Member Handbook

January 1 – December 31, 2015

Your Medicare and Medical Assistance (Medicaid) Health, Long Term Care Services and Supports and Drug Coverage as a member of *HealthPartners Minnesota Senior Health Options (MSHO) (SNP)*

This handbook tells you about your coverage under HealthPartners MSHO through December 31, 2015. It explains Medicare and Medical Assistance (Medicaid) health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports. Long-term services and supports help you stay at home instead of going to a nursing home or hospital. **This is an important legal document. Please keep it in a safe place.**

This HealthPartners MSHO plan is offered by HealthPartners. When this *Member Handbook* says "we," "us," or "our," it means HealthPartners. When it says "the plan" or "our plan," it means HealthPartners MSHO.

You can get this handbook for free in other languages. Call us at 952-967-7029 or 888-820-4285, TTY/TDD 952-883-6060 or 800-443-0156, October 1 through February 14, 8 a.m. to 8 p.m., seven days a week, February 15 to September 30, 8 a.m. to 8 p.m. Monday – Friday. The call is free.

You can ask for this handbook in other formats, such as Braille or large print. Call us at 952-967-7029 or 888-820-4285, TTY/TDD 952-883-6060 or 800-443-0156, October 1 through February 14, 8 a.m. to 8 p.m., seven days a week, February 15 to September 30, 8 a.m. to 8 p.m. Monday – Friday.

Disclaimers

HealthPartners is a health plan that contracts with both Medicare and the Minnesota Medical Assistance Program (Medicaid) to provide benefits of both programs to enrollees. Enrollment in HealthPartners depends on contract renewal.

Limitations, copays and restrictions may apply. For more information, call HealthPartners MSHO Member Services or read the HealthPartners MSHO Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have HealthPartners MSHO pay for your services.

Benefits, List of Covered Drugs, and pharmacy and provider networks, and/or co-payments may change from time to time throughout the year and on January 1 of each year.

Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.

HealthPartners will accept all eligible people who choose our plan. We will not discriminate in regard to your physical or mental condition, health status, need for or receipt of health services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation, national origin, race, color, religion, or political beliefs. Our plan will not use any policy or practice that has the effect of such discrimination.

Attention. If you need free help interpreting this document, call 952-967-7029 or 1-888-820-4285.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم 952-967-7029 أو 1-888-820-4285.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅតាមទូរស័ព្ទមកលេខ 952-967-7029 ឬ 1-888-820-4285 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite 952-967-7029 ili 1-888-820-4285.

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 952-967-7029 los sis 1-888-820-4285.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ 952-967-7029 ຫຼື 1-888-820-4285.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsi bilbiltu 952-967-7029 ykn 1-888-820-4285.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по телефону 952-967-7029 или 1-888-820-4285.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, wac 952-967-7029 ama 1-888-820-4285.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al 952-967-7029 o al 1-888-820-4285.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số 952-967-7029 hoặc 1-888-820-4285.

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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 enrollees 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.

This information is available in other forms to people with disabilities by calling 952-967-7029 (voice) or 888-820-4285 (toll free), 952-883-6060 (TTY), 800-443-0156 (toll free TTY), 7-1-1, or through the Minnesota Relay direct access numbers at 800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 877-627-3848 (speech to speech relay service).

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Chapter 1: Getting started as a member

Table of Contents

A. Welcome to HealthPartners MSHO

HealthPartners MSHO is a Medicare Advantage Plan Special Needs Plan. A Special Needs Plan has a network made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

HealthPartners MSHO was approved by the State and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Minnesota Senior Health Options (MSHO).

MSHO is a demonstration program jointly run by Minnesota and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you receive your Medicare and Medicaid health care services.

B. What are Medicare and Medicaid?

Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. In Minnesota, Medicaid is called Medical Assistance.

Each state decides what counts as income and resources and who qualifies. They also decide what services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Minnesota must approve HealthPartners MSHO each year. You can get Medicare and Medical Assistance (Medicaid) services through our plan as long as:

- we choose to offer the plan, and
- Medicare and the State approve the plan.

If you have questions, please call HealthPartners MSHO Member Services at 952-967-7029 or 888-820-4285, TTY/TDD 952-883-6060 or 800-443-0156, **October 1 through February 14**, 8 a.m. to 8 p.m. **seven days a week, February 15 to September 30**, 8 a.m. to 8 p.m. **Monday - Friday**. The call is free. **For more information**, visit **healthpartners.com/msho**.

Even if our plan stops operating in the future, your eligibility for Medicare and Medical Assistance (Medicaid) services would not be affected.

C. What are the advantages of this plan?

You will now get all your covered Medicare and Medical Assistance (Medicaid) services from HealthPartners MSHO, including prescription drugs. You do not pay extra to join this health plan.

HealthPartners MSHO will help make your Medicare and Medical Assistance (Medicaid) benefits work better together and work better for you. Some of the advantages include:

- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a care coordinator. This is a person who works with you, with HealthPartners MSHO, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and care coordinator.
- The care team and care coordinator will work with you to come up with a care plan specifically designed to meet your health needs. The care team will be in charge of coordinating the services you need. This means, for example:
  - » Your care team will make sure your doctors and other providers know about all medicines you take so they can reduce any side effects.
  - » Your care team will make sure your test results are shared with all your doctors and other providers.

D. What is HealthPartners MSHO's service area?

Our service area includes these counties in Minnesota: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington and Wright.

Only people who live in our service area can get HealthPartners MSHO.

If you move outside of our service area, you cannot stay in this plan.

E. What makes you eligible to be a plan member?

You are eligible for our plan as long as:

- you live in our service area, ***and***
- you have both Medicare Part A and Medicare Part B, ***and***
- you are eligible for Medical Assistance (Medicaid) ***and***
- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated, ***and***
- you are age 65 or over.

F. What to expect when you first join a health plan

When you first join the plan, you will receive a health risk assessment within the first 30 days.

If HealthPartners MSHO is new for you, you can keep seeing the doctors you go to now for up to 120 days for certain reasons. For more information, see Chapter 3, section B, page 4.

After 120 days you will need to see doctors and other providers in the HealthPartners MSHO network. *A network provider is a provider who works with the health plan.* See Chapter 3, section B, page 4 for more information on getting care.

G. What is a care plan?

A *care plan* is the plan for what health services you will get and how you will get them.

After your health risk assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make a care plan.

Every year, your care team will work with you to update your care plan when the health services you need and want change.

H. Does HealthPartners MSHO have a monthly plan premium?

No.

I. About the Member Handbook

This *Member Handbook* is part of our contract with you. The Member Handbook is the name now being used for the document that was called the Evidence of Coverage in the past. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, section 5, page 10 or call 1-800-MEDICARE (1-800-633-4227).

The contract is in effect for the months you are enrolled in HealthPartners MSHO between January 1, 2015 and December 31, 2015.

J. What other information will you get from us?

You should have a HealthPartners MSHO member ID card, a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*.

Your HealthPartners MSHO member ID card

Under our plan, you will have one card for your Medicare and Medical Assistance (Medicaid) services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:

If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medical Assistance (Medicaid) card to get services. Keep those cards in a safe place, in case you need them later.

If you have questions, please call HealthPartners MSHO Member Services at 952-967-7029 or 888-820-4285, TTY/TDD 952-883-6060 or 800-443-0156, **October 1 through February 14**, 8 a.m. to 8 p.m. **seven days a week, February 15 to September 30**, 8 a.m. to 8 p.m. **Monday - Friday**. The call is free. **For more information**, visit **healthpartners.com/msho**.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the HealthPartners MSHO network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page 7).

➔ You can request an annual *Provider and Pharmacy Directory* by calling Member Services at 952-967-7029 or 888-820-4285.

Call Member Services at 952-967-7029 or 888-820-4285 for more information or to get a copy of the *Provider and Pharmacy Directory.* You can also see the *Provider and Pharmacy Directory* at **healthpartners.com/msho**, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network pharmacies and providers.

What are "network providers"?

- Network providers are doctors, nurses, and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities, and other places that provide health services in our plan. They also include home health agencies, medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.
- Network providers have agreed to accept payment from our plan and cost sharing for covered services as payment in full.

What are "network pharmacies"?

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by HealthPartners MSHO.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5, section C, page 10 for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit **healthpartners.com/msho** or call 952-967-7029 or 888-820-4285.

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or *EOB*).

The *Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services.

K. How can you keep your membership record up to date?

You can keep your membership record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- If you have any liability claims, such as claims from an automobile accident
- If you are admitted to a nursing home or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study

If any information changes, please let us know by calling Member Services at 952-967-7029 or 888-820-4285.

In addition, call your county worker to report these changes:

- Name or address changes
- Admission to a nursing home
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID Card
- New insurance (*provide begin and end dates)*
- New job or change in income

Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see Chapter 8, section D, page 5.

Chapter 2: Important phone numbers and resources

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A. How to contact HealthPartners MSHO Member Services

CALL	Local: 952-967-7029 Outside the metro area: 888-820-4285 This call is free. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day. We have free interpreter services for people who do not speak English.
TTY	Local: 952-883-6060 Outside the metro area: 800-443-0156 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.
FAX	952-883-7333

WRITE	HealthPartners Member Services MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 Or deliver in person to: HealthPartners Member Services 8170 33rd Avenue South Bloomington, MN 55425
WEBSITE	**healthpartners.com/msho**

Contact Member Services about:

- **Questions about the plan**
- **Questions about claims, billing or member cards**
- **Coverage decisions about your health care**

  A coverage decision about your health care is a decision about:

  » your benefits and covered services, ***or***

  » the amount we will pay for your health services.

  Call us if you have questions about a coverage decision about health care.

  ➔ To learn more about coverage decisions, see Chapter 9, section 5, page 10.

- **Appeals about your health care**

  An *appeal* is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

  ➔ To learn more about making an appeal, see Chapter 9, section 5, page 10.

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FAX	952-853-8742

WRITE	HealthPartners Member Rights & Benefits MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 Or deliver in person to: HealthPartners Member Services 8170 33rd Avenue South Bloomington, MN 55425
WEBSITE	**healthpartners.com/msho**

- **Complaints about your health care**

  You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section F below).

  - If your complaint is about a coverage decision about your health care, you can make an appeal (see the section above).
  - You can send a complaint about HealthPartners MSHO right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - To learn more about making a complaint about your health care, see Chapter 9, section 10, page 45.

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WEBSITE	**healthpartners.com/msho**

- **Coverage decisions about your drugs**

  A coverage decision about your drugs is a decision about:

  » your benefits and covered drugs, ***or***

  » the amount we will pay for your drugs.

  This applies to your Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs.

  ➔ For more on coverage decisions about your prescription drugs, see Chapter 9, section 6.4, page 25.

CALL	Call us at: Local: 952-967-7029 Outside the metro area: 888-820-4285 This call is free. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day. We have free interpreter services for people who do not speak English.
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FAX	888-883-5434 On weekends, do not use the fax number; use the telephone number instead.

WRITE	HealthPartners Pharmacy Administration Department MS 22205A P.O. Box 1309 Minneapolis, MN 55440-1309 Or deliver in person to: HealthPartners Member Services 8170 33rd Avenue South Bloomington, MN 55425
WEBSITE	**healthpartners.com/msho**

- **Appeals about your drugs**

  An *appeal* is a way to ask us to change a coverage decision.

  ➔ For more on making an appeal about your prescription drugs, see Chapter 9, section 6.5, page 28.

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WEBSITE	**healthpartners.com/msho**

- **Complaints about your drugs**

  You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.

  If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. *(See the section above.)*

You can send a complaint about HealthPartners MSHO right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

➔ For more on making a complaint about your prescription drugs, see Chapter 9, section 10, page 45.

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WEBSITE	**healthpartners.com/msho**

- **Payment for health care or drugs you already paid for**
  - For more on how to ask us to pay you back, or to pay a bill you have gotten, see Chapter 7, section B, page 3. We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the phone number printed on the bottom of the page.
  - If we deny any part of your request, you can appeal our decision. See Chapter 9, section 6.6, page for more on appeals.

CALL	Local: 952-967-7029 Outside the metro area: 888-820-4285 This call is free. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day. We have free interpreter services for people who do not speak English.

TTY	Local: 952-883-6060 Outside the metro area: 800-443-0156 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.
WRITE	HealthPartners Member Services MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 Or deliver in person to: HealthPartners Member Services 8170 33rd Avenue South Bloomington, MN 55425
WEBSITE	**healthpartners.com/msho**

B. How to contact your Care Coordinator

A care coordinator is a Registered Nurse or Licensed Social Worker who provides a free and confidential service to you. You will be contacted by your care coordinator shortly after you enroll. Your care coordinator will schedule a time to meet you and complete a health risk assessment and make a plan for how you can work together and be supported. Your care coordinator will discuss with you the results of your health risk assessment and any supports and/or services you or your caregiver(s) may need. Your care coordinator will help arrange

the supports and services identified in your plan. They will also work with your doctors and care team to help you self-manage your chronic health conditions and reach your health care goals. Your care coordinator will also follow up with you at least once a year to complete another health risk assessment to see how you are doing and to update your plan if your needs have changed.

You will be given your care coordinator's telephone number so you can contact him or her for questions and assistance. You may also call Member Services and ask to speak to your care coordinator. If at any time you would like to work with a different care coordinator, please call (952) 883-6983 and ask to speak with a Supervisor.

CALL	Local: 952-967-7029 Outside the metro area: 888-820-4285 This call is free. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day. We have free interpreter services for people who do not speak English.
TTY	Local: 952-883-6060 Outside the metro area: 800-443-0156 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

FAX	952-883-7333
WRITE	HealthPartners Member Services MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 Or deliver in person to: HealthPartners Member Services 8170 33rd Avenue South Bloomington, MN 55425
WEBSITE	**healthpartners.com/msho**

Contact your care coordinator about:

- **Questions about your health care**
- **Questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)**

  You must have a Long-Term Care Consultation (LTCC) done and be found to be eligible to get additional services or support. You can request to have this assessment in your home, apartment, or facility where you live.

  Your care coordinator will meet with you and your family to talk about your care needs if you call to ask for a visit.

  Your care coordinator will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility.

  Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

  » Skilled nursing care
  » Physical therapy
  » Occupational therapy

» Speech therapy
» Medical social services
» Home health care

C. How to contact the CareLine℠

A registered nurse will assess your symptoms and recommend the most appropriate level of care (convenience care, urgent care, emergency room, or home treatment options.)

CALL	Call CareLine℠ at: Local: 612-339-3663 Outside the metro area: 800-551-0859 This call is free. Nurses are available 24/7, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	Local: 952-883-5474 Outside the metro area: 800-983-5474 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Nurses are available 24/7, 365 days a year.

Contact the CareLine℠ about:

- **Questions about your health care**

D. How to contact the Behavioral Health Navigators

CALL	Local: 952-883-5811 Outside the metro area: 888-638-8787 This call is free. Behavioral Health Navigators are available 8 a.m. – 5:30 p.m. **Monday through Friday**. We have free interpreter services for people who do not speak English.
TTY	Local: 952-883-6060 Outside the metro area: 800-443-0156 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Behavioral Health Navigators are available 8 a.m. – 5:30 p.m. **Monday through Friday**.

Contact the Behavioral Health Navigators about:

- **Questions about your health care**

E. How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Minnesota, the SHIP is called the Senior Linkage Line.®

The Senior Linkage Line is not connected with any insurance company or health plan.

CALL	1-800-333-2433
TTY	Call the Minnesota Relay Service at 711.

If you have questions, please call HealthPartners MSHO Member Services at 952-967-7029 or 888-820-4285, TTY/TDD 952-883-6060 or 800-443-0156, **October 1 through February 14**, 8 a.m. to 8 p.m. **seven days a week, February 15 to September 30**, 8 a.m. to 8 p.m. **Monday - Friday**. The call is free. **For more information**, visit **healthpartners.com/msho**.

WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
WEBSITE	www.mnaging.org

Contact the Senior Linkage Line about:

- **Questions about your Medicare health insurance**

  Senior Linkage Line counselors can:

  » help you understand your rights,

  » help you understand your plan choices,

  » answer your questions about changing to a new plan,

  » help you make complaints about your health care or treatment, ***and***

  » help you straighten out problems with your bills.

F. How to contact the Quality Improvement Organization (BFCC-QIO)

Our state has an organization called KEPRO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KEPRO is not connected with our plan.

CALL	(855) 408-8557
TTY	(855) 843-4776 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	www.keproqio.com

If you have questions, please call HealthPartners MSHO Member Services at 952-967-7029 or 888-820-4285, TTY/TDD 952-883-6060 or 800-443-0156, **October 1 through February 14**, 8 a.m. to 8 p.m. **seven days a week, February 15 to September 30**, 8 a.m. to 8 p.m. **Monday - Friday**. The call is free. **For more information**, visit **healthpartners.com/msho**.

Contact KEPRO about:

- **Questions about your health care**

  You can make a complaint about the care you have received if:

  » You have a problem with the quality of care,

  » You think your hospital stay is ending too soon, ***or***

  » You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

WEBSITE	http://www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting "Help & Resources" and then clicking on "Phone numbers & websites." The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Find health & drug plans." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

H. How to contact Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. In Minnesota, the Medicaid program is called Medical Assistance. To find out more about Medical Assistance and its programs, contact the Minnesota Department of Human Services.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the Minnesota Department of Human Services

CALL	(651) 431-2670 (Twin Cities Metro area) or (800) 657-3739 (Outside the Twin Cities Metro area)
TTY	(800) 627-3529 or 711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Department of Human Services of Minnesota 444 Lafayette Road North St. Paul, MN 55155
WEBSITE	www.dhs.state.mn.us/healthcare

I. How to contact the Ombudsman for State Managed Health Care Programs

The Ombudsman for State Managed Health Care Programs helps people enrolled in Medicaid with service or billing problems. They can help you file a complaint or an appeal with our plan. The Ombudsman can also help you request a state fair hearing.

CALL	(651) 431-2660 (Twin Cities Metro area) or (800) 657-3729 (Outside Twin Cities Metro area)
TTY	(800) 627-3529 or 711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	MN Department of Human Service Ombudsman for State Managed Health Care Programs PO Box 64249 St. Paul, MN 55164-0249

WEBSITE	http://www.dhs.state.mn.us/managedcareombudsman

J. How to contact the Minnesota Office of Ombudsman for Long Term Care

The Minnesota Office of Ombudsman for Long Term Care helps people learn about nursing homes and other long-term care settings. It also helps solve problems between these settings and residents or their families.

CALL	(651) 431-2555 (Twin Cities Metro area) or (800) 657-3591 (Outside Twin Cities Metro area)
TTY	(800) 627-3529 or 711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Minnesota Office of Ombudsman for Long Term Care PO Box 64971 St. Paul, MN 55164-0971
EMAIL	mba.ooltc@state.mn.us
WEBSITE	www.mnaging.org/advocate/oltc.aspx

K. Other resources

How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	http://www.rrb.gov

Chapter 3: Using the plan's coverage for your health care and other covered services

Table of Contents

A. About "services," "covered services," "providers," and "network providers"

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4, section D, page 5.

Providers are doctors, nurses, and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan**.** These providers have agreed to accept our payment and your cost sharing amount as full payment. Network providers bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for covered services.

B. Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan

HealthPartners MSHO covers all services covered by Medicare and Medical Assistance (Medicaid). This includes behavioral health, long term care and prescription drugs.

HealthPartners MSHO will generally pay for the health care and services you get if you follow the plan rules. To be covered:

- The care you get must be a **plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, section D, page 5 of this handbook).
- The care must be **medically necessary.** *Medically necessary* describes the services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.

  Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

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

- You must have a network **primary care provider (PCP)** who has ordered the care or has told you to see another doctor**.** As a plan member, you must choose a network provider to be your PCP.
  - » In most cases, your network PCP must give you approval before you can use other providers in the plan's network. This is called a **referral**. To learn more about referrals, see page 6.
  - » You do not need a referral from your PCP for emergency care or urgently needed care or to see a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page 7.

  ➔ To learn more about choosing a PCP, see page 6.

- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - » The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page 10.
  - » If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to see an out-of-network provider, see page 9.
  - » The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
  - » When you first join the plan, you can continue seeing the providers you see now for up to 120 days for the following reasons:
    - An acute condition
    - A life-threatening mental or physical illness

- 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.

» An exception is made for family planning, which is an open access service covered by us through Medical Assistance (Medicaid). Federal and state law let you choose any provider, even if not in our network, to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. For more information see the "Family Planning Services" section of the benefits chart in Chapter 4.

C. Your care coordinator

A care coordinator is a Registered Nurse or Licensed Social Worker who provides a free and confidential service to you. You will be contacted by your care coordinator shortly after you enroll. Your care coordinator will schedule a time to meet you and complete a health risk assessment and make a plan for how you can work together and be supported. Your care coordinator will discuss with you the results of your health risk assessment and any supports and/or services you or your caregiver(s) may need. Your care coordinator will help arrange the supports and services identified in your plan. They will also work with your doctors and care team to help you self-manage your chronic health conditions and reach your health care goals. Your care coordinator will also follow up with you at least once a year to complete another health risk assessment to see how you are doing and to update your plan if your needs have changed.

You will be given your care coordinator's telephone number so you can contact him or her for questions and assistance. You may also call Member Services and ask to speak to your care coordinator. If at any time you would like to work with a different care coordinator, please call (952) 883-6983 and ask to speak with a Supervisor.

D. Getting care from primary care providers, specialists, other network providers, and out-of-network providers

Getting care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

What is a "PCP," and what does the PCP do for you?

When you become a member of our plan, you must choose a plan provider to be your PCP. Your PCP is a physician, nurse practitioner or physician's assistant who meets state requirements and is trained to give you basic medical care. You will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our plan. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care.

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. You must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 8 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose your PCP?

When you enroll in our Plan, you need to select a clinic. You need to receive care from a PCP who is located at your clinic. You can choose a PCP by using the *Provider Directory* or getting help from Member Services. You need to communicate to HealthPartners which PCP you choose on your application form. If there is a particular plan specialist or hospital that you want to use, check first to be sure your PCP uses that specialist or hospital. You can change your PCP, as explained under the heading "How you switch to another PCP?" later in this section. The name and office telephone number of your PCP is printed on your membership card.

Changing your PCP

You may change your PCP for any reason, at any time. Sometimes a network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our plan. Member Services can assist you in finding and selecting another provider within our network. When you have decided on a new provider, Member Services

will forward the information to our enrollment department. They will update your member record and a new member card will be sent to you. In most cases your new provider will be effective on the first day of the month following the date the request is received by our enrollment department. Please review the card to verify that the provider listed on the new member card is the one you chose.

Services you can get without first getting approval from your PCP

In most cases, you will need approval from your PCP before seeing other providers. This approval is called a **referral.** You can get services like the ones listed below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to network providers (for example, when you are outside the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
- Flu shots, hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are eligible to receive services from Indian health providers, you may see these providers without a referral.

How to get care from specialists and other network providers

A *specialist* is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- *Oncologists* care for patients with cancer.
- *Cardiologists* care for patients with heart problems.
- *Orthopedists* care for patients with bone, joint, or muscle problems.

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 (on-going) condition;
- A life-threatening mental or physical illness;
- 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 written referral when needed, the bill may not be paid. For more information, call Member Services at the phone number printed on the bottom of the page.

What if a network provider leaves our plan?

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. For more information, call Members Services at the phone number printed on the bottom of the page.

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 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 printed on the bottom of the page.

How to get care from out-of-network providers

Out-of-network providers are providers that are not part of the network. If you use out-of-network providers, we may not cover your services. We cover certain health care services that you get from non-network providers. These include care for a medical emergency, including hospital care after you are stable (known as post-stabilization), maintenance care, urgently needed care when you are temporarily out of the service area, care that has been approved in advance by HealthPartners and any services which were determined to be covered through an appeals process.

The exceptions to this rule are when you need urgent or emergency care or dialysis and cannot get to a provider in the plan, such as when you are away from home. You can also go outside the plan for other nonemergency services if HealthPartners MSHO gives you permission first.

An authorization for out of network services must be approved prior to receiving services. If you have questions regarding obtaining an authorization, you may contact your primary care provider or call Member Services.

➔ **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medical Assistance (Medicaid). We cannot pay a provider who is not eligible to participate in Medicare and/or Medical Assistance (Medicaid). If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

E. How to get long-term services and supports (LTSS)

Members have access to Long Term Supports and Services through their Care Coordinator. Together with their Care Coordinator, member's complete a Health Risk Assessment to identify their individual needs. Collaboratively the member and Care Coordinator create an individualized care plan that will support the identified needs of the member. Care Coordinators proceed with coordinating the Long Term Supports and Services to support the member's identified needs and care plan goals. Members may call their Care Coordinator or Member Services to request LTSS.

F. How to get behavioral health services

Members can contact Member Services or Behavioral Health Navigator for assistance in finding a network behavioral health provider. If you know who you want as a provider and need an authorization, you must call HealthPartners Behavioral Health Triage line at 952-883-7501.

G. How to get transportation services

If you need transportation to and from health services that we cover, call 952-883-7400 or 888-288-1439 (toll free). We will provide the most appropriate and cost-effective transportation. We are not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a Specialty provider that is more than 60 miles from your home. Call 952-883-7400 or 888-288-1439 (toll free) if you do not have a primary care clinic that is available within 30 miles of your home and/or if it is over 60 miles to your specialty provider.

H. How to get covered services when you have a medical emergency or urgent need for care

Getting care when you have a medical emergency

What is a medical emergency?

A *medical emergency* is a medical condition recognizable by symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or any prudent layperson with an average knowledge of health and medicine could expect it to result in:

- placing the person's health in serious risk; ***or***
- serious harm to bodily functions; ***or***
- serious dysfunction of any bodily organ or part.

What should you do if you have a medical emergency?

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours, at the phone number on the back of the plan member card.

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4, section D, page 5. If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What if it wasn't a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your additional care *only* if:

- you go to a network provider, ***or***

- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Getting urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only* if:

- you get this care from a network provider, ***and***
- you follow the other rules described in this chapter.

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

For urgent care needs during clinic hours, please call your clinic. For urgent care after your clinic's regular hours, you have several options:

- Call your clinic's after-hours line, if one is available
- Call the CareLine℠ at 612-339-3663 or 800-551-0859 to speak to a registered nurse
- Visit any urgent care clinic that's in your *Provider and Pharmacy Directory*.

Getting urgently needed care when you are outside the plan's service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

➔ Our plan does not cover urgently needed care or any other care that you get outside the United States.

I. What if you are billed directly for the full cost of services covered by our plan?

We cannot pay you back for most medical bills that you pay. State and federal laws prevent us from paying you directly. The exception is if you pay for Part D prescription drugs. If you

paid for a service that you think we should have covered, contact Member Services at the phone number printed on the bottom of the page.

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay our share of the bill.

➔ You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If you have paid more than your share for Medicare Part D drugs or if you have gotten a bill for the full cost of covered medical services, see Chapter 7, section A, page 1 to learn what to do.

What should you do if services are not covered by our plan?

Our plan covers all medical services that are medically necessary, are listed in the plan's Benefits Chart, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

HealthPartners MSHO covers all services:

- that are medically necessary, ***and***
- that are listed in the plan's Benefits Chart (see Chapter 4, section D, page 5)*, **and***
- that you get by following plan rules.

➔ If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

Some services are covered up to a certain limit. If you go over the benefit limit, you will have to pay the full cost to get more of that type of service. See Chapter 4 for specific benefit limits. Call Member Services to find out what the limits are and how close you are to reaching them.

J. How are your health care services covered when you are in a clinical research study?

What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

If you volunteer for a clinical research study, we will pay any costs if Medicare approves the study. If you are part of a study that Medicare has *not* approved, **you will have to pay any costs for being in the study**.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

If you are in a Medicare-approved clinical research study, Medicare pays for most of the covered services you get. While you are in the study, you may stay enrolled in our plan. That way you continue to get care not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers.

You do need to tell us before you start participating in a clinical research study.
Here's why:

- We can tell you if the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your care coordinator should contact Member Services.

When you are in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.

- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

Medicare pays most of the cost of the covered services you get as part of the study. After Medicare pays its share of the cost for these services, our plan will also pay for the rest of the costs.

Learning more

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (http://www.medicare.gov/publications/pubs/pdf/02226.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

K. How are your health care services covered when you are in a religious non-medical health care institution?

What is a religious non-medical health care institution?

A *religious non-medical health care institution* is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is any care that is *not* voluntary and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to *non-religious* aspects of care.
- Our plan will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following applies:
  - » You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - » You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply for this benefit, see Chapter 4 *Benefits chart (what is covered and what you pay)*.

L. Rules for owning durable medical equipment

Will you own your durable medical equipment?

Durable medical equipment means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

You will always own certain items, such as prosthetics. In this section, we discuss durable medical equipment you must rent.

In Medicare, people who rent certain types of durable medical equipment own it after 13 months. As a member of HealthPartners MSHO, however, you usually will not own the rented equipment, no matter how long you rent it.

In certain situations, we will transfer ownership of the durable medical equipment item. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

What happens if you switch to Medicare?

You will have to make 13 payments in a row under Original Medicare to own the equipment if:

- you did not become the owner of the durable medical equipment item while you were in our plan ***and***
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the item.

➔ There are no exceptions to this case when you return to Original Medicare.

Chapter 4: Benefits Chart

Table of Contents

A. Understanding your covered services

This chapter tells you what services HealthPartners MSHO covers. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5. This chapter also explains limits on some services.

Because you get assistance from Medical Assistance (Medicaid), you pay nothing for your covered services as long as you follow the plan's rules. See Chapter 3, section B, page 3 for details about the plan's rules.

If you need help understanding what services are covered, call your care coordinator *and/or* Member Services at 952-967-7029 or 888-820-4285.

B. Our plan does not allow providers to charge you for services

We do not allow HealthPartners MSHO providers to bill you for services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

➔ **You should never get a bill from a provider. If you do, see Chapter 7.**

C. About the Benefits Chart

This benefits chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services.

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Medical Assistance (Medicaid) covered services must be provided according to the rules set by Medicare and Medical Assistance (Medicaid).

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

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

- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can see other network providers. This is called a referral. Chapter 3, section D, page 6 has more information about getting a referral and explains when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization ***or***

service authorization. Covered services that need approval first are marked in the Benefits Chart by an asterisk (*).

All preventive services are free. You will see this apple 🍎 next to preventive services in the benefits chart.

Restricted Recipient Program

The Restricted Recipient Program is a program for members who have misused health services. This includes receiving 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 in your local trade area, one pharmacy, one hospital or other designated health services provider. You must do this for at least 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 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). You must get a referral from your primary care provider, and your Restricted Recipient Case Manager must be notified if you need to see a provider who is not a designated provider. 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 Chapter 9. The Restricted Recipient Program does not apply to Medicare-covered services.

D. The Benefits Chart

Services that our plan pays for	What you must pay
Abdominal aortic aneurysm screening The plan will pay once for an ultrasound screening for people at risk. You must get a referral for it at your "Welcome to Medicare" preventive visit. We may cover additional screenings if medically necessary.	$0
Alcohol misuse screening and counseling The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.	$0
Ambulance services Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are *not* emergencies, the plan *may* pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0

Services that our plan pays for	What you must pay
Annual wellness visit If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months. **Note**: You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first.	$0
Bone mass measurement The plan will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will pay for the services once every 24 months or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.	$0
Breast cancer screening (mammograms) The plan will pay for the following services: ▪ One screening mammogram every 12 months ▪ Clinical breast exams once every 24 months We may cover additional services if medically necessary.	$0
Cardiac (heart) rehabilitation services The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's order. The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0

Services that our plan pays for	What you must pay
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: ▪ discuss aspirin use, ▪ check your blood pressure, or ▪ give you tips to make sure you are eating well. We may cover additional visits if medically necessary.	$0
Cardiovascular (heart) disease testing The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. We may cover additional tests if medically necessary.	$0
Care Coordination The plans pays for care coordination services, including the following: ▪ Assisting you in arranging for, getting, and coordinating assessments, tests and health and continuing care services ▪ Developing and updating your care plan ▪ Communicating with a variety of agencies and persons ▪ Other services as outlined in your care plan	$0

Services that our plan pays for	What you must pay
Cervical and vaginal cancer screening The plan will pay for the following services: ▪ For all women: Pap tests and pelvic exams once every 24 months ▪ For women who are at high risk of cervical cancer: one Pap test every 12 months ▪ For women who have had an abnormal Pap test: one Pap test every 12 months We may cover additional services if medically necessary.	$0
Chiropractic services The plan will pay for the following services: ▪ One evaluation or exam per year ▪ Adjustments of the spine to correct alignment – up to 24 visits per year – service authorization may be required for visits exceeding 24 visits. ▪ Acupuncture for chronic pain management 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	$0
Colorectal cancer screening The plan will pay for the following services: ▪ Flexible sigmoidoscopy (or screening barium enema) every 48 months ▪ Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months.	$0

Services that our plan pays for	What you must pay
For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy). We may cover additional screenings if medically necessary.	
Dental services HealthPartners MSHO will pay for the following services: Diagnostic services including: ▪ Comprehensive exam once every five years ▪ Periodic exam once per calendar year ▪ Limited (problem-focused) exams once per day per provider ▪ X-rays, limited to: » bitewing x-rays once per calendar year » single x-rays for diagnosis of problems » panoramic x-rays 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 Surgical Center (ASC) Preventive services including: ▪ Cleaning once per calendar year up to four times per year if medically necessary (upon federal approval) ▪ Fluoride varnish once per calendar year Restorative services including: ▪ Fillings ▪ Sedative fillings for relief of pain	$0

Services that our plan pays for	What you must pay
Endodontics (root canals) on anterior teeth and premolars only and once per lifetime; retreatment is not covered Periodontics including: ▪ 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 Surgical Center (ASC) Prosthodontics including: ▪ Removable prostheses (dentures and partials)(once every six years per dental arch ▪ Relines, repairs and rebases of removable prostheses (dentures and partials) 180 days immediately following the prosthesis ▪ Replacement of prostheses that are lost, stolen, or damaged beyond repair under certain circumstances ▪ Replacement of partial prostheses if the existing partial prosthesis cannot be altered to meet dental needs Oral surgery (limited to extractions, biopsies and incision and drainage of abscesses) Additional general services including: ▪ Treatment for pain once per day ▪ General anesthesia only when provided in an outpatient hospital or freestanding Ambulatory Surgical Center (ASC) ▪ Extended care facility/house call in certain institutional settings. These include: nursing facilities, skilled nursing facilities, boarding care homes, IMDs (Institutes of Mental Disease/Mental Illness), ICF/DDs (Intermediate Care Facilities for Persons with Developmental Disabilities), hospices, METO (Minnesota Extended Treatment Options), and swing beds (a nursing facility bed in a hospital)	

Services that our plan pays for	What you must pay
▪ Behavioral management when necessary to ensure that a covered dental service is correctly and safely performed ▪ Oral or IV sedation Additional item(s) covered by us through Medicare: ▪ Periodic exam (one additional per calendar year) ▪ Cleaning (one additional per calendar year) ▪ Adult fluoride (one additional per calendar year) ▪ Porcelain crowns are covered up to an annual maximum of $2,000 ▪ Endodontics (Root Canals) on molars ▪ Periodontal maintenance as prescribed by your dentist ▪ Denture services – tissue conditioning	
Depression screening The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals. We may cover additional screenings if medically necessary.	$0
Diabetes screening The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: ▪ High blood pressure (hypertension) ▪ History of abnormal cholesterol and triglyceride levels (dyslipidemia) ▪ Obesity ▪ History of high blood sugar (glucose)	$0

Services that our plan pays for	What you must pay
Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months We may cover additional screenings if medically necessary.	
Diabetic self-management training, services, and supplies The plan will pay for the following services for all people who have diabetes (whether they use insulin or not): ▪ Supplies to monitor your blood glucose, including the following: » A blood glucose monitor » Blood glucose test strips » Lancet devices and lancets » Glucose-control solutions for checking the accuracy of test strips and monitors ▪ For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: » One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or*** » One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. ▪ The plan will pay for training to help you manage your diabetes, in some cases.	$0

Services that our plan pays for	What you must pay
With this *Member Handbook*, we sent you HealthPartners MSHO's list of diabetic supplies. The list tells you the brands and makers of diabetic supplies that we will pay for. This most recent list of brands, makers, and suppliers is also available on our website at **healthpartners.com/msho**.	
Durable medical equipment and related supplies * ***** Certain DME and/or supplies require prior authorization. Contact Member Services at the phone number printed on the bottom of the page for a list of services requiring prior authorization. (For a definition of "Durable medical equipment," see Chapter 12 of this handbook.) The following items are covered: ▪ Wheelchairs ▪ Crutches ▪ Hospital beds ▪ Nebulizers ▪ Oxygen equipment ▪ IV infusion pumps ▪ Walkers We cover additional items, including: ▪ repairs of medical equipment ▪ batteries for medical equipment ▪ medical supplies you need to take care of your illness, injury or disability ▪ incontinence products ▪ nutritional/enteral products when specific conditions are met ▪ family planning supplies (see the "Family planning services" section of this chart for more information) ▪ augmentative communication devices, including electronic tablets	$0

Services that our plan pays for	What you must pay
Additional items covered by us through Medicare: ▪ Light therapy lamp (one per member per year) ▪ One wig for hair loss that is a result of chemotherapy We will pay for all medically necessary durable medical equipment that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	
Elderly Waiver Services (Home and Community-Based Services) The plan will pay for the following services for individuals eligible to get Elderly Waiver (EW) services: ▪ Adult Day Services (ADS): Health and social services given on a regular basis in a licensed setting. ▪ Adult Foster Care: A home that provides care in a family-like setting. ▪ Case Management: Management of your health and long-term care services among different health and social service workers. ▪ Chore Services: Services needed to keep your home clean and safe. ▪ Companion Services: Non-medical social support services for members who need supervision. ▪ Consumer Directed Community Support Services: Services that you manage yourself within a set budget. ▪ Customized Living/24 Hour Customized Living: A group of services given in an assisted living setting. ▪ Environmental Accessibility Adaptations: Physical changes to your home and vehicle needed to assure health and safety.	$0

Services that our plan pays for	What you must pay
▪ Extended State Plan Home Health Care Services: This includes home health aide and nursing services that are over the Medical Assistance (Medicaid) limit. ▪ Extended State Plan Private Duty Nursing: This includes private duty nursing services that are over the Medical Assistance (Medicaid) limit. ▪ Extended State Plan Personal Care Assistance Services: Help with personal care and activities of daily living over the Medical Assistance (Medicaid) limit. ▪ Family and Care Giver Training and Education: Training for unpaid caregivers. ▪ Home Delivered Meals: Meals delivered to your home. ▪ Homemaker Services: General household activities to keep up the home. ▪ Individual Community Living Support Services: (upon federal approval) ▪ Residential Care Services: A group of services offered in a licensed board and lodge setting. ▪ Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief. ▪ Specialized Medical Supplies and Equipment: Supplies and equipment that are over the Medical Assistance limit or coverage. ▪ Transitional Supports Services: One-time costs related to setting up a household (such as when a person leaves a nursing home). ▪ Transportation: A ride to activities and services in the community.	$0

Services that our plan pays for	What you must pay
You must have a Long Term Care Consultation (LTCC) done and be found to be nursing home certifiable to get these Elderly Waiver (EW) services. You can request to have this assessment in your home, apartment, or facility where you live. Your MSHO care coordinator will meet with you and your family to talk about your care needs within 15 days if you call to ask for a visit. Your MSHO care coordinator will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility. You have the right to have friends or family present at the visit. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can choose who you want to provide the services and supports from those providers available from our plan's network. After the visit, your MSHO care coordinator will send you a letter that recommends services that best meet your needs. You will be sent a copy of the service or care plan you helped put together. Your MSHO care coordinator will help you file an appeal if you disagree with suggested services or were informed you may not qualify for these services. If you are currently on the Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, you will continue to get services covered by these programs in the same way you get them now. Your county case-manager will continue to authorize these services and coordinate with your MSHO care coordinator. If you need transition planning and coordination services to help you move	

Services that our plan pays for	What you must pay
to the community, you may be eligible to get Moving Home Minnesota (MHM) services. MHM services are separate from EW services, but you must be eligible for EW. If you are no longer eligible for EW services due to a level of care change, you may be eligible to get Essential Community Services.	
Emergency care *Emergency care* means services that are: ▪ given by a provider trained to give emergency services, ***and*** ▪ needed to treat a medical emergency. A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: ▪ placing the person's health in serious risk; ***or*** ▪ serious harm to bodily functions; ***or*** ▪ serious dysfunction of any bodily organ or part; ***or*** This coverage is only available within the U.S. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, (e.g. you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.).	$0

Services that our plan pays for	What you must pay
Family planning services The law lets you choose any provider to get certain family planning services from. These are called open access services. This means any doctor, clinic, hospital, pharmacy, or family planning office. The plan will pay for the following services: ▪ Family planning exam and medical treatment ▪ Family planning lab and diagnostic tests ▪ Family planning supplies with prescription (condoms) ▪ Counseling and diagnosis of infertility, and related services ▪ Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions ▪ Treatment for sexually transmitted infections (STIs) ▪ 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.) ▪ Genetic counseling The plan will also pay for some other family planning services. However, you must see a provider in the plan's network for the following services: ▪ Treatment for medical conditions of infertility ▪ Treatment for AIDS and other HIV-related conditions ▪ Genetic testing	$0

Services that our plan pays for	What you must pay
Health and wellness education programs Health education programs: ▪ Provider office visit/session in connection with preventive services ▪ Provider office visit/session in connection with the management of a chronic health problem Additional wellness programs covered by us through Medicare: ▪ Safety/Falls kit for members living in the community (one per year) ▪ Silver&Fit Exercise & Healthy Aging program for members living in the community ▪ Health education classes ▪ Transportation to/from Silver&Fit & Healthy Aging locations and health education classes ▪ One first aid kit ▪ One food scale	$0
Health Services The plan will pay for the following services: ▪ 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 ▪ Tuberculosis care management and direct observation of drug intake ▪ Medical nutrition therapy	$0

Services that our plan pays for	What you must pay
▪ Acupuncture for chronic pain management by licensed acupuncturists or within the scope of practice by a licensed provider with acupuncture training or credentialing ***** ***** After 12 visits a service authorization is required; ask your PCP who will direct your care. ▪ Community Paramedic: certain services provided by a community paramedic for some members. They must be a part of a care plan ordered by your primary care provider and must meet other requirements. The services may include: » Health assessments » Chronic disease monitoring and education » Help with medications » Hospital In-reach Community-based Service Coordination	
Hearing services The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We cover additional items and services, including: ▪ Hearing aids and batteries ▪ Repair and replacement of hearing aids due to normal wear and tear, with limits Additional hearing services covered by us through Medicare: ▪ One hearing aid set (per member per calendar year) or coverage for one hearing aid per ear (per member per calendar year) ▪ One pocket hearing amplifier	$0

Services that our plan pays for	What you must pay
HIV screening The plan pays for one HIV screening exam every 12 months for people who: ▪ ask for an HIV screening test, ***or*** ▪ are at increased risk for HIV infection. Additional benefits may be covered by us.	$0
Home delivered meals Additional item(s) covered by us through Medicare: ▪ The plan pays for home delivery meals following an inpatient hospital stay. Meals may be offered for up to four weeks. Eligibility requirements may apply.	$0
Home health agency care * ***** After 15 visits a service authorization is required; ask your PCP who will direct your care. Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. The plan will pay for the following services, and maybe other services not listed here: ▪ Physical therapy, occupational therapy, and speech therapy ▪ Medical and social services ▪ Medical equipment and supplies ▪ Respiratory therapy	$0

Services that our plan pays for	What you must pay
▪ Home Care Nursing (previously known as Private Duty Nursing) ▪ Personal care assistant (PCA) services and supervision of PCA services (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service.)	
Hospice care You can get care from any hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will pay for the following: ▪ Drugs to treat symptoms and pain ▪ Short-term respite care ▪ Home care ***For hospice services and services covered by Medicare Part A or B that relate to your terminal illness:*** ▪ The hospice provider will bill Medicare for your services. Medicare will pay for hospice services and any Medicare Part A or B services. You pay nothing for these services. ***For services covered by Medicare Part A or B that are not related to your terminal illness*** (except for emergency care or urgently needed care): ▪ The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services. ***For services covered by HealthPartners MSHO but not covered by Medicare Part A or B:*** ▪ HealthPartners MSHO will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to	$0 When you are in a hospice program certified by Medicare, your hospice services and your Medicare Part A and B services related to your terminal illness are paid for by Medicare. HealthPartners MSHO does not pay for your services.

Services that our plan pays for	What you must pay
your terminal illness. You pay nothing for these services. ***For drugs that may be covered by HealthPartners MSHO's Medicare Part D benefit:*** ▪ Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, section F, page 16. **Note:** If you need non-hospice care, you should call your care coordinator and/or Member Services at 952-967-7029 or 888-820-4285 to arrange the services. Non-hospice care is care that is not related to your terminal illness. Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.	
Immunizations The plan will pay for the following services: ▪ Pneumonia vaccine ▪ Flu shots, once a year, in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B coverage rules The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, section G, page 8 to learn more.	$0
In-Home Bathroom Safety Devices and Installation Additional item(s) covered by us through Medicare: ▪ Up to $1,000 for home bathroom safety devices and installation (per member per calendar year) for non-Elderly Waiver members living in the community.	$0

Services that our plan pays for	What you must pay
Inpatient hospital care The plan will pay for the following services, and maybe other services not listed here: ▪ Semi-private room (or a private room if it is medically necessary) ▪ Meals, including special diets ▪ Regular nursing services ▪ Costs of special care units, such as intensive care or coronary care units ▪ Drugs and medications ▪ Lab tests ▪ X-rays and other radiology services ▪ Needed surgical and medical supplies ▪ Appliances, such as wheelchairs ▪ Operating and recovery room services ▪ Physical, occupational, and speech therapy ▪ Inpatient substance abuse services ▪ In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. ▪ If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant.* Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If HealthPartners MSHO provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.	$0 You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.

Services that our plan pays for	What you must pay
▪ Blood, including storage and administration The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. ▪ Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient you should ask the hospital staff.	
Inpatient mental health care ▪ The plan will pay for mental health care services that require a hospital stay.	$0
Interpreter Services The plan will pay for the following services: ▪ Spoken language interpreter services ▪ Sign language interpreter services	$0
Kidney disease services and supplies The plan will pay for the following services: ▪ Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. ▪ Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, section B, page 4. ▪ Inpatient dialysis treatments if you are admitted as an	$0

Services that our plan pays for	What you must pay
inpatient to a hospital for special care ▪ Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments ▪ Home dialysis equipment and supplies ▪ Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see "Medicare Part B prescription drugs" below.**	
Medical Assistance (Medicaid) Covered Prescription Drugs Our plan will cover some Medical Assistance (Medicaid) covered drugs that are not covered by Medicare Parts B and D. These include some over-the-counter products, some prescription cough and cold medicines and some vitamins. The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that: ▪ the drug that is normally covered has caused a harmful reaction to you; ***or*** ▪ there is a reason to believe the drug that is normally covered would cause a harmful reaction; ***or*** ▪ 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. If 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 our plan. If the pharmacy won't call your doctor, you can. You can also call HealthPartners MSHO's Member Services at the phone number printed on the bottom of this page.	$0

Services that our plan pays for	What you must pay
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. The plan will pay for three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if your treatment is needed in the next calendar year. We may cover additional benefits if medically necessary.	$0
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. HealthPartners MSHO will pay for the following drugs: ▪ Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself ▪ Antigens	$0

Services that our plan pays for	What you must pay
▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit® or Aranesp®) ▪ IV immune globulin for the home treatment of primary immune deficiency diseases ➔ **Chapter 5 explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. ➔ **Chapter 6 explains what you pay for your outpatient prescription drugs through our plan.**	
Nursing facility care * HealthPartners MSHO is responsible for paying a total of 180 days of nursing home room and board. This includes custodial care. If you need continued nursing home care beyond the 180 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 HealthPartners MSHO, will continue to pay for your care. See the “Skilled nursing facility (SNF) care” section of this chart for more information about the additional nursing home coverage HealthPartners MSHO provides.	$0

Services that our plan pays for	What you must pay
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more. We may cover additional benefits if medically necessary.	$0
Outpatient diagnostic tests and therapeutic services and supplies The plan will pay for the following services, and maybe other services not listed here: ▪ X-rays ▪ Radiation (radium and isotope) therapy, including technician materials and supplies ▪ Surgical supplies, such as dressings ▪ Splints, casts, and other devices used for fractures and dislocations ▪ Lab tests ▪ Blood, beginning with the first pint of blood that you need. The plan will pay for storage and administration beginning with the first pint of blood you need. ▪ Other outpatient diagnostic tests	$0

Services that our plan pays for	What you must pay
Outpatient hospital services The plan pays for medically needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will pay for the following services, and maybe other services not listed here: ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ***** ***** Certain outpatient and/or same day procedures require prior authorization. Contact Member Services at the phone number printed on the bottom of the page for information on services requiring prior authorization. ▪ Labs and diagnostic tests billed by the hospital ▪ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it ▪ X-rays and other radiology services billed by the hospital ▪ Medical supplies, such as splints and casts ▪ Some screenings and preventive services ▪ Some drugs that you can't give yourself	$0

Services that our plan pays for	What you must pay
Outpatient mental health care The plan will pay for mental health services provided by: ▪ a state-licensed psychiatrist or doctor, ▪ a clinical psychologist, ▪ a clinical social worker, ▪ a clinical nurse specialist, ▪ a nurse practitioner, ▪ a physician assistant, ***or*** ▪ any other Medicare-qualified mental health care professional as allowed under applicable state laws. The plan will pay for the following services, and maybe other services not listed here: ▪ Clinic services ▪ Day treatment ▪ Psychosocial rehab services ▪ Crisis response services including assessment, intervention, stabilization, and community intervention ▪ Diagnostic assessments, including screening for presence of co-occurring mental illness and substance abuse disorder ▪ Dialectical Behavioral Therapy (DBT) ▪ Mental health targeted case management (MH-TCM) ***** ▪ Outpatient Mental health services, including explanation of finding, mental health medication management, neuropsychological services, psychotherapy (patient and/or family, family crisis, and group), and psychological testing	$0

Services that our plan pays for	What you must pay
▪ Rehabilitative Mental Health Services, including Assertive Community Treatment (ACT), adult day treatment, Adult Rehabilitative Mental Health Services (ARMHS), Certified Peer Specialist Support Services in some situations, and Intensive Residential Treatment Services (IRTS) ***** ▪ Physician Mental Health Services, including health and behavioral assessment/intervention, inpatient visits, psychiatric consultations to primary care providers, and physician consultation, evaluation, and management	
Outpatient rehabilitation services * ***** After 20 visits of physical therapy and/or occupational therapy a service authorization is required. Your provider is responsible for obtaining prior authorization. The plan will pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0
Outpatient substance abuse services The plan pays for the following services: ▪ Assessment/diagnosis ▪ Outpatient treatment ▪ Inpatient hospital ▪ Residential non-hospital treatment ***** ▪ Outpatient methadone treatment ▪ Detoxification (only if required for medical treatment) ▪ Room and board determined necessary by chemical dependency assessment *****	$0

Services that our plan pays for	What you must pay
A qualified (Rule 25 county) assessor who is a part of our plan's network 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 our plan's network. We will do this within five working days of when we get your request. 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 Chapter 9 section 5.3, page 13.	
Outpatient surgery * * Certain outpatient and/or same day procedures require prior authorization. Contact Member Services at the phone number printed on the bottom of the page for information on services requiring prior authorization. The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0
Partial hospitalization services *Partial hospitalization* is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.	$0

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits The plan will pay for the following services: ▪ Medically necessary health care or surgery services given in places such as: » physician's office » certified ambulatory surgical center » hospital outpatient department ▪ Consultation, diagnosis, and treatment by a specialist ▪ Basic hearing and balance exams given by your primary care provider, if your doctor orders it to see whether you need treatment ▪ Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare and/or Medical Assistance (Medicaid) ▪ Second opinion by another network provider before a medical procedure ▪ Non-routine dental care. Covered services are limited to: » surgery of the jaw or related structures, » setting fractures of the jaw or facial bones, » pulling teeth before radiation treatments of neoplastic cancer, ***or*** » services that would be covered when provided by a physician. For information about other dental services we cover, see the "Dental services" section of this chart. ▪ Preventive and physical exams ▪ Family Planning services. For more information, see the "Family planning" section of this chart.	$0

Services that our plan pays for	What you must pay
Podiatry services The plan will pay for the following services: ▪ Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) ▪ Routine foot care for members when medically necessary including conditions affecting the legs, such as diabetes Additional services covered by us through Medicare: ▪ Up to six routine foot care visits	$0
Prostate cancer screening exams For men, the plan will pay for the following services once every 12 months: ▪ A digital rectal exam ▪ A prostate specific antigen (PSA) test	$0
Prosthetic devices * and related supplies *Prosthetic devices* replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here: ▪ Colostomy bags and supplies related to colostomy care ▪ Pacemakers ▪ Braces ▪ Prosthetic shoes ▪ Artificial arms and legs ▪ Breast prostheses (including a surgical brassiere after a mastectomy) ▪ Orthotics	$0

Services that our plan pays for	What you must pay
▪ Wigs for people with alopecia areata ▪ Some shoes when a part of a leg brace or when custom molded. The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. See “Vision care” later in this section for details.	
Pulmonary rehabilitation services The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0
Sexually transmitted infections (STIs) screening and counseling The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. A primary care provider must order the tests. We cover these tests once every 12 months. The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor’s office.	$0

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care * For additional nursing home services covered by us, see the “Nursing facility care” section. The plan will pay for the following services, and maybe other services not listed here: ▪ A semi-private room, or a private room if it is medically needed ▪ Meals, including special diets ▪ Nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ▪ Blood, including storage and administration » The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. ▪ Medical and surgical supplies given by nursing facilities ▪ Lab tests given by nursing facilities ▪ X-rays and other radiology services given by nursing facilities ▪ Appliances, such as wheelchairs, usually given by nursing facilities ▪ Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:	$0

Services that our plan pays for	What you must pay
▪ A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ▪ A nursing facility where your spouse lives at the time you leave the hospital	
Smoking and tobacco use cessation If you use tobacco but do not have signs or symptoms of tobacco-related disease: ▪ The plan will pay for two attempts to quit with counseling in a 12-month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: ▪ The plan will pay for two attempts to quit with counseling within a 12 month period. Each counseling attempt includes up to four face-to-face visits. We may cover additional benefits if medically necessary.	$0
Transportation If you need transportation to and from health services that we cover, call 952-883-7400 or 888-288-1439 (toll free). We will provide the most appropriate and cost-effective transportation. Our plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a Specialty provider that is more than 60 miles from your home. Call 952-883-7400 or 888-288-1439 (toll free) if you do not have a primary care clinic that is available within 30 miles of your home and/or if it is over 60 miles to your specialty provider.	$0

Services that our plan pays for	What you must pay
▪ 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 (for example, bus or cab or through volunteer driver programs)	
Urgently needed care *Urgently needed care* is care given to treat: ▪ a non-emergency, ***or*** ▪ a sudden medical illness, ***or*** ▪ an injury, ***or*** ▪ a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider. This coverage is only available within the U.S.	$0
Vision care The plan will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration. For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: ▪ people with a family history of glaucoma, ▪ people with diabetes, and ▪ African-Americans. The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract	$0

Services that our plan pays for	What you must pay
surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) The plan will also pay for corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant. We also cover the following: ▪ Eye exams ▪ Eyeglasses, including identical replacement due to damage, loss or theft. Limited to one pair every 24 months unless medically necessary. ▪ 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 circumstances Additional item(s) covered by us through Medicare: ▪ Tints and/or protective coating to first and/or second pair of eyeglasses	
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: ▪ a review of your health, ▪ education and counseling about the preventive services you need (including screenings and shots), and ▪ referrals for other care if you need it. **Important:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

E. Benefits *not* covered by the plan

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not pay for these benefits.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*). Medicare and Medical Assistance (Medicaid) will not pay for them either. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Member Handbook*, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medical Assistance (Medicaid), unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See Chapter 3, section J, page 14 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare and/or Medical Assistance (Medicaid) pays for it.
- A private room in a hospital, except when it is medically needed.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Fees charged by your immediate relatives or members of your household. Exceptions to this may be for some services, such as personal care assistance (PCA) and consumer directed community supports (CDCS) services. Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Routine foot care, except for the limited coverage listed in the benefits chart.
- LASIK surgery.
- Reversal of sterilization procedures, sex change operations.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference.

F. Benefits not covered by the plan but may be covered through another source.

The following benefits are not covered by us under the plan, but may be covered through another source, such as the state, county, federal government, or tribe. 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).

- Case management for people with developmental disabilities
- Intermediate care facility for people who have a developmental disability (ICF/DD)
- 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
- Except Elderly Waiver services, other waiver services provided under Home and Community Based Services waivers
- Job training and educational services
- Day training and habilitation
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays for which our plan is not otherwise responsible. (See the “Nursing facility care” and the “Skilled nursing facility (SNF) care” sections in the Benefits Chart for additional information.)

Chapter 5: Getting your outpatient prescription drugs through the plan

Table of Contents

Introduction

This chapter explains rules for getting your *outpatient prescription drugs.* These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medical Assistance (Medicaid). Chapter 6, section D, page 5 tells you what you pay for these drugs.

HealthPartners MSHO also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4, section D, page 27.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see Chapter 5, Section F, page 16 (*If you are in a Medicare-certified hospice program*).

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. Effective June 1, 2015, your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions. You should ask your prescribers the next time you call or visit if they meet this condition.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception. See Section D (*Why your drug might not be covered*) to learn about asking for an exception.

5. Your drug must be used for a *medically accepted indication.* This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan's network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

➔ To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services at the number at the bottom of the page.

If you don't have the Provider and Pharmacy Directory, you can get a copy from Member Services by contacting the number at the bottom of the page.

At any time, you can get up-to-date information about changes in the pharmacy network on our website at **healthpartners.com/msho**.

Show your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy will bill the plan for our share of the cost of your covered prescription drug. You will need to pay the pharmacy a copay when you pick up your prescription.

If you do not have your plan ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, *you may have to pay the full cost of the prescription when you pick it up.* You can then ask us to pay you back for our share. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

➔ To learn how to ask us to pay you back, see Chapter 7, section B, page 3.

NOTE: If the drug is covered by Medical Assistance (Medicaid), we cannot pay you back if you pay for the drug yourself. State and federal laws prevent us from paying you directly. If you paid for a drug that you think we should have covered, contact Member Services at the number at the bottom of the page.

➔ If you need help getting a prescription filled, you can contact Member Services at the number at the bottom of the page.

What if you want to change to a different network pharmacy?

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy.

If you need help changing your network pharmacy, you can contact Member Services.

What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

➔ To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy.* Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home. Usually, long-term care facilities have their own pharmacies. Residents may get prescription drugs through a facility's pharmacy as long as it is part of our network. If your long-term care facility's pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

➔ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

Can you use mail-order services to get your drugs?

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or

long-term medical condition. The drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.

Our plan's mail-order service requires you to order up to a 90-day supply. A 90-day supply has the same copay as a one-month supply.

How do I fill my prescriptions by mail?

To get information about filling your prescriptions by mail, call Member Services.

Usually, a mail-order prescription will get to you within 5 to 8 days. If your mail-order drug is delayed, you may request that the drug be sent to a retail pharmacy near you. At that time a full month supply of the drug will be filled. You will be charged the copayment that applies.

How will the mail-order service process my prescription?

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the pharmacy receives from you**

   The pharmacy will automatically fill and deliver new prescriptions it receives from you.

2. **New prescriptions the pharmacy receives directly from your provider's office**

   After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. **Refills on mail-order prescriptions**

   For refills, please contact your pharmacy 8 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Call myMailRx Customer Services at 612-623-4002 or 800-591-0011 Monday through Friday 8 a.m. – 6 p.m. and Saturday 8 a.m. – 4 p.m. Our Customer Service Representatives will help you get started.

Can you get a long-term supply of drugs?

You can get a long-term supply of *maintenance drugs* on our plan's Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition. When you get a long-term supply of drugs, your copay may be lower.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services at the number at the bottom of the page for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- **If you need a prescription because of a medical emergency**

  We will cover up to a 30-day supply for prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care.

- **If you need a prescription when you travel or are away from the plan's service area**

  If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network mail-order pharmacy service or through a retail network pharmacy that offers an extended supply.

  If you are traveling within the US, but outside of the plan's service area, and you become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available.

  Prior to filling your prescription at an out-of-network pharmacy, call our Member Services or check our website (**healthpartners.com/msho**) to find out if there is a network pharmacy in the area where you are traveling. If there are no network

pharmacies in that area, our Member Services may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

- **Other times you can get your prescription covered if you go to an out-of-network pharmacy**

  We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

  - If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
  - If you are trying to fill a covered prescription drug that is not regularly stocked at a network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

➔ In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

Will the plan pay you back if you pay for a prescription?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost instead of a copay when you get your prescription. You can ask us to pay you back for our share of the cost.

➔ To learn more about this, see Chapter 7, section A, page 2.

NOTE: If the drug is covered by Medical Assistance (Medicaid), we cannot pay you back if you pay for the drug yourself. State and federal laws prevent us from paying you directly. If you paid for a drug that you think we should have covered, contact Member Services at the number at the bottom of the page.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D. Although some prescription and over-the-counter drugs not covered under Medicare Part D are covered under Medical Assistance (Medicaid), these drugs are not included on the Drug List. However, you can find out about them by calling Member Services or visiting our website at **healthpartners.com/msho**.

The Drug List includes both brand-name and *generic* drugs. Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at **healthpartners.com/msho**. The Drug List on the website is always the most current one.
- Call Member Services at the number at the bottom of the page to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

What is *not* on the Drug List?

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

HealthPartners MSHO will *not* pay for the drugs listed in this section. These are called *excluded drugs.* If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9, section 6.5, page 28.)

Here are three general rules for excluded drugs:

- Our plan's outpatient Medicare Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. Drugs that would be covered under Medicare Part A or Part B are covered under our plan's medical benefit.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use.* Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medical Assistance (Medicaid).

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used to promote weight loss
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are cost sharing tiers?

Every drug on our plan's Drug List is in a cost sharing tier. What you pay for a drug on the Drug List depends on whether the drug is a generic or brand drug. Tier 1 generic drugs have the lowest copay. Tier 1 brand drugs have a higher copay.

To find out the cost sharing for your drug, look for the drug in our plan's Drug List.

➔ Chapter 6, section D, page 7 tells the amount you pay for drugs in each tier.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plan expects your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

➔ To learn more about asking for exceptions, see Chapter 9, section 6.3, page 24.

What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. If there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has written “No substitutions” on your prescription for a brand-name drug, then we will cover the brand-name drug. Your copay may be greater for the brand-name drug than for the generic drug.

2. Getting plan approval in advance

For some drugs, you or your health care provider must get approval from HealthPartners MSHO before you fill your prescription. If you don’t get approval, HealthPartners MSHO may not cover the drug. This is called *prior authorization*.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This is called *step therapy*.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. For example, the plan might limit:

- how many refills you can get, ***or***
- how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at **healthpartners.com/msho**.

D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

You can get a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:

- is no longer on the plan's Drug List, ***or***
- was never on the plan's Drug List, ***or***
- is now limited in some way.

2. You must be in one of these situations:

- **You were in the plan last year and do not live in a long-term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. This temporary supply will be for up to a 30-day supply. If your

prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.

- **You are new to the plan and do not live in a long-term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. This temporary supply will be for up to a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.

- **You were in the plan last year and live in a long-term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. The total supply will be for up to a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 98 days of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You are new to the plan and live in a long-term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The total supply will be for up to a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 98 days of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **Transition policy:**

  For existing members in our plan who have changes in level of care, such as entering a long-term care facility or being discharged from a hospital:

  We will grant early refills when appropriate.

  Please note that this policy applies only to those drugs that are “Part D drugs” and bought at a network pharmacy. The policy can’t be used to buy a non-Part D drug or a drug out-of-network, unless you qualify for out-of-network access. See Chapter 4 for

information about non-Part D drugs and any policies that may apply to non-Part D drugs.

➔ To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

OR

- **You can ask for an exception.**

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

➔ To learn more about asking for an exception, see Chapter 9, section 6.3, page 24.

➔ If you need help asking for an exception, you can contact Member Services.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Move a drug to a higher or lower cost sharing tier.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We move your drug into a higher cost sharing tier.
- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice about the change.
  - » The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - » You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - » You and your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9, section 6.4, page 25.
- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  - » Your provider will also know about this change. He or she can work with you to find another drug for your condition.

➔ If there is a change to coverage for a drug you are taking, **the plan will send you a notice.** Normally, the plan will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

➔ To learn more about drug coverage and what you pay, see Chapter 6, section D, page 7.

If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership, until we have given you a 98-day supply. The first supply will be for up to a 31-day supply, or less if your prescription is written for fewer days. If you need refills, we will cover them during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and you need a drug that is not on our Drug List, we will cover one 31-day supply. We will also cover one 31-day supply if the plan has a limit on the drug's coverage. If your prescription is written for fewer than 31 days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

➔ To learn more about asking for exceptions, see Chapter 9, section 6.3, page 24.

If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

➔ To learn more about the hospice benefit, see Chapter 4, section D, page 22.

G. Programs on drug safety and managing drugs

Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

Programs to help members manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get

a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members who qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

➔ If you have any questions about these programs, please contact Member Services.

Chapter 6: What you pay for your Medicare and Medical Assistance (Medicaid) prescription drugs

Table of Contents

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, ***and***
- drugs and items covered under Medical Assistance (Medicaid), ***and***
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Medical Assistance (Medicaid), you are getting "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

To learn more about prescription drugs, you can look in these places:

- **The plan's *List of Covered Drugs.*** We call this the "Drug List." It tells you:
  - » Which drugs the plan pays for
  - » Which cost sharing tier each drug is in
  - » Whether there are any limits on the drugs

  If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at **healthpartners.com/msho**. The Drug List on the website is always the most current.
- **Chapter 5 of this Member Handbook.** Chapter 5 tells how to get your outpatient prescription drugs through the plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
- **The plan's *Provider and Pharmacy Directory.*** In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, section A, page 4.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your *out-of-pocket costs*. This is the amount of money you, or others paying for you, pay for your prescriptions.
- Your *total drug costs.* This is the amount of money you, or others paying for you, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a report called the *Explanation of Benefits.* We call it the *EOB* for short. The EOB includes:

- **Information for the month**. The report tells what prescription drugs you got. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.

➔ We offer coverage of drugs not covered under Medicare. Payments made for these drugs will not count towards your total out-of-pocket costs. To find out which drugs our plan covers, see the Drug List. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under Medical Assistance (Medicaid). These drugs are not included on the Drug List but you can find out about them by calling Member Services or visiting our website at **healthpartners.com/msho**.

B. Keeping track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your plan ID card.

Show your plan ID card every time you get a prescription filled. This will help us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You can ask us to pay you back for our share of the cost of the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

➔ To learn how to ask us to pay you back for our share of the cost of the drug, see Chapter 7, section A, page 1.

NOTE: If the drug is covered by Medical Assistance (Medicaid), we cannot pay you back if you pay for the drug yourself. State and federal laws prevent us from paying you directly. If you paid for a drug that you think we should have covered, contact Member Services at the number at the bottom of the page.

3. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, HealthPartners MSHO pays all of the costs of your Medicare Part D drugs for the rest of the year. Medical Assistance (Medicaid)-covered drugs will not be included or tracked to move you to the next coverage stage.

4. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. Be sure to keep these reports. They are an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D prescription drug coverage under HealthPartners MSHO. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	**Stage 2:** Catastrophic Coverage Stage
During this stage, **the plan pays part of the costs** of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, **the plan pays all of the costs** of your drugs through December 31, 2015. You begin this stage when you have paid a certain amount of out-of-pocket costs.

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the *copay.* The copay depends on what cost sharing tier the drug is in and where you get it.

The plan's cost sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. To find the cost-sharing tiers for your drugs, you can look in the Drug List.

- Tier 1 Generic drugs have the lowest copay. They are generic drugs. The copay will be from $0 to $2.65, depending on your level of Medicaid eligibility.
- Tier 1 Brand drugs have a higher copay. They are brand name drugs. The copay will be from $0 to $6.60, depending on your level of Medicaid eligibility.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, ***or***
- an out-of-network pharmacy.

➔ In limited cases, we cover prescriptions filled at out-of-network pharmacies. See Chapter 5, section A, page 7 to find out when we will do that.

➔ To learn more about these pharmacy choices, see Chapter 5, section A, page 4 in this handbook and the plan's *Provider and Pharmacy Directory.*

Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. It costs you the same as a one-month supply.

➔ For details on where and how to get a long-term supply of a drug, see Chapter 5, section A, page 7 or the *Provider and Pharmacy Directory.*

How much do you pay?

During the Initial Coverage Stage, you will pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

➔ You can contact Member Services to find out how much your copay is for any covered drug.

Your share of the cost when you get a *one-month or long-term* supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 30-day supply	**The plan's mail-order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. See Chapter 5, section A, page 7 for details.
Cost Sharing Tier 1 – Generic	$0/$1.20/$2.65	$0/$1.20/$2.65	$0/$1.20/$2.65	$0/$1.20/$2.65
Cost Sharing Tier 1 – Brand	$0/$3.60/$6.60	$0/$3.60/$6.60	$0/$3.60/$6.60	$0/$3.60/$6.60

➔ For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory.*

When does the Initial Coverage Stage end?

The Initial Coverage Stage ends when your total out-of-pocket costs reach $4,700. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year.

Your Explanation of Benefits reports will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the $4,700 limit. Many people do not reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $4,700 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay all of the costs for your Medicare drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

Typically, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects). If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost sharing rate") and multiply it by the number of days of the drug you receive.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.20. This means that the amount you pay per day for your drug is $0.04. If you receive a 7 days' supply of the drug, your payment will be $0.04 per day multiplied by 7 days, for a total payment of $0.28.
- You should not have to pay more per day just because you begin with less than a month's supply. Let's go back to the example above. Let's say you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7 days' supply runs out. If you receive a second prescription for the rest of the month, or 23 days more of the drug, you will still pay $0.04 per day, or $0.92. Your total cost for the month will be $0.28 for your first prescription and $0.92 for your second prescription, for a total of $1.20 – the same as your copay would be for a full month's supply.

Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

G. Vaccinations

Our plan covers Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.

2. The second part of coverage is for the cost of **giving you the shot**.

Before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. *Network pharmacies* are pharmacies that have agreed to work with our plan. A *network provider* is a provider who works with the health plan. A network provider should work with HealthPartners MSHO to ensure that you do not have any upfront costs for a Part D vaccine.

How much you pay for a Medicare Part D vaccination

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, see the Benefits Chart in Chapter 4, section D, page 23.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List. You may have to pay a copay for Medicare Part D vaccines.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
   - You will pay a copay for the vaccine.
2. You get the Medicare Part D vaccination at your doctor's office and the doctor gives you the shot.
   - You will pay a copay to the doctor for the vaccine.
   - Our plan will pay for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.
3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
   - You will pay a copay for the vaccine.
   - Our plan will pay for the cost of giving you the shot.

If you paid for a Medicare Part D drug, including a Part D vaccine, that you think we should have covered, contact Member Services at the number at the bottom of the page.

Chapter 7: Asking us to pay our share of a bill you have gotten for covered services or drugs

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A. When you can ask us to pay for your services or drugs

Our network providers must bill the plan for your services and drugs already received. A *network provider* is a provider who works with the health plan.

If you get a bill for the full cost of health care or drugs, send the bill to us. To send us a bill, see Section B of this chapter.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid the bill, we will pay you back. It is your right to be paid back if you paid more than your share of the cost for the services or drugs.
- If the services or drugs are **not** covered, we will tell you.

NOTE: If the service or drug is covered by Medical Assistance (Medicaid), we cannot pay you back if you pay for the service or drug yourself. State and federal laws prevent us from paying you directly. If you paid for a service or drug that you think we should have covered, contact Member Services at the number at the bottom of the page.

➔ Contact Member Services if you have any questions. If you do not know what you should have paid, or if you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask our plan to pay a bill you got or to pay you back:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   You should ask the provider to bill the plan.

   - You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill.
   - If the provider should be paid, we will pay the provider directly.

2. **When a network provider sends you a bill**

   Network providers must always bill the plan.

   - We do not allow providers to add separate charges, called “balance billing.” This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.
   - Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and take care of the problem.

3. **When you use an out-of-network pharmacy to get a prescription filled**

   If you go to an out-of-network pharmacy, you will have to pay the full cost of your Part D prescription.

➔ In only a few cases, we will cover Part D prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost. Please see Chapter 5, section A, page 7 to learn more about out-of-network pharmacies.

4. **When you pay the full cost for a Part D prescription because you do not have your plan ID card with you**

   If you do not have your plan ID card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the Part D prescription yourself.

   - Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

5. **When you pay the full cost for a Part D prescription for a drug that is not covered**

   You may pay the full cost of the Part D prescription because the drug is not covered.

   - The drug may not be on the plan’s *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.

» If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (see Chapter 9, section 6.1, page 22).

» If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (see Chapter 9, section 6.4, page 26).

- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost of the service or drug. If we deny your request for payment, you can appeal our decision.

➔ To learn how to make an appeal, see Chapter 9, section 6.5, page 28.

B. How and where to send us your request for payment

If the service or drug is covered by Medical Assistance (Medicaid), we cannot pay you back if you pay for the service or drug yourself. State and federal laws prevent us from paying you directly. If you paid for a service or drug that you think we should have covered, contact Member Services at the number at the bottom of the page.

Mail your request for payment together with any bills or receipts to us at this address:

HealthPartners
Medicare Part D Pharmacy Claims
MS 21103R
P.O. Box 9463
Minneapolis, MN 55440-9463

Or deliver in person to:

HealthPartners
Member Services
8170 33rd Avenue South
Bloomington, MN 55425

You may also call our plan to request payment. Call Member Services at 952-967-7029 or 888-820-4285 for more information. This call is free.

From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative.

From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

C. We will make a coverage decision

When we get your request for payment, we will make a *coverage decision.* This means that we will decide whether your health care or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the health care or drug.

NOTE: If the service or drug is covered by Medical Assistance (Medicaid), we cannot pay you back if you pay for the service or drug yourself. State and federal laws prevent us from paying you directly. If you paid for a service or drug that you think we should have covered, such as a Medicare Part D drug, contact Member Services at the number at the bottom of the page.

- We will let you know if we need more information from you.
- If we decide that the Part D drug is covered and you followed all the rules for getting it, we will pay our share of the cost for it. If you have already paid for the Part D drug, we will mail you a check for our share of the cost. If you have not paid for the Part D drug yet, we will pay the provider directly.

➔ Chapter 3, section B, page 3 explains the rules for getting your services covered. Chapter 5 page 3 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of the Part D drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

➔ To learn more about coverage decisions, see Chapter 9, section 4, page 7.

D. You can make an appeal

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called *making an appeal.* You can also make an appeal if you do not agree with the amount we pay.

- The appeals process is a formal process with detailed procedures and important deadlines.
- If you want to make an appeal about getting paid back for a drug, go to Chapter 9, Section 4, page 7.

Chapter 8: Your rights and responsibilities

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Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights.

A. You have a right to get information in a way that meets your needs

We must tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has people who can answer questions in different languages. We can provide translated materials upon request. We have qualified Member Services Representatives to respond to callers speaking Hmong and Spanish. If a caller speaks a language not spoken by a Member Services Representative, we use the Language Line Service to conference the caller and an interpreter. We can also give you information in Braille or large print.
- If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You may also file a complaint with HealthPartners by calling Member Services or writing to us with your complaint. Information about filing complaints is in Chapter 9 of this handbook.

B. We must treat you with respect, fairness, and dignity and honor your right to privacy at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Physical or mental condition
- Health status
- Need for or receipt of health services
- Claims experience
- Medical history
- Genetic information
- Disability
- Marital status
- Age

- Sex
- Sexual orientation
- National origin
- Race
- Color
- Religion
- Political beliefs

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation.

We cannot deny services to you or punish you for exercising your rights.

➔ For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697). You can also call the Minnesota Department of Human Rights at 1-800-657-3704 (MN Relay 711).

➔ If you have a disability and need help accessing care or a provider, call Member Services at the number listed at the bottom of this page. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. We must ensure that you get timely access to covered services and drugs

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A *network provider* is a provider who works with the health plan.
  - » Call Member Services or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- You have the right to go to a gynecologist or another women's health specialist without getting a referral. A *referral* is a written order from your primary care provider.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - » This includes the right to get timely services from specialists.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3, section D, page 9.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. We must protect your personal health information

We protect your personal health information as required by federal and state laws.

- Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your health information.

How we protect your health information

- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first.* Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
  - » We are required to release health information to government agencies that are checking on our quality of care.
  - » We are required to give Medicare your health and drug information. If Medicare releases your information for research or other uses, it will be done according to Federal laws.
  - » 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.

You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

- You have the right to know if and how your health information has been shared with others.

If you have questions or concerns about the privacy of your personal health information, call Member Services at the number at the bottom of this page.

E. We must give you information about the plan, its network providers, your covered services, and your rights and responsibilities

As a member of HealthPartners MSHO, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 952-967-7029 or 888-820-4285. This is a free service. Our plan has people who can answer questions in different languages. We can provide translated materials upon request. We have qualified Member Services Representatives to respond to callers speaking Hmong and Spanish. If a caller speaks a language not spoken by a Member Services Representative, we use the Language Line Service to conference the caller and an interpreter. We can also give you information in Braille or large print.

If you want any of the following, call Member Services:

- **Information about how to choose or change plans**
- **Information about our plan, including:**
  - » Financial information
  - » How the plan has been rated by plan members.
  - » You have the right to get the results of an external quality review study from the State, if you ask for them.
  - » The number of appeals made by members
  - » How to leave the plan
- **Information about our network providers and our network pharmacies, including:**
  - » How to choose or change primary care providers
  - » The qualifications of our network providers and pharmacies
  - » How we pay the providers in our network
  - » Whether we use a physician incentive plan that affects the use of referral services;

- » The type(s) of physician incentive arrangements used;
- » Whether stop-loss protection is provided; and
- » Results of a member survey if one is required because of our physician incentive plan.
- » The professional qualifications of health care providers

➔ For a list of providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services at the number at the bottom of the page, or visit our website at **healthpartners.com/msho**.

- **Information about covered services and drugs and about rules you must follow, including:**
  - » Services and drugs covered by the plan
  - » Limits to your coverage and drugs
  - » Rules you must follow to get covered services and drugs
- **Information about why something is not covered and what you can do about it, including:**
  - » Asking us to put in writing why something is not covered
  - » Asking us to change a decision we made
  - » Asking us to pay for a bill you have received

F. Network providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7, section A, page 2.

G. You have the right to leave the plan at any time

No one can make you stay in our plan if you do not want to. You can leave the plan at any time. If you leave our plan, you will still be in the Medicare and Medicaid programs. You have

the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. If you leave our plan, you will remain in our plan's Minnesota Senior Care Plus (MSC+) plan to get your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county.

You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions.

If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

H. You have a right to make decisions about your health care

You have the right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices *in a way that you can understand*.

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another doctor before deciding on treatment.
- **You can say "no.**" You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.

- **You can ask us to cover a service or drug that was denied or is usually not covered.** Chapter 9, section 4, page 7 tells how to ask the plan for a coverage decision.

You have the right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you**.
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an *advance directive.* There are different types of advance directives and different names for them. Examples are a *living will* and a *power of attorney for health care* or *a health care directive*.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. The Senior LinkAge Line is an organization that gives people information about Medicare or Medicaid, including resources for getting a form at www.MinnesotaHelp.info. You can also contact Member Services to ask for the forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Office of Health Facility Complaints at the Minnesota Department of Health at 651-201-4201, or toll-free at 1-800-369-7994.

I. You have the right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, section 10, page 45 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—and it is *not* about discrimination for the reasons listed on page 2—you can get help in these ways:

- You can **call Member Services**.
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see Chapter 2, section E, page 18.
- You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can call the **Minnesota Ombudsman for State Managed Health Programs**. For details about this office and how to contact them, see Chapter 2, section I, page 22.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can **call Member Services** at the number at the bottom of this page.
- You can **call the State Health Insurance Assistance Program**. In Minnesota, the SHIP is called the Senior LinkAge Line. For details about this organization and how to contact it, see Chapter 2, section E, page 18.
- You can **contact Medicare**.

  - » You can visit the Medicare website to read or download "Medicare Rights & Protections." (Go to http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf/)
  - » Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can contact the **Minnesota Ombudsman for State Managed Health Programs**. For details about this office and how to contact them, see Chapter 2, section I, page 22.

J. You also have responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook* to learn what is covered and what rules you need to follow to get covered services and drugs.**
  - » For details about your covered services, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - » For details about your covered drugs, see Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage you have.** Please call Member Services to let us know.
  - » We are required to make sure that you are using all of your coverage options when you receive health care. This is called *coordination of benefits.*
  - » For more information about coordination of benefits, see Chapter 1.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan ID card whenever you get services or drugs.
- **Help your doctors and other health care providers give you the best care.**
  - » Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - » 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.

  - » Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - » Practice preventive health care. Have tests, exams and shots recommended for you based on your age and gender.
  - » If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - » Medicare Part A and Medicare Part B premiums. For most HealthPartners MSHO members, Medicaid pays for your Part A premium and for your Part B premium.
  - » For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a co-pay (a fixed amount). Chapter 6, section D, page 5 tells what you must pay for your drugs.
  - » If you get any services or drugs that are not covered by our plan, you must pay the full cost.

  ➔ If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9 to learn how to make an appeal.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services or notify your county social services offices.
  - » **If you move *outside* of our plan service area, you cannot be a member of our plan.** Chapter 1, section D, page 6 tells about our service area. We can help you figure out whether you are moving outside our service area. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Medical Assistance (Medicaid) know your new address when you move. See Chapter 2 for phone numbers for Medicare and Medical Assistance (Medicaid).
  - » **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

- **Call Member Services at the number at the bottom of the page for help if you have questions or concerns.**

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What's in this chapter?

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should receive the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. If you are having a problem with your care, you can call the Ombudsman for State Managed Health Care Programs at 651-431-2660 or 1-800-657-3729. This chapter will explain the different options you have for different problems and complaints, but you can always call the Ombudsman for State Managed Health Care Programs to help guide you through your problem.

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Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter will tell you what to do if you have a problem with your plan or with your services or payment. These processes have been approved by Medicare and Medical Assistance (Medicaid). Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the Ombudsman for State Managed Health Care Programs

If you need help getting started, you can always call the Ombudsman for State Managed Health Care Programs. The Ombudsman for State Managed Health Care Programs can answer your questions and help you understand what to do to handle your problem. The Ombudsman for State Managed Health Care Programs is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Ombudsman for State Managed Health Care Programs is 651-431-2660 or 1-800-657-3729. The services are free.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). The SHIP counselors can answer your questions and help you understand what to do to handle your problem. The SHIP is not connected with us or with any insurance company or health plan. The SHIP has trained counselors in every state, and services are free. In Minnesota the SHIP is called the Senior LinkAge Line. The phone number for the Senior LinkAge Line is 1-800-333-2433.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Section 3: Problems with your Benefits

Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go to the next section of this chapter, **Section 4, "Coverage decisions and appeals."**	Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint."**

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

What is a coverage decision?

A *coverage decision* is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medical Assistance (Medicaid), either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medical Assistance (Medicaid). If you or your doctor disagrees with our decision, you can appeal.

Section 4.2: Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- You can call us at **Member Services** at 952-967-7029 or 888-820-4285.
- Call the **Ombudsman for State Managed Health Care Programs** for free help. The Ombudsman for State Managed Health Care Programs helps people enrolled in Medical Assistance (Medicaid) with service or billing problems. The phone number is 651-431-2660 or 1-800-657-3729.
- Call the **State Health Insurance Assistance Program (SHIP)** for free help. The SHIP is an independent organization. It is not connected with this plan. In Minnesota the SHIP is called the Senior LinkAge Line. The phone number is 1-800-333-2433.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.

- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - » If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. You can also get the form on the Medicare website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at healthpartners.com/msho. The form will give the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.

  However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help to help you find the rules you need to follow. You only need to read the section that applies to your problem:

- **Section 5** gives you information if you have problems about services, items, and drugs (but not Part D drugs). For example, use this section if:
  - o You are not getting medical care you want, and you believe that this care is covered by our plan.
  - o We did not approve services, items, or drugs that your doctor wants to give you, and you believe that this care should be covered.
    - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Medical Assistance (Medicaid) covered drugs such as over the counter drugs are not covered by Part D. See Section 6 for Part D drug appeals.
  - o You received medical care or services that you think should be covered, but we are not paying for this care.
  - o You got and paid for medical services or items covered by Medicare only, and you want to ask us to pay you back.

        - **NOTE:** If the service or drug is covered by Medical Assistance (Medicaid), we cannot pay you back if you pay for the service or drug yourself. State and federal laws prevent us from paying you directly. If you paid for a Medical Assistance service or drug that you think we should have covered, contact Member Services at the number at the bottom of this page.
    - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
        - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8.

- **Section 6** gives you information about Part D drugs. For example, use this section if:
    - You want to ask us to make an exception to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List).
    - You want to ask us to waive limits on the amount of the drug you can get.
    - You want to ask us to cover a drug that requires prior approval.
    - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
    - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section 7** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
    - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should be using, please call Member Services at 952-967-7029 or 888-820-8245. You can also get help or information from the State Ombudsman for Managed Health Care Programs by calling 651-431-2660 or 1-800-657-3729.

Section 5: Problems about services, items, and drugs (not Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long term care services. You can also use this section for problems with drugs that are not covered by Part D. Medical Assistance (Medicaid) drugs such as over-the-counter drugs are not covered by Part D. Use Section 6 for Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. **You think the plan covers a medical, behavioral health or long-term care service that you need but are not getting.**

   What you can do: You can ask the plan to make a coverage decision. Go to Section 5.2 (page 11) for information on asking for a coverage decision.

2. **The plan did not approve care your doctor wants to give you, and you think it should have.**

   What you can do: You can appeal the plan's decision to not approve the care. Go to Section 5.3 (page 13) for information on making an appeal.

3. **You received services or items that you think the plan covers, but the plan will not pay.**

   What you can do: You can appeal the plan's decision not to pay. Go to Section 5.4 (page 17) for information on making an appeal.

4. **You got and paid for medical services or items covered by Medicare only, and you want the plan to reimburse you for the services or items.**

   What you can do: You can ask the plan to pay you back. Go to Section 5.5 (page 20) for information on asking the plan for payment.

   NOTE: If the service or drug is covered by Medical Assistance (Medicaid), we cannot pay you back directly. Contact Member Services at 952-967-7029 or 888-820-4285 for more information.

5. **Your coverage for a certain service is being reduced or stopped, and you disagree with our decision.**

What you can do: You can appeal the plan's decision to reduce or stop the service.

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 to find out more.

➔ In all cases where we tell you that medical care you have been getting will be stopped, use the information in Section 5.2 of this chapter as your guide for what to do.

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get a medical, behavioral health or long-term care service

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 952-967-7029 or 888-820-4285 TTY: 952-883-6060 or 800-443-0156.
- You can fax us at: 952-883-7333
- You can to write us at:

  HealthPartners
  Member Services
  MS 21103R
  P.O. Box 9463
  Minneapolis, MN 55440-9463

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you asked. If we don't give you our decision within 14 calendar days, you can appeal.

➔ Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, you should ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision **within 72 hours**.

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

The legal term *for "fast coverage decision" is* ***"expedited determination."***

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 952-967-7029 or 888-820-4285 or fax us at 952-853-8742. For the details on how to contact us, go to Chapter 2 page 4.
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

- You can get a fast coverage decision *only* if you are asking for coverage for medical care or an item *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care or an item you have already received.)
- You can get a fast coverage decision *only* if the standard 14 calendar day deadline could *cause serious harm to your health or hurt your ability to function.*
  - ➔ **If your doctor says that you need a fast coverage decision, we will automatically give you one.**
  - ➔ If you ask for a fast coverage decision, without your doctor's support, we will decide if you get a fast coverage decision.
    - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline instead.
    - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the

process for making complaints, including fast complaints, see Section 10 of this chapter.)

If the coverage decision is *Yes*, when will I get the service or item?

You will be approved to get the service or item within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked. If we extended the time needed to make our coverage decision, we will approve the coverage by the end of that extended period.

If the coverage decision is *No*, how will I find out?

If the answer is *No*, we will send you a letter telling you our reasons for saying *No*.

- If we say no, you have the right to ask us to reconsider – and change – this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below). You also have the right to skip Level 1 and ask for a State Fair Hearing if the coverage decision was for a service or item that could be covered by Medical Assistance (see Section 5.4 on page 17).

Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagrees with our decision, you can appeal.

In most cases, you must start your appeal at Level 1.

➔ **Please note:** You may request a State Fair Hearing at any time for services or items covered by Medical Assistance (Medicaid). That means that you do not have to file a Level 1 Appeal with the plan before you request a State Fair Hearing. If you do request a State Fair Hearing instead of filing an appeal with the plan first, the deadline for appealing to the plan does not change, as described below. For information about requesting a State Fair Hearing, see page 17.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at 952-967-7029 or 888-820-4285. For additional details on how to reach us for appeals, see Chapter 2, page 4.
- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
  - You can submit a request to the following address:

    HealthPartners
    Member Rights & Benefits
    MS 21103R
    P.O. Box 9463
    Minneapolis, MN 55440-9463
  - You may also ask for an appeal by calling us at 888-820-4285.

> ***The legal term*** *for "fast appeal" is* ***"expedited reconsideration."***

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get a Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or our website at healthpartners.com/msho.

➔ If the appeal comes from someone besides you or your doctor or other provider, we must receive the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an appeal?

You must ask for an appeal within 90 calendar days from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

➔ **Please note:** If you are appealing because you were told that a service you are getting will be reduced or stopped, you have a shorter timeframe to appeal if you want us to continue covering that service while the appeal is processing. For more information, read *"Will my benefits continue during Level 1 appeals"* on page 16.

Can I get a copy of my case file?

Yes. Ask us for a copy.

➔ We are allowed to charge a fee for copying and sending this information to you.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will the plan make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said *No* to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 30 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
- If we do not give you an answer to your appeal within 30 calendar days or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medical

Assistance (Medicaid) service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

- **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal.

- **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medical Assistance (Medicaid) service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

What happens if I ask for a fast appeal?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.
- If we do not give you an answer within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medical Assistance (Medicaid) service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

- **If our answer is *Yes*** to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

- **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medical Assistance (Medicaid) service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

Will my benefits continue during Level 1 appeals?

If the disputed service or item is covered by Medicare only, we will **not** continue to cover that service or item during your appeal. This includes drugs covered by Part D.

If the disputed service or item could be covered by Medical Assistance (Medicaid), we will continue to cover that service or item during your appeal if the following conditions are met:

- We previously approved coverage for the service or item but then decided to reduce or stop the coverage before the authorization expired. We will send you a notice before taking the action to reduce or stop your coverage.
- You file a Level 1 Appeal within 10 calendar days of the date on our notice or before the intended effective date of the action, whichever is later. Please note, you have 30 calendar days if you are appealing a denial of Nursing Facility Level of Care.
- Your treating provider agrees that you should continue to get the service or item.

If you meet all of these conditions, we will continue to cover the service or item until your Level 1 Appeal is resolved. If you lose the appeal, you may be billed for the service or item.

Section 5.4: Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says *No* at Level 1, what happens next?

If we say no to part or all of your Level 1 Appeal, we will send you a letter.

- If your problem is about a **Medicare** service or item, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a **Medical Assistance (Medicaid)** service or item, you can file a Level 2 Appeal yourself (if you have not already done so). The letter will tell you how to do this. Information is also below.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to the plan.

My problem is about a Medical Assistance service or item. How can I make a Level 2 Appeal?

Level 2 of the appeals process for Medical Assistance services is a State Fair Hearing. Remember, if your service is covered by Medical Assistance, you can request a State Fair Hearing at any time. That means you do not have to file a Level 1 Appeal with the plan before you ask for a State Fair Hearing.

➔ Please note: If you request a State Fair Hearing instead of filing an appeal with the plan first, the deadline for appealing to the plan does not change. See page 17 for more information.

A State Fair Hearing is a hearing at the State to review a decision made by the plan. 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 and appeals; or
- Any other action.

You must ask for a State Fair Hearing within 30 days of the date of the plan's notice to deny, reduce, or stop services. If you file a Level 1 Appeal with the plan first, you must ask for a State Fair Hearing within 30 days of the plan's appeal decision notice. You can have up to 90 days to request a State Fair Hearing if you have a good reason for being late.

Mail or fax your written request to:

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

Fax: 651- 431-7523

A Human Services Judge from the State Appeals Office will hold the hearing. You can choose to attend the hearing in person or by telephone. During your hearing, tell the Judge why you disagree with the decision made by the plan. You can ask a friend, relative, advocate, provider, or lawyer to help you.

The process can take between 30-90 days. If your hearing is about an urgently needed service and you need an answer faster, tell the State Appeals Office when you file your hearing request. If your hearing is about a medical necessity denial, you may ask for an expert medical opinion from an outside reviewer. There is no cost to you.

If you need help at any point in the process, contact the Ombudsman for State Managed Health Care Programs at 651-431-2660 or 1-800-657-3729.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity will do a careful review of the Level 1 decision, and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the Independent Review Entity. You will be notified when this happens.
- The Independent Review Entity is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file. We are allowed to charge you a fee for copying and sending this information to you.

➔ The Independent Review Entity must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

» However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

➔ If you had "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The review organization must give you an answer within 72 hours of when it gets your appeal.

» However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

Will my benefits continue during Level 2 appeals?

If the disputed service or item is covered by Medicare only, we will **not** continue to cover that service or item during your appeal. This includes drugs covered by Part D.

If the disputed service or item could be covered by Medical Assistance (Medicaid), we will continue to cover that service or item during your appeal if the following conditions are met:

- We previously approved coverage for the service or item but then decided to reduce or stop the coverage before the authorization expired. We will send you a notice before taking the action to reduce or stop your coverage.
- You file a request for a State Fair Hearing within 10 calendar days of the date on our notice or before the intended effective date of the action, whichever is later. Please note, you have 30 calendar days if you are appealing a denial of Nursing Facility Level of Care.
- Your treating provider agrees that you should continue to get the service or item.

If you meet all of these conditions, we will continue to cover the service or item until your State Fair Hearing is resolved. If you lose the hearing, you may be billed for the service or item.

How will I find out about the decision?

If you had a State Fair Hearing, the State Appeals Office will send you a written notice explaining its decision.

- If the State Appeals Office says *Yes* to part or all of what you asked for, we must promptly authorize the coverage.
- If the State Appeals Office says *No* to part or all of what you asked for, it means they agree with or affirm the plan's decision. This is called "upholding the decision."

If your Level 2 Appeal went to the Independent Review Entity, it will send you a letter explaining its decision.

- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we receive the IRE's decision.
- If the Independent Review Entity says *No* to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If the decision is *No* for all or part of what I asked for, can I make another appeal?

If you had a State Fair Hearing and you disagree with the ruling, you may appeal to the District Court in your county.

If your Level 2 Appeal went to the Independent Review Entity, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

See Section 9 of this chapter for more information on additional levels of appeal.

Section 5.5: Payment problems

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have gotten for covered services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

➔ **Please note:** If the service or item is covered by Medical Assistance (Medicaid), we cannot pay you back if you pay for the service or item yourself. State and federal laws prevent us from paying you directly. If you paid for a Medical Assistance service or item that you think we should have covered, contact Member Services at the phone number at the bottom of this page.

How do I ask the plan to pay me back for medical services or items I paid for?

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see if you followed all the rules for using your coverage.

- Remember, if the service or item is covered by Medical Assistance (Medicaid), we cannot pay you back directly. You should call Member Services if you paid for a service or item covered by Medical Assistance. Member Services can work with you and your provider to resolve your problem.
- If the medical care you paid for is covered by Medicare only and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we get your request.

  Or, if you haven't paid for the services or items yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying *Yes* to your request for a coverage decision.

- If the medical care is *not* covered, or you did *not* follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if the plan says they will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section 5.3. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.

➔ If we answer "no" to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity. We will notify you by letter if this happens.

  - If the IRE reverses our decision and says we should pay for the service or item, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is *Yes* at any stage of the appeals process after Level 2,

we must send the payment you asked for to you or to the provider within 60 calendar days.

- If the IRE says *No* to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 of this chapter for more information on additional levels of appeal.

➔ If we answer "no" to your appeal and the service or item is usually covered by Medical Assistance (Medicaid), you can request a State Fair Hearing (see Section 5.4 of this chapter).

Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medical Assistance (Medicaid) may cover, such as over-the-counter drugs. **This section only applies to Part D drug appeals.**

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List)
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> ***The legal term** for a coverage decision about your Part D drugs is **"coverage determination."***

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal.

Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter. Also see Sections 6.3 and 6.4.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs, or to use the drug without certain rules and limitations. If a drug is not on our

List of Covered Drugs, or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to all of our drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, section C, page 10).
   - The extra rules and restrictions on coverage for certain drugs include:
     - » Being required to use the generic version of a drug instead of the brand name drug.
     - » Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - » Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - » Quantity limits. For some drugs, the plan limits the amount of the drug you can have.
   - If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the co-pay amount we require you to pay for the drug.

> ***The legal term*** *for asking for removal of a restriction on coverage for a drug is sometimes called asking for a* ***"formulary exception."***

Section 6.3: Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for, and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say* Yes *or* No *to your request for an exception

- If we say *Yes* to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say *No* to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say *No*.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D Drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 952-967-7029 or 888-820-4285.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

  Read Section 4.2 page 8 to find out how to give permission to someone else to act as your representative.

  ➔ You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.

***At a glance:* How to ask for a coverage decision about a drug or payment**

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you want to ask us to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are requesting an exception, provide the "supporting statement." Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the "supporting statement."

  Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A standard coverage decision means we will give you an answer within 72 hours after we get your doctor's statement.
- A fast coverage decision means we will give you an answer within 24 hours.
  - » You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - » You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
  - » If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

    If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.

    If we decide to give you a standard decision, we will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision. You can file a "fast complaint" and get a decision within 24 hours.
  - » If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

> ***The legal term*** *for "fast coverage decision" is* ***"expedited coverage determination."***

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an outside independent organization will review your request and our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request or, if you are asking for an exception, after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review the decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review the decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we will make payment to you within 14 calendar days.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. This statement will also explain how you can appeal our decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 952-967-7029 or 888-820-4285.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request within 60 calendar days from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make you appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term** for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."

- You can ask for a copy of the information in your appeal and add more information.
- You have the right to ask us for a copy of the information about your appeal. We are allowed to charge a fee for copying and sending this information to you.

» If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

> ***The legal term*** *for "fast appeal" is* ***"expedited reconsideration."***

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said *No* to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for:

» If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

» If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No* and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say *No* to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity will review our decision.

- If you want the Independent Review Entity to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the Independent Review Entity, we will send them your case file. You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.

***At a glance:* How to make a Level 2 Appeal**

If you want the Independent Review Organization to review your case, your appeal request must be in writing.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have a right to give the Independent Review Entity other information to support your appeal.
- The Independent Review Entity is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.
  - » If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
  - » If the Independent Review Entity approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If the dollar value of the drug coverage you want meets a certain minimum amount, you can make another appeal at Level 3. The letter you get from the Independent Review Entity will tell you the dollar amount needed to continue with the appeals process. The Level 3 Appeal is handled by an administrative law judge.

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date." Our plan's coverage of your hospital stay ends on this date.
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights.* If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The *Important Message* tells you about your rights as a hospital patient, including:

- Your right to get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be a part of any decisions about the length of your hospital stay.
- Your right to know where to report any concerns you have about the quality of your hospital care.
- Your right to appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does ***not*** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 888-820-4285. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

  You can also see the notice online at https://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

➔ If you need help, please call Member Services at 888-820-4285. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

To make an appeal to change your discharge date, call KEPRO (the QIO for Minnesota) at: 1-855-408-8557 (TTY: 1-855-843-4776).

Call right away!

Call the Quality Improvement Organization ***before*** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

***At a glance:* How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-855-408-8557 and ask for a "fast review".

Call before you leave the hospital and before your planned discharge date.

➔ If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see the section below.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 888-820-4285. You can also call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> ***The legal** term for "fast review" is **"immediate review."***

What happens during the review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

> ***The legal term** for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at 888-820-4285. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/*

What if the answer is *Yes*?

- If the review organization says *Yes* to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is *No*?

- If the review organization says *No* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the review organization says No and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

You can reach KEPRO (the QIO for Minnesota) at: 1-855-408-8557 (TTY: 1-855-843-4776).

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days, the Quality Improvement Organization reviewers will make a decision.

***At a glance:* How to make a Level 2 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state and ask for another review.

What happens if the answer is *Yes*?

- We must pay you or the provider for our share of the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is *No*?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an appeal deadline?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say *Yes* to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you or the provider for our share of the costs of care you have received since the date when we said your coverage would end.

- **If we say *No* to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
  - » If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term** for "fast review" or "fast appeal" is **"expedited appeal."***

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

> ***At a glance:* How to make a Level 2 Alternate Appeal**
>
> You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the Independent Review Entity says *Yes* to your appeal, then we must pay you or the provider for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary.
- If this organization says *No* to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

  The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only*:

- Home health care services.

- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

  ➔ With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.

  ➔ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1: We will tell you in advance when your coverage will be ending

The agency or facility that is providing your care will give you a notice at least two days before we stop paying for your care.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does not mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying our share of the cost for your care.

Section 8.2: Level 1 Appeal to continue your care

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 952-967-7029 or 888-820-4285. Or call your State Health Insurance Assistance Program at 1-800-333-2433.

During a Level 1 Appeal, The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

> ***At a glance:*** **How to make a Level 1 Appeal to ask the plan to continue your care**
>
> Call the Quality Improvement Organization in your state and ask for another review.
>
> Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What should you ask for?

Ask them for an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4.

> ***The legal term*** *for the written notice is* ***"Notice of Medicare Non-Coverage."***
> *To get a sample copy, call Member Services at 952-967-7029 or 888-820-4285 or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at http://www.cms.hhs.gov/BNI/*

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- When you ask for an appeal, the plan must write a letter explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> ***The legal term*** *for the letter explaining why your services should end is* ***"Detailed Explanation of Non-Coverage."***

What happens if the reviewers say *Yes*?

- If the reviewers say *Yes* to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say *No*?

- If the reviewers say *No* to your appeal, then your coverage will end on the date we told you. We will stop paying for the care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said *No* to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

You can ask the Quality Improvement Organization to take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end. The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days.

***At a glance:* How to make a Level 2 Appeal to require that the plan cover your care for longer**

Call the Quality Improvement Organization in your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says *Yes*?

- We must pay you or the provider for the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says *No*?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

> ***At a glance:* How to make a Level 1 Alternate Appeal**
>
> Call our Member Services number and ask for a "fast review."
>
> We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say *Yes*** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

  It also means that we agree to pay you or the provider for the care you have received since the date when we said your coverage would end.

- **If we say *No*** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.
  - » If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term** for "fast review" or "fast appeal" is **"expedited appeal."***

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal.
- **If this organization says *Yes*** to your appeal, then we must pay you or the provider for the cost of care. We must also continue the plan's coverage of your services for as long as it is medically necessary.
- **If this organization says *No*** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

> ***At a glance:* How to make a Level 2 Appeal to require that the plan continue your care**
>
> You do not have to do anything. The plan will automatically send your appeal to the Independent Review Organization.

The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

> ***The formal name** for "Independent Review Organization" is **"Independent Review Entity."** It is sometimes called the **"IRE."***

Section 9: Taking your appeal beyond Level 2

Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting will have to meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Ombudsman for State Managed Health Care Programs. The phone number is 651-431-2660 or 1-800-657-3729.

Section 9.2: Next steps for Medical Assistance (Medicaid) services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medical Assistance (Medicaid). If you disagree with the ruling from the State Fair Hearing process, you may appeal to the District Court in your county by calling the county clerk. You have 30 days to file an appeal with District Court.

If you need help at any stage of the process, you can contact the Ombudsman for State Managed Health Care Programs at 651-431-2660 or 1-800-657-3729.

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems *only,* such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential.*

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- HealthPartners MSHO staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about physical accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

***At a glance:* How to make a complaint**

Call Member Services or send us a letter telling us about your complaint.

➔ If your complaint is about *quality of care*, you have more choices. You can:

1. Make your complaint to the Quality Improvement Organization,
2. Make your complaint to Member Services and to the Quality Improvement Organization, or
3. Make your complaint to Medicare.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

The legal term *for "complaint" is a* ***"grievance."***

The legal term *for "making a complaint" is* ***"filing a grievance."***

Section 10.1: Details and deadlines

- Call Member Services at 952-967-7029 or 888-820-4285. Complaints related to Part D must be made within 60 calendar days after you had the problem you want to complain about. All other complaints must be made within 90 calendar days after you had the problem you want to complain about.
- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

  Once we receive your written complaint, Member Rights & Benefits will begin to investigate your concerns. If we cannot resolve your concerns within 10 days, we will send you an acknowledgement letter, letting you know we received your written complaint.

We will mail our decision within 30 days of our receipt of your written complaint. If we need more information and an extension is in your best interest, we may take an additional 14 days to make our decision. The written decision will include any additional complaint rights you may have. If your concerns are about medical care or non-Medicare Part D drugs, you may also review your concerns with the Managed Care Ombudsman and/or the Minnesota Department of Health.

We will respond within 24 hours if you request a fast or expedited complaint because we are:

1. Processing your request or appeal for a service under our regular timeframe, or
2. Taking extra days to consider your request or appeal.

Please send your written complaint to us at:

HealthPartners
Member Rights & Benefits
MS 21103R
P.O. Box 9463
Minneapolis, MN 55440-9463

Or, you may fax your complaint to Member Rights & Benefits at 952-853-8742.

- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

> ***The legal term*** *for "fast complaint" is* ***"expedited grievance."***

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- **If we do not agree** with some or all of your complaint we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section 10.2: You can file complaints with the Office of Civil Rights

If you have a complaint about disability access or about language assistance, you can file a complaint with the Office of Civil Rights at the Department of Health and Human Services. The regional office for Minnesota is Region V. You can contact them at 1-800-368-1019. You may also have rights under the Americans with Disability Act. You can contact the Ombudsman for State Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 for assistance.

Section 10.3: You can make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (*without* making the complaint to us).
- Or you can make your complaint to us *and also* to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

The phone number for the Quality Improvement Organization is 1-855-408-8557 (TTY: 1-855-843-4776).

Section 10.4: You can tell Medicare about your complaint

You can also send your complaint to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

Chapter 10: Ending your membership in our Plan

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Introduction

This chapter tells about ways you can end your membership in our plan and your health coverage options after you leave the plan. You will still qualify for both Medicare and Medicaid benefits if you leave our plan.

A. When can you end your membership in our plan?

You can end your membership in HealthPartners MSHO at any time. Your membership will end on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month.

- For information on Medicare options when you leave our plan, see the table in Section C of this chapter, page 3.
- For information about your Medical Assistance (Medicaid) services when you leave our plan, see Section C of this chapter, page 4.

These are ways you can get more information about when you can end your membership:

- Call Member Services at 952-967-7029 or 888-820-4285, **October 1 through February 14**, 8 a.m. to 8 p.m. **seven days a week, February 15 to September 30,** 8 a.m. to 8 p.m. **Monday - Friday**. TTY users should call952-883-6060 or 800-443-0156.
- Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433. In Minnesota, the SHIP is called the Senior LinkAge Line.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

B. How do you end your membership in our plan?

Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed at the bottom of this page).

- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in Section C of this chapter.

C. If you leave our plan, how do you get Medicare and Medicaid services?

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
Another Medicare health plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433. In Minnesota, the SHIP is called the Senior LinkAge Line. You will automatically be disenrolled from HealthPartners MSHO when your new plan's coverage begins.

2. You can change to: **Original Medicare *with* a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433. In Minnesota, the SHIP is called the Senior LinkAge Line. You will automatically be disenrolled from HealthPartners MSHO when your Original Medicare coverage begins.
3. You can change to: **Original Medicare *without* a separate Medicare prescription drug plan** **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the Senior LinkAge Line at 1-800-333-2433.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433. In Minnesota, the SHIP is called the Senior LinkAge Line. You will automatically be disenrolled from HealthPartners MSHO when your Original Medicare coverage begins.

How you will get Medicaid services

If you leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services.

You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. Contact your county financial worker if you have questions.

If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

D. Until your membership ends, you will keep getting your medical services and drugs through our plan

If you leave HealthPartners MSHO, it may take time before your membership ends and your new Medicare and Medical Assistance (Medicaid) coverage begins. During this time, you will keep getting your health care and drugs through our plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

E. Your membership will end in certain situations

These are the cases when HealthPartners MSHO must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medical Assistance (Medicaid). Our plan is for people who qualify for both Medicare and Medicaid. If you have Medicare and lose eligibility for Medical Assistance (Medicaid), our plan will continue to provide plan benefits for up to three months. If after three months you have not regained Medical Assistance (Medicaid), coverage with our plan will end. You will need to choose a new Part D plan in order to continue getting coverage for Medicare covered drugs. If you need help, you can call the Senior Linkage Line at 1-800-333-2433.
- If you do not pay your medical spenddown, as applicable.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - » If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to prison.

- If you lie about or withhold information about other insurance you have for prescription drugs.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medical Assistance (Medicaid) first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your ID card to get medical care.
  - » If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

F. We *cannot* ask you to leave our plan for any reason related to your health

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week. You should also call the Ombudsman for State Managed Health Care Programs at 651-431-2660 or 1-800-657-3729. You should also call Medical Assistance (Medicaid) at the Minnesota Department of Human Services at 651-431-2670 (Twin Cities Metro area) or 800-657-3739 (outside the Twin Cities Metro area). TTY users should call 800-627-3529 or 711.

G. You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also see Chapter 9, section 10, page 45 for information about how to make a complaint.

H. Where can you get more information about ending your plan membership?

If you have questions or would like more information on when we can end your membership, you can call Member Services at the number at the bottom of the page.

Chapter 11: Legal notices

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medical Assistance (Medicaid) programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your physical or mental condition, health status, need for or receipt of health services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation, national origin, race, color, religion, or political beliefs. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

C. Notice about Medicare as a second payer and Medical Assistance (Medicaid) Third Party Liability

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization, or insurance or Workers compensation if you are in a car accident or if you are injured at work. We have the right and

responsibility to collect for covered Medicare services for which Medicare is not the first payer. In addition, Federal and State laws provide that Medical Assistance (Medicaid) benefits pay only if no other source of payment exists.

We have the right and responsibility to collect for covered services when there is another source of payment. 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.

Chapter 12: Definitions of important words

Actions: These include:

- Denial or limited authorization of type or level of service
- Reduction, suspension, or stopping of a service that was approved before
- Not providing services in a reasonable amount of time
- Denial of member's request to get services out of network for members living in a rural area with only one health plan.

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

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called "aid paid pending."

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

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

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

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan's cost sharing amount for services.
As a member of HealthPartners MSHO, you only have to pay the plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.

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

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

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

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

Catastrophic coverage stage: The stage in the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the $4,700 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, section G, page 20 explains how to contact CMS.

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

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies.

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

Co-payment (or Co-pay): A fixed amount you pay as your share of the cost each time you get a service or supply. For example, you might pay $2 or $5 for a service or a prescription drug.

Cost sharing: Amounts you have to pay when you get services or drugs. Cost sharing includes co-payments and coinsurance.

Cost sharing tier: A group of drugs on the *List of Covered Drugs* with the same co-pay.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision.

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

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

Daily cost sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a co-payment. A daily cost sharing rate is the co-payment divided by the number of days in a month's supply. Here is an example: If your co-payment for a one-month supply of a drug is $1.20, and a one-

month's supply in your plan is 30 days, then your "daily cost sharing rate" is $0.04 per day. This means you pay $0.04 for each day's supply when you fill your prescription.

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

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

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

Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

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. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

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

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

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy," or "LIS."

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

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

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

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

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

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

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

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

Hospice: A program of care and support for people who are terminally ill to help them live comfortably. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. An enrollee who has six months or less to live has the right to elect hospice. HealthPartners MSHO must give you a list of hospice providers in your geographic area.

Initial coverage stage: The stage before your total Part D drug expenses reach $4,700. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

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

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

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

Low-income subsidy (LIS): See "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, section H, page 21 for information about how to contact Medicaid in your state.

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

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

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

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

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

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

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

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

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. HealthPartners MSHO includes Medicare Part D.

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

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

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

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2, section A, page 3 for information about how to contact Member Services.

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

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

Model of care: The Model of Care describes the management, procedures, and operations system that HealthPartners has in place to provide access to services, coordination of care and structure needed to best provide services and care for the MSHO population.

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

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services. We call them "network providers" when they 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."

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

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

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 Plan's network – to get these services.

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

Ombudsman: An office in your state that helps you if you are having problems with our plan. The ombudsman's services are free.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in our plan, you can choose Original Medicare.

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

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 explains out-of-network providers or facilities.

Out-of-pocket costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. See the definition for "cost sharing" above.

Part A: See "Medicare Part A."

Part B: See "Medicare Part B."

Part C: See "Medicare Part C."

Part D: See "Medicare Part D."

Part D drugs: See "Medicare Part D drugs."

Primary care provider (PCP): Your primary care provider 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 stay 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. See Chapter 3, section D, page 6 for information about getting care from primary care providers.

Prior authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4, section D, page 5. Some drugs are covered only if you get prior authorization from us. Covered drugs that need prior authorization are marked in the *List of Covered Drugs*.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See Chapter 2, section F, page 19 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription or how many refills you can get.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4 to learn more about rehabilitation services.

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. The restricted recipient program does not apply to Medicare-covered services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. The plan may drop you if you move out of the plan's service area.

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

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

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

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

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

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

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

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

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

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

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-820-4285. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-820-4285. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin:
我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1-888-820-4285。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese:
您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-888-820-4285。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-820-4285. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-820-4285. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-820-4285 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-820-4285. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-888-820-4285번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-820-4285. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-028-5824 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-820-4285 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-820-4285. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-820-4285. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-820-4285. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-820-4285. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品
処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-820-4285 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

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HealthPartners MSHO Member Services

CALL	Local: 952-967-7029 Outside the metro area: 888-820-4285 Calls to this number are free. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	Local: 952-883-6060 Outside the metro area: 800-443-0156 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. From **October 1 through February 14**, we take calls from 8 a.m. to 8 p.m., **seven days a week**. You will speak with a representative. From **February 15 to September 30**, call us 8 a.m. to 8 p.m. **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.
FAX	952-883-7333

WRITE	HealthPartners Member Services MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 Or deliver in person to: HealthPartners Member Services 8170 33rd Avenue South Bloomington, MN 55425
WEB SITE	**healthpartners.com/msho**

Senior LinkAge Line, Minnesota's SHIP

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

CALL	1-800-333-2433
TTY	Call the Minnesota Relay Service at 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
WEB SITE	http://www.mnaging.net/ and http://www.minnesotahelp.info/public/