



Hennepin Health

Let us be your
guide to good health.



Member Handbook

Special Needs BasicCare (SNBC)

Medicaid-only

January 1, 2024

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

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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.

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

သတိ။ ဤတွဲရက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

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請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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

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

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဝဲန့ၢ်လိဉ်ဘဉ်တၢ်မၤစၤကလီလၢတၢ်ကကျိးထံဝဲဒၣ်လံာ် တီလံာ်မိတခါအံၤန့ၣ်,ကိးဘဉ် လီၤဝဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທໂປຣໂປຣໄພາຍເລກຂ້າງເທິງນີ້.

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.

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Welcome to Hennepin Health

We are pleased to welcome you as a member of Hennepin Health - SNBC Medicaid-Only product (referred to as “plan” or “the plan”).

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

You will be contacted by Hennepin Health, to complete a health assessment by mail. The assessment 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 assessment, call Hennepin Health Member Services at 612-596-1036 (voice) or 800-647-0550, or TTY 800-627-3529. These calls are 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.

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 (*HealthConnection*): 888-859-0202

Interpreter services:

American Sign Language (ASL): 800-627-3529

Spoken language: 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](https://www.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>

To report fraud and abuse please contact the Hennepin Health Special Investigations Unit by phone at 844-440-3290, by website at: <http://mhp.alertline.com>, or by email to HH.Fraud@hennepin.us. To report fraud or abuse directly to the state, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at 651-431-2650 or 800-657-3750 or 711 (TTY); or use your preferred relay services (This call is free); by fax at 651-431-7569; or by email at DHS.SIRS@state.mn.us. This call is free.

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.

Disability Hub MN™

Disability Hub MN™ is a free statewide resource network that helps you solve problems, navigate the system, and plan for your future. Call Disability Hub MN at 866-333-2466 Monday through Friday from 8:30 a.m. to 5:00 p.m., or visit online at disabilityhubmn.org to learn more about your options and for assistance in making changes. This call is free.

Veterans Linkage Line™

The Veterans Linkage Line™ provides information and referrals to veterans and their families. The Minnesota Department of Veterans Affairs (MDVA) provides the LinkVet call center. During business hours, trained MDVA staff will provide information on veterans' benefits, healthcare, education, and reintegration.

Hours of Operation

Monday-Friday: 7 a.m. to 8 p.m., CST

Saturday: 9 a.m. to 2:30 p.m., CST

Sunday: 11 a.m. to 4:30 p.m., CST

Closed Holidays. Call 888-LinkVet or 888-546-5838 or 711 (TTY) or use your preferred relay services. This call is free.

How to contact the Medicare Program

Medicare is a federal health insurance program for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called end-stage renal disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the federal agency in charge of the Medicare Program. Here are ways to get help and information about Medicare from CMS:

- Call 800-MEDICARE (800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 877-486-2048. This call is free. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov. This is the official government website for Medicare information. This website gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It has tools to help you compare Medicare Advantage plans and prescription drug plans in your area. You can search under “Forms, Help & Resources” and print the “Medicare & You” booklet directly from your computer. Select “Phone Numbers and websites” to find helpful contacts for organizations in your state. If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer.

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://hennepinhealth.org/-/media/hh/members/Directories/snbc-provider-directory.pdf>) that lists plan network providers. The Provider Directory can tell you information about providers such as name, address, phone number, professional qualifications, specialty, and languages spoken by the provider. Call Member Services if you would like information about board certification, medical school attendance, residency program, and board certification status. You may ask for a print copy of this the Provider Directory at any time. To verify current information, you can call the provider, call Member Services at the phone number in Section 1, or visit our website listed in Section 1.

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. You may change your PCC. We can help you find a new PCC. There are three (3) options for selecting and 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 at 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.

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: transplants. 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.

SECTION 2

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.

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:

Cost sharing is an amount that health plan members may be responsible to pay to their providers for their medical services. It includes deductibles and copays. **You do not have cost sharing for services covered under our plan.** If you disenroll from our plan, you may have cost sharing for certain services.

If you have Medicare, you must get most of your prescription drugs through a Medicare prescription drug (Medicare Part D) plan. You may have a copay with no monthly limit for some of these drugs.

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.

SECTION 2

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 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, 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 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.

Disenrollment:

Your coverage with us will end if you decide to leave our plan. You can choose to disenroll at any time. You will remain enrolled until the end of the month. To tell us you want to leave our plan, you can write or fax a letter to us or fill out a disenrollment form and send it to Member Services or to our fax number listed in Section 1. Be sure to sign and date your letter or form. It is helpful to include your date of birth. The effective date depends upon the date your request is received.

Your coverage with us will end for any of the following reasons:

- You are no longer eligible for Medical Assistance (Medicaid).
- You lose eligibility for SNBC because you are no longer disabled.
- You are eligible for Medicare but do not stay continuously enrolled in both Medicare Part A and Medicare Part B.

SECTION 2

- You have cost effective health insurance.
- You have a spenddown and you do not pay it.
- You move out of our plan service area.
- You turn age 65.
- You choose to leave the 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 care coordination. You also have the right to refuse care coordination.

Voluntarily disenroll.

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 primary care qualified health care provider before you become ill. This helps you and your primary care 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.

Work with your care coordinator to create your care plan. If you do not want care coordination, or want to limit how much contact you get from a care coordinator, or change to a different care coordinator, call your health plan to let them know.

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:

Medical claims: Hennepin Health, Attn: Claims, 300 S 6th St MC 604, Minneapolis MN 55487-0604. No balance billing.
Provider Services: 612-596-1036 or 1-800-647-0550
Dental: Delta Dental of Minnesota, P.O. Box 9120, Farmington Hills, MN 55431. Phone: 651-406-5907 or 1-800-328-7373
Member Services: 612-596-1036
Pharmacy: 1-855-673-6541
Hospital admissions: Hennepin Health, 300 S 6th St, Minneapolis, MN 55487. Call within 24 hours when a member is out of our service area.
For emergencies call 911 or go to the nearest hospital.
Complaints: 612-596-1036 or Attn: Appeals & Grievances, 300 S 6th St, Minneapolis, MN 55487. DHS Ombudsman: 651-431-2600, P.O. Box 64941, St. Paul, MN 55164

 **Hennepin Health**
www.hennepinhealth.org

Member ID: [BIN] Rx PCN: [PCN]
Group: [GRP]
Issue: Hennepin Health
ID: 999999998 Grp: 8390
Name: JOHN 1 CSS/8390
Care Type: Hennepin Health-SNBC
Svc Type: Medical, Dental

Clinic: [CLINIC]
Hospital: [HOSPITAL]

H5750-004

COST SHARING

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

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

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. Some services have limitations. If you need help understanding what services are covered, call Member Services at the phone number in Section 1. 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:
 - postoperative procedures
 - pregnancy
 - cancer care

CARE COORDINATION BY CARE GUIDES

You are assigned a care coordinator who will help connect you to the services and resources you need to get the best possible care. Care coordinators can also help you learn more about your health, any health conditions you have, and help you follow your care plan. Care coordinators and Hennepin Health Member Services staff are available to answer questions about Hennepin Health and the SNBC program.

You will be assigned a care coordinator upon admission. The care coordinator will call you within the first ten (10) days to welcome you to the plan. To speak with a care coordinator call member services at 612-596-1036 or 1-800-647-0550. As a member of Hennepin Health’s SNBC population you have access to medical transportation, assistance finding a primary care doctor or a specialty doctor. You will be assigned a care coordinator to assist you with housing, personal care attendants and medical equipment. If you need help with pharmacy issues or renewing your Medical Assistance your care coordinator can help.

Care coordination is always available for you. You can stop using this service at any time by telling your care coordinator or by contacting Hennepin Health. If you want to change your care coordinator, call Hennepin Health Member Services at the phone number in Section 1.

Covered Services:

- An assessment to identify how the care coordinator can help you with health care, housing, food security, and other needs
- Help with scheduling, coordinating, and receiving assessments or tests and health care services such as dental, behavioral health, rehabilitative, and primary care
- Creation and updating of your care plan, based on your unique needs and working with the people you choose

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- With your permission, Hennepin Health care coordinators can communicate with agencies and people who can help meet your needs:
 - Work together with you and others you choose when you have a change in your health care needs or a hospitalization
 - Help you find resources you need in your community
 - Work together with your Home and Community Based Services waiver case managers or other case managers
- With your participation, Hennepin Health care coordinators also do the following:
 - Help you set goals for your health and well-being and work with you to reach them
 - Communicate or meet with you regularly to discuss your health and well-being
 - Remind you when you need preventive services, tests, or appointments that are part of your care plan

Notes:

If you have questions or need help contacting your care coordinator, call Hennepin Health Member Services at the phone number listed in Section 1.

CHILD AND TEEN CHECKUPS (C&TC)

Covered Services:

- Child and Teen Checkups (C&TC) preventive health visits
- These visits provide children, teens and young adults with regular age-appropriate preventive, dental, mental health, developmental, and when needed, specialty services. Depending on age, these visits may include:
- growth measurements
 - health education
 - health history including nutrition
 - developmental screening
 - social-emotional or mental health screening
 - head-to-toe physical exam
 - immunizations

- lab tests
- vision checks
- hearing checks
- oral health, including fluoride varnish application

Notes:

C&TC is a health care program of health visits for members birth up to 20 years old. Starting at age 11, each visit may include one-on-one time with the healthcare provider. This gives time for adolescents and young adults to ask questions privately and learn to manage their own health.

How often a C&TC is needed depends on age, and children in foster care should receive visits more frequently.

- Birth to 2-1/2 years: 0-1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months
- 3 to 20 years: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20 years

A C&TC visit is used for entrance into Head Start, WIC, school, childcare, and camp and sports physicals. Be sure to bring the form to the visit for the provider to fill out.

Members, age 21, are eligible for a well-child visit.

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*

Covered Services:

- Diagnostic services:
 - comprehensive exam (*once every five years*) (*cannot be performed on same date as a periodic or limited evaluation*)
 - periodic exam (*once per calendar year*) (*cannot be performed on same date as a limited or comprehensive evaluation*)
 - limited (problem-focused) exams (*once per day*) (*Cannot be performed on same date as a periodic or comprehensive oral evaluation or dental cleaning service*)
 - oral evaluation (*cannot be performed on same date as full mouth debridement*)
 - detailed periodontal evaluation (*cannot be performed on same date as full mouth debridement*)
 - teledentistry for diagnostic services
 - imaging service, limited to:
 - bitewing (*once per calendar year*)
 - single X-rays for diagnosis of problems (*four per date of service*)
 - panoramic (*once every five years and as medically necessary, once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure*)
 - full mouth X-rays (*once in a five-year period*)
- Preventive services:
 - dental cleanings (*limited to two per calendar year; up to four times per year if medically necessary*)
 - fluoride varnish (*once every six months*) (*cannot be performed on same date as emergency treatment of dental pain service*)
 - sealants (*one every five years per permanent molar*)
 - cavity treatment (*once per tooth per six months*)
 - oral hygiene instruction
- Restorative services:
 - fillings (*limited to once per 90 days per tooth*)

- sedative fillings for relief of pain (*cannot be performed on same date as emergency treatment of dental pain service*)
- individual crowns (must be made of prefabricated stainless steel or resin)
- Endodontics (root canals) (*on anterior teeth and premolars only and once per tooth per lifetime*)
- Oral surgery*
- Orthodontics (only when medically necessary for very limited conditions)
- Periodontics:
 - gross removal of plaque and tartar (full mouth debridement) (*once every five years (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluations service)*)
 - scaling and root planing* (*cannot be performed on same day as dental cleaning or full mouth debridement (once every two years for each quadrant)*)
 - Follow-up procedures (periodontal maintenance) (*every three months/90 days for two years (up to four per calendar year following the completion of scaling and root planing)*)
- Prosthodontics:
 - removable appliances (dentures and partials) (*once every six years per dental arch*)
 - adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials) (*repairs to missing or broken teeth are limited to 5 teeth per 180 days*)
 - 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 (*once per appliance*)
 - precision attachments and repairs
- Additional general dental services:
 - emergency treatment for pain (*once per day*)
 - general anesthesia, deep sedation (*when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery.*)
 - extended care facility/house call in certain institutional settings including: boarding

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care homes, Institutions for Mental Diseases (IMDs), 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) *(cannot be performed on same date as oral hygiene instruction service)*

- behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
- medications *(only when medically necessary for very limited conditions)*
- nitrous oxide *(only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)*
- oral bite adjustments *(limited to once per day)*
- oral or IV sedation *(only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)*

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 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), 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 women
 - 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
- Acupuncture* for pain and other specific conditions, by licensed acupuncturists or within the scope of practice by a licensed provider with acupuncture training or credentialing
- 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 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)

EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION (EIDBI) SERVICES

(for members 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 provides more information on the program once a family gets started with services (<https://www.dhs.state.mn.us/EIDBI-Welcome-Letter>).

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:

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- 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) (<https://www.dhs.state.mn.us/EIDBI-TreatmentModalities>)

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) (<https://www.dhs.state.mn.us/ITP>)
 - ITP Development and Progress Monitoring
- Direct Intervention: Individual, Group, and/or higher intensity (<https://www.dhs.state.mn.us/EIDBI-DirectIntervention>)
- Intervention 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/EIDBICoordinated-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 supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Notes:

If you have an emergency and need treatment right away, either 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 and your Care Guide or Member Services 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.

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**

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- 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:

Medicare Election

You must elect hospice benefits to receive hospice services.

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

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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

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 72 hours.

Notes:

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

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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 services for members eligible for Housing Stabilization Services:

- Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services
- Housing transition - moving expenses (limited to \$3000 per year)
 - 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 required to live in and use in the home, including furniture, window coverings, food preparation items, and bed or bath linens
 - Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water
 - Services necessary for the individual's health and safety such as pest removal and one time cleaning prior to moving in
 - Necessary home accessibility adaptations
- Housing sustaining services to help you maintain housing
- Transportation to receive Housing Stabilization Services (within a 60 mile radius)

Notes:

You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. If you need Housing Stabilization Services, you can ask for an assessment or be supported by your provider or case manager. If you have a targeted case manager or waiver case manager, that case manager can support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you.

Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to receive this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.

If you are approved for moving expenses, your provider must send us the receipt for each moving expense. Work with your provider on how to access this benefit.

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, including therapeutic stock shoes when specific criteria are met and 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

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- 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 in order 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.

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
- Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorders*
- Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program (IOP)
- Forensic Assertive Community Treatment (FACT)
- 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)
 - Adult day treatment*
 - Adult Rehabilitative Mental Health Services (ARMHS)
 - 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*)

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- 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 over age 18*)*
- 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 18 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/Behavioral 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.

NURSING HOME SERVICES*

Covered Services:

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

Not Covered Services:

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

OBSTETRICS AND GYNECOLOGY (OB/GYN) SERVICES*

Covered Services:

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

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Not Covered Services:

- Abortion: This service is not covered under the plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 800-657-3739 or 711 (TTY) or use your preferred relay services for coverage information. This call is free. Also refer to Section 9.
- Planned home births

Notes:

You have “direct access” to OB-GYN providers without a referral for the following services: annual preventive health exam, including follow-up exams that your qualified health care provider says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must 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

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

Notes:

If you need to use a pharmacy when out of the plan service area, call Member Services at the phone number listed in Section 1 first before you pay for a prescription drug or over-the-counter drug, even if the drug is on your list of covered drugs (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

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- 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

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 our approval before the plan will cover 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 or dose 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 paying for the non-preferred drugs. In order to receive a non-preferred drug, your doctor or health care provider will have to get prior authorization.
- **Age requirements:** In some cases, there are age requirements for you to try certain drugs. A prior authorization is needed depending on your age and the specific drug prescribed.
- **Brand-name drugs:** Brand-name version of the drug will be covered by 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 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. You can find a list of specialty drugs here <http://www.hennepinhealth.org/providers/formulary>.

If you are prescribed a drug that is on the Hennepin Health Speciality Drug List, your prescriber will need to send the prescription of that specialty drug to one of Hennepin Health's specialty pharmacies listed below.

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. - 1 p.m., Saturday Closed on Sunday

Name of specialty pharmacy:	Lumicera Health Services
Phone and TTY:	855-847-3553, TTY 711
Fax:	1-855-847-3558
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)

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

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- 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.

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
- Individualized Education Plan (IEP) services that are required to be covered through the school

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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 assessor who is part of the plan network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor. We will do this within five working days of when we get your request. If you agree with the second assessment, 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/clinic visits/surgery
- Removal of port wine stain birthmarks
- Reconstructive surgery (for example, following mastectomy, following surgery for injury, sickness or other diseases; for birth defects)
- Anesthesia services
- Circumcision when medically necessary
- Gender confirmation surgery

Not Covered Services:

- Cosmetic surgery

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)

Quitting is hard. We want to help. Improve your quality of life by quitting smoking, vaping or chewing. Your benefits include education and counseling on how to quit.

Covered Services:

- In-person individual and group tobacco and nicotine cessation education and counseling services if provided by a health care practitioners whose practice includes these services. These practitioners could be:
 - Doctors, physician assistants or advanced practice registered nurses
 - Community health workers
 - Mental health practitioners/professional and certified peer specialists
 - Alcohol and drug counselors, recovery peers
 - Certified tobacco treatment specialists.
- Telemedicine tobacco and nicotine cessation education and counseling services.
- Telephone counseling services provided through Quit Partner, (888-354-7526) (TTY 711). 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
 - A welcome package when you sign upSign up at <https://quitpartnermn.com/>.
- Prescription and over-the-counter drugs approved to stop the use of tobacco and nicotine use or treatment of tobacco and nicotine dependence.

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/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 from your home. Call the transportation phone number in Section 1 if you do not have a primary care clinic that is available within 30 miles of your home and/or if you do not have a specialty provider that is available within 60 miles of your home.

To schedule a ride, call the transportation phone number in Section 1. We encourage you to call us as soon as your 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 supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

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.

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

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

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

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 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 MHCP Member Helpdesk number listed above.
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Job training and educational services
- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance (Medicaid)
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Moving Home Minnesota services
- Nursing home stays that exceed 100 days. Refer to “Nursing Home Services” in Section 7.
- Personal Care Assistance (PCA). Community First Services and Supports (CFSS) will replace PCA services, upon federal approval. Contact your county of residence intake for long-term care services and supports to learn more about PCA services and to arrange for an assessment.
- Post-arrest Community-Based Services Coordination
- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.

SECTION 9

- Relocation service coordination
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Room and board associated with treatment services at children’s residential mental health treatment facilities. Room and board may be covered by your county. Call your county for information.
- Services provided by federal institutions
- Services provided by a state regional treatment center, 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

WHEN TO CALL YOUR COUNTY WORKER

Call your county worker to report these changes:

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

SUBROGATION OR OTHER CLAIM

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

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 an extension has not been requested by you or added by us, 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 an extension has not been requested by you or added by us, 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.

SECTION 13

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**. 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 or if you or your provider requests more time. 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 your 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 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 your preferred relay service. Hours of service are Monday through Friday 8:00 a.m. to 4:30 p.m. This call is free.

Or

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

Fax to: 651-431-7472

DEFINITIONS

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

Action: This includes:

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

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

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

Care Guides: Care guides work in partnership with members to positively impact overall health and wellbeing. All Hennepin Health SNBC members are eligible to work with a care guide. Care guides assist members with problems like finding a doctor or a dentist and locating resources that they think could help a member. Hennepin Health has care guides who are based in the health plan as well as delegated care guides who are employed by community organizations.

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.

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

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

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

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

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

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

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

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

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

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

Formulary: The list of drugs covered under the plan.

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

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

Hospice: A special program for members who are terminally ill and not expected to live more than six months to live comfortably for the rest of the member's time. It offers special services for the member and 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.

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 Guides 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 use 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 Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

Second Opinion: If you do not agree with an opinion you get from a plan network provider, you have the right to get an opinion from another provider. We will pay for this. For 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.

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.

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

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.

Do 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.

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 (Metro area) or 800-369-7994. TTY users, please call 651-201-5797. This call is free. 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

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.

SECTION 15

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

The United States Women's Health and Cancer Rights Act 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: 1-800-627-3529).



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