The Prepaid Medical Assistance Program (PMAP) is now referred to as Families and Children in this Member Handbook.

The Evidence of Coverage (EOC) or Enrollee Handbook is now referred to as the Member Handbook.

This booklet contains important information about your health care services.

HealthPartners Families and Children

Member Handbook
January 1, 2018

HealthPartners
Member Services
MS 21103R
8170 33rd Avenue South
P.O. Box 9463
Minneapolis, MN 55440-9463

Telephone: 952-967-7998 or 1-866-885-8880 (toll free)
(TTY) 952-883-6060 or 1-800-443-0156 (toll free)

Website: www.healthpartners.com

Hours of service: 8:00 a.m. – 6:00 p.m., Monday - Friday

EOC-200.12-PMAP
HPCare_108494 Approved 1/29/2018

1-866-885-8880 (TTY/TDD:711)

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်၊ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မီတခါဆံၤနှဉ်, ကိးဘဉ်လီတဲစီနိုၤဂ်ၤ်လၢထးဆံၤနှဉ်တက့်၊

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ, ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

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Civil Rights Notice

Discrimination is against the law. HealthPartners does not discriminate on the basis of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Auxiliary Aids and Services. HealthPartners provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in our health care programs. **Contact Member Services at 952-967-7998 or 1-866-885-8880**.

Language Assistance Services. HealthPartners provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact Member Services at 952-967-7998 or 1-866-885-8880**.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by HealthPartners. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Age
- Disability
- Sex (including sex stereotypes and gender identity)

Contact the OCR directly to file a complaint:

Director
U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (Voice)
800-537-7697 (TDD)
Complaint Portal – https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Religion
- Creed
- Sex
- Sexual Orientation
- Marital Status
- Public Assistance Status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (Fax)
Info.MDHR@state.mn.us (Email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have a right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome period. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administration actions.

Contact **DHS** directly to file a discrimination complaint:

ATTN: Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

MCO Complaint Notice

HealthPartners: If you believe that HealthPartners has failed to provide these services or discriminated in another way, you can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
Office of Integrity and Compliance, MS 21103K
HealthPartners
P.O. Box 1309
Minneapolis, MN 55440-1309
1-844-363-8732 (phone)
952-883-5522 (fax), or
integrityandcompliance@healthpartners.com

American Indians: American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

TABLE OF CONTENTS

Welcome to HealthPartners Families and Children

We are pleased to welcome you as a member of HealthPartners Families and Children health plan (referred to as "Plan" or "the Plan").

HealthPartners (referred to as "we," "us," or "our") is part of the Families and Children program. We coordinate and cover your medical services. You will get most of your health services through the Plan's network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which qualified health care provider to see.

This Member Handbook together with any amendments that we may send to you, is our contract with you. It is an important legal document. Please keep it in a safe place.

This Member Handbook includes:

- Contact information
- Information on how to get the care you need
- Your rights and responsibilities as a member of the Plan
- Information about cost sharing
- A listing of covered and non-covered health care services
- When to call your county worker
- Using the Plan coverage with other insurance or other sources of payment
- Information on what to do if you have a grievance (complaint) or want to appeal a Plan action, as defined in Section 13
- Definitions

The counties in the Plan service area are as follows: Aitkin, Anoka, Becker, Benton, Carlton, Carver, Cass, Chisago, Clay, Cook, Crow Wing, Dakota, Hennepin, Kittson, Koochiching, Lake, Mahnomen, Marshall, Mille Lacs, Norman, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Roseau, St. Louis, Scott, Sherburne, Stearns, Washington, Wilkin and Wright.

Please tell us how we're doing. You can call or write to us at any time. (Section 1 of this Member Handbook tells how to contact us.) Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with us. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Section 1. Telephone numbers and contact information

How to contact our Member Services

If you have any questions or concerns, please call or write to Member Services. We will be happy to help you. Member Services' hours of service are 8:00 a.m. – 6:00 p.m., Monday – Friday.

CALL:	952-967-7998 or 1-866-885-8880 (toll free)
TTY/TDD:	952-883-6060 or 1-800-443-0156 (toll free)
FAX:	952-883-7333 or 952-883-7666
WRITE:	HealthPartners Member Services MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463
VISIT:	HealthPartners Member Services 8170 33rd Avenue South Minneapolis, MN 55425
WEBSITE:	www.healthpartners.com

Our Plan contact information for certain services

Appeals and Grievances

Call:	952-967-7998 or 1-866-885-8880 (toll free)
Write:	HealthPartners Member Services MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463

See Section 13 for more information.

CareLine℠ Service (Nurse Line)

After regular clinic hours call CareLine: 612-339-3663 or 1-800-551-0859 (toll free)
Available 24 hours BabyLine: 612-333-BABY (2229) or 1-800-845-9297 (toll free)

Chiropractic Services

Call: 952-967-7998 or 1-866-885-8880 (toll free)

Dental Services

Call: 952-967-7998 or 1-866-885-8880 (toll free)

Durable Medical Equipment Coverage Criteria

Call: 952-967-7998 or 1-866-885-8880 (toll free)

Interpreter Services

American Sign Language (ASL) – Call: 952-967-7998 or 1-866-885-8880 (toll free) 952-883-6060 (TDD) or 1-800-443-0156 (toll free TDD)

Spoken Language – Call: 952-967-7998 or 1-866-885-8880 (toll free)

Mental Health/Behavioral Health Services

Call: 952-883-5811 or 1-888-638-8787 (toll free)

Write: HealthPartners
MS 21103M
P.O. Box 1309
Minneapolis, MN 55440-1309

Prescriptions

Call: 952-967-7998 or 1-866-885-8880 (toll free)

Substance Use Disorder Services

Call: 952-883-5811 or 1-888-638-8787 (toll free)

Write: HealthPartners
MS 21103M
P.O. Box 1309
Minneapolis, MN 55440-1309

Transportation

Call RideCare℠: 952-883-7400 or 1-888-288-1439 (toll free)

Other important contact information

People with hearing loss or a speech disability may call the following numbers to access the resources listed in this Member Handbook: 711, Minnesota Relay Service at 1-800-627-3529 (TTY/TDD, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service). Calls to these numbers are free.

For information and to learn more about health care directives and how to exercise an advance directive, please contact HealthPartners Member Services at 952-967-7998 or 1-866-885-8880. You may also visit the Minnesota Department of Health (MDH) website at: http://www.health.state.mn.us/divs/fpc/profinfo/advdir.htm

To Report Fraud and Abuse call Member Services at the phone number in Section 1. To report fraud or abuse directly to the State, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at 651-431-2650 or 1-800-657-3750 or 711 (TTY/TDD); by fax at 651-431-7569; or by email at DHS.SIRS@state.mn.us.

Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS) is a state agency that helps people meet their basic needs. It provides or administers health care, financial help, and other services. DHS administers the Medical Assistance (Medicaid) program through counties. If you have questions about your eligibility for Medical Assistance (Medicaid), contact your county worker.

Ombudsman for Public Managed Health Care Programs

The Ombudsman for Public Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving service and billing problems. They can help you file a grievance or appeal with us. The ombudsman can also help you request a state appeal (state fair hearing). Call 651-431-2660 (Twin Cities metro area) or toll free 1-800-657-3729 (non-metro) or 711 (TTY/TDD). Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m.

Section 2. Important information on getting the care you need

Each time you get health services, check to be sure that the provider is a Plan network provider. In most cases, you need to use Plan network providers to get your services. Members receive a Provider Directory that lists Plan network providers. It is current as of the date it is printed. To verify current information, you can call Member Services at the phone number in Section 1, or visit our website listed in Section 1.

We encourage you to choose a primary clinic and dental clinic. Your primary care clinic can provide most of the health care services you need, and will help coordinate your care. Please confirm with Member Services that you clinic is still a provider with our health plan before signing up. You can go to any primary care clinic that's listed in this book or our online provider search at www.healthpartners.com.

You do not need a referral to see a Plan network specialist. However, your primary care clinic can provide most of the health care services you need, and will help coordinate your care.

Contact your primary care clinic for information about the clinic's hours, prior authorizations, and to make an appointment. If you cannot go to your appointment, call your clinic right away.

You may change your primary care provider or clinic. To find out how to do this, call Member Services at the phone number in Section 1.

Transition of Care:

If you are a newly enrolled member who is currently receiving care from a provider who is not a Plan network provider, we will help you transition to a network provider.

Prior Authorizations:

Our approval is needed for some services to be covered. This is called prior authorization. The approval must be obtained before you get the services or before we pay for them. Many of these services are noted in Section 7. For more information, call Member Services at the phone number in Section 1.

In most cases, you need to use Plan network providers to get your services. If you need a covered service that you cannot get from a Plan network provider, you must get a prior authorization from us to see an out-of-network provider. Exceptions to this rule are:

- Open access services: family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for acquired immune deficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related conditions. You can go to any qualified health care provider, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- Emergency and post-stabilization services

For more information, call Member Services at the phone number listed in Section 1.

The Plan allows direct access to the providers in our network, but keeps the right to manage your care under certain circumstances, such as Restricted Recipient Program. We may do this by choosing the provider you use and/or the services you receive. For more information, call Member Services at the phone number in Section 1.

If we are unable to find you a qualified Plan network provider, we must give you a standing prior authorization for you to see a qualified specialist for any of the following conditions:

- A chronic (on-going) condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first three months (first trimester)
- A degenerative disease or disability
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a prior authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number in Section 1.

If a provider you choose is no longer in our Plan network, you must choose another Plan network provider. You may be able to continue to use services from a provider who is no longer a part of our Plan network for up to 120 days for the following reasons:

- An acute condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first three months (first trimester)
- A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.
- A disabling or chronic condition that is in an acute phase

If your qualified health care provider certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

For more information, call Member Services at the phone number in Section 1.

At HealthPartners, we have staff who can help you figure out the best way to use health care services. If you have questions about things like where to get services, getting authorization for services, or restrictions on prescription drugs, we can help. Call us at 952-967-7998 or 1-866-885-8880 (toll free), 8:00 a.m. – 6:00 p.m., Monday – Friday. If you need language assistance to talk about these issues, HealthPartners can give you information in your language through an interpreter. For sign language services, call 952-883-6060 (TDD) or 1-800-443-0156 (toll free TDD). For other language assistance, call 952-967-7998 or 1-866-885-8880 (toll free).

Covered and non-covered services:

Enrollment in the Plan does not guarantee that certain items are covered. Some prescription drugs or medical equipment may not be covered. This is true even if they were covered before.

Some services and supplies are not covered. All health services must be medically necessary for them to be covered services. Read this Member Handbook carefully. It lists many services and supplies that are not covered. See Sections 7 and 8.

Some services are not covered under the Plan, but may be covered through another source. See Section 9 for more information. If you are not sure whether a service is covered, call our Member Services at the phone number in Section 1.

We may cover additional or substitute services under some conditions.

Cost sharing:

You may be required to contribute an amount toward some medical services. This is called cost sharing. You are responsible to pay your cost sharing amount to your provider. See Section 6 for more information.

Payments to providers:

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. If you paid for a service that you think we should have covered, call Member Services.

You may get health services or supplies not covered by the Plan if you agree to pay for them. Providers must have you sign a form acknowledging that you will be responsible for the bill. Providers must have a signed form before providing services or supplies that are not covered by the Plan.

Interpreter services:

We will provide interpreter services to help you access services. This includes spoken language interpreters and American Sign Language (ASL) interpreters. Face-to-face spoken language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. Please call Member Services at the phone number in Section 1 to find out which interpreters you can use.

Other health insurance:

If you have other health or dental insurance, tell us **before** you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate with your other insurance plan. If your other health or dental insurance changes, tell your county worker.

If you have Medicare, you need to get most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services. The Plan does not pay for prescriptions that are covered under the Medicare Prescription Drug Program.

Private information:

We, and the health care providers who take care of you, have the right to see information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

Restricted Recipient Program:

The Restricted Recipient Program is for members who have misused health services. This includes getting health services that members did not need or using them in a way that costs more than they should.

You must get health services from one designated primary care provider, one pharmacy, one hospital, or other designated health services provider. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options, or consumer directed services.

You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your primary care provider and received by the Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to see a non-designated provider who is the same provider type as one of their designated providers.

Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.

At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. See Section 13.

Cancellation:

Your coverage with us will be canceled if you are not eligible for Medical Assistance (Medicaid) or if you enroll in a different health plan.

If you are no longer eligible for Medical Assistance (Medicaid), you may be eligible to purchase health coverage through MNsure. For information about MNsure, call toll free 1-855-3MNSURE or 1-855-366-7873, or visit www.MNsure.org.

Section 3. Member Bill of Rights

You have the right to:

Get the services you need 24 hours a day, seven days a week. This includes emergencies.

Be told about your health problems.

Get information about treatments, your treatment choices, and how they may help or harm you.

Refuse treatment and get information about what might happen if you refuse treatment.

Refuse care from specific providers.

Know that we will keep your records private according to law.

File a grievance or appeal with us. You can also file a complaint with the Minnesota Department of Health.

Request a state appeal (state fair hearing) with the Minnesota Department of Human Services (also referred to as "the state"). You must appeal to us before you request a state appeal (state fair hearing). If we take more than 30 days to decide your plan appeal and we have not asked for an extension, you do not need to wait for our decision to ask for a state appeal (state fair hearing).

Receive a clear explanation of covered home care services.

Request and receive a copy of your medical records. You also have the right to ask to correct the records.

Get notice of our decisions if we deny, reduce, or stop a service, or deny payment for a service.

Participate with providers in making decisions about your health care.

Be treated with respect, dignity, and consideration for privacy.

Give written instructions that inform others of your wishes about your health care. This is called a "health care directive." It allows you to name a person (agent) to make decisions for you if you are unable to decide, or if you want someone else to decide for you.

Be free of restraints or seclusion used as a means of: coercion, discipline, convenience, or retaliation.

Choose where you will get family planning services, diagnosis of infertility, sexually transmitted disease testing and treatment services, and AIDS and HIV testing services.

Get a second opinion for medical, mental health, and substance use disorder services.
Request a copy of this Member Handbook at least once a year.

Get the following information from us, if you ask for it. Call Member Services at the phone number in Section 1.

- Whether we use a physician incentive plan that affects the use of referral services, and details about the plan if we use one.
- Results of an external quality review study from the state
- The professional qualifications of health care providers

Make recommendations about our rights and responsibilities policy.

Exercise the rights listed here.

Section 4. Member Responsibilities

You have the responsibility to:

Read this Member Handbook and know which services are covered under the Plan and how to get them.

Show your health plan member ID card and your Minnesota Health Care Program card every time you get health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Establish a relationship with a Plan network primary care qualified health care provider before you become ill. This helps you and your primary care qualified health care provider understand your total health condition.

Give information asked for by your qualified health care provider and/or health plan so the right care or services can be provided to you. Share information about your health history.

Work with your qualified health care provider to understand your total health condition. Develop mutually agreed-upon treatment goals when possible. If you have questions about your care, ask your qualified health care provider.

Know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.

Practice preventive health care. Have tests, exams and shots recommended for you based on your age and gender.

Contact us if you have any questions, concerns, problems or suggestions. Call Member Services at the phone number in Section 1.

Section 5. Your Health Plan Member ID Card

Each member will receive a Plan member ID card.

Always carry your Plan member ID card with you.

You must show your Plan member ID card whenever you get health care.

You must use your Plan member ID card along with your Minnesota Health Care Program card. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

Call Member Services at the phone number in Section 1 right away if your member ID card is lost or stolen. We will send you a new card.

Call your county worker if your Minnesota Health Care Program card is lost or stolen.

Here is a sample Plan member ID card to show what it looks like:

Section 6. Cost Sharing

Cost sharing refers to your responsibility to pay an amount towards your medical costs. For people in the Families and Children program, cost sharing consists only of copays.

If your income is at or below 100 percent of federal poverty guidelines, you will pay no more than five percent of your monthly family income for cost sharing. This may reduce the copay and deductible amount to less than the amounts listed here. DHS will tell us each month if you have a reduced cost sharing amount.

Copays

The members listed here **do not** have to pay copays for medical services that are covered by Medical Assistance (Medicaid) (MA) under the Plan:

- Pregnant women (if you become pregnant, tell your county worker right away.)
- Members under age 21
- Members receiving hospice care
- Members residing in a nursing home, hospital, or other long-term care facility for more than 30 days
- American Indians who receive or have received a service(s) from an Indian Health Care Provider, or through Indian Health Service Contract Health Services (IHS CHS) referral from an IHS facility

Some services require copays. A copay is an amount that you will be responsible to pay to your provider.

Copays are listed in the following chart:

Service	Copay Amount
Non-preventive visits (such as visits for a sore throat, diabetes checkup, high fever, sore back, etc.) provided by a physician, physician assistant, advanced practice nurse, certified professional midwife, chiropractor, acupuncturist, podiatrist, audiologist, or eye doctor. There are no copays for mental health services.	$3.00
Diagnostic procedures (for example, endoscopy, arthroscopy)	$3.00
Emergency room visit when it is not an emergency	$3.50
Brand name prescriptions *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$3.00
Generic prescriptions *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$1.00

The most you will have to pay in copays for prescriptions is $12.00 per month. Copays will not be charged for some mental health drugs and most family planning drugs.

If you have Medicare, you must get most of your prescription drugs through a Medicare Prescription Drug Program (Medicare Part D) plan. You may have different copays with no monthly limit for some of these services.

You must pay your copay directly to your provider. Some providers require that you pay the copay when you arrive for the medical service. The hospital may bill you after your non-emergency visit to the emergency room.

If you are unable to pay the copay, the provider must still provide services. This is true even if you have not paid your copay to that provider in the past or if you have other debts to that provider. The provider may still bill you for the unpaid copays.

We get information from the state about which members do not have copays. You may need to pay a copay until you are listed in our system as a person who does not have to pay copays.

Examples of services that **do not** have copays:

- Dental services
- Emergency services
- Eye glasses
- Family planning services and supplies
- Home care
- Immunizations
- Inpatient hospital stays
- Interpreter services
- Medical equipment and supplies
- Medical transportation
- Mental health services
- Preventive care visits, such as physicals
- Rehabilitation therapies
- Repair of eyeglasses
- Services covered by Medicare, except for Medicare Part D drugs
- Some mental health drugs (antipsychotics)
- Some preventive screenings and counseling, such as cervical cancer screenings and nutritional counseling
- Substance use disorder treatment
- Tests such as blood work and X-rays
- Tobacco use counseling and interventions
- 100% federally funded services at Indian Health Services clinics

This is not a complete list. Call Member Services at the phone number in Section 1 if you have questions.

Section 7. Covered Services

This section describes the major services that are covered under the Plan for Medical Assistance (Medicaid) members. It is not a complete list of covered services. Some services have limitations. Some services require a prior authorization. A service marked with an asterisk (*) means a prior authorization is required or may be required. Make sure there is a prior authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Call Member Services at the phone number in Section 1 for more information.

Some services require cost sharing. Cost sharing refers to your responsibility to pay an amount toward your medical costs. See Section 6 for information about cost sharing and exceptions to cost sharing.

Child and Teen Checkups (C&TC)

Covered Services:

- Child and Teen Checkups (C&TC) preventive health visits include:
  - growth measurements
  - health education
  - health history including mental health, nutrition, and substance use
  - developmental screening
  - mental health screening
  - behavioral assessment
  - physical exam
  - immunizations
  - lab tests
  - vision checks
  - hearing checks
  - regular dental checks
  - fluoride varnish treatments at certain ages

Notes:
C&TC is a health care program of well-child visits for members under age 21. C&TC visits help find and treat health problems early. How often a C&TC is needed depends on age:

- Birth to 2 1/2 years: 0-1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months
- 3 to 21 years: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20 years

Contact your Primary Care Clinic to schedule your C&TC well child and preventive health visits.

Chiropractic Care

Covered Services:

- One evaluation or exam per year
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine - up to 24 visits per calendar year. Visits exceeding 24 may require a prior authorization.
- Acupuncture for pain and other specific conditions within the scope of practice by chiropractors with acupuncture training or credentialing*
- X-rays when needed to support a diagnosis of subluxation of the spine

Not Covered Services:

- Other adjustments, vitamins, medical supplies, therapies and equipment from a chiropractor

Dental Services (for adults except pregnant women)

Covered Services:

- Diagnostic services:
  - comprehensive exam *(once every five years)*
  - periodic exam (*once per calendar year)*
  - limited (problem-focused) exams *(once per day per provider)*
  - Teledentistry for diagnostic services
  - X-rays, limited to:
    - bitewing *(once per calendar year)*
    - single X-rays for diagnosis of problems
    - panoramic *(once every five years and as medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma; once every two years in limited situations)*
    - full mouth X-rays *(once every five years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)*
- Preventive services:
  - cleaning (*up to four times per year if medically necessary)*
  - fluoride varnish *(once per calendar year)*
- Restorative services:
  - fillings
  - sedative fillings for relief of pain
- Endodontics (root canals) *(on anterior teeth and premolars only and once per lifetime; retreatment is not covered)*
- Periodontics:
  - gross removal of plaque and tartar (full mouth debridement) *(once every five years)*
  - scaling and root planing *(once every two years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC))*

* *Requires or may require a prior authorization.*

- Prosthodontics:
    - removable prosthesis (dentures and partials) *(once every six years per dental arch)*
    - relines, repairs, and rebases of removable prostheses (dentures and partials)
    - replacement of prosthesis that are lost, stolen, or damaged beyond repair under certain circumstances
    - replacement of partial prostheses if the existing partial cannot be altered to meet dental needs
- Oral surgery *(limited to extractions, biopsies, and incision and drainage of abscesses)*
- Additional general dental services:
    - treatment for pain *(once per day)*
    - general anesthesia *(only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)**
    - extended care facility/house call in certain institutional settings including: nursing facilities, skilled nursing facilities, boarding care homes, Institutes of Mental Disease/Mental Illness (IMD's), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), and swing beds (a nursing facility bed in a hospital)
    - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
    - oral or IV sedation – only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center

Notes:
See Section 1 for Dental Services contact information.

Dental Services (for children and pregnant women)

Covered Services:

- Diagnostic services:
    - comprehensive exam
    - periodic exam
    - limited (problem-focused) exams
    - Teledentistry for diagnostic services
    - X-rays, limited to:
        - bitewing
        - single X-rays for diagnosis of problems
        - panoramic
        - full mouth X-rays
- Preventive services:
    - cleaning
    - fluoride varnish *(once every six months)*
    - sealants for children under age 21 *(one every five years per permanent molar)*

* *Requires or may require a prior authorization.*

- Restorative services:
  - fillings
  - sedative fillings for relief of pain
  - individual crowns *(must be made of prefabricated stainless steel or resin)*
- Endodontics (root canals) *(once per tooth per lifetime)*
- Periodontics:
  - gross removal of plaque and tartar (full mouth debridement)
  - scaling and root planing
- Prosthodontics:
  - removable prosthesis (dentures and partials) (*once every three years per dental arch)*
  - relines, repairs, and rebases of removable prosthesis (dentures and partials)
  - replacement of prosthesis that are lost, stolen, or damaged beyond repair under certain circumstances
  - replacement of partial prosthesis if the existing partial cannot be altered to meet dental needs
- Oral surgery
- Orthodontics *(only when medically necessary for very limited conditions for children under age 21)*
- Additional general dental services:
  - treatment for pain
  - general anesthesia*
  - extended care facility/house call in certain institutional settings including: nursing facilities, skilled nursing facilities, boarding care homes, Institutes of Mental Disease/Mental Illness (IMDs), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) Hospices, Minnesota Extended Treatment Options (METO), and swing beds (a nursing facility bed in a hospital). A school or Head Start program is not an extended care facility.
  - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
  - oral or IV sedation – only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center

Notes:
See Section 1 for Dental Services contact information.

Diagnostic Services

Covered Services:

- Lab tests and X-rays
- Other medical diagnostic tests ordered by your qualified health care provider

* *Requires or may require a prior authorization.*

Doctor and Other Health Services

Covered Services:

- Doctor visits including:
  - care for pregnant women
  - family planning – **open access service**
  - lab tests and X-rays
  - physical exams
  - preventive exams
  - preventive office visits
  - specialists
  - telemedicine consultation
  - vaccines and drugs administered in a qualified health care provider's office
  - visits for illness or injury
  - visits in the hospital or nursing home
- Immunizations
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Clinical trial coverage: Routine care that is: 1) provided as part of the protocol treatment of a cancer Clinical Trial; 2) is usual, customary and appropriate to your condition; and 3) would be typically provided outside of a Clinical Trial. This includes services and items needed for the treatment of effects and complications of the protocol treatment.
- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Community health worker care coordination and patient education services
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Blood and blood products
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Blood and blood products
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Tuberculosis care management and direct observation of drug intake
- Counseling and testing for sexually transmitted diseases (STDs), AIDS and other HIV-related conditions - **open access service**
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must see a provider in the Plan network.

- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Acupuncture for pain and other specific conditions, by licensed acupuncturists or within the scope of practice by a licensed provider with acupuncture training or credentialing*
- Respiratory therapy
- Hospital In-Reach Community-Based Service Coordination: coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services.
- Behavioral Health Home: coordination of behavioral and physical health services
- In-Reach Community-Based Services Coordination (IRSC)
- Clinical Services
  - Community Paramedic Services: certain services are provided by a community paramedic. The services must be a part of a care plan by your primary care provider. The services may include:
    - health assessments
    - chronic disease monitoring and education
    - help with medications
    - immunizations and vaccinations
    - collecting lab specimens
    - follow-up care after being treated at a hospital
    - other minor medical procedures
  - Community Medical Emergency Technician (CMET) services
    - Post-hospital discharge visits ordered by your primary care provider
    - Safety evaluation visits ordered by Primary Care Provider (PCP)

Not Covered Services:

- Artificial ways to become pregnant (artificial insemination, including in-vitro fertilization and related services, fertility drugs and related services)

Early Intensive Developmental and Behavioral Intervention (EIDBI) Services

(for children under age 21)

Covered Services:

- Comprehensive Multi-Disciplinary Evaluation (CMDE)
- EIDBI: Individual or Group*
- Intervention Observation and Direction*
- Family/Caregiver Training and Counseling: Individual or Group*
- Individual Treatment Plan (ITP) Development and Progress Monitoring*
- Coordinated Care Conference
- Travel time*

* *Requires or may require a prior authorization.*

Emergency Medical Services and Post-Stabilization Care

Covered Services:

- Emergency room services
- Post-stabilization care
- Ambulance (air or ground includes transport on water)*

Not Covered Services:

Emergency, urgent, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Notes:
If you have an emergency and need treatment right away, either call 911 or go to the closest emergency room. Show them your member ID card and ask them to call your primary care qualified health care provider.

In all other cases, call your primary care qualified health care provider, if possible. The clinic's phone number is also on your member ID card. You can call the number 24 hours a day, seven days a week and get instructions about what to do.

If you are out of town, go to the closest emergency room. Show them your member ID card and ask them to call your primary care qualified health care provider.

You must call your primary care clinic /qualified health care provider within 48 hours or as soon as you can after getting emergency care at a hospital that is not a part of the Plan network.

Eye Care Services

Covered Services:

- Eye exams
- Eyeglasses, including identical replacement for loss, theft, or damage beyond repair
- Repairs to frames and lenses for eyeglasses covered under the Plan
- Tinted, photochromatic (for example, transition ® lenses) or polarized lenses, when medically necessary
- Contact lenses, when medically necessary under certain conditions

* *Requires or may require a prior authorization.*

Not Covered Services:

- Extra pair of glasses
- Eyeglasses more often than every 24 months, unless medically necessary
- Progressive bifocal/trifocal lenses (without lines)
- Protective coating for plastic lenses
- Contact lens supplies

Family Planning Services

Covered Services:

- Family planning exam and medical treatment – **open access service**
- Family planning lab and diagnostic tests – **open access service**
- Family planning methods (for example, birth control pills, patch, ring, Intrauterine Device (IUD), injections, implants) – **open access service**
- Family planning supplies with prescription (for example, condom, sponge, foam, film, diaphragm, cap) – **open access service**
- Counseling and diagnosis of infertility, including related services – **open access service**
- Treatment for medical conditions of infertility – **NOT** an open access service. You must see a provider in the Plan network. Note: This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS, and other HIV-related conditions – **open access service**
- Treatment for sexually transmitted diseases (STDs) - **open access service**
- Voluntary sterilization – **open access service**
  Note: You must be age 21 or over and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.
- Genetic counseling - **open access service**
- Genetic testing* – **NOT** an open access service**.** You must see a provider in the Plan network.
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must see a provider in the Plan network.

Not Covered Services:

- Artificial ways to become pregnant (artificial insemination, including in vitro fertilization and related services; fertility drugs and related services)
- Reversal of voluntary sterilization
- Sterilization of someone under conservatorship/guardianship

Notes:
Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency to get **open access services**, even if they are not in the Plan network.

* *Requires or may require a prior authorization.*

Hearing Aids

Covered Services:

- Hearing aid batteries
- Hearing aids
- Repair and replacement of hearing aids due to normal wear and tear, with limits

Home Care Services*

Covered Services:

- Skilled nurse visit
- Rehabilitation therapies to restore function (for example, speech, physical, occupational, respiratory)
- Home health aide visit
- Home Care Nursing (HCN)
- Personal Care Assistant (PCA). Community First Services and Supports (CFSS) replaces PCA services, upon federal approval.

Hospice

Covered Services:

Hospice benefits include coverage for the following services, when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care*
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

* *Requires or may require a prior authorization.*

Notes:

Medicare Election

You must elect hospice benefits to receive hospice services.

If the recipient is both Medicare and Medicaid eligible, and elects hospice, he or she must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit recipients from choosing hospice care through one program and not the other when they are eligible for both.

Members age 21 and under can still receive treatment for their terminal condition in addition to hospice services.

If you are interested in using hospice services, please call Member Services at the phone number in Section 1.

Hospital – Inpatient*

Covered Services:

- Inpatient hospital stay
- Your semi-private room and meals
- Private room when medically necessary
- Tests and X-rays
- Surgery*
- Drugs
- Medical supplies
- Therapy services (for example, physical, occupational, speech, respiratory)

Not Covered Services:

- Personal comfort items, such as TV, phone, barber or beauty services, guest services

Hospital – Outpatient

Covered Services:

- Urgent care for conditions that are not as serious as an emergency
- Outpatient surgical center*
- Tests and X-rays
- Dialysis
- Emergency room services
- Post-stabilization care

* *Requires or may require a prior authorization.*

Interpreter Services

Covered Services:

- Spoken language interpreter services
- American sign language (ASL) interpreter services

Notes:
Interpreter services are available to help you get services.

Spoken interpretation is available for any language.

Face-to-face spoken language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. See Interpreter Services in Section 1 for contact information and to find out which interpreters you can use.

Medical Equipment and Supplies

Covered Services:

- Prosthetics* or orthotics
- Durable medical equipment (for example, wheelchairs, hospital beds, walkers, crutches, and wigs for people with alopecia areata)*. Contact Member Services for more information on coverage and benefit limits for wigs.
- Repairs of medical equipment
- Batteries for medical equipment*
- Some shoes, when custom molded or part of a leg brace
- Oxygen and oxygen equipment
- Medical supplies you need to take care of your illness, injury, or disability
- Diabetic equipment and supplies*
- Nutritional/enteral products, when specific criteria are met*
- Incontinence products
- Family planning supplies – **open access service**. See Family Planning Services in this section.
- Augmentative communication devices, including electronic tablets

Not Covered Services:

- Constructive modifications to home, vehicle, or workplace, including bathroom grab bars
- Environmental products (such as air filters, purifiers, conditioners, dehumidifiers)
- Exercise equipment

* *Requires or may require a prior authorization.*

Notes:
You need a prescription/qualified health care provider's order in order for medical equipment and supplies to be covered.

Please call the durable medical equipment coverage criteria phone number in Section 1 if you need more information on our durable medical equipment coverage criteria.

Mental Health/Behavioral Health Services

Covered Services:

- Case management for transitional youth *(for members ages 17 through 20)*
- Clinical Care Consultation
- Crisis response services including:
  - Screening
  - Assessment
  - Intervention
  - Stabilization
  - Community intervention *(for members over age 18)*
- Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorders
- Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP) *(for members over age 18 who meet certain criteria)*
- Inpatient psychiatric hospital stay, including extended psychiatric inpatient hospital stay
- Mental health provider travel time
- Mental Health Targeted Case Management (MH-TCM)
- Subacute psychiatric level of care *(for members under age 21)*
- Outpatient mental health services including:
  - Explanation of findings
  - Certified family peer specialists *(for members under age 21)*
  - Family psychoeducation services (*for members under age 21*)
  - Mental health medication management
  - Neuropsychological services
  - Psychotherapy (patient and/or family, family, crisis, and group)
  - Psychological testing
- Physician Mental Health Services including:
  - Health and behavior assessment/intervention
  - Inpatient visits
  - Psychiatric consultations to primary care providers
  - Physician consultation, evaluation, and management

- Rehabilitative Mental Health Services including:
  - Assertive Community Treatment (ACT) *(for members over age 18)*
  - Adult day treatment *(for members over age 18)*
  - Adult Rehabilitative Mental Health Services (ARMHS) is available to members 18 or over
  - Certified Peer Specialist (CPS) support services in limited situations
  - Children's mental health residential treatment services *(for members under age 21)*
  - Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment *(for members under age 21)*
  - CTSS mental health service plan development *(for members under age 21)*
  - Family psychoeducation services *(for members under age 21)*
  - Intensive Residential Treatment Services (IRTS)* *(for members over age 18)*
  - Intensive Treatment Foster Care Services *(for members under age 21)*
  - Partial Hospitalization Program (PHP)
  - Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services *(for members ages 16 through 20)*
- Treatment services at children's residential mental health treatment facilities (Rule 5 - children's group residential facilities with mental health certification). Treatment services do not include coverage for room and board. Room and board may be covered by your county. Call your county for information.*
- Psychiatric Residential Treatment Facility (PRTF) for children, effective October 1, 2017 and upon federal approval
- Certified Community Behavioral Health Clinics (CCBHC)
- Forensic Assertive Community Treatment (FACT)
- Telemedicine

Not Covered Services:

The following services are not covered under the Plan but may be available through your county. Call your county for information. Also see Section 9.

- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Treatment and room and board services at certain children's residential mental health treatment facilities (Rule 5 - children's group residential facilities with mental health certification) in bordering states

* *Requires or may require a prior authorization.*

Notes:
See Mental Health Services in Section 1 for information on where you should call or write.

Use a Plan network provider for mental health services.

If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to go to any qualified health professional that is not in the Plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision.

We will not determine medical necessity for court-ordered mental health services. Use a Plan network provider for your court-ordered mental health assessment.

Obstetrics and Gynecology (OB/GYN) Services

Covered Services:

- Prenatal, delivery, and postpartum care
- Childbirth classes
- Hospital services for newborns
- HIV counseling and testing for pregnant women – **open access service**
- Treatment for HIV-positive pregnant women
- Treatment for newborns of HIV-positive mothers
- Testing and treatment of sexually transmitted diseases (STDs) – **open access service**
- Pregnancy-related services received in connection with an abortion *(does not include abortion-related services)*
- Doula services by a certified doula supervised by either a physician, nurse practitioner, or certified nurse midwife and registered with the Minnesota Department of Health (MDH)
- Services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives

Not Covered Services:

- Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) for coverage information. Also see Section 9.
- Planned home births

Notes:
You have “direct access” to OB-GYN providers without a referral for the following services: annual preventive health exam, including follow-up exams that your qualified health care provider says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as **open access**, you can go to any qualified health care provider clinic, hospital, pharmacy, or family planning agency.

Out-of-Area Services

Covered Services:

- A service you need when temporarily out of the Plan service area*
- A service you need after you move from our service area while you are still a Plan member*
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- Medically necessary urgent care when you are outside of the Plan service area. (Call Member Services at the phone number in Section 1 as soon as possible.)
- Covered services that are not available in the Plan service area*

Not Covered Services:

- Emergency, urgent, or other health care services or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Out-of-Network Services

Covered Services:

- Certain services you need that you cannot get through a Plan network provider*
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- A second opinion for mental health and substance use disorder
- Open access services
- Pregnancy-related services received in connection with an *abortion (does not include abortion-related services)*
- A non-emergency medical service you need when temporarily out of the network or plan area that is or was prescribed, recommended, or is currently provided by a network provider

Prescription Drugs (for members who do NOT have Medicare)

Covered Services:

- Prescription drugs
- Medication therapy management (MTM) services
- Certain over-the-counter drugs *(when prescribed by a qualified health care provider with authority to prescribe)*

* *Requires or may require a prior authorization.*

Not Covered Services:

- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs or products to promote weight loss
- Drugs not clinically proven to be effective
- Experimental or investigational drugs

Notes:
The drug must be on our covered drug list (formulary).

The formulary includes the prescription drugs covered by HealthPartners. The drugs on the list are selected by the Plan with the help of a team of doctors and pharmacists. The list has to be similar to the list covered by Medical Assistance (Medicaid). In addition to the prescription drugs covered by HealthPartners, some over-the-counter drugs are covered for you under your Medical Assistance (Medicaid) benefits. You can search for prescription drugs using our online search tool at https://www.healthpartners.com/public/pharmacy/formularies/medicaid/. A list of over-the-counter drugs is also posted on the website. You can also call Member Services and ask for a written copy of our *Formulary*.

There are limits or restrictions on coverage for some formulary drugs. These restrictions and limits may include:

- Prior authorization: HealthPartners requires you or your health care provider to get our approval before the plan will cover certain drugs
- Quantity Limits: For certain drugs, HealthPartners limits the amount or dose of the drug that we will cover
- Step Therapy: In some cases, HealthPartners requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition
- Brand name drugs* with generic equivalents on our Formulary: HealthPartners may require you to try a generic version of a formulary medication before covering the brand name version through a prior authorization. We require a prior authorization before a drug is dispensed as written (DAW).

You can get more information about the restrictions applied to specific covered drugs by visiting our website at https://www.healthpartners.com/public/pharmacy/formularies/medicaid/.

We will cover a non-formulary drug if your qualified health care provider shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your qualified health care provider is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.

* *Requires or may require a prior authorization.*

We will cover an antipsychotic drug, even if it is not on our drug list, if your provider certifies this is best for you. There is no copay for antipsychotic drugs. In certain cases, we will also cover other drugs used to treat a mental illness or emotional disturbance even if the drug is not on our approved drug list. We will do this for up to one year if your provider certifies the drug is best for you and you have been treated with the drug for 90 days before: 1) we removed the drug from our drug list; or 2) you enrolled in the Plan.

For most drugs, you can get only a 30-day supply at one time.

If HealthPartners does not cover your drug or has restrictions or limits on your drug that you don't think will work for you, you can do one of these things:

- You can ask your health care provider if there is another covered drug that will work for you.
- You and/or your health care provider can ask HealthPartners to make an "exception" and cover the drug for you or remove the restrictions or limits. If your exception request is approved, the drug will be covered at the appropriate generic or brand name copay level.

Your qualified health care provider will get an exception to our covered drug list if your provider says you need a drug that is not on the list and we agree that it is medically necessary.

If a pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your qualified health care provider. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by us under the Plan. If the pharmacy won't call your qualified health care provider, you can. You can also call Member Services at the phone number in Section 1 for help.

Specialty drugs are prescribed to treat serious or chronic medical conditions such as multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. These drugs may be oral or injectable. They can be self-administered or administered by a family member. You can find a list of specialty drugs here https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_006662.pdf.

We have a program for specialty drugs through a Specialty Pharmacy Network. If you need specialty drugs, you must use one of the providers in the Specialty Pharmacy Network as your specialty drug pharmacy. Specialty drug providers are experts in supplying drugs and services to patients with complex health conditions. They will give you information about your condition and the drugs that have been prescribed to you. You will have 24-hour access to pharmacists who can answer your questions. Please call Member Services at the number listed in Section 1 to find out which providers are in the Specialty Pharmacy Network program.

Prescription Drugs (for members who have Medicare)

Covered Services:

- Some over-the-counter products, some prescription cough and cold products, and some vitamins that are not covered under the Medicare Prescription Drug Program (Medicare Part D)

Not Covered Services:

- Prescription drugs that are eligible to be covered under the Medicare Prescription Drug Program (Medicare Part D)
- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs or products to promote weight loss
- Drugs not clinically proven to be effective
- Experimental or investigational drugs

Notes:
Medicare pays for most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). **You must enroll in a Medicare prescription drug plan** to receive most of your prescription drug services. You will get your prescription drug services through your Medicare prescription drug plan – not through our Plan. You may have to pay a copay for prescriptions covered by your Medicare prescription drug plan.

Rehabilitation

Covered Services:

- Rehabilitation* therapies to restore function: physical therapy, occupational therapy, speech therapy
- Audiology services including hearing tests

Not Covered Services:

- Vocational rehabilitation
- Health clubs and spas

* *Requires or may require a prior authorization.*

Substance Use Disorder Services

Covered Services:

- Screening/Assessment/Diagnosis
- Outpatient treatment
- Inpatient hospital
- Residential non-hospital treatment*
  A prior authorization may be required. If you have questions, call the HealthPartners Behavioral Health Navigators at 952-883-7501 or 1-866-669-3856 (toll free).
- Outpatient methadone treatment
- Detoxification (Only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification)

Notes:
See Section 1 for Substance Use Disorder Services contact information.

A qualified Rule 25 county assessor who is part of the Plan network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor. We will do this within five working days of when we get your request. To get assistance selecting a second assessment you may call the Behavioral Health Navigators at 952-883-5811 or 1-888-638-8787 (toll free). If you agree with the second assessment, we will authorize services according to substance use disorder standards and the second assessment. You have the right to appeal. See Section 13 of this Member Handbook.

Not Covered Services:

Payment for room and board determined necessary by substance use disorder assessment is the responsibility of the Minnesota Department of Human Services.

Surgery

Covered Services:

- Office/clinic visits/surgery*
- Removal of port wine stain birthmarks
- Reconstructive surgery (for example, following mastectomy, following surgery for injury, sickness or other diseases; for birth defects)*
- Anesthesia services
- Circumcision when medically necessary*
- Gender confirmation surgery

* *Requires or may require a prior authorization.*

Not Covered Services:

- Cosmetic surgery

Telemedicine Services

- Telemedicine services covers medically necessary services and consultations delivered by a licensed health care provider while the patient is at an originating site and the health care provider is at a distant site. Coverage is limited to three (3) telemedicine services, per member, per calendar week.

Transplants*

Covered Services:

- Organ and tissue transplants, including: bone marrow, cornea, heart, heart-lung, intestine, intestine-liver, kidney, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, stem cell, and other transplants
- Ventricular Assist Device: inserted as a bridge to a heart transplant or as a destination therapy treatment

Notes:
The type of transplant must be: 1) listed in the Minnesota Department of Human Services Provider Manual; 2) a type covered by Medicare; or 3) approved by the state's medical review agent.

Transplants must be done at transplant centers that meet the United Network for Organ Sharing (UNOS) standards or at Medicare approved transplant centers.

Stem cell or bone marrow transplants centers must meet the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT).

Transportation to/from Medical Services

Covered Services:

- Emergency ambulance (air or ground includes transport on water)*
- Non-emergency ambulance
- Volunteer driver transport
- Unassisted transport (taxicab or public transit)
- Assisted transport
- Lift-equipped/ramp transport
- Protected transport
- Stretcher transport

* *Requires or may require a prior authorization.*

Not Covered Services:

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. These services are not covered under the Plan, but may be available through the local county or tribal agency. Call your local county or tribal agency for more information.

Notes:
If you need transportation to and from health services that we cover, call the Transportation phone number in Section 1. We will provide the most appropriate and cost-effective form of transportation.

The Plan is not required to provide transportation to your primary care clinic if it is more than 30 miles from your home or if you choose a Specialty provider that is more than 60 miles from your home. Call the Transportation phone number in Section 1 if you do not have a primary care clinic that is available within 30 miles of your home and/or if your home is more than 60 miles away from your specialty provider.

To arrange transportation to and from a covered health service, contact RideCare at 952-883-7400 or 1-888-288-1439 (toll free), Monday through Friday, 7 a.m. to 5 p.m. When possible, please call three to four business days before your scheduled appointment.

Urgent Care

Covered Services:

- Urgent care within the Plan service area
- Urgent care outside of the Plan service area

Not Covered Services:

- Urgent, emergency, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Notes:
An urgent condition is not as serious as an emergency. This is care for a condition that needs prompt treatment to stop the condition from getting worse. Urgent care is available 24 hours a day.

Call Member Services at the phone number in Section 1 as soon as possible when you get urgent care outside the Plan service area.

Section 8. Services we do not cover

If you get services or supplies that are not covered, you may have to pay for them yourself. Some "not covered" services and supplies are listed under each category in Section 7. Below is a list of other services and supplies that are not covered under the Plan. This is not a complete list. Call Member Services for more information.

- Health care services or supplies that are not medically necessary
- Supplies that are not used to treat a medical condition
- Hospital inpatient and nursing home incidental services, such as TV, phone, barber and beauty services, and guest services
- Cosmetic procedures or treatments
- Experimental or investigative services
- Emergency, urgent, or other health care services delivered or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.
- Homeopathic and herbal products
- Autopsies (exams that are done on the bodies of people who have died to find out the cause of death)

Section 9. Services that are not covered under the Plan but may be covered through another source

These services are not covered under the Plan, but may be covered through another source, such as the state, county, federal government, tribe, or a Medicare prescription drug plan. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) or 711 (TTY/TDD).

- Child welfare targeted case management
- Case management for members with developmental disabilities
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Nursing home stays
- Abortion services
- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance (Medicaid)
- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center, a state-owned long term care facility, or an institution for mental disease (IMD), unless approved by us or the service is ordered by a court under conditions specified in law
- Services provided by federal institutions

- Waiver services provided under Home and Community-Based Services waivers
- Job training and educational services
- Day training and habilitation services
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Room and board associated with treatment services at children's residential mental health treatment facilities (Rule 5). Room and board may be covered by your county. Call your county for information.
- Post-arrest Community-Based Services Coordination
- HIV case management

Section 10. When to call your county worker

Call your county worker to report these changes:

- Name changes
- Address changes including moving out of Minnesota
- Pregnancy begin/end dates
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID card
- New insurance or Medicare – begin/end dates
- Change of income including employment changes

Section 11. Using the Plan coverage with other insurance

If you have other insurance, tell us before you get care. We will let you know if you should use the Plan network providers or the health care providers used by your other insurance. We will coordinate our payments with them. This is called "coordination of benefits." Examples of other insurance include:

- No-fault car insurance
- Workers' compensation
- Medicare
- Tricare
- Other Health Maintenance Organization (HMO) coverage
- Other commercial insurance

When you become a member of the Plan, you agree to:

- Let us send bills to your other insurance
- Let us get information from your other insurance
- Let us get payments from your other insurance instead of having payments sent to you
- Help us get payments from your other insurance

If your other insurance changes, call your county worker.

Section 12. Subrogation or other claim

This first paragraph applies to certain non-citizens in the Families and Children program:

You may have other sources of payment for your medical care. They might be from another person, group, insurance company, or other organization. If you have a claim against another source for injuries, we will make a claim for medical care we covered for you. State law requires you to help us do this. The claim may be recovered from any settlement or judgment received by you from another source. This is true even if you did not get full payment of your claim. The amount of the claim will not be more than state law allows.

This second paragraph applies to members in the Families and Children program except certain non-citizens:

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and state laws provide that Medical Assistance (Medicaid) benefits pay only if no other source of payment exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than federal and state laws allow.

Section 13. Grievance, appeal and state appeal (state fair hearing) process

This section tells you about the grievance and appeal system including notices, grievances (complaints), health plan appeals and state appeal (state fair hearing). It tells you how and when to use the grievance and appeal system if you are not satisfied with your health care or disagree with a decision we made. It tells you about your rights when using the grievance and appeal system.

Please call Member Services at the phone number in Section 1 if you have questions or want help filing a grievance or appeal.

Grievance and appeal system terms to know:

A grievance is when you are not satisfied with the services you have received and may include any of the following:

- quality of care or services provided
- failure to respect your rights
- rudeness of a provider or health plan employee
- delay in appropriate treatment or referral
- not acting within required time frames for grievances and appeals

A denial, termination or reduction (DTR) (notice of action) is a form or letter we send you to tell you about a decision we make on a claim, a request for service, payment of a claim, or any other request. The notice will tell you how to file an appeal with the health plan or request a state appeal if you disagree with our decision.

A health plan appeal is your request for us to review a decision we made. You may ask for an appeal if you disagree with our decision in any of the following **actions** (decisions)**:**

- denial or limited authorization of the type or level of service requested by your provider
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of payment for a service
- not providing services (including transportation) in a reasonable amount of time
- denial of a member's request to get services out of network for members living in a rural area with only one health plan
- not providing a response to your grievance or appeal in the required timelines

Your provider may appeal on your behalf with your written consent. Your treating provider (for example, Nurse Practitioner (NP), Physician Assistant (PA)) may appeal a preauthorization decision *without* your consent.

A state appeal (state fair hearing) is your request for the state to review a decision we made. You must appeal to HealthPartners before asking for a state appeal. If we take more than 30 days to decide your appeal and we have not asked for an extension, you do not need to wait for our decision to ask for a state appeal.

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of a payment for a service
- not providing services in a reasonable amount of time
- our failure to act within required timelines for preauthorizations and appeals
- enrollment in the Plan
- any other action

If you disagree with our decision or have a grievance (complaint) about something other than a decision we made, you can do any of the following:

You can call Member Services at the phone number in Section 1 to file a grievance or appeal.

You can write to us to file a grievance or appeal. Write to the address listed in Section 1 under "Appeals and Grievances."

You can write to the Minnesota Department of Human Services to request a state appeal.

Write to: Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

File online at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG

Or fax to: 651- 431-7523

You can also file a complaint (grievance) with the Minnesota Department of Health.

Write to: Minnesota Department of Health
Health Policy and Systems Compliance Monitoring Division
Managed Care Systems
P.O Box 64882
St. Paul, MN 55164-0882
1-800-657-3916 or (651) 201-5100
711 (TTY/TDD)
http://www.health.state.mn.us/hmo

You can call or write to the Ombudsman for Public Managed Health Care Programs. They may be able to help you with access, service, or billing problems. They can also help you file a grievance or appeal with us or request a state appeal.

Call: 651-431-2660 (Twin Cities metro area) or toll-free 1-800-657-3729 (non-metro area) or 711 (TTY/TDD). Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m.

Or

Write to: Minnesota Department of Human Services
Ombudsman for Public Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249

Fax to: 651-431-7472

Important Timelines

You must follow the timelines for filing grievances, health plan appeals, and state appeals. If you go over the time allowed, we may not review your grievance or appeal and the state may not accept your request for an appeal.

You may file a grievance with us **at any time** from the date of the incident about which you are complaining. There is no timeline for filing a grievance with us.

You must appeal to us **within 60 days** from the date of the DTR (notice of action). We can give you more time if you have a good reason for missing the deadline. You must file an appeal with us **before** you request a state appeal. If we take more than 30 days to decide your appeal and we have not asked for an extension, you can request a state appeal without waiting for us.

You must request a state appeal **within 120 days** of our appeal decision.

If we are stopping or reducing a service, you can keep getting the service if you file a health plan appeal **within 10 days** from the date on the notice, or before the service is stopped or reduced, whichever is later. **You must ask to keep getting the service when you file an appeal.** The service can continue until the appeal is decided. If you lose the appeal, you may be billed for these services.

If you lose the appeal, you may keep getting the service during a state appeal if you request a state appeal within 10 days from the date of the decision on your plan appeal.

For the Restricted Recipient Program, a member who receives a notice of restriction may file an appeal with us. You must file an appeal **within 60 days** from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. A member may request a state appeal after receiving our decision that we have decided to enforce the restriction.

To file an oral or written appeal with us:

Call Member Services at the phone number in Section 1. Tell us why you disagree with our decision. Oral appeals must be followed by a written appeal, unless you are requesting an expedited, or "fast," resolution. We will help you complete a written appeal. We will ask you to sign and return the written appeal.

You can also send us a letter about your appeal. In the letter, explain why you disagree with our decision. Send the letter to the address listed in Section 1 under "Appeals and Grievances." We can help you write the appeal. Call Member Services at the phone number in Section 1 if you need help.

Expedited, or "fast" appeals, are for urgently needed services. If we agree that it is urgent, we will give you a decision within 72 hours. We will try to call you with the decision before we send the decision in writing.

We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

If your appeal is not urgent, we will tell you within 10 days that we received it. We will give you a written decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

The person making the decision will not be the same person who was involved in the prior review or decision-making.

If we are deciding an appeal about a service that was denied because it was not medically necessary, the decision will be made by a health care professional with appropriate clinical expertise in treating your condition or disease.

You or your representative may present your information in person, by telephone, or in writing. You or your representative may review the case file, including medical records and any other documents and records considered by us during the appeal process.

To file a state appeal with the Minnesota Department of Human Services:

You must ask for a state appeal **within 120 days** from the date of the decision of the plan appeal.

A human services judge from the state Appeals Office will hold a hearing. You may ask to attend the hearing by telephone, by video, or in person.

Tell the state why you disagree with the decision we made.
You can ask a friend, relative, advocate, provider, or lawyer to help you. Your provider must have your written permission to request a state appeal for you.

The process can take 90 days. If your hearing is about an urgently needed service, tell the Judge or the Ombudsman when you call or write to them.

If your hearing is about a service that was denied because it was not medically necessary, you may ask for review by a medical expert. The medical expert is independent of both the state and HealthPartners. The state pays for this review. There is no cost to you.

If you do not agree with the human service judge's decision, you may ask the state to reconsider their decision. Send a written request for reconsideration to the Minnesota Department of Human Services Appeals Office within 30 days from the date of the decision. The contact information is listed earlier in this section.

If you do not agree with the state's decision, you may appeal to the district court in your county.

Important information about your rights when filing a grievance, appeal, or requesting a state appeal:

There is no cost to you to file an appeal or a grievance.

If you decide to file a grievance or appeal, or request a state appeal, it will not affect your eligibility for medical services. It will also not affect your enrollment in our health plan.

You can have a relative, friend, advocate, provider, or lawyer help with your grievance, appeal, or a state appeal.

There is no cost to you for filing a health plan appeal, grievance, or a state appeal. We may pay for some expenses such as transportation, childcare, photocopying, etc.

If you ask to see your medical records or other documents, we used to make our decision, or want copies, we or your provider must provide them to you at no cost. You may need to put your request in writing.

To file an oral grievance with us:

Call Member Services at the phone number in Section 1 and tell us about the problem.

We will give you a decision within 10 days. We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 10 days that we are taking extra time and the reasons why.

If your grievance is about our denial of an expedited appeal or a grievance about urgent health care issues, we will give you a decision within 72 hours.

To file a written grievance with us:

Send a letter to us about your grievance. Write to the address listed in Section 1 under "Appeals and Grievances."

We can help you put your grievance in writing. Call Member Services at the phone number in Section 1 if you need help.

We will tell you that we received your grievance within 10 days.

We will give you a written decision within 30 days. We may take up to 14 extra days if we need more information and it is in your best interest. We will tell you we are taking the extra time and why.

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for Public Managed Health Care Programs for help. The contact information is listed earlier in this section.

Section 14. Definitions

These are the meanings of some words in this Member Handbook.

Action: This includes:

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of payment for a service
- not providing services in a reasonable amount of time
- not acting within required time frames for grievances and appeals
- denial of a member's request to get services out-of-network for members living in a rural area with only one health plan

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 a written or oral appeal.

Child: Member under age 21.

Child and Teen Checkups (C&TC): A special health care program of well-child visits for members under age 21. It includes screening to check for health problems. It also includes referrals for diagnosis and treatment, if necessary.

Clinical Trial: A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

Copay/Copayment: A fixed amount you may pay as your share of the cost each time you get certain services, supplies, or prescription drugs. Co-pays are usually paid at the time services, supplies, or prescription drugs are provided. For example, you might pay $2 or $5 for services, supplies or prescription drugs.

Cost Sharing: Amounts you may be responsible to pay toward your medical services. See Section 6 for information on cost sharing.

Covered Services: The health care services that are eligible for payment.

Denial, Termination or Reduction (DTR) (Notice of Action): A form or letter we send you to tell you about a decision on a claim, service, or any other action taken by us.

Direct Access Services: You can go to any provider in the Plan network to get these services. You do not need a referral or prior authorization from your PCP or PCC before getting services.

Durable Medical Equipment (DME): Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, oxygen equipment and supplies.

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 function of a body part or could cause serious physical or mental harm. The medical symptoms may be a serious injury or severe pain. This is also called 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 for an emergency medical condition.

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

Experimental Service: A service that has not been proven to be safe and effective.

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

Families and Children: The name of the prepaid medical assistance program (PMAP) you are in.

Family Planning: Information, services, and supplies that 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.

Fee-for-Service: A method of payment for health services. The medical provider bills the Minnesota Department of Human Services (DHS) directly. DHS pays the provider for the medical services. This method is used when you are eligible for Minnesota Health Care Programs but are not enrolled in a health plan.

Formulary: The list of drugs covered under the Plan.

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.

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

Hospice: A special program for members who are terminally ill and not expected to live more than six months to live comfortably for the rest of the member's time. It offers special services for the member and his or her family. This is also known as Hospice Services.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Inpatient Hospital Stay: A stay in a hospital or treatment center that usually lasts 24 hours or more.

Investigative Service: A service that has not been proven to be safe and effective.

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 behavioral health (including Mental Health and Substance Use Disorder). 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, supplies and prescription drugs 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 or find health problems.

Medicare: The federal health insurance program for people age 65 or over. It is also for some people under age 65 with disabilities, and people with End-Stage Renal Disease.

Medicare Prescription Drug Plan: An insurance plan that offers Medicare Prescription Drug Program (Medicare Part D) drug benefits.

Medicare Prescription Drug Program: The prescription drug benefit for Medicare members. It is sometimes called Medicare Part D. Drug coverage is provided through a Medicare prescription drug plan.

Member: A person who is receiving services through a certain program, such as a Minnesota Health Care Program or Medicare.

Member Handbook: This is the document you are reading. This document tells you what services are covered under the Plan. It tells what you must do to get covered services. It tells your rights and responsibilities. It also tells our rights and responsibilities.

Network: Our contracted health care providers for the Plan.

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.

Ombudsman for Public Managed Health Care Programs: A person at the Minnesota Department of Human Services who can help you with access, service or billing problems. The ombudsman can also help you file a grievance or appeal or request a state appeal (state fair hearing).

Open Access Services: Federal and state law allow you to choose any qualified health care provider, clinic, hospital, pharmacy, or family planning agency - even if not in our network - to get these services.

Outpatient Hospital Services: Services provided at a hospital or outpatient facility that are not at an inpatient level of care. These services may also be available at your clinic or another health facility.

Out-of-Area Services: Health care provided to a member by an out-of-network provider outside of the Plan service area.

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. This is also known as a non-participating provider.

Out-of-Network Services: Health care provided to a member by a provider who is not part of the Plan network.

Participating Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Physician Incentive Plan: Special payment arrangements between us and the doctor or doctor group that may affect the use of referrals. It may also affect other services that you might need.

Physician Services: Services provided by an individual licensed under state law to practice medicine or osteopathy. Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: An organization that has a network of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you.

Prepaid Medical Assistance Program (PMAP): A program in which the state contracts with health plans to cover and manage health care services for Medical Assistance (Medicaid) enrollees.

Post-stabilization Care: A hospital service needed to help a person's conditions stay stable after having emergency care. It starts when the hospital asks for our approval for coverage. It continues until: the person is discharged; our Plan network qualified health care provider begins care; or we, the hospital, and qualified health care provider agree to a different arrangement.

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescriptions: Medicines and drugs ordered by a medical provider.

Prescription Drug Coverage: A health plan that helps pay for prescription drugs and medications. Also see "Medicare Prescription Drug Program."

Preventive Services: Services that help you stay healthy, such as routine physicals, immunizations, and well-person care. These services help find and prevent health problems. Follow-up on conditions that have been diagnosed (like a diabetes checkup) are ***not*** preventive.

Primary Care Clinic: The primary care clinic (PCC) you choose for your routine care. This clinic will provide most of your care. The name of your clinic appears on your member ID card.

Primary Care Physician: Your primary care physician (PCP) is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she 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 see your primary care provider before you see any other health care provider.

Primary Care Provider: Your primary care provider (PCP) is the doctor or other qualified health care provider you see at your primary care clinic. This person will manage your health care.

Prior Authorization: Our approval that is needed for some services before you get them. This is also known as preauthorization or service authorization.

Provider: A qualified health care professional or facility approved under state law to provide health care.

Rehabilitation Services and Devices: Treatment and equipment you get to help you recover from an illness, accident or major operation.

Restricted Recipient Program: A program for members who have received 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 pharmacy, one hospital or other designated health care provider. 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.

Second Opinion: If you do not agree with an opinion you get from a Plan network provider, you have the right to get an opinion from another provider. We will pay for this. For medical conditions, the second opinion will be from another Plan network provider. For mental health services, the second opinion will be from an out-of-network provider. For substance use disorder services, the second opinion will be from a different qualified assessor who is not in the Plan network.

Service Area: The area where a person must live to be able to become or remain a member of the Plan. Contact Member Services at the phone number in Section 1 for details about the service area.

Standing Authorization: Written consent from us to see an out-of-network specialist more than one time (for ongoing care).

Skilled Nursing Care: Care or treatment that can only be done by licensed nurses.

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

State Appeal (State Fair Hearing): A hearing at the state to review a decision made by us. You must request a hearing in writing. Your provider may request a state appeal (state fair hearing) with your consent. You may ask for a hearing if you disagree with any of the following:

- a denial, termination, or reduction of services
- enrollment in the Plan
- denial of part or all of a claim for a service
- our failure to act within required timelines for prior authorizations and appeals
- any other action

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.

United States: For the purpose of this Member Handbook, the United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, The Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Urgently Needed Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. This is also known as Urgent Care.