HealthPartners®

HealthPartners Care
Minnesota Senior Care (MSC)

Certificate of Coverage
January 1, 2008

Attention. If you want free help translating this information, call HealthPartners® at 952-967-7998 or 1-866-885-8880.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم HealthPartners® 952-967-7998 أو 1-866-885-8880.

កំណាត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ HealthPartners® 952-967-7998 ឬ 1-866-885-8880 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite HealthPartners® 952-967-7998 ili 1-866-885-8880.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu HealthPartners® 952-967-7998 lossis 1-866-885-8880.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໌ຫາ HealthPartners® 952-967-7998 ຫຼື 1-866-885-8880.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, lakkoofsi bilbiltu HealthPartners® 952-967-7160 ykn 1-866-885-8880.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните HealthPartners® 952-967-7998 или 1-866-885-8880.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, wac HealthPartners® 952-967-7159 ama 1-866-885-8880.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a HealthPartners® al 952-967-7050 o al 1-866-885-8880.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi HealthPartners® 952-967-7998 hoặc 1-866-885-8880.

LB4-HP1 11-07

This information is available in other forms to people with disabilities by calling 952-967-7998 (voice), or 1-866-885-8880 (toll free), or 952-883-6060 (TDD), or 711, or through the Minnesota Relay Service at 1-877-627-3848 (speech to speech relay service).

If you ask, we will give you this Certificate of Coverage in one of these languages: Spanish; Hmong; Laotian; Russian; Somali; Vietnamese; or Cambodian. Call HealthPartners Health Plan Member Services at 952-967-7998 or 1-866-885-8880 (toll free) or 952-883-6060 (TDD/Hearing Impaired).

HealthPartners Health Plan will accept all eligible people who choose or are assigned to the Plan. We will not discriminate in regard to your physical or mental condition; health status; need for health services; marital status; age; sex; sexual orientation; national origin; race; color; religion or political beliefs.

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

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

Hours of Service: 8:00 AM – 5:00 PM, Monday - Friday

Table of Contents

Welcome to HealthPartners Health Plan

We are pleased to welcome you as a member of HealthPartners Care Minnesota Senior Care Plan (referred to as "Plan").

HealthPartners (referred to as "we," "us", or "our") is part of the Minnesota Senior Care 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 doctor to see.

This Certificate of Coverage (COC) explains how to get your health services through the Plan. This COC is an important legal document. Please keep it in a safe place.

This COC, together with any amendments that we may send to you, is our contract with you. It explains your rights, services, and responsibilities as a member of the Plan. It also explains our responsibilities to you.

This COC tells you:

- What is covered under the Plan and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for copays.
- What to do if you are unhappy about something related to getting your health services.
- Contact information, including telephone numbers.

The counties in the Plan service area are as follows: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Please tell us how we're doing. We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time. (Section 1of this COC 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 other contact information

How to contact our Member Services

If you have any questions or concerns, please call or write to our Member Services. We will be happy to help you. Member Services' hours of service are 8:00 AM – 5:00 PM Monday - Friday

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

TDD: 952-883-6060 or 1-800-443-0156 (toll free)

FAX: 952-883-7333 or 952-883-7666

WRITE: HealthPartners
Member Services
P.O. Box 9463
Minneapolis, MN 55440-9463

VISIT: HealthPartners
Member Services
8170 33rd Avenue South
Minneapolis, MN 55445

WEBSITE: www.healthpartners.com

Our Plan contact information for certain services

Appeals and Grievances. See Section 13 for more information.
Call: 952-967-7998 or 1-866-885-8880 (toll free)
Or
Write: HealthPartners
Member Services
P.O. Box 9463
Minneapolis, MN 55440-9463

Chemical Dependency Services:
Call: 952-883-5811 or 1-888-638-8787 (toll free)
Or
Write: HealthPartners
21103M
P.O. Box 1309
Minneapolis, MN 55440-1309

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

Health Questions Phone 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)

Mental Health Services:
Call: 952-883-5811 or 1-888-638-8787 (toll free)
Or
Write: HealthPartners
21103M
P.O. Box 1309
Minneapolis, MN 55440-1309

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

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

Other important contact information

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 program through counties. If you have questions about your eligibility for Medical Assistance, contact your county worker.

Ombudsman for State Managed Health Care Programs

The Ombudsman for State 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 Fair Hearing. Call 651-431-2660 or toll free 1-800-657-3729.

Office of Ombudsman for Older Minnesotans

Contact the Office of Ombudsman for Older Minnesotans for assistance with concerns about nursing homes, adult care homes (i.e., assisted living, foster care), hospital access or discharge for people with Medicare, and home health care. Call 651-431-2555 or toll free 1-800-657-3591.

How to contact the Medicare program

Medicare is a health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare Plans (including our Plan). Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.

- Visit www.medicare.gov. This is the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Web sites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

Linkage Line – a State program that gives free local health insurance counseling to people with Medicare

The Linkage Line is a State program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. The Linkage Line can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. The Linkage Line has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact the Linkage Line at 1-800-333-2433 or write to them at MNSHIP, Minnesota Board on Aging, P.O. Box 64976, St. Paul, MN 55164-0976. You may also find the Web site for the Linkage Line at www.medicare.gov on the Web. Under "Search Tools," select "Helpful Phone Numbers and Websites."

Section 2. Important Information on getting the care you need

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

- You chose or have been assigned to a Plan network doctor or clinic. The name of the doctor or clinic you must go to is on your member card. This is your **Primary Care Clinic**. The clinic's phone number is also on your member card.

- Your Primary Care Clinic or doctor will arrange all of your medical care. It is important that one doctor knows about all your medical needs. The doctor can make sure you get the care you need.

- Your clinic or doctor will refer you to other doctors or health care providers when needed.

- Contact your Primary Care Clinic for information about the clinic's hours, referrals and service authorizations.

- Call your Primary Care Clinic 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.

- 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 coverage changes, tell your county worker.

- You may be required to pay a copay for certain services. A copay is an amount that you will be responsible to pay to your provider. See Section 6 for more information about copays.

- Enrollment in a health plan does not guarantee that certain items are covered. Some prescription drugs or medical equipment may not be covered. This is true even if you could get them before.

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

- 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.

- 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.

- Our approval is needed for some services to be covered. This is called **service 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 our Member Services at the phone number in Section 1.

- Some services are only covered when you get a referral. A referral is written consent from your primary care doctor or clinic that you need to get before you see certain providers, such as specialists, for covered services. Get the referral **before** you see the provider.

- Almost all health services must be approved by your Primary Care Clinic. Exceptions to this rule are:
  - Dental, routine vision care, chiropractic care, and obstetrics and gynecology services: You must get these services from providers in our network.
  - Open access services. Family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for AIDS or other HIV-related conditions are open access services. You can go to any doctor, clinic, pharmacy, or family planning agency – even if it is not in our network – to get these services.
  - For chemical dependency services, call the phone number listed in Section 1.
  - For mental health, call the phone number listed in Section 1.
  - Emergency and post stabilization care: If you get emergency care from a provider not in the Plan network, you must follow some rules. See Section 7. It tells you what emergency care is covered. It also tells you the rules.

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

- A written referral may be for one visit or it may be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of these conditions:
  - A chronic (ongoing) condition;
  - A life-threatening mental or physical illness;
  - A pregnancy that is beyond the first three months (trimester);
  - A degenerative disease or disability;
  - Any other condition or disease that that is serious or complex enough to require treatment by a specialist.

If you do not get a written referral, the bill may not be paid. For more information, call Member Services at the phone number in Section 1.

- We cannot pay you back for 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.

- 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 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 (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 doctor 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.

- Home and Community Based Services are not covered under the Plan. Please contact your county if you need these services.

- We may cover additional or substitute services under some conditions.
- 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. 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 Plan network primary care provider prior to the referral.

- Your coverage with us will be canceled if you are not eligible for Medical Assistance. It will also be canceled if you change health plans.

- If you are no longer eligible for Medical Assistance, you may be able to purchase health coverage with us. Call Member Services at the phone number in Section 1.

- We, and the health 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.

- The Restricted Recipient Program is a program for members who have received medical care and have not followed the rules or have misused services. If you are placed in this program, we may replace your regular member card with a Restricted Recipient Program card. You must get health services from one doctor, one drug store, one hospital or other provider. You must do this for 24 months of eligibility for Minnesota Health Care Programs (MHCP). You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice option or consumer directed services. 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 fee for service. You will not lose eligibility for MHCP because of placement in the program. At the end of the 24 months, your health care services will be reviewed. If you still do not follow the rules, you will be placed in the program for an additional 24 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. See Section 13.

Section 3. Enrollee bill of rights

You have the right to:

- Be treated with respect, dignity, and consideration for privacy.
- 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 will help or harm you.
- Refuse treatment. 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.
- Request and receive a copy of your medical records. You also have the right to ask to correct the records.
- File a grievance or appeal with us. You can also file a complaint with the Minnesota Department of Health.
- Request a State Fair Hearing with the Minnesota Department of Human Services (also referred to as "the State"). You may request a State Fair Hearing before or at any time during our grievance or appeal process. You do not have to file a grievance or appeal with us before you request a State Fair Hearing.

- A clear explanation of covered nursing home and home care services.

- 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 decide for you if you are unable to decide, or if you want someone else to decide for you.

- Choose where you will get family planning services.

- Get a second opinion for medical, mental health, and chemical dependency services.

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

- Request a copy of this Certificate of Coverage at least once a year.

- Get the following information from us, if you ask for it:

    - Whether we use a physician incentive plan that affects the use of referral services;
    - The type(s) of incentive arrangement used;
    - Whether stop-loss protection is provided; and
    - Results of a member survey if one is required because of our physician incentive plan.

- Get the results of an external quality review study from the State, if you ask for them.

- Make recommendations about our rights and responsibilities policy.

- Exercise the rights listed here.

Section 4. Enrollee responsibilities

You have the responsibility to:

- Read this Certificate of Coverage and know which services are covered under the Plan and how to get them.

- Show your member card and your Minnesota Health Care Programs card every time you go for 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 doctor before you become ill. This helps you and your primary care doctor understand your total health condition.

- Give information asked for by your doctor. Share information about your health history.

- Follow all your doctor's instructions. If you have questions about your care, ask your doctor.

- Work with your doctor to understand your total health condition. It is important to 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.

Let us know if you have any questions, concerns, problems or suggestions. If you do, please call Member Services at the phone number in Section 1.

Section 5. Your health plan member (ID) card

- Each member will receive a member card.

- Always carry your member card with you.

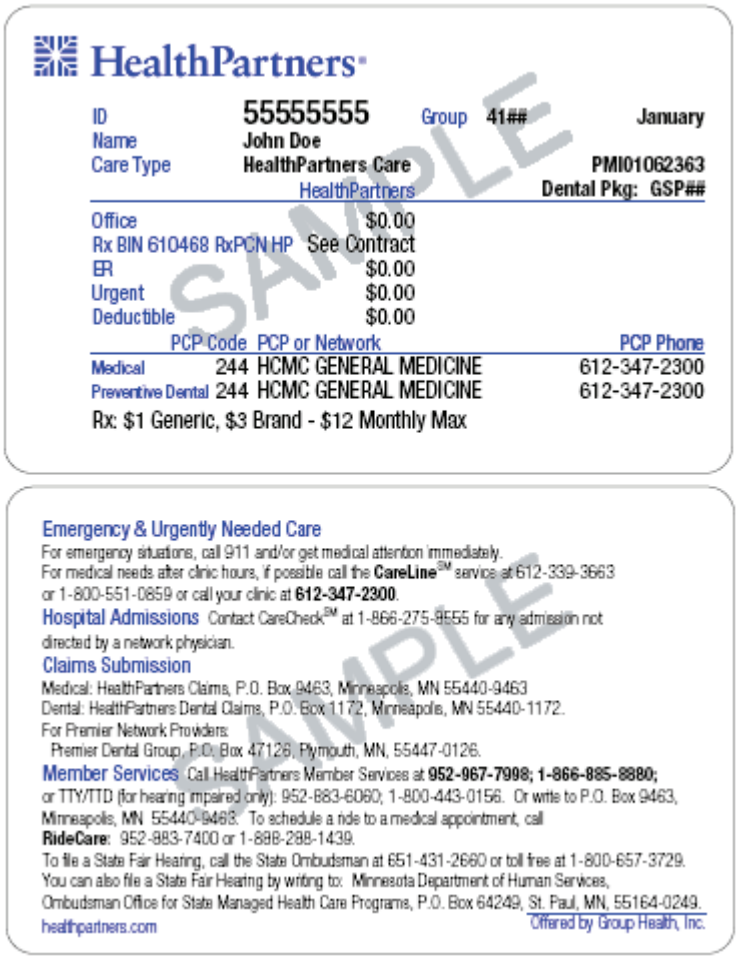
- You must show your member card whenever you get health care.

- You must use your member card along with your Minnesota Health Care Programs 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 card is lost or stolen. We will send you a new card.

- Call your county worker if your Minnesota Health Care Programs Card is lost or stolen.

Here is a sample member card to show what it looks like.



HealthPartners®

ID	55555555	Group 41##	January
Name	John Doe		
Care Type	HealthPartners Care		PMI01062363
	HealthPartners		Dental Pkg: GSP##
Office	$0.00		
Rx BIN 610468 RxPCN HP	See Contract		
ER	$0.00		
Urgent	$0.00		
Deductible	$0.00		

	PCP Code	PCP or Network	PCP Phone
Medical	244	HCMC GENERAL MEDICINE	612-347-2300
Preventive Dental	244	HCMC GENERAL MEDICINE	612-347-2300

Rx: $1 Generic, $3 Brand - $12 Monthly Max

SAMPLE

Emergency & Urgently Needed Care
For emergency situations, call 911 and/or get medical attention immediately.
For medical needs after clinic hours, if possible call the **CareLine**℠ service at 612-339-3663 or 1-800-551-0859 or call your clinic at **612-347-2300**.

Hospital Admissions Contact CareCheck℠ at 1-866-275-9555 for any admission not directed by a network physician.

Claims Submission
Medical: HealthPartners Claims, P.O. Box 9463, Minneapolis, MN 55440-9463
Dental: HealthPartners Dental Claims, P.O. Box 1172, Minneapolis, MN 55440-1172.
For Premier Network Providers:
Premier Dental Group, P.O. Box 47126, Plymouth, MN, 55447-0126.

Member Services Call HealthPartners Member Services at **952-967-7998; 1-866-885-8880;** or TTY/TTD (for hearing impaired only): 952-883-6060; 1-800-443-0156. Or write to P.O. Box 9463, Minneapolis, MN 55440-9463. To schedule a ride to a medical appointment, call **RideCare:** 952-883-7400 or 1-888-288-1439.
To file a State Fair Hearing, call the State Ombudsman at 651-431-2660 or toll free at 1-800-657-3729. You can also file a State Fair Hearing by writing to: Minnesota Department of Human Services, Ombudsman Office for State Managed Health Care Programs, P.O. Box 64249, St. Paul, MN, 55164-0249.

healthpartners.com

Offered by Group Health, Inc.

Section 6. Copays

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

► The people listed here do not have to pay copays for medical services that are covered by Medical Assistance (MA) under the Plan.
- People receiving hospice care
- People residing in a nursing home or other long-term care facility for more than 30 days

Copays are listed in the following chart. See Section 7 for more information about services.

<table>
<tr><th colspan="2">Medical Assistance (MA)</th></tr>
<tr><th>These are examples of services that do not have copays</th><th>These services have these copays</th></tr>
<tr><td>
• Chemical dependency treatment services
• Dental Services
• Emergency Services
• Family planning services
• Home care
• Immunizations
• Inpatient hospital stays
• Interpreter services
• Medical equipment and supplies
• Mental health services
• Physical, occupational, and speech therapy
• Preventive care visits, like physicals
• Repair of eyeglasses
• Services covered by Medicare, except Medicare Prescription Drug Program (Medicare Part D) services
• Some mental health drugs (anti-psychotics)
• Tests such as blood work, X-rays and ultrasounds
• Transportation (emergency, special medical, and common carrier)
• 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.
</td><td>
• Non-preventive visits – like for a sore throat, diabetes checkup, high fever, sore back, etc. – provided by a physician, physician assistant, advanced practice nurse, chiropractor, podiatrist (foot doctor), audiologist (hearing), vision care (eye doctor)…….....…….....…….$3
• Diagnostics only (for example, colonoscopy).$3
• Eyeglasses…….……..…….....…….....$3
• Emergency room visit when it is not an emergency….....$6
• Prescriptions
Brand name……..…..$3
Generic…….....$1
The most you will have to pay in copays for prescriptions is $12 per month. Copays will not be charged for some mental health drugs and most family planning drugs.
</td></tr>
<tr><td colspan="2">If you have Medicare, you must get most of your prescription drugs through a Medicare prescription drug (Medicare Part D) plan. You may have different copays with no monthly limit for some of these services.</td></tr>
</table>

Paying your copays

You must pay your copay to your provider. Most providers require that you pay the copay when you arrive for your appointment. If you see a provider for non-preventive visits, eyeglasses, or non-emergency visits to a hospital emergency room, you will not have to pay more than one copay per day per provider.

If you are unable to pay the copay, the provider must still provide services. Providers must take your word that you cannot pay. Providers cannot ask for documentation to prove that you cannot pay.

A health care provider CANNOT refuse to see you if you say you cannot pay the copay, 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 people do not have copays. You may need to pay a copay until you are listed in our system as a person who is exempt from copays.

Section 7. Covered Services

This section describes the major services that are covered under the Plan for Minnesota Senior Care enrollees. It is not a complete list. Some services have limitations or require a referral or service authorization. Get the referral or service authorization before you get a service. All health 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 copays. A copay is an amount that you will be responsible to pay to your provider. See Section 6 for information about copays and exceptions to copays.

Services or items identified with an asterisk* in the following Benefits table requires a referral or service authorization.

Some services or items require a referral or service authorization and are identified in the benefits table below. In addition to those items identified in the benefits table, the services shown here require authorization.

- Bariatric surgery;
- Orthodontia.

A. CHEMICAL DEPENDENCY SERVICES

COVERED SERVICES:

- Assessment/diagnosis
- Outpatient treatment
- Partial hospitalization
- Inpatient hospital
- Primary residential inpatient stay*
- Outpatient methadone treatment
- Detoxification, if required for medical treatment
- Room and board determined necessary by chemical dependency assessment – starting July 1, 2008*

NOTES:

- See Section 1 for Chemical Dependency Services information on where you should call or write.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

- A qualified Plan network assessor will decide what type of chemical dependency 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 not in the Plan network. 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 Personalized Assistance Line (PAL) 952-883-5811 or 1-888-638-8787 (toll free). If you agree with the second assessment, we will authorize services according to chemical dependency standards and the second assessment. You have the right to appeal. (See Section 13 of this Certificate.)

NOT COVERED SERVICES:

- Extended care and halfway house care are not covered under the Plan, but may be available through the county or tribe through June 30, 2008. Contact your county or tribe for more information.

B. CHIROPRACTIC CARE

COVERED SERVICES:

- Manual manipulation of the spine for subluxation only
- X-rays when needed to get a diagnosis of subluxation of the spine

NOT COVERED SERVICES:

- Other adjustments, vitamins, medical supplies, therapies and equipment
- Exams and consultations
- Office visits that do not include manual manipulation of the spine.

C. DENTAL SERVICES

COVERED SERVICES:

- Routine/preventive services
- Sealants
- X-rays
- Restorative services
  - Oral surgery
  - Fillings
  - Endodontics
  - Periodontics
  - Some partials
  - Some crowns

*Requires a referral or service authorization. Ask your doctor who will direct your care.

- Dentures, with limits
- Implants, only when medically necessary for very limited conditions
- Orthodontia, when medically necessary for very limited conditions*

NOTES:

- See Section 1 for Dental Services contact information.

D. DIAGNOSTIC SERVICES (Lab and X-ray)

COVERED SERVICES:

- Lab tests and X-rays
- Other medical diagnostic tests ordered by your doctor

E. DOCTOR AND OTHER HEALTH SERVICES

COVERED SERVICES:

- Doctor visits
  -family planning - **open access service**
  -gynecological (gyn) service (You have direct access to gyn providers without a referral for the following: annual preventive health exam, including follow-up exams that your doctor says are necessary; evaluation and treatment for gynecologic conditions or emergencies. To get the "direct access" services, you must go to a provider in the Plan network.)
  - lab and x-rays
  - physical exams
  - preventive exams
  - preventive office visits
  - specialists
  - telemedicine consultation
  - vaccines and drugs administered in a doctor's office
  - visits for illness or injury
  - visits in the hospital or nursing home

- Immunizations

- 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; 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 (foot care) services

*Requires a referral or service authorization. Ask your doctor who will direct your 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. (This service starts 60 days after federal approval.)*
- Health education and counseling (e.g. 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
- Treatment for sexually transmitted diseases (STDS) – **open access service**

NOT COVERED SERVICES:

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

F. EMERGENCY MEDICAL SERVICES AND POST-STABILIZATION CARE

COVERED SERVICES:

- Emergency room services
- Post-stabilization care
- Ambulance (air or ground)

NOTES:

- In an emergency that needs treatment right away, either call 911 or go to the closest emergency room. Show them your member card. Ask them to call your primary care doctor.
- In all other cases, call your primary care doctor, if possible. The number is on your member card. The number is answered 24 hours a day, 7 days a week. The doctor will tell you what to do.
- If you are out of town, go to the closest emergency room. Show them your member card and ask them to call your primary care doctor.
- You must call your Primary Care Clinic 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.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

NOT COVERED SERVICES:

- Emergency care or other health care services received from providers located outside the United States and Canada

G. EYE CARE SERVICES

COVERED SERVICES:

- Eye exams
- Eyeglasses, including identical replacement due to damage, loss or theft
- Repairs to frames and lenses for eyeglasses covered under the Plan
- Tints or polarized lenses, when medically necessary
- Contact lenses, when medically necessary under certain conditions

NOT COVERED SERVICES:

- Extra pair of glasses
- Eyeglasses more than every 24 months, unless medically necessary
- Bifocal lenses without lines and progressive bifocals
- Protective coating for plastic lenses
- Contact lenses supplies

H. 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 (birth control pills, patch, ring, IUD, injections, implants) – **open access service**
- Family planning supplies with prescription (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**

*Requires a referral or service authorization. Ask your doctor who will direct your care.

- Treatment for AIDS and other HIV-related conditions – **not** an open access service. You must see a provider in the Plan network.
- Voluntary sterilization (You must be age 21 or older 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.) – **open access service**
- Genetic counseling – **open access service**
- Genetic testing – **not** an open access service. You must see a provider in the Plan network.

NOTES:

- Federal and State law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency to get open access services. You can get open access services from any provider, even if they are not in the Plan network.

NOT COVERED:

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

I. HEARING SERVICES

COVERED SERVICES:

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

J. HOME CARE SERVICES*

COVERED SERVICES:

- Skilled nursing
- Rehabilitation therapies (for example. speech, physical, occupational, respiratory)
- Home health aide
- Private duty nursing
- Personal Care Assistant (PCA) services

*Requires a referral or service authorization. Ask your doctor who will direct your care.

K. HOSPICE *

COVERED SERVICES:

- Doctor, nurse, and other professional services
- Medical social services
- Medical equipment and supplies
- Physical, occupational, and speech therapies
- Short-term inpatient care including respite care
- Counseling, including dietary counseling
- Home health aide and homemaker services
- Outpatient drugs for symptom management and pain relief

NOTES:

- You must elect hospice benefits to receive hospice services.
- If you are interested in hospice services, please call Member Services at the phone number in Section 1

L. 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 (e.g. physical, occupational, speech, respiratory)

NOT COVERED SERVICES:

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

*Requires a referral or service authorization. Ask your doctor who will direct your care.

M. 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

N. INTERPRETER SERVICES

COVERED SERVICES:

- Spoken language interpreter services
- Hearing interpreter services.

NOTES:

- Interpreter services are available to help you get services.
- Oral interpretation is available for any language.
- See Interpreter Services in Section 1 for contact information.

O. MEDICAL EQUIPMENT & SUPPLIES*

COVERED SERVICES:

- Prosthetics or orthotics
- Durable medical equipment (e.g.: wheelchair, hospital bed, walker, crutches, wigs for people with alopecia areata)
- Repairs of medical equipment
- Batteries for medical equipment
- Some shoes when part of a leg brace or custom molded
- Oxygen and oxygen equipment
- Supplies you may need to take care of a medical problem
- Diabetic equipment and supplies
- Nutritional/enteral products
- Incontinence products
- Family planning supplies – **open access services** (See Family Planning Services in Section 7)

*Requires a referral or service authorization. Ask your doctor who will direct your care.

NOTES:

- You need a prescription/doctor's order.
- 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.

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

P. MENTAL HEALTH SERVICES

COVERED SERVICES:

- Adult Mental Health Crisis Services (Non-residential and residential)): assessment, mobile intervention, treatment planning, and stabilization services
- Adult Rehabilitative Mental Health Services (ARMHS): basic living/social skills, community intervention, medication education, and services to help you stay in the community
- Assertive Community Treatment (ACT)
- Consultation between your primary care doctor and a psychiatrist about your care
- Crisis assessment and intervention provided in an emergency room or urgent care setting
- Day treatment and partial hospitalization
- Diagnostic assessment
- Explanation of findings
- Inpatient psychiatric hospital stay
- Intensive Residential Treatment Services (IRTS)*
- Medication management
- Mental health services provided via two-way interactive video, which would otherwise be covered as direct face-to-face services
- Neuropsychological services
- Psychological testing
- Psychotherapy: individual, family, multifamily, and group

*Requires a referral or service authorization. Ask your doctor who will direct your care.

NOTES:

- See Mental Health Services in Section 1 for information on where you should call or write.
- Get mental health services from the Plan network of mental health providers.
- 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 who is not in the Plan network. We will pay for this. To get **assistance selecting** a second opinion, you may call the Personalized Assistance Line (PAL) 952-883-5811 or 1-888-638-8787 (toll free). 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.

NOT COVERED SERVICES:

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

- Treatment at Rule 36 facilities which are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Mental Health Targeted Case Management for persons with serious and persistent mental illness (SPMI) or serious emotional disturbance (SED).

Q. NURSING HOME SERVICES*

COVERED SERVICES:

- Nursing Home Daily Rate – We are responsible for paying a total of 90 days of nursing home room and board. If you need continued nursing home care beyond the 90 days, the Minnesota Department of Human Services (DHS) will pay directly for your care. If DHS is currently paying for your care in the nursing home, DHS, not us, will continue to pay for your care.
- Skilled nursing care
- Therapy services
- Drugs
- Medical supplies and equipment

NOT COVERED SERVICES:

- A private room, unless your doctor orders it for a medical reason
- Personal comfort items, such as TV, phone, barber or beauty services, guest services

*Requires a referral or service authorization. Ask your doctor who will direct your care.

R. OUT-OF-AREA SERVICES

COVERED SERVICES:

- A service you need when you are 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 care or other health care services received from providers located outside the United States and Canada.

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 chemical dependency
- Open access services

T. PRESCRIPTION DRUGS FOR PEOPLE WHO DO NOT HAVE MEDICARE

COVERED SERVICES:

- Prescription drugs
- Medication therapy management (MTM) services
- Certain over-the-counter drugs (when prescribed by a physician).

*Requires a referral or service authorization. Ask your doctor who will direct your care.

NOTES:

- The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor 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 doctor is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.
- 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 anti-psychotic 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.
- Your provider will get an exception to our covered drug list if your provider says you need a drug that is not on the list.
- If a pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. 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 doctor, you can. You can also call Member Services at the phone number in Section 1 for help.

NOT COVERED SERVICES:

- Drugs used to treat impotence
- Drugs used to enhance fertility
- Drugs used to treat hair loss for a cosmetic reason
- Drugs or products to promote weight loss

U. PRESCRIPTION DRUGS FOR PEOPLE WHO HAVE MEDICARE

COVERED SERVICES:

- Benzodiazepines, barbiturates, 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). See NOTES under T in Section 7.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

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 your prescriptions covered by your Medicare prescription drug plan.

NOT COVERED SERVICES:

- Prescription drugs that are covered under the Medicare Prescription Drug Program (Medicare Part D).
- Drugs used to treat impotence
- Drugs used to enhance fertility
- Drugs used to treat hair loss for a cosmetic reason
- Drugs or products to promote weight loss.

V. PREVENTIVE CARE AND SCREENING TESTS

COVERED SERVICES:

- Immunizations
- Age and risk appropriate routine examinations (e.g., physical, vision, and hearing)
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Health education and counseling (e.g., smoking cessation, nutrition counseling, diabetes education)
- Family planning visit - **open access service**
- Bone mass measurement

W. REHABILITATION SERVICES

COVERED SERVICES:

- Physical, occupational, speech, and respiratory therapies; and audiology.*

NOT COVERED SERVICES:

- Vocational rehabilitation
- Health clubs and spas

*Requires a referral or service authorization. Ask your doctor who will direct your care.

X. SURGERY*

COVERED SERVICES:

- Office/clinic visits/surgery
- Port wine stain removal
- Reconstructive surgery (e.g., following mastectomy; following surgery for injury, sickness or other diseases; for birth defects.)
- Anesthesia services
- Circumcision when medically necessary.

NOT COVERED SERVICES:

- Cosmetic surgery
- Sex reassignment surgery

Y. TRANSPLANTS *

COVERED SERVICES:

- Organ and tissue transplants, including: kidney, cornea, bone marrow, stem cell, heart, heart-lung, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, intestine, intestine-liver, and other transplants.

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) be 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).

Z. TRANSPORTATION

COVERED SERVICES:

- Emergency ambulance (air or ground)
- Non-emergency ambulance

*Requires a referral or service authorization. Ask your doctor who will direct your care.

- Special transportation (for people who, because of physical or mental impairment, cannot safely use a common carrier and do not need an ambulance)
- Common carrier transportation (e.g., bus or cab)

NOTES:

- If you need transportation to and from health services that we cover, call the Transportation phone number in Section 1.
- The Plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home. Call the Transportation number at the phone number in Section 1 if you do not have a Primary Care Clinic that is available within 30 miles of your home.

NOT COVERED SERVICES:

- Mileage reimbursement (for example, when you use your own car). This service is not covered under the Plan, but may be available through another source. See Section 9 for information on mileage reimbursement.

AA. URGENT CARE

COVERED SERVICES:

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

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 are.

NOT COVERED SERVICES:

- Emergency care or other health care services received from providers located outside the United States and Canada.

*Requires a referral or service authorization. Ask your doctor who will direct your care.

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 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, guest services
- Cosmetic procedures or treatment
- Experimental or investigative services
- Emergency care or other health care services received from providers located outside the United States and Canada
- Autopsies.

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

These services are not covered by us 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 651-431-2760 or 1-800-657-3739 (toll-free).

- Case management for people with severe emotional disturbance (SED) or serious and persistent mental illness (SPMI);
- Case management for people with developmental disabilities
- Intermediate care facility for people who are mentally retarded (ICF/MR);
- Nursing home stays for which the Plan is not otherwise responsible. See Section 7.
- 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 which 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
- Chemical dependency extended care and halfway house care are not covered under the Plan, but may be available through the county or tribe through June 30, 2008. Contact your county or tribe for information.
- Services provided by federal institutions
- Waiver services provided under Home and Community Based waivers
- Job training and educational services;
- Day training and habilitation

- In certain cases, mileage reimbursement for rides not otherwise covered under the Plan, to get to and from health appointments (for example, in your own car). If you live in the eleven county metro area (Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, or Wright Counties), contact the Minnesota Non-Emergency Transportation Program (MNET) at 1-866-467-1724. If you do not reside in one of these eleven counties, contact your county worker for more information. If MNET expands to other counties, the State will send you a notice.

Section 10. When to Call Your County Worker

Call your county worker to report these changes:

- Name or address changes
- When you are admitted to a nursing home
- Adding or losing a household member
- Lost or stolen Minnesota Health Care Program card
- New insurance or Medicare – begin/end dates
- New job or income 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
- Other 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 payments going to you.
- Help us get payments from your other insurance companies.

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 Minnesota Senior Care 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 people in the Minnesota Senior Care 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 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 Fair Hearing process

If you disagree with a decision or have a complaint, 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 listed under "Appeals and Grievances."
- You can write to the Minnesota Department of Human Services to request a State Fair Hearing. You may request a State Fair Hearing at any time during the Plan grievance or appeal process. You do not have to file a grievance or appeal with us before you request a State Fair Hearing.
- You can call or write to the Minnesota Department of Health.

Timelines for filing grievances, appeals, and State Fair Hearings:

- You must request a State Fair Hearing **within 30 days** of receiving a notice from us. You have up to 90 days if you have a good reason for being late.
- You must file a grievance or appeal with us **within 90 days** of receiving the Notice of Action or from the date of the incident about which you are complaining.
- For the Restricted Recipient Program, an enrollee who receives a notice of restriction must file an appeal within 30 days of getting the notice. You may also request a State Fair Hearing within 30 days of getting the notice. You have up to 90 days if you have a good reason for being late.

Continuation of services:

- If we are stopping or reducing a service, you can keep getting the service if you file a health plan appeal or request a State Fair Hearing **within 10 days after we send you the notice, or before the service is stopped or reduced, whichever is later.** The participating treating provider must agree the service should continue. The service can continue until the appeal or State Fair Hearing is resolved. If you lose the appeal or State Fair Hearing, you may have to pay for these services yourself.

Your Rights:

- If you decide to file a grievance or appeal, or request a State Fair Hearing, it will not affect your eligibility for medical services. It will also not affect your enrollment in the health plan.
- Your provider may file a grievance or appeal, or request a State Fair Hearing, on your behalf. The provider must have your written consent. The treating provider may appeal utilization review decisions with us without your written consent.
- You can have a relative, friend, advocate, provider or lawyer help with your grievance, appeal, or State Fair Hearing.
- You may request a State Fair Hearing at any time during the Plan grievance or appeal process. You do not have to file a grievance or appeal with us before you request a State Fair Hearing.
- There is no cost to you for filing an appeal with us or for a State Fair Hearing. We may pay for some expenses such as transportation, child care, photocopying, etc.
- If you have seen a medical provider who is part of our Plan network and want another opinion, you can get a second opinion. You must see another Plan network medical provider.
- If you have seen a mental health provider who is part of the Plan network and have been told that no structured mental health treatment is needed, you may get a second opinion. See "Mental Health Services" in Section 7 of this Certificate for more information.
- If you have seen a chemical dependency assessor who is part of our Plan network and you disagree with the assessment, you may get a second opinion. See "Chemical Dependency Services" in Section 7 of this Certificate for more information.
- If you ask to see your medical records, or want a copy, your provider or we must provide them to you at no cost. You may need to put your request in writing.

To file an oral grievance with us

A Grievance is an expression of discontent about any matter other than an action. This includes, but is not limited to, discontent with:

- quality of care or services provided
- failure to respect your rights.

1. Call Member Services at the phone number in Section 1 and tell us about the problem.
2. 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.
3. 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.
4. If you do not agree with our decision, you can file a written grievance or appeal with us, request a State Fair Hearing with the Minnesota Department of Human Services, or file a complaint with the Minnesota Department of Health.

To file a written grievance with us

1. Send a letter to us about your grievance. Write to the address listed in Section 1 listed under "Appeals and Grievances."
2. We can help you put your grievance in writing. Call Member Services at the phone number in Section 1 if you need help.
3. We will notify you within 10 days that the grievance has been received.
4. We will give you a written decision within 30 days from the day we get your grievance. 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 30 days that we are taking extra time and the reasons why.
5. 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.
6. If you do not agree with our decision, you can file an appeal with us, request a State Fair Hearing with the Minnesota Department of Human Services or file a complaint with the Minnesota Department of Health.

To file an oral or written appeal with us

An Appeal is your oral or written request for review of our action on a request for services. This includes:

- the denial or limited authorization in the type or level of service;
- the reduction, suspension, or stopping of a service that was approved before;
- the 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.

1. Call Member Services at the phone number in Section 1 and request an oral appeal. Tell us why you disagree with the decision, or
2. Send a letter about your appeal. In the letter, explain why you disagree with the decision. Send the letter to the address in Section 1 listed under "Appeals and Grievances."
3. We can help you write your appeal. Call Member Services at the phone number in Section 1 if you need help.
4. If your appeal is about an urgently needed service we will give you a decision within 72 hours. We will try to call you with the decision before we send the written decision.

5. We will notify you within 10 days that your appeal has been received.
6. We will give you a written decision within 30 days from the day we get your appeal. 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 30 days that we are taking extra time and the reasons why.
7. The person making the decision will not be the same person who was involved in any prior level of review or decision-making.
8. If we are deciding an appeal regarding denial of a service for lack of medical necessity or one that involves clinical issues, the person making the decision will be a health care professional with appropriate clinical expertise in treating the condition or disease.
9. You, or your representative, may present your evidence in person, by telephone or in writing.
10. You, or your representative, may examine the case file, including medical records and any other documents and records considered by us during the appeal process.
11. If you do not agree with our decision, you can request a State Fair Hearing with the Minnesota Department of Human Services.

To file a State Fair Hearing with the Minnesota Department of Human Services

A State Fair Hearing is a hearing at the State to review a decision made by us. You must request a hearing in writing. You may ask for a hearing if you disagree with:

- the delivery of health services;
- enrollment in the Plan;
- denial in full or part of a claim or service;
- our failure to act within required timelines for service authorizations, grievances and appeals; or
- any other action or grievance

You must ask for a State Fair Hearing **within 30 days** of the date of the Notice of Action or the decision in a Plan appeal. You can have up to 90 days to request a State Fair Hearing if you have a good reason for being late.

Write to: Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941
Or fax to: 651-431-7523

1. A Human Services Judge from the State Appeals Office will hold a hearing. You may attend the hearing in person or by telephone.
2. Tell the State why you disagree with the decision made by us.
3. You can ask a friend, relative, advocate, provider, or lawyer to help you.
4. The process can take between 30-90 days. If your hearing is about an urgently needed service, tell the Judge or the Ombudsman when you call or write to them.
5. If your hearing is about a medical necessity denial, you may ask for an expert medical opinion. This will be from an outside reviewer. There is no cost to you.

State Ombudsman for Managed Health Care Programs

A State Ombudsman may be able to help with your problem. They can also help you file a grievance or appeal to us. They can also help you request a State Fair Hearing.

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

Or Call: 651-431-2660 or toll free 1-800-657-3729

To file a complaint with the Minnesota Department of Health

Write to: Minnesota Department of Health
Health Policy and Systems Compliance Division
Managed Care Systems
PO Box 64882
St. Paul, MN 55164-0882

Or Call: 651-201-5100 (Twin Cities metro) or toll free 1-800-657-3916

Section 14. Definitions

These are the meanings of some words in this Certificate of Coverage.

Action: This includes:
- the denial or limited authorization in the type or level of service;
- the reduction, suspension, or stopping of a service that was approved before;
- the 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: Your oral or written request to us for review of an action. This request may also be from your provider acting on your behalf with your written consent. Grievances may be appealed, except where the law requires the decision to be kept private.

Autopsy: An exam that is done on the body of someone who dies. It is done to find out what caused a person's death.

Certificate of Coverage: What the document you are reading is called. This Certificate tells you what services are covered under the Plan. It tells what you must do to get services. It tells your rights and responsibilities. It also tells our rights and responsibilities.

Chemical Dependency: Using alcohol or drugs in a way that harms you.

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: An amount that you are responsible to pay to the provider. Some adult members must pay a part of the provider's charges for some services. Copays are usually paid at the time service is provided. See Section 6 for required copay amounts.

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

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

Durable Medical Equipment: Equipment that can withstand repeated use. It is used for a medical purpose. The equipment must be medically necessary and ordered by a doctor.

Emergency: A condition that needs treatment right away. It is a condition that a prudent person believes needs prompt care, and without prompt care, it could cause: serious physical or mental harm; continuing severe pain; serious damage to body functions, organs, or parts; or death. Labor and childbirth can sometimes be an emergency.

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

Experimental: 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 us. This study is external and independent.

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.

Formulary: The list of drugs covered under the Plan.

Grievance: Expression of discontent about any matter other than an action. This includes, but is not limited to, discontent with:

- quality of care or services provided
- failure to respect your rights.

Home and Community Based Services: Additional home health care services that are provided to help you remain in your home.

Hospice: A special program for members who are terminally ill and not expected to live more than six months. It offers special services for the member and his or her family.

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

Long Term Care Consultation: A review done to find the type and level of services needed.

Medically Necessary: Care that is appropriate for the condition. This includes care related to physical conditions and mental health. It includes the kind and level of service. It includes the number of treatments. It also includes where you get service and how long it continues. Medically necessary care must:

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

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

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

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

Minnesota Senior Care: A program in which the State contracts with health plans to cover and manage health care services for Medical Assistance enrollees age 65 and older.

Network: Our contracted health care providers for the Plan.

Notice of Action: A form or letter we send you telling you about a decision on a claim, a service, or any other action taken by us.

Ombudsman: A person at the Minnesota Department of Human Services who can help you file a grievance or appeal to us or request a State Fair Hearing.

Open Access Services: Federal and State law allow you to choose any physician, 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 which are not at an inpatient level of care. These services may also be available at your clinic or other health facility.

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

Out-of-Network Services: Health care provided to an enrollee by a non-network provider.

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

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

Prescriptions: Medicines and drugs ordered by a medical provider.

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 diabetes checkup) are **not** preventive.

Primary Care Clinic: The clinic you chose for your routine care. This clinic will provide or approve most of your care. The name of your clinic appears on your member card.

Primary Care Provider: The doctor or other health professional you see at your Primary Care Clinic. This person will manage your health care.

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

Referral: Written consent from your primary care provider or clinic that you need to get before you see certain providers, such as specialists, for covered services. Your primary care doctor or clinic must write you a referral.

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 doctor, one drug store, one hospital or other provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs.

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 chemical dependency 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.

Service Authorization: Our approval that is needed for some services before you may get them.

Skilled Nursing Care: Services that can only be done by, or under the supervision of licensed nursing personnel.

Standing Referral: Written consent from your Primary Care Clinic to see a specialist more than one time (for ongoing care).

State Fair Hearing: A hearing at the State to review a decision made by us. You must request a hearing in writing. You may ask for a hearing if you disagree with:

- the delivery of health services;
- enrollment in the Plan;
- denial in full or part of a claim or service;
- failure of the Plan to act within required timelines for service authorizations, grievances and appeals; or
- any other action or grievance

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

United States: For the purpose of this Certificate of Coverage, 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.

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