Hennepin Health
your community health plan

Member Handbook

Families and Children

This is also known as Prepaid Medical Assistance Program (PMAP)

January 1, 2025

This booklet contains important information about your health care services.

Hennepin Health, 300 South Sixth Street, MC 604, Minneapolis, Minnesota 55487-0604
Member Services: 612-596-1036 (TTY: 800-627-3529), Monday–Friday, 8 a.m.–4:30 p.m.,
hennepinhealth.org

DHS accepted 12/27/2024
MC-1695-MC

Hennepin Health Toll Free 1-800-647-0550 TTY 1-800-627-3529

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

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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

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

ဟ်သူဉ်ဟ်သးဘဉ်တက့်။ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မိတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤနူဉ်တက့်။

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈ່ຽ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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 (afcelinta) 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. Hennepin Health 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

You have the right to file a complaint if you believe you were treated in a discriminatory way by Hennepin Health. You can file a complaint and ask for help filing a complaint by mail, phone, fax, or email at:

Hennepin Health
300 South Sixth Street MC 604
Minneapolis MN 55487-0604
Toll-free: 1-800-647-0550 (voice)
TTY: 1-800-627-3529 (MN Relay)
Fax: 612-632-8815
Email: hennepinhealth@hennepin.us

or in person at:

Hennepin Health
525 Portland Avenue South, 8th Floor
Minneapolis

Auxiliary Aids and Services: Hennepin Health 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:** Hennepin Health Member Services at hennepinhealth@hennepin.us, or call Hennepin Health Member Services at 612-596-1036 (toll-free 1-800-647-0550) or your preferred relay service.

Language Assistance Services: Hennepin Health 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:** Hennepin Health Member Services at hennepinhealth@hennepin.us, or call Hennepin Health Member Services at 612-596-1036 (toll-free 1-800-647-0550) or your preferred relay service.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Hennepin Health. You may also contact any of the following 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
- religion (in some cases)

Contact the OCR directly to file a complaint:

Office of Civil Rights, U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: ocrmail@hhs.gov

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
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll-free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)

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
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

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. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have a right to appeal 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 administration 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

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 go to your primary care provider prior to the referral.

TABLE OF CONTENTS

TABLE OF CONTENTS

Welcome to Hennepin Health

We are pleased to welcome you as a member of Hennepin Health-PMAP (referred to as "plan" or "the plan").

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

If you are new to Hennepin Health, you will be receiving a New Enrollee screening to complete by mail. This is a voluntary screening. It will take only a few minutes to fill out. We encourage you to complete this screening. The screening will help us connect you to health care services or other services available to you as a member. Based on your answers, we may contact you for additional information. If you have questions about this screening, please call Hennepin Health Member Services at 612-596-1036 or 800-647-0550, or TTY 800-627-3529. This call is free.

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: Hennepin County

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

SECTION 1

TELEPHONE NUMBERS AND CONTACT INFORMATION

How to contact our Member Services

If you have any questions or concerns, call, email, or write to Member Services. We will be happy to help you. Member Services' hours of service are 8:00 a.m. to 4:30 p.m., Monday through Friday.

- CALL: 612-596-1036 or 800-647-0550. This call is free.
- TTY: 711, or through the Minnesota Relay direct access numbers at 800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over) or 877-627-3848 (speech to speech relay service)
- FAX: 612-904-4267
- WRITE:

  Hennepin Health
  300 S 6th St MC 604
  Minneapolis MN 55487-0604

- VISIT:

  Hennepin Health
  525 Portland Avenue South, 8th floor
  Minneapolis

- WEBSITE: hennepinhealth.org
- EMAIL: HennepinHealth@hennepin.us

Our plan contact information for certain services

Appeals and Grievances: 612-596-1036 or 800-647-0550. This call is free.

WRITE:

Hennepin Health
300 S 6th St MC 604
Minneapolis MN 55487-0604

Refer to Section 13 for more information.

Chiropractic services: 612-596-1036 or 800-647-0550. This call is free.

Dental services: 651-348-3233 or 866-298-5549 (TTY users should call: 711)

Durable Medical Equipment Coverage Criteria: 612-596-1036 or 800-647-0550. This call is free.

24-Hour Nurse Line (*Health*Connection): 888-859-0202

Interpreter Services:
American Sign Language (ASL): 800-627-3529
Spoken Language: 612-596-1036 or 800-647-0550. This call is free.

Mental Health/Behavioral Health Services: 612-596-1036 or 800-647-0550. This call is free.

Prescriptions, Navitus Health Solutions: 833-210-5966

Substance Use Disorder Services: 612-596-1036 or 800-647-0550. This call is free.

Transportation: 612-596-1036 or 800-647-0550. This call is free.

Other important contact information

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

For information and to learn more about health care directives and how to exercise an advance directive, contact Hennepin Health at 612-596-1036 or 800-647-0550. This call is free. More information about health care directives can be found: HennepinHealth.org/members/forms-resources. You may also visit the Minnesota Department of Health (MDH) website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/advdir.html

If you suspect fraud or abuse by someone receiving benefits or health care providers working with the Minnesota Health Care Programs, please contact the Hennepin Health Special Investigations Unit by phone at 844-440-3290, by website at: http://mhp.alertline.com, or by email at HH.Fraud@hennepin.us. You can also report suspected fraud and abuse to the Minnesota Department of Human Services (DHS) by:

- submitting the Program Integrity Oversight hotline form (recommended) (https://mn.gov/dhs/general-public/office-of-inspector-general/report-fraud/),
- calling the Program Integrity Oversight Hotline at 651-431-2650 or 800-657-3750 or 711 (TTY), or use your preferred relay services (This call is free),
- sending your report via email to OIG.Investigations.DHS@state.mn.us, or
- sending a letter via US Mail to the Office of Inspector General – Program Integrity Oversight Division – PO Box 64982, St. Paul, MN 55164-0982.

SECTION 1

Minnesota Department of Human Services

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

Ombudsperson for Public Managed Health Care Programs

The ombudsperson for Public Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving access, service and billing problems. They can help you file a grievance or appeal with us. The ombudsperson can also help you request a State Appeal (Fair hearing with the state). Call 651-431-2660 or 800-657-3729 or 711 (TTY), or use your preferred relay services. This call is free. Hours of service are Monday through Friday, 8:00 a.m. to 4:30 p.m.

IMPORTANT INFORMATION ON GETTING THE CARE YOU NEED

Each time you get health services, check to be sure that the provider is a plan network provider. In most cases, you need to use plan network providers to get your services. Members have access to a Provider Directory (https://hennepinweb2.evips.com/directory/) that lists plan network providers. The Provider Directory can tell you the following information about providers such as: name, address, phone number, professional qualifications, specialty, board certification, and languages spoken by the provider., Call Member Services, if you would like information about board certification, information about medical school attendance, ed and residency program, and board certification status. You may ask for a print copy of the Provider Directory at any time. To verify current information, you can call Member Services at the phone number in Section 1, or visit our website listed in Section 1.

When you are a member or become a member of Hennepin Health you chose or were assigned to a primary care clinic (PCC). Your PCC can provide most of the health care services you need, and will help coordinate your care. This provider will also advise you if you need to use specialists. You may change your PCC. There are three (3) options for changing your PCC:

1. Contact our Member Service department, press option 1 for Member Services
2. Send an email to hennepinhealth@hennepin.us - you will receive a reply within 2 business days.
3. Visit us in the Member Service Center:

   Hennepin Health
   525 Portland Avenue South, 8th floor
   Minneapolis

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

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

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

Transition of care:

If you are a newly enrolled member who is currently receiving care from a provider who is not a plan network provider, we will help you transition to a network provider. If a drug you are currently taking is not covered under your new plan, you may be able to receive up to a 90-day temporary supply. For more information, call Member Services at the phone number in Section 1.

SECTION 2

Utilization management:

Hennepin Health wants you to get the right amount of quality care. We want to make sure that the health care services provided are medically necessary, right for your condition and are provided in the best care facility. We also need to make sure that the care you get is a covered benefit. The process to do this is called utilization management (UM). We follow policies and steps to make decisions about approving medical services. We do not reward providers or staff for denying coverage. We do not give incentives for UM decisions. We do not reward anyone for saying no to needed care.

Prior authorizations:

Our approval is needed for some services to be covered. This is called prior authorization. The approval must be obtained before you get the services or before we pay for them. Many of these services are noted in Section 7. Work with your qualified health care provider to get a prior authorization when required. In urgent situations, we will make a decision within 72 hours after we receive the request from your doctor. For more information, call Member Services at the phone number in Section 1.

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

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

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

The plan allows direct access to the providers in our network, but keeps the right to manage your care under certain circumstances, such as: transplant services. We may do this by choosing the provider you use and/or the services you receive. When we manage your care, our nurse care manager and network providers will coordinate your care. For more information, call Member Services at the phone number in Section 1.

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

- A chronic (on-going) condition

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

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

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

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

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

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

At Hennepin Health, we have staff who can help you figure out the best way to use health care services. If you have questions about things like where to get services, getting authorization for services, or restrictions on prescription drugs, we can help. Call us at 612-596-1036 between 8:00 a.m. and 4:30 p.m., Monday through Friday. If you need language assistance to talk about these issues, Hennepin Health can give you information in your language through an interpreter. For sign language services, call 800-627-3529. For other language assistance, call 612-596-1036.

Covered and non-covered services:

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

SECTION 2

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

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

We may cover additional or substitute services under some conditions.

Requests to cover new medical procedures, devices, or drugs are reviewed by utilization management area. This group includes doctors and other health care experts. They use national guidelines and medical and scientific evidence to decide whether Hennepin Health should approve new equipment, procedures, or drugs.

Cost sharing:

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

Payments to providers:

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

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

Cultural awareness:

We understand that your beliefs, culture, and values play a role in your health.

We want to help you maintain good health and good relationships with your qualified health care provider. We want to ensure you get care in a culturally sensitive way.

Interpreter services:

We understand that your beliefs, culture, and values play a role in your health.

We want to help you maintain good health and good relationships with your qualified health care provider. We want to deliver care with cultural competency. We will provide

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

Other health insurance:

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

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

Private information:

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

Restricted Recipient Program:

The Restricted Recipient Program (RRP) is for members who have misused health services. This includes getting health services that members did not need, using them in a way that costs more than they should, or in a way that may be dangerous to a member's health. Hennepin Health will notify members if they are placed in the Restricted Recipient Program.

If you are in the Restricted Recipient Program, you must get health services from one designated primary care provider [in your local trade area], one clinic, one hospital used by the primary care provider and one pharmacy. Hennepin Health may designate other health services providers. You may also be assigned to a home health agency. You will not be allowed to use the personal care assistance choice or flexible use options, or consumer directed services.

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

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

At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. 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 (Fair Hearing with the State) after receiving our decision that we have decided to enforce the restriction. Refer to Section 13.

Cancellation:

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

If you are no longer eligible for Medical Assistance (Medicaid), you may be eligible to purchase health coverage through MNsure. For information about MNsure, call 855-3MNSURE or 855-366-7873 TTY, use your preferred relay services, or visit www.MNsure.org. This call is free.

MEMBER BILL OF RIGHTS

You have the right to:

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

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

Be told about your health problems.

Have an open discussion to get information about appropriate or medically necessary treatment options for your conditions including how treatments will help or harm you, regardless of cost or benefit coverage.

Receive information about our organization, our services, our practitioners and providers, and member rights and responsibilities.

Participate with providers in making decisions about your health care.

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

Refuse care from specific providers.

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

Ask for and get a copy of your medical records. You also have the right to ask to correct the records.

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

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

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

Receive a clear explanation of covered home care services.

SECTION 3

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

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

Get a second opinion for medical, mental health, and substance use disorder services.

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

Request a written copy of this Member Handbook at least once a year.

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

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

Make recommendations about our rights and responsibilities policy.

Exercise the rights listed here.

MEMBER RESPONSIBILITIES

You have the responsibility to:

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

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

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

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

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

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

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

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

SECTION 5

YOUR HEALTH PLAN MEMBER IDENTIFICATION (ID) CARD

Each member will receive a plan member ID card.

Always carry your plan member ID card with you.

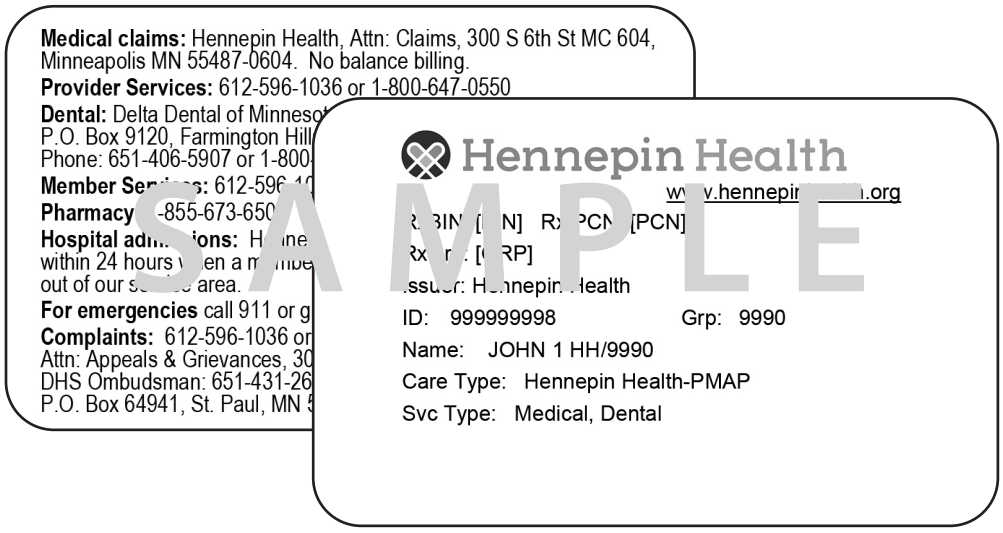
You must show your plan member ID card whenever you get health care.

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

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

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

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



COST SHARING

Cost sharing is an amount that health plan members may be responsible to pay to their providers for their medical or pharmacy services. It includes deductibles and copays. **You do not have cost sharing for medical or pharmacy services covered under Medical Assistance.**

Copays

Copays are listed in the following chart:

Service	Copay amount
Non-preventive visits (such as visits for a sore throat, diabetes checkup, high fever, sore back, mental health services, etc.) provided by a physician, physician assistant, advanced practice nurse, certified professional midwife, chiropractor, acupuncturist, podiatrist, audiologist, or eye doctor. There are no copays for mental health services.	$0.00
Diagnostic procedures (for example, endoscopy, arthroscopy)	$0.00
Emergency room visit when it is not an emergency	$0.00
Brand name prescriptions *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$0.00
Generic prescriptions *The most you will have to pay in copays for prescriptions is $12.00 per month.*	$0.00

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

Call Member Services at the phone number in Section 1 if you have questions.

SECTION 7

COVERED SERVICES

This section describes the major services that are covered under the plan for Medical Assistance (Medicaid) members. It is not a complete list of covered services. If you need help understanding what services are covered, call Member Services at the phone number in Section 1. Some services have limitations. Some services require a prior authorization. A service marked with an asterisk (*) means a prior authorization is required or may be required. Make sure there is a prior authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Refer to Section 2 for more information on prior authorizations. You can also call Member Services at the phone number in Section 1 for more information.

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

ACUPUNCTURE SERVICES*

Covered Services:

- Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing.
- Up to 40 units of acupuncture services are allowed per calendar year without authorization. Ask for prior authorization if additional units are needed
- Acupuncture services are covered for the following:
  - acute and chronic pain
  - depression
  - anxiety
  - schizophrenia
  - post-traumatic stress syndrome
  - insomnia
  - smoking cessation
  - restless legs syndrome
  - menstrual disorders
  - xerostomia (dry mouth) associated with the following:
    - Sjogren's syndrome
    - radiation therapy

- nausea and vomiting associated with the following:
  - post-operative procedures
  - pregnancy
  - cancer care

CHILD AND TEEN CHECKUPS (C&TC)

Covered Services:

- Child and Teen Checkups (C&TC) provides a regular schedule of preventive well-child checkups for children and youth under 21 years old.

  Children should be seen at these ages:

0-1 month	12 months
2 months	15 months
4 months	18 months
6 months	30 months
9 months	3 years and every year until 21 years old

These preventive well-child checkups look at growth, development, and overall health according to the Minnesota C&TC Schedule of Age-Related Screening Standards (https://edocs.dhs.state.mn.us/lfserver/public/DHS-3379-ENG). These checkups are meant to keep kids healthy by finding any health concerns or problems early. Finding health concerns early prevent them from becoming bigger problems later. Keeping your child healthy means they are more likely to grow into healthy adults.

What is covered

Minnesota Health Care Programs (MHCP) covers each age-related preventive well-child checkup and all the required screenings as part of each checkup according to the Minnesota C&TC Schedule of Age-Related Screening Standards (https://edocs.dhs.state.mn.us/lfserver/public/DHS-3379-ENG).

This includes:

- head-to-toe exam
- immunizations and lab tests as needed
- checks on development and growth
- health history including nutrition
- health education

- hearing and vision checks
- information on good physical and mental health
- time to ask questions and get answers about your child's health, behavior, and development and to talk about learning, feelings, relationships, parenting and caregiver well-being
- fluoride varnish to keep teeth healthy and dental referrals

Notes:

C&TC is a health care benefit promoting preventive health visits for children and youth under 21 years old.

More checkups can be covered, if needed. Children living in out-of-home placement or foster care should receive them more frequently.

These checkups are good for entrance into childcare, Head Start, and should be combined with Minnesota State High School League sports physical needs. Be sure to bring forms that need to be filled out by your doctor to the appointment.

Starting at age 11, each visit may include patient and provider one-on-one time. This gives time for adolescents and young adults to ask questions privately and learn to manage their own health.

Contact your Primary Care Clinic to schedule a C&TC preventive health visit.

CHIROPRACTIC CARE*

Covered Services:

- One evaluation or exam per calendar year
- Manual manipulation (adjustment) of the spine to treat subluxation of the spine - up to 24 treatments per calendar year, limited to six per month.* Treatments exceeding 24 per calendar year or six per month require a prior authorization.
- X-rays when needed to support a diagnosis of subluxation of the spine

Not Covered Services:

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

DENTAL SERVICES

IMPORTANT: This is not a comprehensive list. Specific coverage is not guaranteed.
Service limits may apply to services listed in the dental services section. Some services may or may not require prior authorization due to medical necessity. To find out more about these services, you can contact Member Services.

Covered Services:

- Diagnostic services:
  - exam and oral evaluation
  - imaging services, which include:
    - bitewing
    - single X-rays for diagnosis of problems
    - panoramic
    - full mouth X-rays
- Preventive services:
  - cavity arresting treatment
  - dental cleaning(s)
  - fluoride varnish
  - sealants
  - oral hygiene instruction
- Restorative services:
  - fillings
  - sedative fillings for relief of pain
  - individual crowns, restricted to resin and stainless steel
- Endodontics: (root canals)
  - other endodontic procedures
- Periodontics:
  - gross removal of plaque and tartar (full mouth debridement)
  - scaling and root planing
    - follow-up procedures (periodontal maintenance) *(for two years following scaling and root planing)*

- Prosthodontics:
  - removable appliances (dentures, partials, overdentures) *(one appliance every three years per dental arch)*
  - adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials)
  - replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances
  - replacement of partial appliances if the existing partial cannot be altered to meet dental needs
  - tissue conditioning liners
  - precision attachments and repairs
- Oral surgery
  - tooth extractions*
    - wisdom tooth extraction*
- Orthodontics with Prior Authorization
- Additional general dental services:
  - emergency treatment of dental pain
  - general anesthesia, deep sedation
  - extended care facility/house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), nursing facilities, school or Head Start program, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital)
  - behavioral management when necessary to ensure that a covered dental service is safely performed
  - nitrous oxide
  - oral bite adjustments
  - oral or IV sedation

Notes:

If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance (Medicaid).

If you begin orthodontia services, we will not require completion of the treatment plan in order to pay the provider for services received.

If you are new to our health plan and have already started a dental service treatment plan (ex. Orthodontia care), please contact us for coordination of care.

Refer to Section 1 for Dental Services contact information.

DIAGNOSTIC SERVICES

Covered Services:

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

Notes:

Diagnostic tests are covered if they meet Medicare or our coverage criteria and the test is medically necessary. Not every test will be covered.

Services may be provided in a physician office, a clinic setting, an outpatient hospital setting, an independent laboratory or radiology setting.

DOCTOR AND OTHER HEALTH SERVICES*

Covered Services:

- Doctor visits including:
  - allergy immunotherapy and allergy testing
  - care for pregnant people
  - family planning – **open access service**
  - lab tests and X-rays
  - physical exams
  - preventive exams
  - preventive office visits

- specialists
- telemedicine consultation
- vaccines and drugs administered in a qualified health care provider's office
- visits for illness or injury
- visits in the hospital or nursing home

- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Behavioral Health Home: coordination of primary care, mental health services, and social services
- Blood and blood products
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Clinical Services
- Clinical trial coverage*: Routine care that is: 1) provided as part of the protocol treatment of a Clinical Trial; 2) is usual, customary and appropriate to your condition; and 3) would be typically provided outside of a Clinical Trial. This includes services and items needed for the treatment of effects and complications of the protocol treatment.
- Community health worker care coordination and patient education services
- Community Medical Emergency Technician (CMET) services
  - Post-hospital/post-nursing home discharge visits ordered by your primary care provider
  - Safety evaluation visits ordered by primary care provider (PCP)
- Community Paramedic Services: certain services are provided by a community paramedic. The services must be a part of a care plan by your primary care provider. The services may include:
  - health assessments
  - chronic disease monitoring and education
  - help with medications
  - immunizations and vaccinations
  - collecting lab specimens
  - follow-up care after being treated at a hospital

  - other minor medical procedures
- Counseling and testing for sexually transmitted diseases (STDs), AIDS and other HIV-related conditions - **open access service**
- Enhanced asthma care services (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma, when specific criteria are met)
  - Home visits to determine if there are asthma-triggers in the member's home
  - Must be provided by a registered environmental health specialist, healthy homes specialist, and lead risk assessor. Your local public health agency can help you find one of these health care professionals to help you or you can contact Member Services
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Hospital In-Reach Community-Based Service Coordination (IRSC): coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services.
- Immunizations
- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Respiratory therapy
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Treatment for AIDS and other HIV-related conditions - **NOT an open access** service. You must use a provider in the plan network.
- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Tuberculosis care management and direct observation of drug intake

Not Covered Services:

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

SECTION 7

EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION (EIDBI) SERVICES

(for children under age 21)

The purpose of the EIDBI benefit is to provide medically necessary, early and intensive intervention for people with Autism Spectrum Disorder (ASD) and related conditions. Families can learn more about EIDBI by taking the EIDBI 101 online training (https://www.dhs.state.mn.us/EIDBI101). The EIDBI Welcome Letter for Caregivers (https://www.dhs.state.mn.us/EIDBI-Welcome-Letter) provides more information on the program once a family gets started with services.

Families can learn more about autism, as well as resources and supports, by visiting the Minnesota Autism Resource Portal https://mn.gov/autism.

The benefit is also intended to:

- Educate, train and support parents and families
- Promote people's independence and participation in family, school and community life
- Improve long-term outcomes and the quality of life for people and their families.

EIDBI services are provided by enrolled EIDBI providers who have expertise in the approved modalities which include:

- Applied Behavior Analysis (ABA)
- Developmental, Individual Difference, Relationship-Based (DIR)/Floortime model
- Early Start Denver Model (ESDM)
- PLAY Project
- Relationship Development Intervention (RDI)
- Early Social Interaction (ESI)

Covered Services:

- Comprehensive Multi-Disciplinary Evaluation (CMDE) which is needed to determine eligibility and medical necessity for EIDBI services (https://www.dhs.state.mn.us/CMDE)
- Individual Treatment plan (ITP) development (initial)
    - ITP Development and Progress Monitoring (https://www.dhs.state.mn.us/ITP)
- Direct Intervention: Individual, group, and/or higher intensity (https://www.dhs.state.mn.us/EIDBI-DirectIntervention)

- Observation and direction (https://www.dhs.state.mn.us/EIDBI-ObservationandDirection)
- Family/caregiver training and counseling: Individual and/or group (https://www.dhs.state.mn.us/EIDBI-CaregiverTrainingandCounseling)
- Coordinated care conference (https://www.dhs.state.mn.us/EIDBI-Coordinated-CareConference)
- Travel time

EMERGENCY MEDICAL SERVICES AND POST-STABILIZATION CARE

Covered Services:

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

Not Covered Services:

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

Notes:

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

In all other cases, call your primary care qualified health care provider, if possible. You can call the number 24 hours a day, seven days a week and get instructions about what to do.

If you are out of town, use the closest emergency room or call 911. Show them your member ID card and ask them to call your primary care qualified health care provider.

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

SECTION 7

FAMILY PLANNING SERVICES*

Covered Services:

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

Not Covered Services:

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

Notes:

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

HEARING AIDS

Covered Services:

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

HOME CARE SERVICES*

Covered Services:

- Skilled nurse visit*
- Rehabilitation therapies to restore function (for example, speech, physical, occupational, respiratory)
- Home health aide visit*

HOSPICE

Covered Services:

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

- Physician services
- Nursing services
- Medical social services
- Counseling

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

Notes:

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

Medicare Election

You must elect hospice benefits to receive hospice services.

If you are eligible for both Medicare and Medical Assistance, and elect hospice, you must elect Medicare hospice care in addition to Medical Assistance hospice care. Federal guidelines prohibit you from choosing hospice care through one program and not the other when you are eligible for both.

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

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

HOSPITAL – BASED PEER SUPPORT FOR SUBSTANCE USE DISORDER (SUD) (Members must be 18 years or older with a history of SUD with emergency department use or inpatient hospitalization for SUD.)

Covered Services:

- Peer support counseling
- Follow-up sessions (1-3 sessions)
- Patient navigation
- Support for basic needs and additional services

HOSPITAL – INPATIENT*

Covered Services:

Inpatient hospital services are covered if determined to be medically necessary. This includes:

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

Not Covered Services:

- Personal comfort items, such as TV, phone, barber or beauty services, guest services
- Charges related to hospital care for investigative services, plastic surgery, or cosmetic surgery are not covered unless determined medically necessary through the medical review process

SECTION 7

Notes:

For further information on different types of inpatient admissions including inpatient mental/behavioral health or substance use disorder (SUD), refer those specific sections in this member handbook.

Non-emergency care received at a hospital may require a prior authorization. Work with your qualified health care provider to get a prior authorization when required. You can also call Member Services at the phone number in Section 1 for more information.

HOSPITAL – OUTPATIENT

Covered Services:

- Urgent care for conditions that are not as serious as an emergency
- Outpatient surgical center
- Tests and X-rays
- Dialysis
- Emergency room services
- Post-stabilization care
- Observation services- if you're not admitted as an inpatient to the hospital, you may enter "outpatient observation" status until your provider determines your condition requires an inpatient admission to the hospital or a discharge home. Observation services are covered up to 48 hours. Hennepin Health will consider observation services up to 72 hours for unusual circumstances when submitted with additional documentation.

Notes:

Non-emergency care received at a hospital may require a prior authorization. Please work with your qualified health care provider to get a prior authorization when required. You can also call Member Services at the phone number in Section 1 for more information.

HOUSING STABILIZATION SERVICES (for members 18 years old and older)*

Covered Services:

The plan will pay for the following Housing Stabilization Services for people who qualify:

- Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services
- Housing transition - moving expenses up to $3000 per year for people leaving a Medical Assistance funded institution or provider-controlled setting who are moving into their own home. Moving expenses include:
  - Only for people leaving a Medical Assistance funded institution or provider-controlled setting who are moving into their own home
  - Applications, security deposits, and the cost of securing documentation that is required to obtain a lease on an apartment or home
  - Essential household furnishings including furniture required to live in and use in thea home, including furniture, window coverings, food preparation items, and bed or bath linens
  - Set-up fees or deposits for utilities including telephone, electricity, heating, and water
  - Services necessary for the individual's health and safety such as pest removal and one time cleaning before moving in
  - Necessary home accessibility adaptations
- Housing sustaining services to help you keep your housing
- Transportation for Housing Stabilization Services when a provider is discussing housing-related needs with the member while driving. This time is billed as transition/sustaining units. Mileage is not reimbursed.

Not Covered Services:

The plan will not pay for:

- Rent or house payments
- Food
- Clothing
- Recreational items, including streaming devices, computers, televisions, cable television access, speakers and so forth

- Items that are owned or leased by a provider
- Any items, expenses or services that are paid for by another program

Notes:

You must have an assessment done to find out if you qualify for Housing Stabilization Services. If you have a targeted case manager or waiver case manager, you can ask for their help to find out if you qualify for Housing Stabilization Services. You can also contact a Housing Stabilization Services provider to help you.

The Department of Human Services (DHS) will review the assessment to decide whether you qualify for Housing Stabilization Services. DHS will send you a letter about whether you qualify for Housing Stabilization Services. If you qualify, the letter will say services are approved. If you do not qualify, the letter will say services are denied.

Work with your provider if you need help with moving expenses. If you are approved for moving expenses, your provider must send us the receipt for each moving expense.

INTERPRETER SERVICES

Covered Services:

- Spoken language interpreter services
- Sign language interpreter services

Notes:

Interpreter services are available to help you get covered services.

Refer to Interpreter Services in Section 1 for contact information and to find out which interpreters you can use.

MEDICAL EQUIPMENT AND SUPPLIES*

Covered Services:

- Prosthetics or orthotics
- Durable medical equipment (for example, wheelchairs, hospital beds, walkers, crutches, and wigs for people with hair loss due to any medical condition). 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
- Airway clearance devices
- Electrical stimulation devices
- 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**. Refer to Family Planning Services in this section.
- Augmentative communication devices, including electronic tablets
- Allergen-reducing products (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma)
- Seizure detection devices

Not Covered Services:

- Constructive modifications to home, vehicle, or workplace, including bathroom grab bars
- Environmental products (such as air filters, purifiers, conditioners, dehumidifiers) unless covered as allergen-reducing products for eligible members
- Exercise equipment

Notes:

You will need to use your qualified health care provider and get a prescription for medical equipment and supplies to be covered.

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

SECTION 7

MENTAL HEALTH/BEHAVIORAL HEALTH SERVICES*

Covered Services:

- Certified Community Behavioral Health Clinic (CCBHC)
- Children's Intensive Behavioral Health Services (CIBHS) *(for members under age 21)*
- Clinical care consultation
- Crisis response services including:
  - screening
  - assessment
  - intervention
  - stabilization including residential stabilization
  - community intervention *(for members age 18 or older)*
- Diagnostic assessments* including screening for the presence of co-occurring mental illness and substance use disorders
- Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP) *(for adult members age 18 or older and adolescent members age 12-17 who meet certain criteria)*
- Forensic Assertive Community Treatment (FACT) *(for members age 18 or older)*
- Inpatient psychiatric hospital stay, including extended psychiatric inpatient hospital stay*
- Mental health provider travel time
- Mental Health Targeted Case Management (MH-TCM)
- Outpatient mental health services including:
  - Explanation of findings
  - Family psychoeducation services *(for members under age 21)*
  - Mental health medication management
  - Neuropsychological services
  - Psychotherapy (patient and/or family, family, crisis, and group)
  - Psychological testing

- Physician mental health services including:
  - Health and behavior assessment/intervention
  - Inpatient visits
  - Psychiatric consultations to primary care providers
  - Physician consultation, evaluation, and management
- Rehabilitative mental health services including:
  - Assertive Community Treatment (ACT) *(for members age 18 or older)*
  - Adult day treatment *(for members age 18 or older)*
  - Adult Rehabilitative Mental Health Services (ARMHS) is available to members age 18 or older
  - Certified family peer specialists *(for members under age 21)*
  - 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)*
  - Family psychoeducation services *(for members under age 21)*
  - Intensive Residential Treatment Services (IRTS) *(for members age 18 or older)**
  - Intensive Treatment Foster Care Services *(for members under age 21)*
  - Partial Hospitalization Program (PHP)*
  - Intensive Rehabilitative Mental Health Services (IRMHS)/Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services (for members ages 8 through 20)
- Psychiatric Residential Treatment Facility (PRTF) for members age 21 and under*
- Telehealth

Not Covered Services:

- Conversion therapy

The following services are not covered under the plan but may be available through your county. Call your county for information. Also refer to 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:

Refer to 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 use any qualified health professional that is not in the plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision.

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

OBSTETRICS AND GYNECOLOGY (OB/GYN) SERVICES

Covered Services:

- Prenatal, delivery, and postpartum care
- Childbirth classes
- Hospital services for newborns*
- HIV counseling and testing for pregnant people – **open access service**
- Treatment for HIV-positive pregnant people
- Treatment for newborns of HIV-positive birth parents
- 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 DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672 or 711 (TTY), or use your preferred relay services for coverage information. Also refer to Section 9. This call is free.
- Planned home births

Notes:

You have "direct access" to OB-GYN providers 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 use a provider in the plan network. For services labeled as **open access**, you can use any qualified health care provider clinic, hospital, pharmacy, or family planning agency.

OPTICAL SERVICES

Covered Services:

- Eye exams
- Initial eyeglasses, when medically necessary (eyeglass frames selection may be limited)
- Replacement eyeglasses, when medically necessary
    - Identical replacement of covered eyeglasses for loss, theft, or damage beyond repair
- Repairs to frames and lenses for eyeglasses covered under the plan
- Tinted, photochromatic (for example, Transition® lenses) or polarized lenses, when medically necessary
- Contact lenses, when medically necessary

Not Covered Services:

- Extra pair of glasses
- Progressive bifocal/trifocal lenses (without lines)
- Protective coating for plastic lenses
- Contact lens supplies

SECTION 7

OUT-OF-AREA SERVICES*

Covered Services:

- A service you need when temporarily out of the plan service area. Members should work with their primary care provider to identify a provider who can assist them while they are out of the area so care is not interrupted. A prior authorization is needed for any care provided out of network.
- A service you need after you move from our service area while you are still a plan member*
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- Medically necessary urgent care when you are outside of the plan service area. (Call Member Services at the phone number in Section 1 as soon as possible.)
- Covered services that are not available in the plan service area

Not Covered Services:

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

Notes:

If you need to use a pharmacy when out of the plan service area, call Member Services at the phone number in Section 1 first before you pay for a prescription drug or over-the-counter drug, even if the drug is on our list of covered drugs (LOCD) (formulary). We cannot pay you back if you pay for it.

OUT-OF-NETWORK SERVICES*

Covered Services:

- Certain services you need that you cannot get through a plan network provider
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- A second opinion for mental health and substance use disorder

- Open access services
- Pregnancy-related services received in connection with an abortion *(does not include abortion-related services)*
- A non-emergency medical service you need when temporarily out of the network or plan area that is or was prescribed, recommended, or is currently provided by a network provider
- Services related to the diagnosis, monitoring, and treatment of a rare disease or condition

Notes:

Sometimes members need to see a very specialized type of doctor. We will work with your qualified health care provider to make sure you get the specialist or service when you need it, for as long as you need it, even if the provider is not currently a network provider. There is no cost to you when we authorize the care or service before you see the 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 excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved or authorized by the Food and Drug Administration (FDA)
- Medical cannabis

SECTION 7

Notes:

The list of covered drugs (formulary) includes the prescription drugs covered by Hennepin Health. 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 Fee-for-Service Medical Assistance (Medicaid). The list also must include drugs listed in the Department of Human Services' Preferred Drug List (PDL). In addition to the prescription drugs covered by Hennepin Health, 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 hennepinhealth.org. A list of covered drugs (formulary) 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).

If a drug you are currently taking is not covered under your new plan, you may be able to receive up to a 90-day temporary supply. For more information, call Member Services.

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

- **Prior authorization (PA):** Hennepin Health requires you or your health care provider to get prior authorization for certain drugs. This means that you will need to get approval from Hennepin Health before you fill your prescriptions. If you don't get approval, Hennepin Health may not cover the drug.
- **Quantity limits (QL):** For certain drugs, Hennepin Health limits the amount of the drug that Hennepin Health will cover.
- **Preferred/non-preferred (P/NP):** For some groups of drugs, Hennepin Health requires you to try the preferred drugs before payment for the non-preferred drugs. 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 Hennepin Health only when:
    1. Your prescriber informs Hennepin Health in writing that the brand name version of the drug is medically necessary; OR
    2. Hennepin Health 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 hennepinhealth.org. 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 hennepinhealth.org.

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

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.

Most drugs and certain supplies are available up to a 30 day supply. Certain drugs you take on a regular basis for a chronic or long-term condition are available up to a 90-day supply and are identified on Hennepin Health's List of Covered Drugs as 90DS under the Special Code column.

If Hennepin Health 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 Hennepin Health 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.

The drug must be on our list of covered drugs (formulary). If you request an exception, your doctor must provide a statement to support your request and send this to us. You can also call Member Services at the phone number in Section 1 for help.

If a pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your qualified health care provider. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by us under the plan. If the

pharmacy won't call your qualified health care provider, you can. You can also call Member Services at the phone number in Section 1 for help.

If the pharmacy staff tells you the pharmacy is out of network, contact Member Services.

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 Hennepin Health Specialty Drug List, your prescriber will need to send the prescription of that specialty drug to one of the following Hennepin Health Specialty Pharmacies.

Name of specialty pharmacy:	Hennepin Healthcare Clinic & Specialty Center Pharmacy
Phone and TTY:	612-873-6600, TTY 711
Fax:	612-873-1535
Hours of operation:	8 a.m. - 6 p.m., Monday through Friday 9 a.m. - 4:30 p.m., Saturday Closed on Sunday https://www.hennepinhealthcare.org/clinic/clinic-and-specialty-center/

Name of specialty pharmacy:	Lumicera Health Services
Phone and TTY:	855-847-3553, TTY 711
Fax:	855-847-3558
Hours of operation:	8 a.m. - 7 p.m., Monday through Thursday 8 a.m. - 6 p.m., Friday Closed Saturday and Sunday (Pharmacist on call for questions only) https://www.lumicera.com/

You will also need to call the specialty pharmacy that receives your prescription to set up an account. You will need to have your Hennepin Health 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 excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved or authorized by the FDA
- 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.

RECUPERATIVE CARE (for members 21 years old and older)

Recuperative care helps qualified members avoid being readmitted to the hospital. It provides short-term lodging, medical care and support for up to sixty (60) days for those who are recovering from an illness and are unhoused. This care is for members who need help to recover, but don't need to stay in the hospital.

Covered Services:

- Basic nursing care, like checking health and pain
- Wound care
- Help with taking medicine
- Teaching about health
- Checking and updating shots (immunizations)
- Planning for recovery and going home
- Checking and planning for medical, emotional, and social needs

- Creating and following a care plan
- Helping with legal issues, finding a place to live, getting rides, and other community services
- Helping with health care and other benefits
- Following up on care plans
- Providing medical, social, and emotional support, like counseling
- Community health worker services

Not Covered Services:

- Services related to a member's emotional health needs that exceed those a provider can support
- Services related to Activities of Daily Living (ADL) that a member cannot perform on their own, such as standing up or using the bathroom
- Payment for room and board associated with recuperative care services is the responsibility of the Minnesota Department of Human Services

Notes:

A member must have a referral from a hospital or clinic to receive recuperative care.

REHABILITATION

Covered Services:

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

Not Covered Services:

- Vocational rehabilitation
- Health clubs and spas

SCHOOL BASED COMMUNITY SERVICES (for members under age 21)

School-Based Community Services (SBCS) are certain medically necessary services MHCP will reimburse when provided to children in the school by a qualified health care provider employed or contracted by the school. Minnesota public schools will be able to bill for these services.

SBCS are optional. They are not new or expanded services, but are part of the Medical Assistance (MA) benefit package. Schools have the option in providing these services to help students that are not receiving health-related services through an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP) or when the services are not identified in the IEP.

Covered Services:

- Rehabilitative Services
  - Audiology
  - Occupational therapy
  - Physical therapy
  - Speech language pathology
- Mental Health Services
  - Children's therapeutic services and supports
  - Diagnostic assessments
  - Explanation of findings
  - Family Psychoeducation
  - Health behavior assessment/intervention
  - Outpatient mental health services
  - Psychological testing
  - Psychotherapy
  - Psychotherapy for crisis

Not Covered Services:

- Personal care assistance
- Assistive Technology

- Home Care Nursing
- Special transportation
- IEP services that are required to be covered through the school

SUBSTANCE USE DISORDER SERVICES (SUD)*

Covered Services:

- Screening/assessment/diagnosis including Screening Brief Intervention Referral to Treatment (SBIRT) authorized services and comprehensive assessments
- Comprehensive assessments
- Outpatient treatment
- Inpatient hospital*
- Residential non-hospital treatment*
- Outpatient medication assisted treatment
- Detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification)*
- SUD treatment coordination
- Peer recovery support
- Withdrawal management

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:

Refer to Section 1 for Substance Use Disorder Services contact information.

A qualified professional who is part of the plan network will make recommendations for substance use disorder services for you. You may elect up to the highest level of care recommended by the qualified professional. You may receive an additional assessment at any point throughout your care, if you do not agree with your recommended services. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment. You have the right to appeal. Refer to Section 13 of this Member Handbook.

SURGERY*

Covered Services:

- Office or clinic visits and 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 affirming surgery

Not Covered Services:

- Cosmetic surgery

TEACHING KITCHEN

The goal of this lieu of service (ILOS) is to improve member self-management of diabetes, congestive heart failure (CHF), and pregnancy, and related outcomes through improved nutrition. Through class and group experiences enrollees will learn and retain the skills needed to improve individual and family lifestyle and wellness goals. Participation in the teaching kitchen would also build new skills for accessing healthy food, preparing healthy meals, promote healthy mealtime routines with household members and families, and reduce the impact of food insecurity for Hennepin Health enrollees who are pregnant, have diabetes, or suffer from CHF.

Notes:

- Members are not required to use this service. If you choose to use this service, you keep all your rights. Your health plan cannot deny access to any services just because you were offered, are using, or have used this service before.

Benefit is available to enrollees with any of the following three conditions: diabetes, pregnancy, or congestive heart failure (CHF). In order to receive the food benefit, an enrollee with one of the three aforementioned conditions will need to attend a nutrition class taught by a dietitian at either NorthPoint Health and Wellness or Hennepin Healthcare Red Leaf Center for Family Healing. After attending, they will be eligible to receive a benefit of eight weeks of medically tailored grocery delivery, considering member medical and cultural dietary needs.

SECTION 7

TELEHEALTH SERVICES

- Telehealth services cover medically necessary services and consultations delivered by a licensed health care provider by telephone or video call with the member. The member's location can be their home. Telehealth is defined as the delivery of health care services or consultations through the use of real time, two-way interactive audio and visual communications. The purpose of telehealth is to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment education, and care management of a patient's health care while the patient is at an originating site and the licensed health care provider is at a distant site.

TELEMONITORING*

Telemonitoring is the use of technology to provide care and support to a member's complex health needs from a remote location such as in a member's home. Telemonitoring can track a member's vital signs using a device or equipment that sends the data electronically to their provider for review. Examples of vital signs that can be monitored remotely include heart rate, blood pressure, and blood glucose levels.

Covered Services:

- Telemonitoring services for members with high-risk, medically complex conditions like congestive heart failure, chronic obstructive pulmonary disease (COPD) or diabetes when medically necessary

TOBACCO AND NICOTINE CESSATION (quit smoking, vaping or chewing)

Covered Services:

- In-Person Counseling: You can get help with quitting tobacco or nicotine through individual or group sessions led by trained health care practitioners.
- Telephone Counseling: You can call Quit Partner for support. This service can be accessed by phone and does not require video. Quit Partner offers: free one-on-one coaching over the phone or online, two weeks of patches, gum or lozenges, text message tips, reminders and encouragement, regular emails to support you, and a welcome package when you sign up.
    - Quit Partner phone: 888-354-7526 (TTY 711)
    - Hours: 24 hours/day, 7 days a week
    - Sign up at https://quitpartnermn.com
- Medications: You can get both prescription and over-the-counter medications

approved by the Food and Drug Administration to help you quit smoking or using nicotine.

- Telemedicine: Services can also be provided through telemedicine. (video calls or online)

Notes:

No Limits: There are no limits on how often you can use these services or how many times you can receive counseling or medications for tobacco and nicotine cessation services.

Multiple Services: You can use different types of support at the same time, like counseling and medications.

No prior authorization needed for any tobacco and nicotine cessation services and Food and Drug Administration approved drugs for tobacco cessation treatment.

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 a transplant center that is 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).

TRANSPORTATION TO AND FROM MEDICAL SERVICES*

Covered Services:

- Ambulance (air or ground includes transport on water)
- 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 also including out of state travel. 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 of 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 you do not have a specialty provider that is available within 60 miles your home.

To schedule a ride, call the transportation phone number in Section 1. We encourage you to call us as soon as you medical appointment has been scheduled, or at least three days in advance to allow us time for scheduling. We ask that you have the following information available when you call:

- Name
- Date of birth
- Hennepin Health member number
- Home address and phone number
- Date, time, phone number and location of/for the appointment
- Doctor's name

If you live within three blocks of a bus stop, we will mail single ride bus passes. Bus passes that are lost or stolen will not be replaced. The plan will not give non-emergency rides to members who have access to a private vehicle.

Only members who meet these conditions may qualify for a ride:

1. Members with a physical or mental disability. A "Certification of Need for Exception from Public Transportation" must be completed every three months by the provider. The form must state why you cannot take a bus.

2. Members who have acute same-day appointments that are verified by the clinic or Hennepin Health nurse line. A reminder call from your doctor is not considered a same-day appointment.

3. Members who live more than three blocks from a bus stop.

4. Members whose bus ride to a clinic includes three or more transfers.

If you meet one of these conditions, it is important that you notify us when you call to schedule your transportation needs.

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 received from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Notes:

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

You may also call the nurse line at 888-859-0202, TTY 711, The nurse line provides clinical support 24 hours per day, 7 days a week.

It's good to know what urgent care clinic is nearest to you. You can find an urgent care clinic here (https://hennepinhealth.org/members/find-provider-clinic). Or you can call Member Services.

SECTION 7

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

SERVICES WE DO NOT COVER

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 DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672 or 711 (TTY), or use your preferred relay services. This call is free.

- 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 received 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 800-657-3739 or 711 (TTY), or use your preferred relay services. This call is free.

- 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 HCCS number previously listed.
- 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
- Personal Care Assistance (PCA). Community First Services and Supports (CFSS) replaces PCA services at the member's annual assessment starting October 1, 2024. Contact your county of residence intake for long-term care services and supports to learn more about CFSS (PCA) services and to arrange for an assessment.
- Post-arrest Community-Based Services Coordination
- If you have Medicare Part A or Part B or both, prescriptions are 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 recuperative care services
- 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, a state-owned long term care facility unless approved by us or the service is ordered by a court under conditions specified in law
- 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 or end dates
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID card
- New insurance or Medicare – begin or end dates
- Change of income including employment changes

USING THE PLAN COVERAGE WITH OTHER INSURANCE

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

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

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

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

If your other insurance changes, call your county worker.

SECTION 12

SUBROGATION OR OTHER CLAIM

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

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

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

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

GRIEVANCE, APPEAL AND STATE APPEAL (FAIR HEARING WITH THE STATE) PROCESS

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

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 made 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 (Fair Hearing with the state) if you disagree with our decision.

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

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

- Not providing a response to your grievance or appeal in the required timelines
- 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 may Appeal a Prior Authorization decision without your consent.

A State Appeal (Fair Hearing with the state) is your request for the state to review a decision we made. You must appeal to Hennepin Health before asking for a State Appeal. If we take more than 30 days to decide your appeal and you have not requested an extension or we did not add 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 (Fair Hearing with the state). 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 you have not requested an extension or we did not add 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. 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".

You may submit any documents and give information in person, by telephone, or in writing. Your records will be kept private according to law. You will receive a letter from us confirming we have received your appeal request.

Your appeal request should include:

- Your name
- Date of birth
- Address
- Member number
- Phone number
- Reasons for appeal

You may also include any information you want us to review, such as medical records, provider's letters, or other information that explains why you need the item or service. Call your provider if you need this information. We recommend keeping a copy of everything you send us for your records.

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 or if you or your provider requests extra time. 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 or if you request extra time. 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.

If you appeal, we will send you or your representative the case file upon request, including medical records and any other documents and records considered by us during the appeal process.

To file a State Appeal (Fair Hearing with the state) with the Minnesota Department of Human Services:

You must file a health plan Appeal with 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 ombudsperson 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 Hennepin Health. 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** for issues or concerns that occurred when you were enrolled in the health plan. 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 in writing 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 or if you or your provider requests extra time. 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:	800-657-3916 (This call is free) or 651-201-5100. 711 (TTY), or use your preferred relay services.
Visit:	https://www.health.state.mn.us/facilities/insurance/clearinghouse/complaints.html

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

Important information about your rights when filing a grievance, appeal, or requesting a State Appeal (Fair Hearing with the state):

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 for 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. If you ask, we must give you a copy of the guidelines we used to make our decision, at no cost to you. 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 ombudsperson 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
	800-657-3729 or 711 (TTY), or use your preferred relay services. This call is free. Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m.
Or	
Write to:	Ombudsperson for Public Managed Health Care Programs P.O. Box 64249 St. Paul, MN 55164-0249
Or	
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 previously approved.
- 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 $1-$3.50 for services, supplies or prescription drugs.

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

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

Cultural Competency: Cultural and language competence is the ability of managed care organizations and the providers within their network to provide care to members with

diverse values, beliefs, and behaviors, and to tailor the delivery of care to meet members' social, cultural, and language 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 use any provider in the plan network to get these services. You do not need a referral or prior authorization from your PCP or PCC before getting services.

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

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

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

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

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

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

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

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

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

Fee-for-Service (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 MHCP 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 their 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.

Housing Stabilization Services: Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person's transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

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.

Medical Assistance: Minnesota's Medicaid program for people with low income.

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.

Ombudsperson 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 ombudsperson can also help you file a grievance or appeal or request a State Appeal (Fair Hearing with the state).

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.

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.

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.

Prescriptions: Medicines and drugs ordered by a medical provider.

Prescription Drug Coverage: A health plan that helps pay for prescription drugs and medications. Also refer to "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 Provider: Your primary care provider (PCP) is the doctor or other qualified health care provider you go to 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.

Quality of Care Complaint: For purposes of this handbook, "quality of care complaint" means an expressed dissatisfaction regarding health care services resulting in potential or actual harm to a member. Quality of care complaints may include: access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that could impact the quality of health care services.

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

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 MHCP. 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 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 is not 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. You can also refer to the Introduction for information on counties in the plan 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.

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.

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

State Appeal (Fair Hearing with the State): 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 with your written 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.

ADDITIONAL INFORMATION: HEALTH CARE DIRECTIVES

Questions and answers about health care directives

Minnesota law

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury. The information that follows tells about health care directives and how to prepare them. It does not give every detail of the law.

What is a health care directive?

A health care directive is a written document that informs others of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a health care directive.

Why have a health care directive?

A health care directive is important if your attending physician determines you can't communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your directive may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

Must I have to have a health care directive? What happens if I don't have one?

You don't have to have a health care directive. But writing one helps to make sure your wishes are followed. You will still receive medical treatment if you don't have a written directive. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a health care directive.

How do I make a health care directive?

There are forms for health care directives. You don't have to use a form, but your health care directive must meet the following requirements to be legal:

• Be in writing and dated.

• State your name.

- Be signed by you or someone you authorize to sign for you, when you can understand and communicate your health care wishes.

- Have your signature verified by a notary public or two witnesses.

- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make. Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider.

Information about how to obtain forms for preparation of your health care directive can be found at the end of this document, under "How to obtain additional information."

I prepared my directive in another state. Is it still good?

Health care directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements. But requests for assisted suicide will not be followed.

What can I put in a health care directive?

You have many choices of what to put in your health care directive. For example, you may include:

- The person you trust as your agent to make health care decisions for you. You can name alternative agents in case the first agent is unavailable, or joint agents.

- Your goals, values, and preferences about health care.

- The types of medical treatment you would want (or not want).

- How you want your agent or agents to decide.

- Where you want to receive care.

- Instructions about artificial nutrition and hydration.

- Mental health treatments that use electroshock therapy or neuroleptic medications.

- Instructions if you are pregnant.

- Donation of organs, tissues, and eyes.

• Funeral arrangements.

• Who you would like as your guardian or conservator if there is a court action.

You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your health care directive.

What information can I request to be included in my health record?

You or your health care agent can request your health care provider to enter in your health care record any instructions relating to administering, dispensing, or prescribing an opioid.

Are there any limits to what I can put in my health care directive?

There are some limits about what you can put in your health care directive. For instance:

• Your agent must be at least 18 years of age.

• Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for the naming of the agent in your directive.

• You cannot request health care treatment that is outside of reasonable medical practice.

• You cannot request assisted suicide.

How long does a health care directive last? Can I change it?

Your health care directive lasts until you change or cancel it. As long as the changes meet the health care directive requirements listed above, you may cancel your directive by any of the following:

• A written statement saying you want to cancel it.

• Destroying it.

• Telling at least two other people you want to cancel it.

• Writing a new health care directive.

SECTION 15

What if my health care provider refuses to follow my health care directive?

Your health care provider generally will follow your health care directive, or any instructions from your agent, as long as the health care follows reasonable medical practice. But you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agent to arrange to transfer you to another provider who will follow the agent's directions.

What if I've already prepared a health care document? Is it still good?

Before August 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable health care powers of attorney, and mental health declarations. The law changed so people can use one form for all their health care instructions. Forms created before August 1, 1998, are still legal if they followed the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

What should I do with my health care directive after I have signed it?

You should inform others of your health care directive and give people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a health care directive. You should give them a copy. It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.

What if I believe a health care provider has not followed health care directive requirements?

Complaints of this type can be filed with the Office of Health Facility Complaints at 651-201-4200 or 800-369-7994. This call is free. TTY users, please call 651-201-5797. Or email: health.ohfc-complaints@state.mn.us

What if I believe a health plan has not followed health care directive requirements?

Complaints of this type can be filed with the Minnesota Health Information Clearinghouse at 651-201-5178 or 800-657-3793. This call is free. TTY users, please call 651-201-5797.

Email: health.clearinghouse@state.mn.us

I-PMA004

How to obtain additional information

If you want more information about health care directives, please contact your health care provider, your attorney, or Minnesota Board on Aging's Senior LinkAge Line® at 800-333-2433. This call is free.

TTY: Minnesota Relay at 711 or 800-627-3529. This call is free.

ADDITIONAL INFORMATION: WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The United States Women's Health and Cancer Rights Act (WHCRA) of 1998 helps protect many women with breast cancer who choose to have their breasts rebuilt (reconstructed) after a mastectomy. A mastectomy is surgery to remove all or part of the breast. This federal law requires health plans that cover mastectomies to provide certain benefits if a member chooses reconstructive surgery after a mastectomy. The law also requires that health plans provide members written notice of the availability of this coverage.

Covered services include:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Treatment of any physical complications as a result from the mastectomy, including swelling of the lymph glands (lymphedema)
- Any prostheses (breast forms that fit into your bra) that are needed before or during the reconstruction of the breast

Hennepin Health covers these services as described in the Member's Handbook. If you have more questions or concerns, you can contact Hennepin Health Member Services: 612-596-1036 (TTY: 800-627-3529).

Hennepin Health
300 South Sixth Street, MC 604
Minneapolis, Minnesota 55487-0604

Call: 612-596-1036 or 800-647-0550. This call is free.

TTY: 800-627-3529 or 711, Monday–Friday, 8 a.m.–4:30 p.m.

hennepinhealth.org