HealthPartners® Inspire (SNBC)

Member Handbook
January 1, 2019

This booklet contains important information about your health care services.

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

Telephone: 952-967-7998 or 1-866-885-8880 (toll free)
711 (TTY)

Website: www.healthpartners.com

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

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

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

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

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請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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

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

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်.
ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဖဲဒဉ်လ်ာ် တီလ်ာ်မီတခါအံၤန္ဉ်,ကိးဘဉ်လီတဲစီနိ်ာ်ဂ်ၤလၢထးအံၤန္ဉ်တကွ်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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

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

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

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

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

Civil Rights Notice

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

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

Auxiliary Aids and Services

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

Language Assistance Services

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

Civil Rights Complaints

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

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

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

- Race
- Color
- National Origin
- Age
- Disability
- Sex

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

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

Minnesota Department of Human Rights (MDHR)

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

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

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

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

Minnesota Department of Human Services (DHS)

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

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

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

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

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

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

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

HealthPartners Complaint Notice
You have the right to file a complaint with HealthPartners if you believe you have been discriminated against because of any of the following:

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

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
Office of Integrity and Compliance, MS 21103K
HealthPartners
P.O. Box 1309
Minneapolis, MN 55440-1309
Toll Free: 1-844-3633-8732
TTY: 711
Fax: 952-883-5522
Email: integrityandcompliance@healthpartners.com

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

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Gives you contact information for our Plan and other organizations that can help you.

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Tells you important things you need to know about getting health care as a member of our Plan.

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Tells you which health care services are covered and not covered for you as a member of our Plan. Also tells you about restrictions and/or limitations on covered services.

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Welcome to HealthPartners

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

HealthPartners (referred to as "we," "us," or "our") is part of Special Needs BasicCare (SNBC). The Minnesota Department of Human Services designed this voluntary program to provide special care for people with disabilities. It combines doctor, hospital, nursing home, dental, behavioral health, rehabilitative, and other health care into one coordinated care system. You will get most of your health services through the Plan's network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which qualified health care provider to see.

This Member Handbook is our contract with you. It is an important legal document.

This Member Handbook includes:

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

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

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

Medical Equipment and Supplies

Covered Services:

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

Not Covered Services:

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

Notes:

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

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

Mental Health/Behavioral Health Services

Covered Services:

- Case management for transitional youth *(for members ages 17 through 21)*
- Clinical Care Consultation
- Crisis response services including:
    - Screening
    - Assessment
    - Intervention
    - Stabilization
    - Community intervention
- Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorders

** Requires or may require a prior authorization.*

- Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP)
- Inpatient psychiatric hospital stay, including extended inpatient psychiatric hospital stay*****
- Mental health provider travel time
- Mental Health Targeted Case Management (MH-TCM)
- Subacute psychiatric level of care *(for members under age 21)*
- Outpatient mental health services including:
    - Explanation of findings
    - Certified family peer specialists *(for members under age 21)*
    - Family psychoeducation services (*for members under age 21*)
    - Mental health medication management
    - Neuropsychological services
    - Psychotherapy (patient and/or family, family, crisis, and group)
    - Psychological testing
- Physician Mental Health Services including:
    - Health and behavior assessment/intervention
    - Inpatient visits
    - Psychiatric consultations to primary care providers
    - Physician consultation, evaluation, and management
- Rehabilitative Mental Health Services including:
    - Assertive Community Treatment (ACT)
    - Adult day treatment
    - Adult Rehabilitative Mental Health Services (ARMHS) is available to members 18 or over
    - Certified Peer Specialist (CPS) support services in limited situations
    - Children's mental health residential treatment services *(for members under age 21)*
    - Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment *(for members under age 21)*
    - CTSS mental health service plan development *(for members under age 21)*
    - Family psychoeducation services *(for members under age 21)*
    - Intensive Residential Treatment Services (IRTS)*****
    - Intensive Treatment Foster Care Services *(for members under age 21)*
    - Partial Hospitalization Program (PHP)
    - Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services *(for members ages 18 through 20)*
- Treatment services at children's residential mental health treatment facilities. Treatment services do not include coverage for room and board. Room and board may be covered by your county. Call your county for information.*****
- Psychiatric Residential Treatment Facility (PRTF) for children 21 and under*****
- Certified Community Behavioral Health Clinics (CCBHC)
- Forensic Assertive Community Treatment (FACT)
- Telemedicine

** Requires or may require a prior authorization.*

Not Covered Services:

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

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

Notes:

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

Use a Plan network provider for mental health services.

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

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

Nursing Home Services*

Covered Services:

- Nursing Home Room and Board – We are responsible for paying a total of 100 days of nursing home room and board. If you need continued nursing home care beyond the 100 days, the Minnesota Department of Human Services (DHS) will pay directly for your room and board. If DHS is currently paying for your room and board in the nursing home, DHS, not us, will continue to pay for your room and board.
- Nursing care
- Therapy services
- Drugs covered under Medical Assistance
- Medical supplies and equipment

Not Covered Services:

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

** Requires or may require a prior authorization.*

Obstetrics and Gynecology (OB/GYN) Services

Covered Services:

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

Not Covered Services:

- Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) or 711 (TTY) for coverage information. Also see Section 9.
- Planned home births

Notes:

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

Out-of-Area Services

Covered Services:

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

** Requires or may require a prior authorization.*

Not Covered Services:

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

Out-of-Network Services

Covered Services:

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

Prescription Drugs (for members who do NOT have Medicare)

Covered Services:

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

Not Covered Services:

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

Notes:

The drug must be on our list of covered drugs (formulary). On July 1, 2019, our formulary will be changing to more closely match the formulary of all Medicaid plans. If a drug you are taking will be affected, you will receive notice from HealthPartners.

** Requires or may require a prior authorization.*

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

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization (PA):** HealthPartners requires you or your health care provider to get prior authorization for certain drugs. This means that you will need to get approval from HealthPartners before you fill your prescriptions. If you don't get approval, HealthPartners may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, HealthPartners limits the amount of the drug that HealthPartners will cover.
- **Preferred/Non-Preferred (P/NP):** For some groups of drugs, HealthPartners requires you to try the preferred drugs before paying for the non-preferred drugs. In order to receive a non-preferred drug, your doctor or health care provider will have to get prior authorization.
- **Age Requirements:** In some cases, there are age requirements for you to try certain drugs. A prior authorization is needed depending on your age and the specific drug prescribed.
- **Brand-name Drugs*:** Brand-name version of the drug will be covered by HealthPartners only when:
    1. Your prescriber informs HealthPartners in writing that the brand name version of the drug is medically necessary; OR
    2. HealthPartners prefers the dispensing of the brand-name version over the generic version of the drug; OR
    3. Minnesota Law requires the dispensing of the brand-name version of the drug

You can find out if your drug requires prior authorization, has quantity limits, has Preferred/Non-Preferred status, or has an age requirement by contacting Member Services or visiting our website at https://www.healthpartners.com/public/pharmacy/formularies/medicaid/. A drug restriction or limit can be removed if your doctor submits a statement or documentation supporting the request. You can also get more information about the restrictions applied to specific covered drugs by contacting Member Services or visiting our website at https://www.healthpartners.com/public/pharmacy/formularies/medicaid/.

If HealthPartners changes prior authorization requirements, quantity limits, and/or other restrictions on a drug you are currently taking, HealthPartners will notify you and your prescriber of the change at least 10 days before the change becomes effective.

** Requires or may require a prior authorization.*

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

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

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

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

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

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

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

Specialty drugs are used by people with complex or chronic diseases. These drugs often require special handling, dispensing, or monitoring by a specially-trained pharmacist.

If you are prescribed a drug that is on the HealthPartners Specialty Drug List, your prescriber will need to send the prescription of that specialty drug to one of HealthPartners's Specialty Pharmacies listed below:

Name of Specialty Pharmacy:	**Cystic Fibrosis Medications** **Fairview Specialty Pharmacy**
Phone:	612-672-5260 **Toll-free:** 800-595-7140
Fax:	866-347-4939
Hours of Operation:	Mon-Fri: 8 a.m. – 7 p.m. (CST) Sat: 8 a.m. – 4 p.m. (CST) Sun: Closed

Name of Specialty Pharmacy:	**Infertility Medications** **Walgreens** retail store in Minnesota
Phone:	612-377-3308
Fax:	612-377-5670
Hours of Operation:	Pharmacy is open 24 hours

Name of Specialty Pharmacy:	**AllianceRx Walgreens Prime – Frisco, Texas**
Phone:	800-424-9002
Fax:	800-874-9179
Hours of Operation:	(Central Time) Monday-Friday: 7 a.m. – 7 p.m. Saturday: 9 a.m. – 3 p.m.

	All other specialty medications
Name of Specialty Pharmacy:	**CVS Caremark Specialty Pharmacy**
Phone:	800-368-1624
Fax:	800-441-5809
Hours of Operation:	Mon-Fri: 9 a.m. – 9 p.m. CST, Sat: 10 a.m. – 2 p.m. CST

You will also need to call the Specialty Pharmacy that receives your prescription to set up an account. You will need to have your HealthPartners Member ID card when you call the Specialty Pharmacy.

Prescription Drugs (for members who have Medicare)

Covered Services:

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

Not Covered Services:

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

Notes:

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

Rehabilitation

Covered Services:

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

Not Covered Services:

- Vocational rehabilitation
- Health clubs and spas

Substance Use Disorder Services

Covered Services:

- Screening/Assessment/Diagnosis
- Outpatient treatment
- Inpatient hospital
- Residential non-hospital treatment*
- Outpatient methadone treatment
- Detoxification (Only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification)
- Substance use disorder treatment coordination
- Peer recovery support

Not Covered Services:

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

Notes:

See Section 1 for Substance Use Disorder Services contact information.

A qualified assessor who is part of the Plan network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor. We will do this within five working days of when we get your request. If you agree with the second assessment, we will authorize services according to substance use disorder standards and the second assessment. You have the right to appeal. See Section 13 of this Member Handbook.

** Requires or may require a prior authorization.*

Surgery

Covered Services:

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

Not Covered Services:

- Cosmetic surgery

Telemedicine Services

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

Transplants*

Covered Services:

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

Notes:

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

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

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

** Requires or may require a prior authorization.*

Transportation to/from Medical Services

Covered Services:

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

Not Covered Services:

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

Notes:

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

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

To arrange transportation to and from a covered health service, contact RideCare at 952-883-7400 or 1-888-288-1439 (toll free), 711 (TTY), Monday through Friday, 7 a.m. to 7 p.m

Urgent Care

Covered Services:

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

Not Covered Services:

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

** Requires or may require a prior authorization.*

Notes:

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

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

Section 8. Services we do not cover

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

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

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

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

- Abortion services
- Case management for members with developmental disabilities
- Child welfare targeted case management
- Day training and habilitation services
- HIV case management
- Home Care Nursing (HCN): To learn more about HCN services, contact a home care agency for an assessment. To find a home care agency in your area, call the MHCP Member Helpdesk number listed above.
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Job training and educational services

- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance (Medicaid)
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays that exceed 100 days. See "Nursing Home Services" in Section 7.
- Personal Care Assistance (PCA). Community First Services and Supports (CFSS) replaces PCA services upon federal approval. Contact your county of residence intake for long-term care services and supports to learn more about PCA services and to arrange for an assessment.
- Post-arrest Community-Based Services Coordination
- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Room and board associated with treatment services at children's residential mental health treatment facilities. Room and board may be covered by your county. Call your county for information.
- Services provided by federal institutions
- Services provided by a state regional treatment center or a state-owned long-term care facility.
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Home and Community-Based Services waivers

Section 10. When to call your county worker

Call your county worker to report these changes:

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

Section 11. Using the Plan coverage with other insurance

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

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

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

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

If your other insurance changes, call your county worker.

Section 12. Subrogation or other claim

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

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

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

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

Grievance and appeal system terms to know:

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

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

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

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

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

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

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

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of a payment for a service
- not providing services in a reasonable amount of time
- our failure to act within required timelines for prior authorizations and appeals
- financial liability, including copayments or other cost sharing
- any other action

Important Timelines For Appeals

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

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

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

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

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

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

To file an oral or written appeal with us:

You may appeal by phone, writing, fax, or in person. The contact information and address is found in Section 1 under "Appeals and Grievances."

If you call us with your appeal, it must be followed by a written appeal, unless you are requesting a fast resolution. We will help you complete a written appeal. We will ask you to sign and return the written appeal.

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

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

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

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

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

You or your representative may present your information in person, by telephone, or in writing.

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

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

You must file a health plan Appeal to us before you ask for a State Appeal. You must ask for a state appeal **within 120 days** from the date of our appeal decision (resolution).

Your appeal to the state must be in writing. You can write to the Minnesota Department of Human Services to request a state appeal.

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

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

Or fax to: 651-431-7523

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

A human services judge from the state Appeals Office will hold a hearing. You may ask to attend the hearing by telephone, by video, or in person. You can ask your providers or others to give testimony. You can provide documents for the judge to consider.

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

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

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

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

Grievances (Complaints)

You may file a Grievance with us **at any time**. There is no timeline for filing a grievance with us. **To file an oral grievance with us:**

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

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

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

To file a written grievance with us:

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

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

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

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

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health.

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

Call: 1-800-657-3916 or (651) 201-5100
711 (TTY)

Visit: http://www.health.state.mn.us/hmo

You can also call the Ombudsman for Public Managed Health Care Programs for help. The contact information is listed below this section.

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

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

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

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

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

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

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

Or

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

Fax to: 651-431-7472

Section 14. Definitions

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

Action: This includes:

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

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

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing a written or oral appeal.

Child: Member under age 21.

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

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

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

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

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

Cultural Competency: The ability of managed care organizations and the providers within their network to provide care to recipients with diverse values, beliefs, and behaviors, and to tailor the delivery of care to meet recipients' social, cultural, and linguistic needs. The ultimate goal is a health care delivery system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, sexual orientation, disability, religion, or socioeconomic status.

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

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

Disenroll or Disenrollment: The process of ending your membership in our plan.

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

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

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

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

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

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

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

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

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

Formulary: The list of drugs covered under the Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Network: Our contracted health care providers for the Plan.

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

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

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

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

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

Out-of-Network Provider or Out-of-Network Facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. This is also known as a non-participating provider.

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

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

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

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

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

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

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

Prescriptions: Medicines and drugs ordered by a medical provider.

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

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

Primary Care Clinic: The primary care clinic (PCC) you choose for your routine care. This clinic will provide most of your care.

Primary Care Physician: Your primary care physician (PCP) is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

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

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

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

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

Restricted Recipient Program (RRP): A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated primary care provider, one pharmacy, one hospital or other designated health care provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

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

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

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

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

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

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

Special Needs BasicCare (SNBC): A voluntary managed care program for people with disabilities. SNBC is for people who have Medical Assistance (Medicaid) and are ages 18-64. SNBC covers the basic Medical Assistance (Medicaid) health care services, except for personal care assistance and home care nursing.

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

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

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

Substance Use Disorder: Using alcohol or drugs in a way that harms you.

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

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