plan that describes the member's condition and the treatment that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the healthcare professional. The treatment plan shall be developed in collaboration with the member, the member's family, or the member representative.

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.