Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. These terms may also be used in other member documents. The terms are listed in alphabetical order. If you can’t find a term you’re looking for or if you need more information than a definition includes, contact Member Services.

[Plans should insert definitions as appropriate to the plan type described in the Member Handbook. You may insert definitions not included in this model and exclude definitions not applicable to your plan or to your contractual obligations with CMS and the state or enrolled Medicare/Medicaid members.]

[If revisions to terminology (e.g., changing “Member Services” to “Customer Service” or using a different term for Medicaid) affect glossary terms, plans should rename the term and alphabetize it correctly within the glossary.]

[If you use any of the following terms in your Member Handbook, you must add a definition of the term to the first section where you use it and here in Chapter 12, with a reference from the section where you use it: IPA, network, PHO, plan medical group, and point of service.]

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

# Actions: These include:

* Denial or limited authorization of type or level of service
* Reduction, suspension, or stopping of a service that was approved before
* Denial of all or part of a payment or service
* Not providing services in a reasonable amount of time
* Not acting within required time frames for grievances or appeals
* Denial of member’s request to get services out of network for members living in a rural area with only one health plan

# Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

# Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

# Anesthesia: Drugs that make you fall asleep for an operation.

# Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 [plans may insert reference, as applicable] explains appeals, including how to make an appeal.

# Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

# Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need. [Plans should change “care coordinator” to the term used by the state or plan and place the paragraph in correct alphabetical order.]

# Care plan: A plan for what health services you will get and how you will get them.

# Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

# [Plans with a single coverage stage should delete this paragraph.] Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the $7,400 limit for your prescription drugs.

# Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 [plans may insert reference, as applicable] explains how to contact CMS.

# Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

# Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

# [Plans that do not have copayments should delete this paragraph.] [**Copayment/Copay**]**:** A fixed amount you pay as your share of the cost each time you get a prescription drug. For example, you might pay $2 or $5 for a prescription drug.

# [Plans that do not have cost-sharing should delete this paragraph.] Cost-sharing: Amounts you have to pay when you get prescription drugs. Cost-sharing includes [copayments/copays].

# Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 [plans may insert reference, as applicable] explains how to ask us for a coverage decision.

# Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

# Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription [and over-the-counter] drugs, equipment, and other services covered by our plan.

# Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

# [Plans that do not have cost-sharing for Medicare Part D drugs should delete this paragraph. Plans may revise the information in this definition to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.] Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a [copayment/copay]. A daily cost-sharing rate is the [copayment/copay] divided by the number of days in a month’s supply.

Here is an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is $1.45. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days’ supply of the drug, your payment will be less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

# Direct access services: You can use any provider in our plan’s network to get these services. You do not need a referral or [prior authorization /service authorization] before getting services.

# Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

# [Plans that do not have cost sharing should add this paragraph.] Drug tiers: Groups of drugs on our *List of Covered Drugs* (Drug List). Generic [,] [or] brand, [or over-the-counter (OTC)] drugs are examples of drug tiers. Every drug on the Drug List is in one of [insert number of tiers] tiers. All drugs in the same tier level have the same copay. Refer to the Drug List for more information and examples.

# Dual eligible individual: A person who qualifies for Medicare and Medicaid coverage.

# Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

# Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function. The medical symptoms may be a serious injury or severe pain. This is also called an emergency medical condition.

# Emergency care/services: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. This is also called emergency room care.

# Emergency medical transportation: Ambulance services, including ground and air transportation for an emergency medical condition

# Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

# Excluded services: Services the plan does not pay for. Medicare and Medical Assistance (Medicaid) will not pay for them either.

# External Quality Review Study: A study about how quality, timeliness and access of care are provided by <plan name>. This study is external and independent.

# Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-income subsidy,” or “LIS.”

# Family planning: Information, services and supplies to help a person decide about having children. These decisions include choosing to have a child, when to have a child or not to have a child.

# Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

# Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

# Health plan: An organization that has a network of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators [plans should change “care coordinator” to the term used by the state and/or plan] to help you manage all of your providers and services. They all work together to provide the care you need.

# Health risk assessment: A review of a patient’s medical history and current condition. It is used to figure out the patient’s health and how it might change in the future.

# Home and Community-Based Services (HCBS): Additional services that are provided to help you remain in your home.

# Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

# Home health care: Health care services for an illness or injury given in your home or in the community where normal life activities take the member.

Housing Stabilization Services: Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person’s transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

# Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

* A member who has a terminal prognosis has the right to elect hospice.
* A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
* <Plan name> must give you a list of hospice providers in your geographic area.
* This is also known as Hospice Services.

# Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

# Hospital outpatient care: Care in a hospital that usually doesn’t require an overnight stay. An overnight stay for observation could be outpatient care.

# Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan’s cost sharing amount for services. Show your <plan name> Member ID Card when you get any services or prescriptions. Call Member Services at the number at the bottom of this page if you get any bills you do not understand.

[Plans with cost sharing, insert: As a member of <plan name>, you only have to pay your cost sharing amounts when you get services covered by our plan. We do not allow providers to bill you more than this amount. If you believe a provider has improperly or inappropriately billed you, call Member Services at the number at the bottom of this page.]

[Plans with no cost sharing, insert: Because <plan name> pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services. If you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.]

# [Plans with a single coverage stage should delete this paragraph.] Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $[insert initial coverage limit]. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

# Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

# *List of Covered Drugs* (Drug List): A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

# Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital.

# Low-income subsidy (LIS): Refer to “Extra Help.”

# Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

* It covers extra services and drugs not covered by Medicare.
* Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
* Refer to Chapter 2 [plans may insert reference, as applicable] for information about how to contact Medicaid in your state. In Minnesota, Medicaid is called Medical Assistance.

# Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

* be the services that other providers would usually order.
* help you get better or stay as well as you are.
* help stop your condition from getting worse.
* help prevent and find health problems.

# Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

# Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

# Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Medicare Part B.

# Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dually eligible individual.”

# Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

# Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

# Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

# Medicare Part D: The Medicare prescription drug benefit program. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. <Plan name> includes Medicare Part D.

# Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Medicare Part D drugs. Medicaid may cover some of these drugs.

# Member (member of our plan, or plan member): A person with Medicare and Medical Assistance (Medicaid) who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

# *Member Handbook* and Disclosure Information: This document, along with your enrollment form and any other attachments or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

# Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2 [plans may insert reference, as applicable] for information about how to contact Member Services.

# Minnesota Senior Care Plus (MSC+): A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance (Medicaid) enrollees age 65 and older.

# Minnesota Senior Health Options (MSHO): A program in which the State and CMS contract with health plans, including our plan, to provide services only for seniors eligible for both Medicare and Medical Assistance (Medicaid), including those covered by MSC+.

# Model of care: [Plans should insert appropriate definition.]

# Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

# Network providers: These are providers who agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called plan providers or participating providers.

# Notice of Action: A form or letter we send to you telling you about a decision on a claim, a service or any other action taken by our plan. This is also called a Denial, Termination, or Reduction (DTR).

# Nursing home certifiable: A decision that you need a nursing home level of care. A screener uses a process called a Long Term Care Consultation to decide.

# Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

# Ombudsman or Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s/ombudsperon’s services are free. You can find more information about the ombudsman/ombudsperson in Chapters 2 [plans may insert reference, as applicable] and 9 [plans may insert reference, as applicable] of this handbook.

# Open access services: Federal and state law allow you to choose any [insert as appropriate: physician **or** qualified health care provider], clinic, hospital, pharmacy, or family planning agency – even if not in our plan’s network – to get these services.

# Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 [plans may insert reference, as applicable] explains how to ask us for a coverage decision.

# Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

* You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
* Original Medicare is available everywhere in the United States.
* If you do not want to be in our plan, you can choose Original Medicare.

# Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out‑of‑network pharmacies are not covered by our plan unless certain conditions apply.

# Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 [plans may insert reference, as applicable] explains out-of-network providers or facilities. This is also known as a non-participating provider.

# [Plans that do not have cost-sharing should delete this paragraph.] Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the [services or] drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost-sharing” above.

# Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a health care professional.

# Palliative care: Palliative care helps people with serious illnesses feel better. It prevents or treats symptoms and side effects of disease and treatment. Palliative care also treats emotional, social, practical, and spiritual problems that illnesses can bring up. Palliative care can be given at the same time as treatments meant to cure or treat the disease. Palliative care may be given when the illness is diagnosed, throughout treatment, during follow-up, and at the end of life.

# Part A: Refer to “Medicare Part A.”

# Part B: Refer to “Medicare Part B.”

# Part C: Refer to “Medicare Part C.”

# Part D: Refer to “Medicare Part D.”

# Part D drugs: Refer to “Medicare Part D drugs.”

# Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to <plan name>’s Notice of Privacy Practices for more information about how <plan name> protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

# Physician services: Health care services provided or coordinated by a medical physician licensed under state law (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

# Prescription drugs: Drugs and medications that can be dispensed only with an order given by a properly authorized person.

# Primary care clinic (PCC): The facility where you get most of the health care services you need, such as annual checkups, and helps coordinate your care. You may need to choose a primary care clinic when you enroll in our plan.

# [Plans that do not use PCPs may omit this paragraph.] Primary care [insert as appropriate: **physician** or **provider**] (PCP): Your primary care [insert as appropriate: physician **or** provider] is the doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

* They also may talk with other doctors and health care providers about your care and refer you to them.
* In many Medicare health plans, you must use your primary care [insert as appropriate: physician **or** provider] before you use any other health care provider.
* Refer to Chapter 3 [plans may insert reference, as applicable] for information about getting care from primary care [insert as appropriate: physicians **or** providers].

# Prior authorization: [Plans may delete applicable words or sentences if it does not require prior authorization for any medical services or any drugs. Plans that use “service authorization” insert the term with this definition and place the paragraph in correct alphabetical order.] An approval from <plan name> you must get before you can get a specific service or drug or use an out-of-network provider. <Plan name> may not cover the service or drug if you don’t get approval.

Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

* Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

Some drugs are covered only if you get prior authorization from us.

* Covered drugs that need prior authorization are marked in the *List of Covered Drugs* (Drug List).

# Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

# Provider: The general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services.

# Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to members. Refer to Chapter 2 [plans may insert reference, as applicable] for information about how to contact the QIO for your state.

# **Quality of care complaint:** In this handbook, “quality of care complaint” means an expressed dissatisfaction about health care services resulting in potential or actual harm to a member. Complaints may be about access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that can have a negative effect on the quality of health care services.

# Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

# Referral: A referral means that your primary care [insert the term the plan uses (e.g., provider **or** physician)] (PCP) must give you approval before you can use someone that is not your PCP. If you don’t get approval, <plan name> may not cover the services. You don’t need a referral for certain specialists, such as women’s health specialists. You can find more information about referrals in Chapter 3 [plans may insert reference, as applicable] and about services that require referrals in Chapter 4 [plans may insert reference, as applicable].

# Rehabilitation services and devices: Treatment and equipment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4 [plans may insert reference, as applicable] to learn more about rehabilitation services.

# Restricted Recipient Program: A program for members who got medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. <MCO Name> may designate other health care providers. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months. The restricted recipient program does not apply to Medicare-covered services.

# Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get <plan name>.

# Skilled nursing care: Care or treatment that can only be given by licensed nurses.

# Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

# Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

# Specialist: A doctor who provides health care for a specific disease or part of the body.

# State Appeal (Medicaid Fair Hearing with the state): A hearing at the state to review a decision made by our plan. You must ask for a hearing in writing. You may ask for a hearing if you disagree with any of the following:

* A denial, termination or reduction of service
* Enrollment in the Plan
* Denial in full or part of a claim or service
* Our failure to act within required timelines for [prior authorization/service authorization] and appeals
* Any other action

# State Medicaid agency: In Minnesota, this agency is the Minnesota Department of Human Services.

# Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

# Subrogation: Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this plan for a service that is covered by another source or third party payer.

# Substance use disorder: Using alcohol or drugs in a way that harms you.

# Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

# Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

[This is the back cover for the Member Handbook (EOC). Disregard the footer at the bottom of the page when customizing the back cover. Plans may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the plan contact information.]

**<Plan name> Member Services**

| Type | Details |
| --- | --- |
| **CALL** | [Insert phone number(s)] The call is free.  [Insert days and hours of operation, including information on the use of alternative technologies.]  Member Services also has free language interpreter services available for non-English speakers. |
| **TTY** | [Insert number]  [Insert if plan uses a direct TTY number: You need special telephone equipment to call this number.]  The call is free. [Insert days and hours of operation.] |
| **FAX** | [Optional: insert fax number] |
| **WRITE** | [Insert address]  [**Note:** plans may add email addresses here.] |
| **WEBSITE** | [Insert URL] |

**Senior LinkAge Line®, Minnesota’s SHIP**

**Senior LinkAge Line®** is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare in Minnesota.

| Type | Details |
| --- | --- |
| **CALL** | 1-800-333-2433 The call is free. |
| **TTY** | Call the Minnesota Relay Service at 711 or use your preferred relay service. The call is free.  [Insert if the SHIP uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.] |
| **WRITE** | Minnesota Board on Aging  PO Box 64976  St. Paul, MN 55164-0976 |
| **WEBSITE** | [www.seniorlinkageline.com](http://www.seniorlinkageline.com) |