HealthPartners Products for Commercial Business

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HealthPartners Primary Clinic & HealthPartners Primary Clinic Choice Plans

How HealthPartners Primary Clinic Plans Work

HealthPartners Primary Clinic Plan members do not have out of network benefits. Members have access to a large network of HealthPartners providers committed to providing high quality care and excellent service.

Members must utilize the primary clinic's panel of specialty providers or obtain a referral from the primary clinic for care outside of the specialty panel. Not all contracted providers will be considered in network for members with this plan type.

HealthPartners Primary Clinic Choice Plan members do have out of network benefits and receive the highest level of benefits when care is received from a network provider.

Selecting a clinic

Upon enrollment, HealthPartners members select a primary care clinic in the network. Each covered family member may select a different primary care medical group.

Insurance card identifies a Primary Care Clinic Plan Member

Sample Insurance Card Primary Clinic Choice Plan

FRONT OF MEMBER CARD


Emergency & Urgently Needed Care
Print Date: 07/08
For emergency situations, call 911 and/or get medical attention immediately.
For medical needs after clinic hours, if possible call the CareLine℠ service at 612-339-3663 or 1-800-551-0659 or call your clinic.
Precertification
Contact CareCheck℠ at 952-883-5800 or 1-800-942-4872 for any admission not directed by a network physician.
Claims Submission: Provider: healthpartners.com/electronicconnectivity
Medical: HealthPartners Claims, P.O. Box 1289, Minneapolis, MN, 55440-1289.
Pharmacy: Provider: healthpartners.com/formulary
Member Services: healthpartners.com
HealthPartners Member Services, P.O. Box 1309, Minneapolis, MN, 55440-1309, phone 952-883-5000 or 1-800-883-2177. For TTY call 952-883-5127 or 1-888-850-4762.
Minnesota Commissioner of Health Appeals: phone 651-201-5100 or 1-800-657-3916.
Coverage includes optometry care through the PHCS network.
AWAY FROM HOME CARE
Offered by HealthPartners

BACK OF MEMBER CARD

"Offered by HealthPartners" indicates the member is in a fully-insured group.
"Administered By HealthPartners Administrators, Inc." indicates the member is in a self- insured group.

Primary care clinic plans may require referrals for claims payment

Most employer groups choose plans with an open access network which do not require a referral. Some employers, however, choose primary clinic plans which may require referrals.

A few examples of the primary clinic plan product types which may require referrals are:

- **HealthPartners Primary Clinic Copay Options IV SI**
- **Park Nicollet First Plan**
- **HP Tiered Referral - Benefit Level 1, 2, 3 & 4**

Providers are encouraged to check eligibility and contact Member Services to verify if referrals are required. Eligibility may be checked on the Provider Portal at www.HealthPartners.com/provider/. After logging in, select Eligibility from the drop down menu under the heading Applications. Member Services contact information is listed on page 1 of this manual under HealthPartners Contacts.

The preferred method for referral submission is online through the Provider Portal using the Referral Maintenance Application at www.HealthPartners.com/provider. After logging in, select Referral Inquiry or Referral Maintenance to create, update, view and retrieve/answer Referral Authorization Inquiries (RAI). Otherwise a referral can also be made by completing a *Provider Recommendation Form* (found in Claims Section of this manual) and faxing or mailing it to the Claims department.

Importance of Primary Care Clinics responding to all RAIs

An RAI is generated when a member receives services outside of their assigned primary clinic's specialty referral network. To process claims, Primary Care Clinics need to respond to these RAI's even if the care was not referred by the Primary Clinic care system. RAI notifications are sent to Primary Care providers via the Provider Portal. There is no indicator on the Provider Portal that an RAI has been sent when you log on so it is important to check your work queues regularly to view and respond to RAI's.

HealthPartners Open Access / HealthPartners Open Access Choice Plans, Distinctions, HealthPartners Open Access Perform Network & Small Group Perform, CareChoices Network, the Park Nicollet and HealthPartners Achieve & Peak Networks and HealthPartners Open Access State of Wisconsin

HealthPartners Open Access , Open Access Choice, and Distinctions Plans

HealthPartners Open Access and **HealthPartners Open Access Choice** plans allow members to access any primary or specialty care provider within the Open Access Network without a referral. Members do not select a primary care clinic.

Members who have a **HealthPartners Open Access Choice** plan can visit an open access network provider or an out-of-network provider. Members receive the highest level of benefits when care is received from a network provider.

Providers in the **Distinctions** open access network are designated to one of the two or three benefit tiers. Member liability will vary on which tier the provider is in.

The Mayo Clinic *primary* care (family medicine, internal medicine, pediatrics) providers are not part of the **Distinctions** network (unless the delivery network indicates **Distinctions *w/Mayo***). The Mayo *specialty* providers are in the **Distinctions** network.

The **Distinctions** plan is also available as a choice product. Members enrolled in the **Distinctions Choice** product have a supplemental benefit tier in addition to their HealthPartners benefits. Members on this plan will receive their HealthPartners benefits when accessing providers within the **Distinctions** network. If they access a provider outside of the Open Access network, they will receive their supplemental benefits.

HealthPartners Open Access Perform and Small Group Perform Networks

- The Open Access Perform Network allows members to visit more than 700,000 network providers and 5,800 network hospitals in the United States as part of HealthPartners strategic alliance with CIGNA HealthCare.

- This network DOES NOT include in-network access to Mayo Health System, Mayo Clinic-Rochester, St. Mary's Hospital, or Rochester Methodist Hospital. The Small Group Perform Network, in addition, excludes Gunderson Lutheran and Sanford-Sioux Falls. Members WILL be able to access these locations using their out-of-network benefits.

- Members do not select a primary care clinic and do not need referrals to see a specialist.

CareChoices Network

The CareChoices network is an open access network where members choose a care system as their main provider of care. When members access their care system for medical care, they receive their best benefit level. Members are also able to access other providers in the network but would pay a higher copay or coinsurance amount.

In addition, a member's monthly premium contribution is determined by the care system they choose. Member premiums are based on the chosen care system's Total Cost Index (TCI). The higher the TCI for the provider, the higher the premium and co-payments/coinsurance are for the member.

Park Nicollet and HealthPartners Achieve & Peak Networks

Achieve is offered to all group markets and **Peak** to the individual market.

- The Park Nicollet and HealthPartners Achieve & Peak Networks are focused networks and not all contracted providers will be in-network.
- Members do not select a primary care clinic and do not need referrals to see a specialist.
- These networks are only marketed in the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Morrison, Benton, Stearns, Sherburne, Wright, Meeker, Chisago, McLeod and Washington.

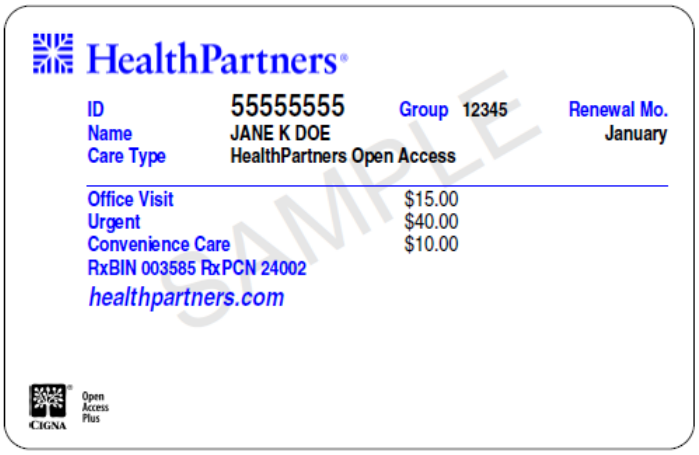
HealthPartners Open Access State of Wisconsin

- The State of Wisconsin has a custom network. This is a focused network and not all contracted providers will be in-network.
- This network is marketed only to employees who live in Pierce, Polk, St. Croix, Burnett and Douglas counties, and to State of WI members living in MN.
- Members do not have out-of-network coverage and have no benefits outside of the network.

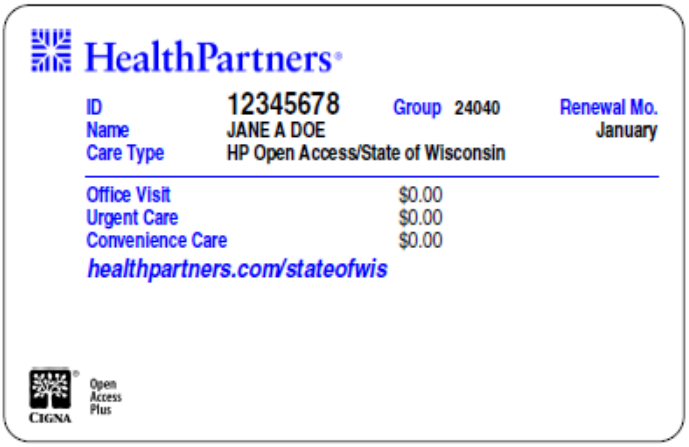
Insurance card identifies an Open Access Plan Member

Sample Insurance Card for Member with Open Access Plan

SAMPLE # 1 FRONT OF CARD



SAMPLE #2 FRONT OF CARD



SAMPLE #3 FRONT OF CARD

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HealthPartners Workers' Compensation Managed Care Plan

HealthPartners Workers' Compensation Managed Care Plan (WCMCP) is certified by the Minnesota Department of Labor and Industry (DOLI).

How the Plan Works

Providers in this network work with HealthPartners Worker's Compensation Managed Care Plan case managers, who are registered nurses, to manage the medical care of injured workers from the point of injury to the time they return to maximum function.

The injured employee is directed to call HealthPartners 24-hour CareLine which will direct the patient to the designated clinic assigned for their associated employer group. If the employee wants to be seen by his/her own family practice physician, Managed Care statutes state the patient must have been treated by this physician at least twice within the last two years. The employee will receive follow-up care from this facility or another participating facility if specialty care is needed.

Member Identification

After identifying that the patient was injured at work, please follow your normal protocol of asking the patient where he/she works. The patient may be accompanied by an assigned qualified rehabilitation consultant (QRC). The QRC may be assigned by the insurer, commissioner or chosen by the patient.

Medical Record Dictation

Due to differences in data privacy between workers' compensation (W/C) and general medical care, two separate dictations should be made when a patient is seen for both a workers' compensation injury/illness and a non-work related condition. The W/C dictation should indicate that this is a workers' compensation injury. If this is the first encounter for the W/C injury/illness, it should document the basis for the work-relatedness.

Report of Work Ability Form

Within 24 hours of each visit, please fax a completed *Report of Work Ability Form* to the HealthPartners Case Management Office at 952-853-8732. Also, please give a copy of the form to the patient. This form is essential for the employer to determine appropriate accommodations that conform to the medical assessment of the patient's safe, functional capabilities. More complete information is available on the DOLI website at www.doli.mn.gov

Claim Submission

Submit all claims with a copy of the medical progress notes to the patient's Workers' Compensation carrier. You may contact the case management office at 952-883-5396 for the correct billing address.

PreCertification/Referrals

Please call the HealthPartners case management office at the number listed below to request a pre-certification or referral. If specialty care is needed, please direct the patient to participating providers listed in the HealthPartners Workers' Compensation Provider Directory. When sending a patient to a provider outside of your clinic, make sure you refer to an appropriate in-network facility. Clearly state to the employee exactly what services are being approved and when to check back with you. If the patient needs a specialist who is not listed in the HealthPartners WCMCP Provider Directory, which can be found at http://www.healthpartners.com/files/41795.pdf, call a HealthPartners case manager for assistance at 952-883-5396.

To schedule an appointment within 24 hours of injury:

24/7 CareLine: 952-883-5484 or 888-544-5484 toll free

For referrals, treatment and other case management questions**: 952-883-5396 or 888-779-3625 toll free or 952-853-8732 fax**

HealthPartners Products for Medicare Eligible Individuals

HealthPartners Products for Medicare Eligible Individuals

I. HEALTHPARTNERS FREEDOM MEDICAL PLANS: BASIC, VITAL, BALANCE & ULTIMATE. HEALTHPARTNERS FREEDOM PLANS WITH MEDICARE PRESCRIPTION DRUG COVERAGE; VITAL W/RX, BALANCE W/RX, ULTIMATE W/RX & ULTIMATE W/ENHANCED RX.

Type of Program: These are Medicare "Cost" plans

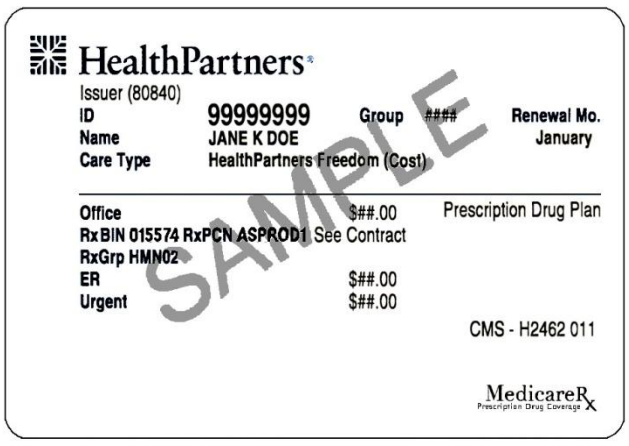
Primary Payer: Medicare is primary for all Medicare Part A services and for Part B Medicare services not received from plan providers. HealthPartners is primary for all Medicare Part B services that are received through the health plan's network.

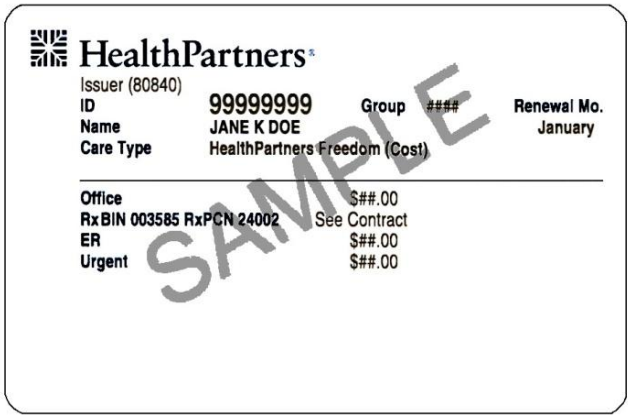
Medicare Status: Medicare is not assigned to HealthPartners

Copays: Basic covers Medicare-covered services only and has 20% coinsurance for most outpatient services. Vital covers office visits with a $15 copay for primary care and a $40 copay for specialists. Balance has a $15 office visit copay. Ultimate has no office visit copay.

Status of Product: Open to new enrollment although plan options with the Part D prescription drug benefit are subject to Medicare enrollment limitations as to when and how often individuals may elect or change Part D coverage.

ID Card: Two versions: one with Medicare RX symbol indicates Part D coverage and one without. Both cards will indicate "HealthPartners Freedom (Cost)" in Care Type field.




HealthPartners
Issuer (80840)
ID 99999999 Group #### Renewal Mo.
Name JANE K DOE January
Care Type HealthPartners Freedom (Cost)
Office $##.00
RxBIN 003585 RxPCN 24002 See Contract
ER $##.00
Urgent $##.00
SAMPLE


Emergency & Urgently Needed Care
For emergency situations, call 911 and/or get medical attention immediately.
For medical advice call the CareLine℠ nurse service any time at 612-339-3663 or 800-551-0859 or call your clinic at **952-555-5555**.
Hospital Admissions Contact CareCheck℠ at 866-275-8555 for any admission not directed by a network physician.
Claims Submission
Medical: HealthPartners Claims, P.O. Box 1289, Minneapolis, MN 55440-1289
Preventive Dental: HealthPartners Dental Claims, P.O. Box 1172, Minneapolis, MN 55440-1172.
Member Services: HealthPartners Member Services, P.O. Box 9463, Minneapolis, MN, 55440-9463, phone **952-883-7979 or 800-233-9645.**
For TTY call 952-883-6060 or 800-443-0156.
Minnesota Commissioner of Health Appeals: phone 651-201-5100 or 800-657-3916.
healthpartners.com Offered by Group Health, Inc.
SAMPLE

II. HEALTHPARTNERS SENIOR HEALTH ADVANTAGE

Type of Program: This is a *Medicare Select* plan.

Primary Payer: Medicare is primary for all Part A and Part B Medicare services.

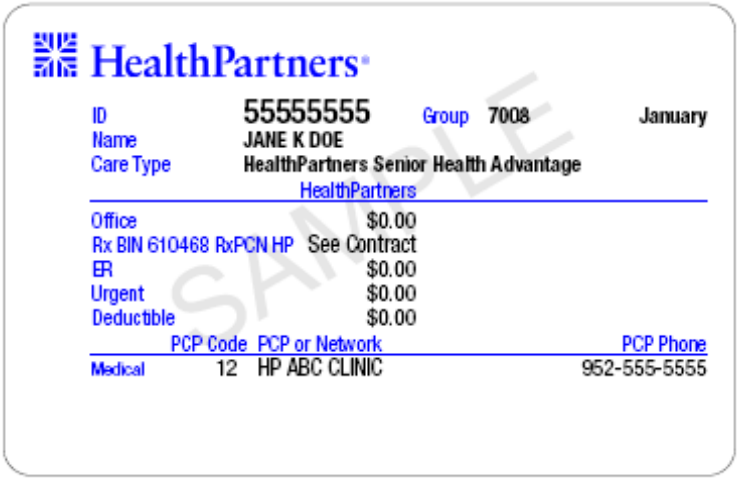
Medicare Status: Medicare is not assigned to HealthPartners

Copays: There is no office visit copayment.

Status of Product: Open to new individual enrollment.

ID Card: Standard HealthPartners member card with "HealthPartners Senior Health Advantage" in Care Type field

Referral Required: This is a primary care clinic based plan. Members must utilize the Primary Clinic's panel of specialty providers or obtain a referral from the Primary Clinic for care outside of the specialty panel. Not all contracted providers will be considered in network for members with this plan type.


HealthPartners
ID 55555555 Group 7008 January
Name JANE K DOE
Care Type HealthPartners Senior Health Advantage
HealthPartners
Office $0.00
Rx BIN 610468 RxPCN HP See Contract
ER $0.00
Urgent $0.00
Deductible $0.00
PCP Code PCP or Network PCP Phone
Medical 12 HP ABC CLINIC 952-555-5555
SAMPLE

III. HEALTHPARTNERS MEDICARE SUPPLEMENT PLAN

Type of Program: This is a *Medicare Supplement* plan.

Primary Payer: Medicare is primary for all Part A and Part B Medicare services.

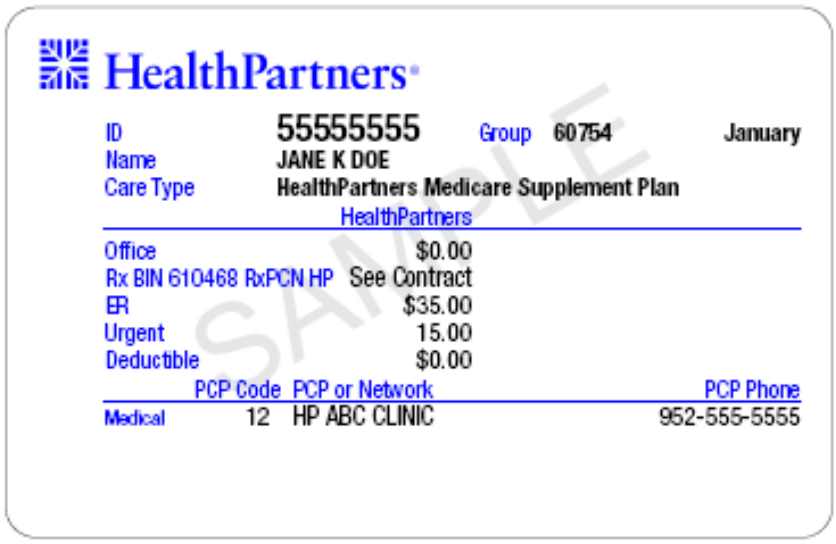
Medicare Status: Medicare is not assigned to HealthPartners

Copays: There is no office visit copayment

Status of Product: Closed to new enrollment

ID Card: Standard HealthPartners member card with "HealthPartners Medicare Supplement Plan" in Care Type field

Referral Required: This is a primary care clinic based plan. Members must utilize the primary clinic's panel of specialty providers or obtain a referral from the primary clinic for care outside of the specialty panel. Not all contracted providers will be considered in network for members with this plan type.



Medicare Part D for Low-Income Medicare beneficiaries

The Medicare prescription drug benefit (also known as Medicare Part D) was effective January 1, 2006.

Medicaid eligible Medicare beneficiaries (dual eligibles) will automatically qualify for low-income assistance through Medicare Part D.

For additional information on Medicare Part D, visit *www.Medicare.gov*.

For more information about low-income subsidy assistance or to request an application, call the Senior LinkAge Line ® at 1-800-333-2433.

For more information on how the new Medicare Part D impacts HealthPartners members in your facility, please visit *www.healthpartners.com*.

What is covered under Medicare Part D?

- Prescription drugs
- Biological products
- Insulin
- Certain Vaccines
- Medical supplies associated with the injection of insulin

For more information regarding this go to:
http://www.cms.hhs.gov/partnerships/downloads/determine.pdf

Where do providers submit claims for HealthPartners Part D Medicare beneficiaries?

Submit claims electronically to our pharmacy benefit management company (PBM), MedImpact. Providers are encouraged to ask pharmacies to submit claims electronically to MedImpact.

If a Part D drug is dispensed in an outpatient setting and it is not possible to submit an electronic claim to MedImpact, please send a paper claim to:

HealthPartners Pharmacy Benefits
Attn: Part D Claims
PO Box 1309
Minneapolis, MN 55440-1309

2014 Medicare Information

The following pages contain important information on our Medicare Products.

There is a fax back verification form for you to complete at the back of this section.

Please complete the form and return it to HealthPartners at this fax number:
952-853-8848

2014 Key Points: HealthPartners Freedom Medicare Products

HealthPartners Freedom is a Medicare Cost plan that is open access. Medicare is the primary payer for Part A (inpatient hospital) services, and HealthPartners is the primary payer for most Part B (outpatient) services.

General Responsibilities of Providers to *HealthPartners Freedom Members*

1. **No Discrimination:** Members will not be discriminated based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

2. **Access to Care:** Covered Services are available 24 hours per day, 7 days per week, when medically necessary. General hours of operation will be convenient to, and not discriminate against, Medicare members.

3. **Inform Members of Follow-Up Care:** Members are informed of specific health care needs that require follow-up care and receive, as appropriate training in self-care and other measures necessary to promote their health.

4. **Involve Members in Treatment**:
   Providers will:
   a) educate members regarding their health needs,
   b) share findings of history and physical examinations,
   c) discuss potential treatment options (without regard to plan coverage), side effects of treatment, and management of symptoms.

   However, the patient has the right to choose the final course of action among clinically acceptable choices. Members have the right to choose no treatment as an option.

5. **Include Member Input in Treatment Plan:** Members have a right to have input into their treatment plan. If they are unable to fully participate in their treatment decisions, they have the right to be represented by parents, guardians, family members or other conservators, as they choose.

6. **Encourage Members to Participate in Decision Making:** Providers will encourage the member or their representative to participate in decision making regarding his or her health care, including but not limited to; withholding resuscitative services, or forgoing or withdrawing life sustaining treatments.

7. **Confidentiality and Communications:** There will be appropriate and confidential exchange of information among providers in the network. In addition, there will be appropriate communication between primary care and specialty care to assure continuity of care and coordination of services.

8. **Right to Access Medical Records:** Member has a right to access their medical records, per HealthPartners policies.

9. **Advise Members when Service is Not Covered:** Providers shall advise members when a service is not covered and document the discussion of the non-covered service in the medical record.

10. **Appeals, Grievances and Complaints:** Providers will fully cooperate with HealthPartners policies and procedures related to member complaints, grievances, and organization determinations involving benefits, appeals, and expedited appeals.

11. **Respect, Dignity and Privacy:** Providers will ensure that all members are treated with respect, dignity, and are considerate of the enrollee's privacy.

PROVIDER REFERENCE TOOL*

2014 BENEFIT COMPARISON OF MEDICARE VS. HEALTHPARTNERS FREEDOM PLANS

*For greater detail, refer to the Evidence of Coverage for the member's policy.

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Doctor & Hospital Choice	Medicare beneficiaries may use any doctor, specialist, or hospital that accepts Medicare.	• This is an open access plan; however, members must use HealthPartners Freedom network providers to receive plan level of coverage (except for emergency & urgently needed care or as provided under the Extended Absence benefit). • Medicare benefits are not "locked-in" giving members option to go outside network but they will receive Medicare coverage only and will be responsible for any Medicare deductibles, coinsurance and all charges not covered by Medicare • The **Extended Absence benefit** provides the plan level of coverage when outside the service area. Members **must** call to activate this benefit prior to leaving the service area or they will have Medicare coverage only.
Premium	$104.90*/month for the Medicare Part B premium *This is the 2014 Part B premium amount and is subject to change in 2015.	Members must continue to pay $104.90*/month for Medicare Part B premium in addition to the plan premium: **Medical plan options:** • $47/month for Basic • $54/month for Vital • $94/month for Balance • $145/month for Ultimate

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Premium (cont'd)		**Plans with Part D prescription drug coverage** • $66.10/month for Vital w/Rx • $117.80/month for Balance w/Rx • $187.70/month for Ultimate w/Rx • $343.30/month for Ultimate w/Enhanced Rx Note: Basic is not eligible for drug coverage. *This is the 2014 Part B premium amount and is subject to change in 2015.
Inpatient Services		
Hospital	Coverage based on 90 day benefit period: • Days 1- 60: $1,216* deductible • Days 61- 90: $304*/day copay • Days 91-150: $608*/day copay for 60 lifetime reserve days • Beyond lifetime reserve days: all costs *This is the 2014 amount and is subject to change in 2015.	• **Basic**: $600 copayment per benefit period for Medicare-covered stays; no coverage for additional non-Medicare covered days. • **Vital:** $300 copayment per benefit period for Medicare-covered stays; unlimited days. • **Balance:** $200 copayment per benefit period for Medicare-covered stays; unlimited days. • **Ultimate:** $100 copayment per benefit period for Medicare-covered stays; unlimited days.
Skilled Nursing Facility	Requires 3-day hospitalization to qualify; Must meet Medicare skilled criteria: • Days 1-20: 100% coverage • Days 21-100: $152.00*/day copayment • Limit of 100 days per benefit period. *This is the 2014 amount and is subject to change in 2015.	Requires 3-day hospitalization to qualify; Must meet Medicare skilled criteria: • **Basic:** 100% coverage days 1-20; $130 copay/day for days 21-100 • **Vital:** 100% coverage days 1-20; $100 copay/day for days 21-100 • **Balance & Ultimate:** 100% coverage up to 100 days

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Home Health Care	• No copayment for medically necessary skilled nursing and rehabilitative care for members who are home bound. • 80% of approved amount for Home IV Therapy.	**All Freedom plans:** • No copayment for Medicare covered home health visits. • 20% of approved amount for Home IV Therapy. • Inhalation drugs and Enteral formula are paid under the members DME benefit and may require PA.
Mental Health		
Inpatient	Same deductible and coinsurance as Hospital above 190-day lifetime limit psychiatric hospital.	• **Basic**: $600 copayment per benefit period for Medicare-covered stays; no coverage for additional non-Medicare covered days. • **Vital:** $300 copayment per benefit period for Medicare-covered stays; unlimited days. • **Balance:** $200 copayment per benefit period for Medicare-covered stays; unlimited days. • **Ultimate:** $100 copayment per benefit period for Medicare-covered stays; unlimited days **All Freedom plans:** 190-day lifetime limit in a Medicare-certified psychiatric hospital**.**
Outpatient	• 35% coinsurance for most outpatient Mental Health services. • 20% coinsurance for Substance Abuse treatment	• **Basic:** 80% coverage per visit • **Vital:** $40 copayment per individual therapy visit; $20 per group therapy visit • **Balance:** $15 copayment per individual therapy visit; $7.50 per group therapy visit • **Ultimate:**100% coverage per visit

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Outpatient Services		
Doctor office visits	• 80% coverage for Medicare approved amounts. • 100% coverage for preventive services including Welcome to Medicare physical exam during first 12 months of new Part B coverage. • One Annual Wellness exam every 12 months, thereafter.	• **Basic:** 80% coverage of Medicare-approved amounts; 100% coverage for the Medicare-covered initial preventive physical exam and annual wellness visits. • **Vital:** $15 copayment for primary care, $40 specialist copayment; no copayment for one routine physical exam each year. • **Balance:** $15 copayment; no copayment for one routine physical exam each year. • **Ultimate:** No copayment; no copayment for one routine physical exam each year.
Immunizations	• 100% coverage & no referral required for flu and pneumonia vaccines • 80% coverage of Medicare approved amount for Hepatitis B vaccine	• 100% coverage for flu, pneumonia, or Hepatitis B vaccine. • No referral needed for pneumonia or flu vaccines
Hearing Exams/ Hearing aids	No coverage for routine exams, 80% coverage of Medicare approved amount for diagnostic hearing exams. No coverage for hearing aids	• **Basic:** No coverage for routine exams; 80% coverage of Medicare approved amount for diagnostic hearing exams. • **Vital:** 100% coverage for routine hearing tests; up to one visit per year; $40 copay for Medicare covered diagnostic hearing exams • **Balance:** 100% coverage for routine hearing tests; up to one visit per year; $15 copay for Medicare covered diagnostic hearing exams • **Ultimate:** 100% coverage for routine hearing tests (up to one visit per year) or Medicare covered diagnostic hearing exams **Hearing Aids – All Plans:** • No coverage

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Vision Services	• 80% coverage of Medicare approved amounts for diagnosis & treatment services. Coverage for one pair of eyeglasses or contact lenses after each cataract surgery. • Routine exams & eyeglasses not covered	**Basic:** • 80% coverage for exams for diagnosis & treatment services • Routine exams not covered **Vital:** • $0-40 copayment for Medicare-approved diagnosis & treatment services • 100% coverage for routine eye exams up to one visit per year **Balance:** • $0-15 copayment for Medicare-approved diagnosis & treatment services • 100% coverage for routine eye exams up to one visit per year **Ultimate:** • 100% coverage for Medicare-approved diagnosis & treatment services • 100% coverage for routine eye exams up to one visit per year **All Freedom Plans:** • 100% coverage for one pair of eyeglasses or contact lenses after each cataract surgery
Chiropractic Care	80% coverage of Medicare-allowable fees	• **Basic:** 80% coverage for each Medicare-covered visit. • **Vital:** $15 copayment for each Medicare-covered visit. • **Balance:** $15 copayment for each Medicare-covered visit. • **Ultimate:** 100% coverage for Medicare-covered chiropractic services.

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Podiatry	• 80% coverage of Medicare approved amounts for medically necessary foot care • Routine foot care not covered	• **Basic:** 80% coverage for each Medicare-covered visit; no coverage for routine visits • **Vital:** $40 copay for each Medicare-covered visit; no coverage for routine visits • **Balance**: $15 copay for each Medicare-covered and routine visit • **Ultimate:** 100% coverage for each Medicare-covered and routine visit
Acupuncture	Not covered	• **Basic:** No coverage • **Vital:** $35 copayment for each visit • **Balance:** $15 copayment for each visit • **Ultimate:** 100% coverage
Outpatient Rehabilitation	80% coverage of Medicare approved amounts	• **Basic:** 80% coverage for each Medicare-covered physical, occupational, and speech therapy visit • **Vital:** $40 copayment for each Medicare-covered physical, occupational, and speech therapy visit • **Balance:** $15 copayment for each Medicare-covered physical, occupational, and speech therapy visit • **Ultimate:** 100% coverage for Medicare-covered physical, occupational, and speech therapy visits
Durable Medical Equipment & Prosthetics	80% coverage of Medicare approved amount	**All Freedom plans:** 80% coverage for each Medicare covered item.
Emergency Care		
Emergency Room visit	80% coverage of doctor and facility charges Usually not covered outside the U.S.	• **Basic:** $100 copayment • **Vital:** $75 copayment • **Balance:** $65 copayment • **Ultimate:** $50 copayment Worldwide emergency coverage for Vital, Balance & Ultimate plans.

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Dental		
Dental Services	In general, not covered	• **Basic:** Not covered • **Vital:** Not covered • **Balance & Ultimate:** 100% coverage for one oral exam, one cleaning and one set of dental x-rays per year. **Vital, Balance & Ultimate:** Additional optional comprehensive dental coverage is available.
Prescription Drug Coverage		
Prescription Drugs	• 80% for prescription drugs covered under Medicare Part B • Most drugs are not covered.	• 80% for prescription drugs covered under Medicare Part B **Freedom plans with Part D prescription coverage** • **Vital w/Rx:** - Premium (medical & Rx): $66.10/month - Annual deductible: $175 all drugs tiers except Tier 5-specialty drugs - Initial coverage: $5 preferred generic drug copay; $20 nonpreferred generic drug copay; $45 preferred brand drug copay;$95 nonpreferred brand drug copay; 33% for specialty drugs up to $2,850 - Coverage gap (from $2,850 to $4,550 out of pocket): 72% coinsurance for generics; 50% manufacturer discount on brand drugs; 2.5% plan pays - Catastrophic Threshold: $4,550

Prescription Drug Coverage		
Prescription Drugs (cont'd)		• **Balance w/Rx:** - Premium(medical & Rx): $117.80/month - Annual deductible: $125 for all drugs tiers except Tier 5-specialty drugs - Initial coverage: $5 preferred generic drug copay; $15 non-preferred generic drug copay; $45 preferred brand drug copay;$95 non-preferred brand drug copay;33% for specialty drugs up to $2,850 - Coverage gap (from $2,850 to $4,550 out of pocket): 72% coinsurance for generics; 50% manufacturer discount on brand drugs;2.5% plan pays - Catastrophic Threshold: $4,550 • **Ultimate w/Rx:** - Premium (medical & Rx): $187.70/month - Annual deductible: $175 for all drugs tiers except Tier 5-specialty drugs - Initial coverage: $5 preferred generic drug copay; $15 non-preferred generic drug copay;$45 preferred brand drug copay; $95 non-preferred brand drug copay; 33% for specialty drugs up to $2,850 - Coverage gap (from $2,850 to $4,550 out of pocket): 72% coinsurance for generics; 50% manufacturer discount on brand drugs; 2.5% plan pays - Catastrophic Threshold: $4,550 • **Ultimate w/Enhanced Rx:** - Premium (medical & Rx): $343.30/month - Annual deductible: $100 for all drug tiers except Tier 5-specialty drugs - Initial coverage: $5 preferred generic drug copay; $12 non-preferred generic drug copay; $40 preferred brand name drug copay; $65 non-preferred brand drug copay; 33% for specialty drugs up to $2,850

Prescription Drug Coverage		
		- Coverage gap: $5 preferred generic drug copay; $12 non-preferred generic drug copay; 40% coinsurance for preferred brand name drug copay; additional manufacturer discount on brand drugs - Catastrophic Threshold: $4,550 Catastrophic copays for all plans: - Generic: $2.55 or 5%, whichever is greater - Brand: $6.35 or 5%, whichever is greater Rx Drug Days Supply: 30 Must use formulary drugs, unless non-formulary drug approved. • Employer groups: Coverage varies by group

HealthPartners' Medicare Product Portfolio
January 2014

	Medicare Cost	Carve-out / PDP	Medicare Select	Medicare Supplement	Medicare Carve-out
aka	1876 Cost, TEFRA Cost (formerly HCPP)		Medigap Medicare PPO	Medigap	
HP Product Name	Freedom (formerly HealthPartners 65+)	National Retiree Group Plan + HealthPartners Prescription Drug Plan	Senior Health Advantage	Medicare Supplement	
CMS Plan #	H2462	S1822			
Underwriting Corporation	Group Health Plan 501(c)3	HealthPartners Inc 501(c)4 (PDP) HPIC (medical)	HealthPartners Inc 501(c)4	HealthPartners Inc 501(c)4	HealthPartners Inc 501(c)4
Regulated by	• CMS • MN Dept of Health • WI OCI	• CMS • MN Dept of Health • WI OCI	MN DoC & MDH	MN DoC	same as commercial
Funding	prepayment from CMS and member premium	prepayment from CMS and group or member premium	member premium	member premium	group and/or member premium
Sold to	individuals and groups	groups	individuals	individuals (closed to new)	groups
Network	HealthPartners open access	None	HealthPartners network	HealthPartners network minus HPMG	same as commercial
Service Area	87 MN counties 8 WI counties	National (50 states;no territories)	24+ counties	21 counties	same as commercial
Enrollment rules	No health history underwriting	No health history underwriting	No underwriting	closed to new sales	same as commercial
Primacy	• MCR prime for Part A • HP prime for Part B • No "lock in" – members may access MCR benefits outside network	• MCR prime for A&B services • HP prime for Part D	• MCR prime for Parts A&B • No "lock in" – members may access MCR benefits outside network	• MCR prime for Parts A&B • No "lock in" – members may access MCR benefits outside network	• MCR prime for Parts A&B • No "lock in" – members may access MCR benefits outside network
Rx	• Standard • Enhanced	• PDP			

HealthPartners®

Subject Medicare Responsibilities for Providers and HealthPartners	**Attachments** ☐ Yes ☒ No
Key words Medicare Responsibilities for Providers and HealthPartners	**Number** **AM013**
Category Business Practices (BP)	**Effective Date** **November 1, 2003**
Manual HPI Administrative Policies	**Last Review Date** **April 1, 2013**
Issued By Professional Services Network Management and Hospital and Regional Network Management	**Next Review Date** **April 1, 2014**
Applicable ▪ All Primary Care Medical Groups and Providers ▪ All Specialty Care Medical Groups and Providers ▪ All Facilities and Providers	**Origination Date** **November 1, 2003** **Retired Date**
Review Responsibility Bev Vacinek, Rob Sauer, Laurena Lockner, Brenda Thommen, Melanie Teske	**Contact** Bev Vacinek

Products

☐ Fully Insured ☐ Self-Insured ☒ Medicare Cost ☐ Medicaid ☒ MSHO

I.

PURPOSE

To explain the requirements for Providers and HealthPartners in providing care to Medicare Members.

II.

POLICY

This policy outlines the requirements for Providers and HealthPartners in providing care to Medicare Members.

III. **PROCEDURE(S)**

Provider Responsibility:

1. Provider will allow Medicare Members direct access to screening mammography services, influenza vaccinations and routine and preventive services to women's health specialists included in the Medicare network. 42 CFR § 422.100(g)(1); § 422.112(a)(3)

2. Provider will not collect a co-pay or co-insurance from Medicare Members seeking influenza or pneumococcal vaccines. 42 CFR § 422.100(g)(2)

3. Provider will provide all Covered Services to Medicare Members in a manner consistent with professionally recognized standards of health care. 42 CFR § 422.504(a)(3)(iii)

4. Provider shall, and shall cause each Subcontractor to:

   a. Document, in a prominent part of the Medicare Member's current medical record whether or not the Medicare Member has executed an advance directive
   b. Not refuse care or otherwise discriminate against a Medicare Member based on whether or not the Medicare Member has executed an advance directive; and
   c. Comply with Minnesota law regarding advance directives. 42 CFR § 422.128(b)(1)(ii)(e-g)

5. Provider must cooperate with HealthPartners in respect to HealthPartners obligation to disclose to Centers for Medicare and Medicaid Services (CMS) Medicare plan quality and performance indicators, including:

   a. Disenrollment rates for Medicare Members electing to receive benefits through the Medicare Plan for the previous two years; 42 CFR § 422.504(f)(2)(iv)(A)
   b. Information on Medicare Member satisfaction; 42 CFR § 422.504(f)(2)(iv)(B) and
   c. Information on health outcomes. 42 CFR § 422.504(f)(2)(iv)(c)

6. Provider must be knowledgeable of Medicare requirements as communicated in the HealthPartners Participating Provider Agreement, the HPI Administrative Manual, and the Provider Training Manual.

7. Provider will not employ or contract with any providers that are excluded from participation in Medicare for the provision of any of the following:

   a. Health care
   b. Utilization review
   c. Medical social work
   d. Administrative services. 42 CFR § 422.752(a)(8)

8. Provider must certify (based on knowledge, information and belief) that the encounter data and medical records it submits are accurate, complete and truthful. 42 CFR § 422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)

9. Provider will participate and fully cooperate with the activities of any independent quality review and improvement organization appointed by HPI. In addition, Provider will participate and fully cooperate with HPI's medical policies, quality assurance programs, practice guidelines and utilization management programs and will consult with HPI, when requested, regarding these policies, guidelines and programs. 42 CFR § 422.504 (a)(5); 42 CFR § 422.202 (b)

10. Provider will not deny, limit, or condition the coverage or furnishing of benefits to Medicare Members on the basis of any factor that is related to health status, including but not limited to the following:

    a. Medical condition, including mental as well as physical illness.
    b. Claims experience
    c. Receipt of health care
    d. Medical history
    e. Genetic information
    f. Evidence of insurability, including conditions arising out of acts of domestic violence
    g. Disability 42 CFR § 422.110(a)

11. Provider must cooperate with HealthPartners in regards to HealthPartners obligation to provide to CMS all necessary information for:

a. Members and potential Members to make informed decisions regarding their Medicare choices
b. CMS to administer and evaluate the program 42 CFR § 422.64(a); 42 CFR § 422.504(a) (4); 42 CFR § 422.504(f) (2);

12. Provider must cooperate with HealthPartners in regards to HealthPartners obligation to disclose information, in a manner and form required by CMS, to all Medicare Members. 42 CFR § 422.64; § 422.504(a)(4); § 422.504(f)(2)

13. Provider will participate in and fully cooperate with HealthPartners policies and procedures pertaining to member complaints, grievances, organization determinations involving benefits and member liability, appeals and expedited appeals. 42 CFR § 422.562(a)

HealthPartners Responsibility:

1. HealthPartners will not deny, limit, or condition the coverage or furnishing of benefits to Medicare Members on the basis of any factor that is related to health status, including but not limited to the following:

   a. Medical condition, including mental as well as physical illness.
   b. Claims experience
   c. Receipt of health care
   d. Medical history
   e. Genetic information
   f. Evidence of insurability, including conditions arising out of acts of domestic violence or
   g. Disability. 42 CFR § 422.110(a)

2. HealthPartners will make timely and reasonable payment to non-contracted suppliers or providers for services covered by the plan. These services include:

   a. Ambulance services dispatched through 911 or its local equivalent
   b. Emergency and urgently needed services
   c. Maintenance and post-stabilization care services
   d. Renal dialysis services provided while the Medicare Member was temporarily out of the service area.
   e. Services for which coverage has been denied by the health plan and found (upon appeal) to be services the Medicare Member was entitled to have furnished or paid for. 42 CFR § 422.100(b), 422.100(b)(1)(iv)

3. HealthPartners will maintain and monitor a network of appropriate healthcare providers that is supported by written agreements and is sufficient to provide adequate access to covered services and meet the needs of the Medicare population. 42 CFR § 422.112(a)(1)

4. HealthPartners will make mammography, influenza vaccinations and routine and preventive services provided by Women's Health Specialists in the Medicare Network available to Medicare Members without a referral. 42 CFR § 422.100(g)(1); § 422.112(a)(3)

5. HealthPartners may only distribute marketing materials, election forms, or make such materials available to individuals eligible to select a Medicare product upon meeting the requirements as set forth in 42 CFR § 422.2262.

6. HealthPartners must provide to CMS all necessary information required for:

   a. Members and potential Members to make informed decisions regarding their Medicare choices
   b. CMS to administer and evaluate the program. This information includes, but is not limited to:

i. The benefits covered under Medicare plans; 42 CFR § 422.504(f)(2)(i)
ii. The monthly basic and supplemental premium 42 CFR § 422.504(f)(2)(ii)
iii. The service and continuation area, if any, and the enrollment in each plan
iv. 42 CFR § 422.504(f)(2)(iii)
v. Plan quality and performance indicators for the benefits under the plan including:

   a. Disenrollment rates for Medicare enrollees for the previous 2 years, excluding disenrollment due to death or moving outside the plan's service area, calculated according to CMS guidelines;
   b. Information on Medicare Member satisfaction;
   c. Information on health outcomes;
   d. Plan-level appeal data
   e. The recent record regarding compliance of HPI with the CMS requirements;
   f. Other information determined by CMS to be necessary to assist members in making informed choices 42 CFR § 422.111(f)(8); 42 CFR § 422.504(f)(2)(iv)

vi. Information about appeals and their disposition; and 42 CFR § 422.504 (E)(v)
vii. Information about all formal actions, reviews, findings, or similar actions by States, other regulatory agencies or any other certifying or accrediting boards. 42 CFR § 422.504 (E)(vi)
viii. In addition, HPI must also disclose information, in a manner and form required by CMS, to all Members. 42 CFR § 422.64; § 422.504(a)(4); § 422.504(E)(vii)
ix. HealthPartners must establish a formal mechanism to consult with the network providers regarding the medical policy, quality assurance programs and medical management procedures. HealthPartners must ensure that practice and utilization management guidelines:

   a. are based on reasonable medial evidence or a consensus of health care professionals in the particular field
   b. consider the needs of the members
   c. are developed in consultation with network providers and
   d. are reviewed and updated periodically 42 CFR § 422.202 (b)(1)(iv)

x In addition, the guidelines must be communicated to network providers, and as appropriate, to members. Decisions with respect to utilization management, member education, coverage of services and other areas in which the guidelines apply are consistent with the guidelines. 42 CFR § 422.202(b)(2-3)

7. HealthPartners must have an agreement with an independent quality review and improvement organization approved by CMS. In addition, HealthPartners must operate a Quality Assurance and Performance Improvement program. 42 CFR § 422.504(a)(5)

8. HealthPartners does not offer a continuation of enrollment option to Medicare Members when they no longer reside in the service area. 42 CFR § 422.54(b)

9. Requirements of other laws and regulations. The MA organization agrees to comply with:
   a. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and
   b. HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. 42 CFR § 422.504(h)

10. HealthPartners will not employ or contract with any providers that are excluded from participation in Medicare for the provision of any of the following:
   a. Health care

b. Utilization review
c. Medical social work
d. Administrative services. 42 CFR § 422.752(a)(8)

11. HealthPartners will not impose cost sharing for influenza and pneumococcal vaccinations for Medicare Members. 42 CFR § 422.100(g)(2)

12. HealthPartners must certify (based on knowledge, information and belief) that the encounter data it submits are accurate, complete and truthful. 42 CFR § 422.504(l)(2)

13. HealthPartners must establish and maintain the following in regards to grievances, organization determinations and appeals:
    a. A grievance procedure for addressing issues that do not involve organization determinations
    b. A procedure for making timely organization determinations
    c. Appeal procedures that meet the requirements for issues that involve organization determinations 42 CFR § 422.562(a)(1)

14. HealthPartners must ensure that all Medicare Members receive written information about the grievance and appeal procedures as well as the complaint process available to them under the QIO process. 42 CFR § 422.562(a)(2)

IV. DEFINITIONS N/A

V. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS N/A

VII. OTHER RESOURCES N/A

CMS: 42 CFR 422
CMS MANAGED CARE MANUAL CHAPTER 4

VIII. APPROVAL(S)

Rita Murtada, Sr. Director
Hospital and Regional Network Management

Charles Abrahamson, Vice President
Network Management and Provider Relations

IX. ENDORSEMENT N/A

Miscellaneous Medicare Information Web Sites

Center for Medicare and Medicaid http://www.cms.hhs.gov

Wisconsin Physician Services

Local Medicare Part B Carrier

http://www.wpsic.com

CMS Manuals and Provider Updates

Overview Manuals

HealthPartners, Inc

http:/www.healthpartners.com.

Medicare Communications

E-mail/Fax Back Verification Form

Please complete this form and e-mail back to
contractedcare@HealthPartners.com
or fax back to 952-853-8848

Clinic/Vendor Name _____

Date Medicare Training took place _____

Method of Training _____
(Ex. Staff meeting, Medicare in-service, distribution of copies of the manual)

Name and title of accountable staff member:

_____

Additional Comments:

Thank you.

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HealthPartners Products for State Public Programs

Minnesota Health Care Programs
HealthPartners Care and
HealthPartners Minnesota Senior Health Options (MSHO) Plan
(HMO SNP)
Provider Reference Guide

HEALTHPARTNERS CARE (HPCARE)

The HealthPartners Care plans provide care to recipients of Prepaid Medical Assistance Programs (PMAP), MinnesotaCare Programs (MNCare), and Minnesota Senior Care Plus (MSC+). These products are Primary Care clinic based and not all contracted providers will be in network for these members. Referrals to specialty providers may be required.

As a health plan, we are allowed to set prior authorization thresholds. Member Services will help you with questions you may have on benefits. The HealthPartners Coverage Policy Manual will be of assistance to primary care clinic staff.

HealthPartners Care Service Area

HealthPartners Care Service Area includes the following counties: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, McLeod, Meeker, Ramsey, Scott, Sherburne, Stearns, Washington, and Wright. HealthPartners Care MNCare program also participates in McLeod and Meeker counties

Prepaid Medical Assistance Programs (PMAP)

The benefits are based on the Medical Assistance (MA) benefit packages. PMAP covers health care for the following people who have Medical Assistance.

- Children under the age of 21
- Parents and caretakers of a dependent child
- Pregnant women
- Certain low-income adults without a dependent child

MinnesotaCare (MNCare)

There are two levels of coverage under MinnesotaCare—each with distinctive benefits and copays.

Minnesota Senior Care Plus (MSC+)

MSC+ is for members age 65 or older with Prepaid Medical Assistance and fee-for-service Medicare. The benefits are similar to PMAP coverage with the addition of Elderly Waiver Services and Nursing Facility services for those who are assessed as needing those services.

HEALTHPARTNERS MINNESOTA SENIOR HEALTH OPTIONS (MSHO) PLAN

HealthPartners MSHO Plan covers health care and Elderly Waiver services for people who are ages 65 and over, have Medical Assistance, and both Medicare Parts A and B. MSHO integrates primary, acute, and long-term care and Medicaid and Medicare services through managed care for the elderly. MSHO benefits include all Medicare and Medicaid services including home and community based "waiver" services as needed and 180 days of nursing home care for community enrollees. Home and community based services include assisted living, adult day care, home modifications, personal care attendant services, chore services, home delivered meals, and others.

One of the most attractive benefits of the MSHO plan is each member is assigned a Care Coordinator. The Care Coordinator will perform an initial assessment of the member within 30 days of enrollment and annually thereafter. Following the assessment, the Care Coordinator will develop a personalized care plan. The Care Coordinator will follow the member through different settings of care and update the member's care plan to accommodate the members' changing needs.

HealthPartners MSHO Plan Service Area
HealthPartners MSHO Plan's service area includes the following counties: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington and Wright.

Medicare Prescription Drug Coverage (Part D Drug Coverage)
HealthPartners MSHO Plan combines Medicare, Medicaid and Part D prescription drug coverage all in one plan. In addition, HealthPartners MSHO Plan covers some other drug classes and over the counter medications that are not covered by Medicare.

MSHO Supplemental Benefits 2014
The MSHO plan provides comprehensive coverage for all seniors covered by Medicare and Medical Assistance. HealthPartners also offers supplemental benefits to MSHO members. These benefits may change each year.

The MSHO Supplemental Benefits for 2014 are as follows:

Dental
• Second annual visit for cleaning and exam
• Adult fluoride
• Scaling and root planning
• Full mouth debridement
• Periodontal maintenance
• Root canals on molars
• Denture services – tissue conditioning
• Porcelain crowns, up to $2,000
• Bridges, up to $2,000
• Electric toothbrush* and replacement heads
Vision and Hearing Aids
• Second pair of eyeglasses
• Tints and coatings on eyeglasses (up to two pairs)
• Additional hearing aid coverage

Durable Medical Equipment (DME)
• Second pair of orthotics and orthotic shoes
• Light therapy lamp
Health and Wellness
• Silver & Fit Exercise & Healthy Aging Program fitness center membership or home exercise kit for members living in the community
• Transportation to/from supplemental benefit covered services
• Safety/falls kit for members living in the community*
• 10,000 Steps® program with pedometer for members living in the community
• Health education classes
• Foot care visits for non-Elderly Waiver members living in the community
• Personal emergency response system for non-Elderly Waiver members living in the community
• In-home safety devices and installation for non-Elderly Waiver members living in the community, up to $1,000
• Home delivery meals for non-Elderly Waiver members living in the community
*One per lifetime
For more information, contact Member Services.

Product Names with Group Number and Medical Package Codes

State Public Program Members	Group Number	Medical Package Code
MA Kids & Pregnant Women N**o** Copay	4183	HP2
MA Adults with Copay	4183	HPC2
MA Adults No Copays	4183	HPD2
MA Adults Copay Max (0)	4183	HPC4
MA Adult Copay Max (1-6)	4183	HPC4A
MA Adult Copay Max (7-17)	4183	HPC4B
MA Adult Copay Max (18-110)	4183	HPC4C
MA Adults - Medcaid Expansion with copay	4183	HP25
MA Adults - Medicaid Expansion No copay	4183	HP26
MA Adults - Medicaid Expansion Copay Max (0)	4183	HP27
MA Adults - Medicaid Expansion Copay Max (1-6)	4183	HP27A
MA Adults - Medicaid Expansion Copay Max (7-17)	4183	HP27B
MA Adults - Medicaid Expansion Copay Max (18-110)	4183	HP27C
MA Adult <65 FFS Medicare with Copay	4183	HPMC2
MA Adult <65 FFS Medicare No Copay	4183	HPM2
MA Adult <65 FFS Medicare Copay Max (0)	4183	HPMC4
MA Adult <65 FFS Medicare Copay Max (1-6)	4183	HMC4A
MA Adult <65 FFS Medicare Copay Max (7-17)	4183	HMC4B
MA Adult <65 FFS Medicare Copay Max (18-110)	4183	HMC4C
MSC+ NHC (Medicare AB) with Copay	4184	GSP01
MSC+ NHC (Medicare AB) Copays Max (0)	4184	GSP16
MSC+ NHC (Medicare AB) Copays Max (1-6)	4184	GSP26
MSC+ NHC (Medicare AB) Copays Max (7-17)	4184	GSP27
MSC+ NHC (Medicare AB) Copays Max (18-110)	4184	GSP28
MSC+ Institutional (Medicare AB) No copay	4184	GSP03
MSC+ Non-NHC (Medicare AB) with Copay	4184	GSP02
MSC+ Non-NHC (Medicare AB) Copays Max (0)	4184	GSP17
MSC+ Non-NHC (Medicare AB) Copays Max (1-6)	4184	GSP29
MSC+ Non-NHC (Medicare AB) Copays Max (7-17)	4184	GSP30
MSC+ Non-NHC (Medicare AB) Copays Max (18-110)	4184	GSP31
MSC+ NHC (Medicare B no A)	4186	GSP04
MSC+ NHC (Medicare B no A) Copays Max (0)	4186	GSP18
MSC+ NHC (Medicare B no A) Copays Max (1-6)	4186	GSP32
MSC+ NHC (Medicare B no A) Copays Max (7-17)	4186	GSP33
MSC+ NHC (Medicare B no A) Copays Max (18-110)	4186	GSP34
MSC+ Institutional (Medicare B no A) No Copay	4186	GSP06
MSC+ Non-NHC (Medicare B no A) with Copay	4186	GSP05
MSC+ Non-NHC (Medicare B no A) Copays Max (0)	4186	GSP19
MSC+ Non-NHC (Medicare B no A) Copays Max (1-6)	4186	GSP35
MSC+ Non-NHC (Medicare B no A) Copays Max (7-17)	4186	GSP36
MSC+ Non-NHC (Medicare B no A) Copays Max (18-110)	4186	GSP37
MSC+ NHC (Medicare A no B) with Copay	4187	GSP07

State Public Program Members	Group Number	Medical Package Code
MSC+ NHC (Medicare A no B) Copays Max (0)	4187	GSP20
MSC+ NHC (Medicare A no B) Copays Max (1-6)	4187	GSP38
MSC+ NHC (Medicare A no B) Copays Max (7-17)	4187	GSP39
MSC+ NHC (Medicare A no B) Copays Max (18-110)	4187	GSP40
MSC+ Institutional (Medicare A no B) No Copay	4187	GSP09
MSC+ Non-NHC (Medicare A no B) with copay	4187	GSP08
MSC+ Non-NHC (Medicare A no B) Copays Max (0)	4187	GSP21
MSC+ Non-NHC (Medicare A no B) Copays Max (1-6)	4187	GSP41
MSC+ Non-NHC (Medicare A no B) Copays Max (7-17)	4187	GSP42
MSC+ Non-NHC (Medicare A no B) Copays Max (18-110)	4187	GSP43
MSC+ NHC (No Medicare) with Copay	4188	GSP10
MSC+ NHC (No Medicare) Copays Max (0)	4188	GSP22
MSC+ NHC (No Medicare) Copays Max (1-6)	4188	GSP44
MSC+ NHC (No Medicare) Copays Max (7-17)	4188	GSP45
MSC+ NHC (No Medicare) Copays Max (18-110)	4188	GSP46
MSC+ Institutional (No Medicare) No Copay	4188	GSP12
MSC+ Non-NHC (No Medicare) with Copay	4188	GSP11
MSC+ Non-NHC (No Medicare) Copays Max (0)	4188	GSP23
MSC+ Non-NHC (No Medicare) Copays Max (1-6)	4188	GSP47
MSC+ Non-NHC (No Medicare) Copays Max (7-17)	4188	GSP48
MSC+ Non-NHC (No Medicare) Copays Max (18-110)	4188	GSP49
MSHO Community Non-Nursing Home Certifiable	4182	GPM07
MSHO Community Nursing Home Certifiable	4182	GPM08
MSHO Institutional	4182	GPM09
MSHO Community Non-Nursing Home Certifiable With Hospice	4182	GPH07
MSHO Community Nursing Home Certifiable - With Hospice	4182	GPH08
MSHO LIS1 Community Non-Nursing Home Certifiable	4181	GPM82
Minnesota Care Adult (Non-Parents)	4190	HP24
Minnesota Care Adult (Non-Parents) FFP	4190	HP24A
Minnesota Care Adult (Parents)	4190	HP1
Minnesota Care Child	4190	HP8

INFORMATION FOR BOTH HEALTHPARTNERS CARE AND HEALTHPARTNERS MSHO

Spoken Language Interpreter Services

HealthPartners Care members may use the following spoken language interpreter services:

Kim Tong Translation Service
2994 Rice St.
Little Canada, MN 55113
Phone: 651-252-3200
Fax: 651-252-3214
24 Hour Service
Face to face and phone interpretation
Website: http://kttsmn.com/

Itasca Corporation
1560 Livingston Ave
Suite 101
West St. Paul, MN 55118
Phone: 651-457-7400
Fax: 651-457-7700
Website: http://www.itascacorp.biz

The Bridge World Language Center, Inc.
110 2nd St S Ste 213
Waite Park, MN 56387
Phone: 320-259-9239
Fax: 320-654-1698
Website: http://www.bridgelanguage.com

Garden and Associates
4301 Highway 7 Suite 140
St. Louis Park, MN 55416
Phone: 952-920-6160
Fax: 952-922-8150
24 Hour Service
Website: http://www.gardentranslation.com/

The Language Banc
1625 Park Ave
Minneapolis, MN 55404
Phone: 612-588-9410
Fax: 612-588-9420
24 Hour Service
Website: http://www.thelanguagebanc.com/

Arch Language
1885 University Avenue West, Suite 75
Saint Paul, MN 55104
Phone: 651-789-7897
Fax: 651-789-7898
24 Hour Service
Website: http://www.ArchLanguage.com

The Minnesota Language Connection, Inc.
International Court Building
2550 University Ave W. Suite 245-N
Saint Paul, MN 55114
Phone: 651-644-7100
Fax: 651-644-7600
24 Hour Service
Website: www.minnesotalanguageconnection.com

To arrange for these services, please contact your provider and they will submit *a Spoken Language Interpreter Work Order* directly to the interpreter service. If you have questions please contact HealthPartners Member Services 952-967-7998.

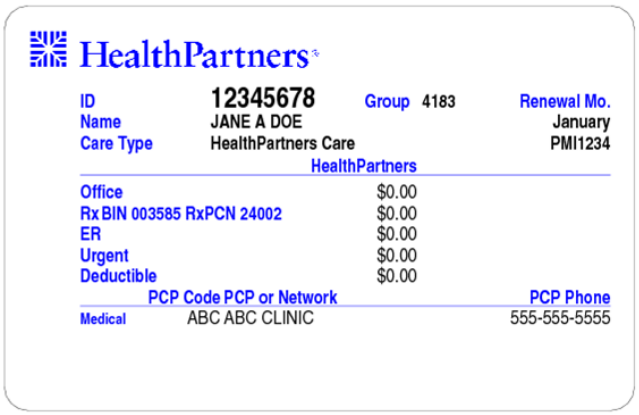
Insurance Card Identifies State Public Program Member

Member Card:

- The member's identification number, name, and PMI number appear at the top of the card.
- Under the member name is "Care Type" which shows the member's product. For MSHO, it reads "HealthPartners - MSHO (HMO SNP)"
- Copays appear in the middle of section of the card.
- The member's clinic number and clinic name appear next to "Medical" and "Dental" on the bottom of the card.


HealthPartners
Issuer (80840)
ID 12345678 Group 4182 Renewal Mo.
Name JANE A DOE January
Care Type HealthPartners MSHO HMO SNP PMI1234
HealthPartners
Office $0.00 Prescription Drug Plan
RxBIN 015574 RxPCN ASPROD1 See Contract
RxGrp MHN99
ER $0.00
Urgent $0.00
PCP Code PCP or Network CMS - H24221234
Medical ABC ABC CLINIC
MS-ID Card GP051061
MedicareRx Prescription Drug Coverage


Emergency & Urgently Needed Care
For emergency situations, call 911 and/or get medical attention immediately.
For medical advice call the CareLine℠ nurse service any time at 612-339-3663 or 800-551-0859 or call your clinic at **555-555-5555**.
Hospital Admissions Contact CareCheck℠ at 866-275-8555 for any admission at an out-of-network hospital or facility.
Claims Submission
Medical: HealthPartners Claims, P.O. Box 1289, Minneapolis, MN 55440-1289
Dental: HealthPartners Dental Claims, P.O. Box 1172, Minneapolis, MN 55440-1172.
Member Services Call HealthPartners Member Services at **952-967-7029 or 888-820-4285** or TTY/TTD (for hearing impaired only): 952-883-6060; 800-443-0156. Or write to P.O. Box 9463, Minneapolis, MN 55440-9463. To schedule a ride to a medical appointment, call **RideCare:** 952-883-7400 or 888-288-1439.
To file a State Fair Hearing, please send your request to: Appeals Office/Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. Or, fax your request to: 651-431-7523. A State Ombudsman may be able to help you with your problem. They can also help you request a State Fair Hearing. You may call them at 651-431-2660 or toll free at 1-800-657-3729.
healthpartners.com Offered by HealthPartners


HealthPartners
ID 12345678 Group 4183 Renewal Mo.
Name JANE A DOE January
Care Type HealthPartners Care PMI1234
HealthPartners
Office $0.00
Rx BIN 003585 RxPCN 24002 $0.00
ER $0.00
Urgent $0.00
Deductible $0.00
PCP Code PCP or Network PCP Phone
Medical ABC ABC CLINIC 555-555-5555


Emergency & Urgently Needed Care
For emergency situations, call 911 and/or get medical attention immediately.
For medical advice call the CareLine℠ nurse service any time at 612-339-3663 or 800-551-0859 or call your clinic at **555-555-5555**.
Hospital Admissions Contact CareCheck℠ at 866-275-8555 for any admission not directed by a network physician.
Claims Submission
Medical: HealthPartners Claims, P.O. Box 1289, Minneapolis, MN 55440-1289
Dental: HealthPartners Dental Claims, P.O. Box 1172, Minneapolis, MN 55440-1172.
Member Services Call HealthPartners Member Services at **952-967-7998; 866-885-8880;** or TTY/TTD (for hearing impaired only): 952-883-6060; 800-443-0156. Or write to P.O. Box 9463, Minneapolis, MN 55440-9463. To schedule a ride to a medical appointment, call **RideCare:** 952-883-7400 or 888-288-1439.
To file a State Fair Hearing, please send your request to: Appeals Office/Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. Or, fax your request to: 651-431-7523. A State Ombudsman may be able to help you with your problem. They can also help you request a State Fair Hearing. You may call them at 651-431-2660 or toll free at 1-800-657-3729.
healthpartners.com Offered by HealthPartners

Pharmacy / Formulary

The HealthPartners formulary should be used when writing prescriptions. In addition, all classes of drugs on the Medical Assistance formulary are covered. Many over-the-counter drugs are also covered as long as they are prescribed by a plan physician and obtained at a plan pharmacy.

A new preferred drug list was launched for members on HealthPartners Medicaid plans**. HealthPartners Care and MSHO formulary can be accessed on the HealthPartners web site.**

Noncovered Services

A provider may bill HealthPartners Care members for non-covered services only if:

1) The Provider notified the member in writing of the member liability for non-covered services using the State approved waiver form; and,
2) Prior to performance of the service, the provider receives written authorization from the member for the non-covered services

The agreement should include information specific to the date, the estimated cost of the service and the service to be delivered. A provider cannot bill members for missing scheduled appointments.

Public programs products may require referrals for claims payment

All HealthPartners public programs products are primary clinic based and may require referrals. Providers are encouraged to check eligibility and call Member Services to verify if referrals are required. Eligibility may be checked on the Provider Portal at www.healthpartners.com/provider/. After logging in, select "Eligibility" from the drop down menu under the heading Applications.

The preferred method for referral submission is online through the Provider Portal using the Referral Maintenance Application at www.HealthPartners.com/provider. After logging in, select Referral Inquiry or Referral Maintenance to create, update, view and retrieve/answer Referral Authorization Inquiries (RAI). Otherwise a referral can also be made by completing a *Provider Recommendation Form* (found in Claims Section of this manual) and faxing or mailing it to the Claims department.

An RAI is generated when a member assigned to a Primary Clinic product receives services outside of the Primary Clinic's specialty referral network. The member may or may not have been directed by the Primary Care Clinic care system; however, it is important for Primary Care providers to respond to these RAI's indicating if the care was referred by the Primary Clinic care system or not. The RAI response is needed so the outstanding claim can be processed appropriately. RAI notifications are sent to Primary Care providers via the Provider Portal. There is no indicator on the portal that an RAI has been sent when you log on so it is important to check your work queues regularly to view and respond to RAI's.

Please note: The current policies and procedures remain in effect and in place regarding prior authorization or Recommendation For Further Services for the HealthPartners Transplant Centers of Excellence, HealthPartners Direct Access Mental Health Network, HealthPartners Referral Mental Health Network, the WLS (Weight Loss Surgery) Designated Network, Low Back Pain or other designated networks remain in effect.

HealthPartners Care members may self-refer to the following providers:

- Mental health/chemical health providers in HealthPartners Behavioral Health network
- HealthPartners plan wide urgent care providers
- HealthPartners plan wide vision providers for routine eye care
- Members may self-refer to any provider for family planning services
- Tribal Health Clinics

Members can learn about the providers in these plan-wide networks in several ways:

- Visit **healthpartners.com** to view a list of providers.

- Review the provider directory that was mailed to them in their enrollment packet.
- Call Member Services to ask about a particular provider.

WHERE TO CALL FOR ASSISTANCE

Please verify member eligibility EVERY month!

Electronic claim transactions for Minnesota Health Care Programs (MHCP) are accepted through MN-ITS *Interactive* or MN-ITS *Batch*. Claims sent through ITS or NSF will no longer be accepted.

Verify recipient eligibility through MN-ITS or by calling EVS at (651) 431-4399 or 1-800-657-3613.

Learn more about MN-ITS and register online at http://mn-its.dhs.state.mn.us.

HealthPartners Member Services:

HealthPartnersCare Main Number:	952-967-7998	or	1-866-885-8880
MSHO Main Number:	952-967-7029	or	1-888-820-4285
Fax:	952-883-7333	or	952-883-7666
TTY:	952-883-6060	or	1-800-443-0156
Spanish:	952-967-7050		
Somali	952-967-7159		
Oromo:	952-967-7160		
Hmong	952-883-7575		

Claims Helpline: 952-883-7699 or 888-663-6464

RideCare (PMAP, MSC+ and MSHO): 952-883-7400 or 888-288-1439
CareLine: 612-339-3663 or 800-551-0859 (Providers Only: 952-883-5883)

Medical Management

- General Medical Management Line: 952-883-7888 or 877-499-7888
- Prior Authorization for Services and Procedures: 952-883-5724 or 888-467-0774
- Outpatient Case Management: 952-883-6983 or 877-499-7888 or Fax 952-883-6664
- Inpatient Case Management: 952-883-6277 or 877-499-7888 or Fax 952-883-6975