Hennepin Health

EFFECTIVE
JANUARY 2016

Evidence of Coverage

Special Needs BasicCare Medicaid only (SNBC)

Administered by Hennepin Health: 612-596-1507

This booklet contains important information about your health care services.

DHS approved 12/9/2015

Hennepin Health 612-596-1036 Monday–Friday, 8 a.m.–4:30 p.m.

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

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

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請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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

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

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တိလံာ်မိတခါအံၤန္ဉ်,ကိးဘဉ်လီတဲစိနိ်ဂ််လၢထးအံၤန္ဉ်တက့်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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

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

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

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

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

LB2 (8-16)

For accessible formats of this publication or assistance with additional equal access to our services, write to **hennepinhealth@hennepin.us**, call **612-596-1036** 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 enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

Discrimination Notice

Discrimination is against the law. Hennepin Health will accept all eligible Beneficiaries who select or are assigned to Hennepin Health without regard to medical condition, health status, receipt of health care services, claims experience, medical history, genetic information, disability (including mental or physical impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, or public assistance status.

Free Auxiliary aids and services. Hennepin Health provides aids and services, including qualified interpreters and information in accessible formats, in a timely manner, to ensure that people with disabilities have an equal opportunity to participate in Hennepin Health's health care programs.

To ask for these aids and services, contact: Hennepin Health Member Services at hennepinhealth@hennepin.us, or call Hennepin Health Member Services at 612-596-1036 (voice) or 1-800-647-0550 (toll-free), or your preferred relay service.

Free language assistance services. Hennepin Health provides translated documents and spoken language interpreting, in a timely manner, when language assistance

services are necessary to ensure limited English speakers have meaningful access to information and services.

To ask for these aids and services, contact: Hennepin Health Member Services at hennepinhealth@hennepin.us, or call Hennepin Health Member Services 612-596-1036 (voice) or 1-800-647-0550 (toll-free), or your preferred relay service.

Complaint Notice

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

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

The U.S. Department of Health and Human Services' Office for Civil Rights does not discriminate on the basis of race, color, national origin, age, disability or sex, including sex stereotypes and gender identity, in its health programs and activities. Contact the federal agency directly to file a complaint:

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

Minnesota Department of Human Rights

In Minnesota, you have the right to file a complaint with the Minnesota Department of Human Rights if you believe you have been discriminated against because of race, color, national origin, religion, creed, sex, sexual orientation, marital status, public assistance status or disability. Contact the Minnesota Department of Human Rights directly to file a complaint:

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

Minnesota Department of Human Services (DHS)

The Minnesota Department of Human Services does not discriminate on the basis of race, color, national origin, creed, religion, medical condition, health status, receipt of health care services, claims experience, medical history, genetic information, sexual orientation, public assistance status, marital status, age, disability (including mental or physical impairment) or sex, including sex stereotypes and gender identity, in health programs or activities.

- Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination.
- The complaint must contain your name, address, and describe the discrimination you are complaining about.
- Upon receiving your complaint, the Department of Human Services will review your complaint and notify you in writing about whether it has authority to investigate. If it does, DHS will investigate the complaint.

The Department of Human Services will notify you in writing of the outcome of the investigation. You have the right to appeal the outcome of the investigation 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 under this process, 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 using this complaint procedure does not stop you from seeking out other legal or administrative actions.

Contact the Minnesota Department of Human Services directly to file a discrimination complaint:

ATTN: 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

Hennepin Health Complaint Notice

If you believe that Hennepin Health has failed to provide these services or discriminated in another way on the basis of medical condition, health status, receipt of health care services, claims experience, medical history, genetic information, disability (including mental or physical impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, or public assistance status, you can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Hennepin Health
Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, MN 55415
Toll Free: 1-800-657-3778 (voice)
1-800-627-3529 (MN Relay)
612-632-8815 (Fax)
hennepinhealth@hennepin.us (Email)

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Welcome to Hennepin Health!

We are pleased to welcome you as a member of Hennepin Health–SNBC (referred to as "Plan" or "the Plan"), which is administered by Hennepin Health.

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

This Evidence of Coverage or EOC, together with any amendments that we may send to you, is our contract with you. It is an important legal document. Please keep it in a safe place.

This EOC 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 14
- Definitions

The counties in the Plan service area are as follows: Hennepin County

Please tell us how we're doing. You can call, or write to us at any time. (Section 1 of this EOC 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, please call, or write to Member Services. We will be happy to help you. Member Services' hours of service are 8 a.m. to 4:30 p.m., Monday through Friday.

• CALL: 612-596-1507 (or toll free: 1-888-562-8000)

• TTY/TDD: 711, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over) or 1-877-627-3848 (speech to speech relay service)

• WRITE OR VISIT:

Hennepin Health
Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, MN 55415

• WEBSITE: www.hennepinhealth.org

Our Plan contact information for certain services

Appeals and Grievances: 1-800-657-3778. See Section 13 for more information.

Chemical Dependency Services: 612-596-1507 (or toll free: 1-888-562-8000)

Chiropractic Services: 612-596-1507 (or toll free: 1-888-562-8000)

Dental Services: 651-406-5907 or 1-800-774-9049 (TTY users should call: 711)

Durable Medical Equipment Coverage Criteria: 612-596-1507
(or toll free: 1-888-562-8000)

24-Hour Nurse Line (*Health*Connection): 1-888-859-0202

Interpreter Services:

Sign language: 1-800-627-3529

Spoken language: 612-596-1507 (or toll free: 1-888-562-8000)

Mental Health/Behavioral Health Services: 612-596-1507 (or toll free: 1-888-562-8000)

Prescriptions: 1-866-561-9034

Transportation: 612-596-1507 (or toll free: 1-888-562-8000)

Other important contact information

People with hearing loss or a speech disability may call the following numbers to access the resources listed in this Evidence of Coverage: 711, Minnesota Relay Service at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over) or 1-877-627-3848 (speech to speech relay service). Calls to these numbers are free.

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 program through counties. If you have questions about your eligibility for Medical Assistance, contact your county worker.

Ombudsman for State Managed Health Care Programs

The Ombudsman for State Managed Health Care Programs, at the Minnesota Department of Human Services, helps people enrolled in a health plan in resolving service and billing problems. They can help you file a grievance or appeal with us. The ombudsman can also help you request a state fair hearing. Call 651-431-2660 (Twin Cities metro area) or toll free 1-800-657-3729 (non-metro) or 1-800-627-3529 (TDD).

Office of Ombudsman for Long-Term Care

The Office of Ombudsman for Long-Term Care can assist people with concerns about nursing homes, and Medicare beneficiaries who have hospital access or discharge concerns. Call 651-431-2555 (Twin Cities metro) or 1-800-657-3591 (toll free).

Disability Linkage Line®

The Disability Linkage Line® provides information and assistance on disability-related questions. An Options Counselor will answer your call, listen to your needs, explore possible options, and provide you the information you need. Their goal is to provide you information on any topic related to disabilities and community resources. Common requests include information on employment, disability benefits, housing, modifications, assistive technology, personal care assistance and disability awareness and rights. Call 1-866-333-2466 (toll free) Monday through Friday from 8:30 a.m. to 5:00 p.m.

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. The line will roll to Crisis Connection counselors for coverage 24-hours a day, 7 days a week (including holidays) for immediate crisis intervention and psychological counseling. Call 1-888-LinkVet (1-888-546-5838, toll 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 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.

- Visit www.medicare.gov. This is the official government Web site for Medicare information. This Web site 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 Web sites" 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 Web site 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 receive a Provider Directory. It lists Plan network providers. It is current as of the date it is printed. 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.

You may choose a Plan network qualified health care provider or clinic. This is your primary care clinic. We encourage you to consult with your primary care clinic for health services.

Your primary care clinic or qualified health care provider will arrange most of your medical care. It is important that one qualified health care provider knows about all your medical needs. The qualified health care provider can make sure you get the care you need.

You do not need a referral to see 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, service authorizations and to make an appointment. If you cannot go to 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.

If you need help getting information about the special access services that are available from a provider, 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.

Service authorizations:

Our approval is needed for some services to be covered. This is called service 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. 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 service authorization from us to see 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 AIDS or other HIV-related conditions are open access services. You can go to any qualified health care provider, clinic, pharmacy or family planning agency that is licensed in Minnesota and registered with the Department of Human Services (DHS), even if it is not in our network to get these services.
- Emergency and post-stabilization services
- Mental/Behavioral health services
- Chemical Dependency services. But you must get services at your designated provider on any Rule 5 Assessment.

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

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

If we are unable to find you a qualified Plan network provider, we must give you a standing service authorization for you to see 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 service 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 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 612-596-1507 between 8:30 a.m. and 4 p.m., Monday through Friday. If you need language assistance to talk about these issues, Hennepin Health can get help in your language through an interpreter. For sign language services, call 1-800-627-3529. For other language assistance, call 612-596-1507.

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 EOC carefully. It lists many services and supplies that are not covered. See Sections 7 and 8.

Some services are not covered under the Plan, but may be covered through another source. See 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.

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 services.

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.

Interpreter services:

We will provide interpreter services to help you access services. This includes spoken language interpreters and sign language interpreters. Face-to-face oral language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. Please 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 see information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

Restricted Recipient Program:

The Restricted Recipient Program is for members who have misused health services. This includes receiving health services that members did not need or using them in a way that costs more than they should.

You must get health services from one designated primary care provider, one pharmacy, one hospital, or other designated health services providers. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options, or consumer directed services.

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

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

At the end of the 24 months, your use of health services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. See Section 13.

Cancellation:

Membership in our Plan is voluntary. Your coverage with us will be cancelled 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 would also be helpful to include your date of birth. The effective date depends upon the date your request was received.

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

- You are no longer eligible for Medical Assistance.
- 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.
- You have cost effective health insurance.
- You have a spenddown and you do not pay it.
- You move out of our Plan service area.

If you are no longer eligible for Medical Assistance, you may be eligible to purchase health coverage through MNsure. For information about MNsure, call toll free 1-855-3MNSURE or 1-855-366-7873, or visit www.MNsure.org.

MEMBER BILL OF RIGHTS

You have the right to:

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

Be told about your health problems.

Get information about treatments, your treatment choices, and how they will help or harm you.

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.

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

Request a state fair hearing with the Minnesota Department of Human Services (also referred to as "the state"). You may request a state fair hearing before or at any time during our appeal process. You do not have to file an appeal with us before you request a state fair hearing.

Receive a clear explanation of covered nursing home and home care services.

Request and receive 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.

Participate with providers in making decisions about your health care.

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

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 decide for you if you are unable to decide, or if you want someone else to decide for you.

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

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 chemical dependency services.

Request a copy of this Evidence of Coverage at least once a year.

Get in writing your primary care doctor's name, address, and telephone number. This will be given to you, or, in some cases, your representative.

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
- The type(s) of incentive arrangement used
- Whether stop-loss protection is provided
- Results of a member survey if one is required because of our physician incentive plan
- Results of an external quality review study from the state

Make recommendations about our rights and responsibilities policy.

Exercise the rights listed here.

MEMBER RESPONSIBILITIES

You have the responsibility to:

Read this Evidence of Coverage and know which services are covered under the Plan and how to get them.

Show your health plan member card and your Minnesota Health Care Program (ID) 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. If you have questions about your care, ask your qualified health care provider.

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

Practice preventive health care. Have tests, exams and shots 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.

YOUR HEALTH PLAN MEMBER CARD

Each member will receive a Plan member card.

Always carry your Plan member card with you.

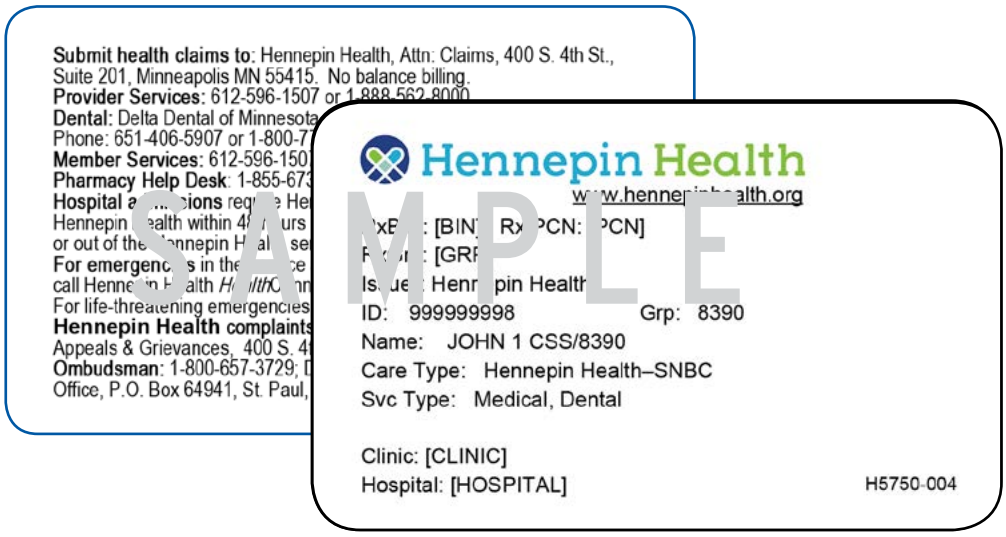
You must show your Plan member card whenever you get health care.

You must use your Plan member card along with your Minnesota Health Care Program (ID) 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 card is lost or stolen. We will send you a new card.

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

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



COST SHARING

Cost sharing is an amount that health plan members may be responsible to pay to their providers for their medical 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 services.

COVERED SERVICES

This section describes the major services that are covered under the Plan for Medical Assistance members. It is not a complete list of covered services. Some services have limitations. Some services require a service authorization. A service marked with an asterisk (*) means a service authorization is required or may be required. Make sure there is a service authorization in place before you get the service. All health care services must be medically necessary for them to be covered. Call Member Services at the phone number in Section 1 for more information.

CARE COORDINATION BY CARE GUIDES

Every Hennepin Health–SNBC member is assigned a Care Guide. Your Care Guide will get to know and develop a care plan tailored to your needs. Care Guides also can:

- Help you understand and access health services
- Make sure you receive continued health care coverage
- Work with your doctors
- Remind you to get preventive health and dental care
- Coordinate home care so you can stay in your home
- Ensure smooth transitions of care between facilities
- Connect you with social services for needs such as housing, clothing and food

Covered Services:

- Assisting you in arranging for, getting, and coordinating assessments, tests, health care and continuing care services
- Developing and updating your care plan
- Communicating with a variety of agencies and people
- Other services as outlined in your care plan

CHEMICAL DEPENDENCY SERVICES*

Covered Services:

- Assessment/diagnosis
- Outpatient treatment
- Inpatient hospital
- Residential non-hospital treatment
- Outpatient methadone treatment
- Detoxification (*only if required for medical treatment*)

Notes:

See Section 1 for Chemical Dependency Services contact information.

A qualified Rule 25 county assessor who is part of Hennepin Health–SNBC network will decide what type of chemical dependency care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor not in the Plan network. We will do this within five working days of when we get your request. If you agree with the second assessment, we will authorize services according to chemical dependency standards and the second assessment. You have the right to appeal. See Section 13 of this Evidence of Coverage.

Not Covered Services:

Payment for room and board determined necessary by chemical dependency assessment is the responsibility of the Minnesota Department of Human Services.

CHILD AND TEEN CHECKUPS (C&TC)

Covered Services:

• Child and Teen Checkups (C&TC) preventive health visits include:

- growth measurements
- health education
- health history including mental health, nutrition, and chemical use
- developmental screening
- mental health screening
- physical exam
- immunizations
- laboratory tests
- vision checks
- hearing checks
- regular dental checks

Notes:

C&TC is a health care program of well-child visits for members under age 21. C&TC visits help find and treat health problems early. How often a C&TC is needed depends on age.

Contact your Primary Care Clinic to schedule your C&TC visits.

CHIROPRACTIC CARE*

Covered Services:

• One evaluation or exam per year

• Manual manipulation (adjustment) of the spine to treat subluxation of the spine - up to 24 visits per calendar year. Visits exceeding 24 require a service authorization.

- Acupuncture for chronic pain management within the scope of practice by chiropractors with acupuncture training or credentialing
- X-rays when needed to support a diagnosis of subluxation of the spine

Not Covered Services:

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

DENTAL SERVICES (for adults except pregnant women)

Covered Services:

- Diagnostic services:
  - comprehensive exam (*once every five years*)
  - periodic exam (*once per calendar year*)
  - limited (problem-focused) exams (*once per day per provider*)
  - x-rays, limited to:
    - bitewing (*once per calendar year*)
    - single x-rays for diagnosis of problems
    - panoramic (*once every five years and as medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma; once every two years in limited situations*)
    - full mouth x-rays (*once every five years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center [ASC]*)
- Preventive services:
  - cleaning (*up to four times per year if medically necessary*)
  - fluoride varnish (*once per calendar year*)
- Restorative services:
  - fillings
  - sedative fillings for relief of pain

- Endodontics (root canals) (*on anterior teeth and premolars only and once per lifetime; retreatment is not covered*)
- Periodontics:
    - gross removal of plaque and tartar (full mouth debridement) (*once every five years*)
    - scaling and root planing (*once every two years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center [ASC]*)
- Prosthodontics:
    - removable prostheses (dentures and partials) (*once every six years per dental arch*)
    - relines, repairs, and rebases of removable prostheses (dentures and partials)
    - replacement of prosthesis that are lost, stolen or damaged beyond repair under certain circumstances
    - Replacement of partial prostheses if the existing partial cannot be altered to meet dental needs
- Oral surgery (*limited to extractions, biopsies, and incision and drainage of abscesses*)
- Additional general dental services:
    - treatment for pain (*once per day*)
    - general anesthesia (*only when provided in an outpatient hospital or free-standing Ambulatory Surgery Center [ASC]*)
    - extended care facility/house call in certain institutional settings. These include: nursing facilities, skilled nursing facilities, boarding care homes, Institutes of Mental Disease/Mental Illness (IMD's), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), and swing beds (a nursing facility bed in a hospital)
    - behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
    - oral or IV sedation

Notes:

See Section 1 for Dental Services contact information.

DENTAL SERVICES (for children and pregnant women)

Covered Services:

- Diagnostic services:
    - comprehensive exam
    - periodic exam
    - limited (problem-focused) exams
    - x-rays, limited to:
        - o bitewing
        - o single x-rays for diagnosis of problems
        - o panoramic
        - o full mouth x-rays
- Preventive services:
    - cleaning
    - fluoride varnish (*once every six months*)
    - sealants for children under age 21 (*one every five years per permanent molar*)
- Restorative services:
    - fillings
    - sedative fillings for relief of pain
    - Individual crowns (*must be made of prefabricated stainless steel or resin*)
- Endodontics (root canals) (*once per tooth per lifetime*)
- Periodontics:
    - gross removal of plaque and tartar (full mouth debridement)
    - scaling and root planing
- Prosthodontics:
    - removable prostheses (dentures and partials) (*once every three years per dental arch*)
    - relines, repairs, and rebases of removable prostheses (dentures and partials)

- replacement of prosthesis that are lost, stolen, or damaged beyond repair under certain circumstances
- replacement of partial prostheses if the existing partial cannot be altered to meet dental needs

• Oral surgery

• Orthodontics* *(only when medically necessary for very limited conditions for children under age 21)*

• Additional general dental services:

- treatment for pain
- general anesthesia
- extended care facility/house call in certain institutional settings. These include: nursing facilities, skilled nursing facilities, boarding care homes, Institutes of Mental Disease/Mental Illness (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) Hospices, Minnesota Extended Treatment Options (METO), and swing beds (a nursing facility bed in a hospital). A school or Head Start program is not an extended care facility.
- behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
- oral or IV sedation

Notes:

See 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

DOCTOR AND OTHER HEALTH SERVICES

Covered Services:

- Doctor visits including:
    - care for pregnant women
    - family planning – **open access service**
    - lab tests and x-rays
    - physical exams
    - preventive exams
    - preventive office visits
    - specialists
    - telemedicine services
    - vaccines and drugs* administered in a qualified health care provider's office
    - visits for illness or injury
    - visits in the hospital or nursing home
- Immunizations
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Clinical trial coverage*: Routine care that is: 1) provided as part of the Protocol Treatment of a cancer 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.
- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Community health worker care coordination and patient education services

- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Blood and blood products
- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Tuberculosis care management and direct observation of drug intake
- Counseling and testing for sexually transmitted diseases (STDs), AIDS and other HIV-related conditions – **open access service**
- Treatment for AIDS and other HIV-related conditions – **NOT** an open access service. You must see a provider in the Plan network.
- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Acupuncture* for chronic pain management by licensed acupuncturist or within the scope of practice by a licensed provider with acupuncture training or credentialing.
- Respiratory therapy
- Hospital In-reach Community-based Service Coordination: coordination of services targeted at reducing hospital emergency department (ED) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ED and other health care services.
- In-Reach Community-Based Services Coordination (IRSC)
- Community Paramedic Services: certain services provided by a community paramedic for some members. They must have a care plan that was ordered by their primary care provider and must meet other requirements. 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.

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

- Comprehensive Multi-Disciplinary Evaluation (CMDE)
- EIDBI Intervention: Individual or Group *
- Intervention Observation and Direction *
- Family/Caregiver Training and Counseling: Individual or Group*
- Individual Treatment Plan (ITP) Development and Monitoring*
- Coordinated Care Conference
- Travel time*

EMERGENCY MEDICAL SERVICES AND POST-STABILIZATION CARE

Covered Services:

- Emergency room services
- Post-stabilization care
- Ambulance (air or ground)*

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:

In an emergency that needs treatment right away, either call 911 or go to the closest emergency room. Show them your member card and ask them to call your primary care 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, go to the closest emergency room. Show them your member 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 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.

EYE CARE SERVICES

Covered Services:

- Eye exams
- Eyeglasses, including identical replacement for loss, theft, or damage beyond repair*
- Repairs to frames and lenses for eyeglasses covered under the Plan*
- Tints or polarized lenses, when medically necessary*
- Contact lenses, when medically necessary under certain conditions*

Not Covered Services:

- Extra pair of glasses
- Eyeglasses more often than every 24 months, unless medically necessary
- Bifocal/Trifocal lenses without lines and progressive bifocals/trifocals
- Protective coating for plastic lenses
- Contact lenses supplies

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 (e.g. birth control pills, patch, ring, IUD, injections, implants) – **open access service**
- Family planning supplies with prescription (e.g. 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 see a provider in the Plan network. Note: This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS and other HIV-related conditions – **open access service**
- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Voluntary sterilization – **open access service**
  Note: You must be age 21 or over and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.
- Genetic counseling – **open access service**
- Genetic testing – **NOT** an open access service. You must see a provider in the Plan network.
- Treatment for AIDS and other HIV-related conditions – **NOT** an open access service. You must see 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

Notes:

Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency to get **open access services**. You can get open access services from any provider licensed in Minnesota and registered with the Department of Human services (DHS), even if they are not in the Plan network.

HEALTH AND WELLNESS PROGRAMS

Covered Services:

Minnesota in Motion is a fitness program for members. Eligible Hennepin Health–SNBC members can enroll in Minnesota in Motion and visit specific Twin Cities YMCA facilities at no cost for:

- Full access to the specific Hennepin Health locations
- A fitness assessment
- Use of fitness equipment and group exercise classes
- Hennepin Health-sponsored special events, seminars and social gatherings

Not Covered Services:

- Any locations other than specified by Hennepin Health
- Special classes requiring additional registration fees. You may ask for a special rate for Hennepin Health–SNBC members only when you pay the extra fee.

HEARING AIDS

Covered Services:

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

HIV/AIDS SERVICES

Covered Services:

- Counseling and testing for AIDS and other HIV-related conditions (open access service)
- Treatment for people who are HIV-positive (**not** an open access service)*
- Special nutritional products if ordered by a doctor

Notes:

People with HIV/AIDS who would like an HIV/AIDS specialist as their primary care provider should contact Care Guide or Member Services at the phone number in Section 1.

If you would like to get a standing service authorization to a specialist, contact Care Guide or Member Services at the phone number in Section 1.

If you are currently receiving HIV case management services, let your Care Guide know.

For services labeled as "open access," you can go to any provider licensed in Minnesota and registered with the Department of Human services (DHS), even those that are not part of our Plan network.

HOME CARE SERVICES

Covered Services:

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

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

If the recipient is both Medicare and Medicaid eligible, he or she must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit recipients from choosing hospice care through one program and not the other when they are eligible for both. Select Yes, to indicate that, as the elected hospice provider, you have explained that when a person is dual eligible they must use their Medicare benefits, as well as their Medicaid benefits for hospice service to be covered.

You must elect hospice benefits to receive hospice services.

Members age 21 and under receiving hospice services have coverage for services related to treatment of the terminal condition.

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

HOSPITAL – INPATIENT*

Covered Services:

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

Not Covered Services:

- Personal comfort items such as TV, phone, barber or beauty services, guest services

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

INTERPRETER SERVICES

Covered Services:

- Spoken language interpreter services
- Sign language interpreter services

Notes:

Interpreter services are available to help you get services.

Oral interpretation is available for any language.

Face-to-face oral language interpreter services are only covered if the interpreter is listed in the Minnesota Department of Health's Spoken Language Health Care Interpreter Roster. See 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 (e.g., wheelchair, hospital bed, walker, crutches, and wigs for people with alopecia areata) Contact Member Services for more information on coverage and benefit limits for wigs.
- Repairs of medical equipment
- Batteries for medical equipment
- Some shoes when part of a leg brace or when custom molded
- Oxygen and oxygen equipment
- Medical supplies you need to take care of your illness, injury, or disability
- Diabetic equipment and supplies
- Nutritional/enteral products when specific criteria are met
- Incontinence products

- Family planning supplies – **open access service**. See Family Planning Services in this section.
- Augmentative communication devices, including electronic tablets

Not Covered Services:

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

Notes:

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

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

MENTAL HEALTH/BEHAVIORAL HEALTH SERVICES

Covered Services:

- Case management for transitional youth (*for members under age 21*)
- Clinical Care Consultation
- Crisis response services* including:
    - Assessment
    - Intervention
    - 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)
- Inpatient psychiatric hospital stay*, including extended psychiatric inpatient hospital stay

- Mental Health Mobile Crisis Intervention Services
- Mental Health Provider travel time*
- Mental Health Targeted Case Management (MH-TCM)
- Subacute psychiatric level of care (*for members under age 21*)
- Outpatient Mental Health Services* including:
    - Explanation of findings
    - Certified family peer specialists (*for members under age 21*)
    - Family psychoeducation services (*for members under age 21*)
    - Mental health medication management
    - Neuropsychological services
    - Psychotherapy (patient and/or family, family, crisis, and group)
    - Psychological testing
- Rehabilitative Mental Health Services* including:
    - Assertive Community Treatment (ACT)
    - Adult day treatment
    - Adult Rehabilitative Mental Health Services (ARMHS) is available to members 18 or over
    - Certified Peer Specialist (CPS) support services in limited situations
    - Children's mental health residential treatment services (*for members under age 21*)
    - Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment (*for members under age 21*)
    - CTSS mental health service plan development (*for members under age 21*)
    - Family psychoeducation services (*for members under age 21*)
    - Intensive Residential Treatment Services (IRTS)
    - Intensive Treatment Foster Care Services (*for members under age 21*)
    - Partial Hospitalization Program (PHP)
    - Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services (*for members under age 21*)

- Physician Mental Health Services including:
    - Health and behavior assessment/intervention
    - Inpatient visits
    - Psychiatric consultations to primary care providers
    - Physician consultation, evaluation, and management
- Treatment services at children's residential mental health treatment facilities (Rule 5 - children's group residential facilities with mental health certification). Treatment services do not include coverage for room and board. Room and board may be covered by your county. Call your county for information.

Not Covered Services:

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

- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Treatment and room and board services at certain children's residential mental health treatment facilities (Rule 5 - children's group residential facilities with mental health certification) in bordering states

Notes:

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

Mental health services are open access. You may use any qualified health care provider licensed in Minnesota, registered with the Department of Human Services that is willing to see Hennepin Health–SNBC members.

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

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

NURSING HOME SERVICES*

Covered Services:

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

Not Covered Services:

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

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 registered with the Minnesota Department of Health (MDH)
- Services provided by a licensed health professional at licensed birth centers including services of certified nurse midwives and licensed traditional midwives.

Not Covered Services:

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

Notes:

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

OUT-OF-AREA SERVICES*

Covered Services:

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

Not Covered Services:

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

OUT-OF-NETWORK SERVICES*

Covered Services:

- Certain services you need that you cannot get through a Hennepin Health–SNBC network provider
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- A second opinion for mental health and chemical dependency
- Open access services
- Pregnancy-related services received in connection with an abortion (*does not include abortion-related services*)

PRESCRIPTION DRUGS (for members who do NOT have Medicare)

Covered Services:

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

Not Covered Services:

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

Notes:

The drug must be on our covered drug list (formulary).

The formulary includes the prescription drugs covered by Hennepin Health–SNBC. The drugs on the list are selected by the plan with the help of a team of doctors and pharmacists. The list has to be similar to the list covered by Medical Assistance (Medicaid). In addition to the prescription drugs covered by Hennepin Health–SNBC, 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 www.hennepinhealth.org. A list of over-the-counter drugs is also posted on the website. You can also call Member Services and ask for a written copy of our *Formulary*.

There are limits or restrictions on coverage for some formulary drugs. These restrictions and limits may include:

- Prior Authorization: Hennepin Health–SNBC requires you or your healthcare provider to get our approval before the plan will cover certain drugs
- Quantity Limits: For certain drugs, Hennepin Health–SNBC limits the amount or dose of the drug that we will cover
- Step Therapy: In some cases, Hennepin Health–SNBC requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition

You can get more information about the restrictions applied to specific covered drugs by visiting our website at www.hennepinhealth.org.

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 anti-psychotic drugs. In certain cases, we will also cover other drugs used to treat a mental illness or emotional disturbance even if the drug is not on our approved drug list. We will do this for up to one year if your provider certifies the drug is best for you and you have been treated with the drug for 90 days before: 1) we removed the drug from our drug list; or 2) you enrolled in the Plan.

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

If Hennepin Health–SNBC 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–SNBC 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.

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.

Specialty drugs are prescribed to treat serious or chronic medical conditions such as multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. These drugs may be oral or injectable. They can be self-administered or administered by a family member. You can find a list of specialty drugs here http://www.mhp4life.org/~/media/mhp/forms/MetHP%201015.pdf

We have a program for specialty drugs through a Specialty Pharmacy Network. If you need specialty drugs, you must use one of the providers in the Specialty Pharmacy Network as your specialty drug pharmacy. Specialty drug providers are experts in supplying drugs and services to patients with complex health conditions. They will give you information about your condition and the drugs that have been prescribed to you. You will have 24-hour access to pharmacists who can answer your questions. Please call Member Services at the number listed in Section 1 to find out which providers are in the Specialty Pharmacy Network program.

PRESCRIPTION DRUGS (for members who have Medicare)

Covered Services:

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

Not Covered Services:

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

Notes:

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

REHABILITATION

Covered Services:

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

Not Covered Services:

- Vocational rehabilitation
- Health clubs and spas, except for specific YMCA facilities in the Minnesota in Motion program. Information about this program is in this section under "Health and Wellness Programs". For more information call Member Services at the phone number in Section 1.

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

Not Covered Services:

- Cosmetic surgery
- Sex reassignment surgery

TELEMEDICINE SERVICES*

- Telemedicine services covers medically necessary services and consultations delivered by a licensed health care provider defined in Minnesota Statutes §62A.671, subd. 6. Coverage is limited to three (3) telemedicine services per Enrollee per calendar week.

TRANSPLANTS*

Covered Services:

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

Notes:

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

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

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:

- Emergency ambulance (air or ground)
- Non-emergency ambulance
- Special transportation (*for members who, because of physical or mental impairment, cannot safely use a common carrier and do not need an ambulance*)
- Common carrier transportation (for example, bus, cab, or through volunteer driver programs)

Not Covered Services:

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. These services are not covered under Hennepin Health–SNBC, but may be available through another source. Call your county 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 over 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 it is over 60 miles to your specialty provider.

To schedule an appointment, you must call Transportation Services for transportation at least three days in advance and provide your:

- Name
- Hennepin Health–SNBC member number
- Home address and phone number
- Date, time, phone number and location of/for the appointment

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–SNBC 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, please tell us when you call. Even if you meet the conditions above (except #1), you must call at least three days in advance to schedule a ride.

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.

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.

- Health care services or supplies that are not medically necessary
- Supplies that are not used to treat a medical condition
- Hospital inpatient and nursing home incidental services, such as TV, phone, barber and beauty services, and guest services
- Cosmetic procedures or treatment
- Experimental or investigative 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.
- Homeopathic and herbal products
- Autopsies (exams that are done on the bodies of people who have died to find out the cause of death)

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 1-800-657-3739 (toll free).

- Child welfare targeted case management
- Case management for members with developmental disabilities
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Personal Care Assistance (PCA) services
- Home Care Nursing services
- Nursing home stays that exceed 100 days. See "Nursing Home Services" in Section 7.
- Abortion 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
- 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.
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center, a state-owned long term care facility, or an institution for mental disease (IMD), unless approved by us or the service is ordered by a court under conditions specified in law
- Services provided by federal institutions
- Waiver services provided under Home and Community Based Services waivers

- Job training and educational services
- Day training and habilitation services
- HIV services under the Ryan White Act
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Room and board associated with treatment services at children's residential mental health treatment facilities (Rule 5). Room and board may be covered by your county. Call your county for information.

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
- 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

This first paragraph applies to certain non-citizens in Special Needs BasicCare (SNBC):

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

This second paragraph applies to members in Special Needs BasicCare (SNBC):

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 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 FAIR HEARING PROCESS

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

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

Grievance system terms to know:

A grievance is your discontent about any of the following:

• quality of care or services provided

• failure to respect your rights

• rudeness of a provider or employee

• delay in appropriate treatment or referral

A notice of action is a form or letter we send you to tell you about a decision we make on a claim, a request for service or any other request. The notice will tell you how to file an appeal or request a state fair hearing if you disagree with our decision.

An 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

• 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

Your provider may appeal on your behalf with your written consent. Your treating provider may appeal a service authorization decision without your consent.

A state fair hearing is your request for the state to review a decision we made. You may ask for a hearing if you disagree with any of the following:

• denial or limited authorization of the type or level of service

• denial of all or part of a payment for a service

• our failure to act within required timelines for service authorizations and appeals

• enrollment in the Plan

• any other action

If you disagree with our decision or have a grievance (complaint) about something other than a decision we made, you can do any of the following:

You can call Appeals and Grievances at the phone number in Section 1 to file a grievance or appeal.

You can write to us to file a grievance or appeal. Write to the address listed in Section 1 under "Appeals and Grievances."

You can write to the Minnesota Department of Human Services to request a state fair hearing.

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

You may request a state fair hearing at any time before, during or after our appeal process. You do not have to file an appeal with us before you request a state fair hearing.

You can file a complaint with the Minnesota Department of Health.

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

You can call or write to the Ombudsman for State 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 fair hearing.

Call: 651-431-2660 (Twin Cities metro area) or toll-free 1-800-657-3729 (non-metro area) or 1-800-627-3529 (TDD)

Write to: Minnesota Department of Human Services
Ombudsman for State Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249

Fax to: 651-431-7472

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

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

Your provider may file a grievance or appeal, or request a state fair hearing, on your behalf. The provider must have your written consent. Your treating provider may appeal service authorization decisions *without* your consent.

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

You may request a state fair hearing at any time before, during, or after the Plan appeal process. You do not have to file an appeal with us before you request a state fair hearing.

There is no cost to you for filing an appeal or requesting a state fair hearing. We may pay for some expenses such as transportation, childcare, photocopying, etc.

If you ask to see your medical records or want a copy, we or your provider must provide them to you at no cost. You may need to put your request in writing.

If you have seen a medical provider who is part of our Plan network and want another opinion, you can get a second opinion. You must see another Plan network medical provider.

If you have seen a mental health provider who is part of the Plan network and have been told that no structured mental health treatment is needed, you may get a second opinion. See "Mental Health Services" in Section 7 for more information.

If you have seen a chemical dependency assessor who is part of our Plan network and you disagree with the assessment, you may get a second opinion. See "Chemical Dependency Services" in Section 7 for more information.

You must follow the timelines for filing grievances, appeals, and state fair hearings. If you go over the time allowed, we may not review your grievance or appeal and the state may not accept your request for a hearing.

You must file a grievance with us **within 90 days** from the date of the incident about which you are complaining.

You must file an appeal with us **within 90 days** from the date on the notice of action.

You must request a state fair hearing **within 30 days** from the date on the notice of action or **within 30 days** from the date of the resolution of a Plan appeal. You have up to 90 days if you have a good reason for being late.

If we are stopping or reducing a service, you can keep getting the service if you file a health plan appeal or request a state fair hearing **within 10 days** from the date we send you 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 or request a state fair hearing.** The network provider who is treating you must agree that you should keep getting the service. The service can continue until the appeal or state fair hearing is resolved. If you lose the appeal or state fair hearing, you may be billed for these services.

For the Restricted Recipient Program, a member who receives a notice of restriction may file an appeal with us or may request a state fair hearing. You must file an appeal or request a state fair hearing **within 30 days** from the date on the notice from us. You have up to 90 days if you have a good reason for being late.

To file an oral grievance with us:

Call Appeals and Grievances at the phone number in Section 1 and tell us about the problem.

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

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

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help. The contact information is listed earlier in this section.

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 Appeals and Grievances at the phone number in Section 1 if you need help.

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

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

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

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help. The contact information is listed earlier in this section.

To file an oral or written appeal with us:

Call Appeals and Grievances at the phone number in Section 1. Tell us why you disagree with our decision. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited, or "fast," resolution. We will help you complete a written appeal. We will ask you to sign and return the written appeal.

You can also send us a letter about your appeal. In the letter, explain why you disagree with our decision. Send the letter to the address listed in Section 1 under "Appeals and Grievances." We can help you write the appeal. Call Appeals and Grievances at the phone number in Section 1 if you need help.

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

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

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

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

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

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

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

If you do not agree with our decision, you can request a state fair hearing with the Minnesota Department of Human Services. Write to the Department of Human Services Appeals Office. The contact information is listed earlier in this section. You may also call the Ombudsman for State Managed Health Care Programs for help. The contact information is listed earlier in this section.

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

You must ask for a state fair hearing **within 30 days** from the date on the notice of action or **within 30 days** from the date of the resolution of the Plan appeal. You can have up to 90 days to request a state fair hearing if you have a good reason for being late.

A human services judge from the state Appeals Office will hold a hearing. You may attend the hearing in person, by telephone or by video.

Tell the state why you disagree with the decision we made.

You can ask a friend, relative, advocate, provider or lawyer to help you.

The process can take 30 - 90 days. If your hearing is about an urgently needed service, tell the Judge or the Ombudsman when you call or write to them.

If your hearing is about a service that was denied because it was not medically necessary, you may ask for review by a medical expert. This will be from an outside reviewer. There is no cost to you.

If you do not agree with the Minnesota Department of Human Services Appeals Office's decision, you may ask the state Appeals Office 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 on 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.

DEFINITIONS

These are the meanings of some words in this Evidence of Coverage.

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: Your oral or written request to us for review of an action. This request may also be from your provider acting on your behalf with your written consent. Oral appeals must be followed by a written and signed appeal, unless you are requesting an expedited resolution. We will help you complete a written and signed appeal.

Care Guide: A Hennepin Health–SNBC staff person who can help evaluate your needs, assist you with your appointments and coordinate your care.

Chemical Dependency: Using alcohol or drugs in a way that harms you.

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: An amount that you may be responsible to pay to the provider for specific medical services. Copays are usually paid at the time service is provided. See Section 6 for required copay amounts.

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

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

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

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

Durable Medical Equipment: Equipment that can withstand repeated use. It is used for a medical purpose. The equipment must be medically necessary and ordered by a qualified health care provider.

Emergency: A condition that needs treatment right away. It is a condition that a prudent person believes needs prompt care, and without prompt care, it could cause: serious physical or mental harm; continuing severe pain; serious damage to body functions, organs, or parts; or death. Labor and childbirth can sometimes be an emergency.

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

Evidence of Coverage: What the document you are reading is called. 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.

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 us. 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: 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 discontent about any matter other than an Action. This includes, but is not limited to:

• quality of care or services provided

• failure to respect your rights

• rudeness of a provider or employee

• delay in appropriate treatment or referral

Home Health Care: Care that is provided in your home that is medically necessary and ordered by a doctor. This includes skilled nurse visit, home health aide, and home care therapies.

Hospice: A special program for members who are terminally ill and not expected to live more than six months. It offers special services for the member and his or her family.

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: Care that is appropriate for the condition. This includes care related to physical conditions and mental health. It includes the kind and level of service. It includes the number of treatments. It also includes where you get the service and how long it continues. Medically necessary care must:

• be the service that most other providers would usually order

• help you get better, or stay as well as you are

• help stop the condition from getting worse

• help prevent and 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 enrollees. It is sometimes called Medicare Part D. Drug coverage is provided through a Medicare prescription drug plan.

Network: Our contracted health care providers for the Plan.

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.

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

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

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

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

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.

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.

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 enrollees

Prescriptions: Medicines and drugs ordered by a medical provider.

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 clinic you choose for your routine care. This clinic will provide most of your care.

Primary Care Provider: The doctor or other qualified health care provider you see at your primary care clinic. This person will manage your health care.

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

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

Second Opinion: If you do not agree with an opinion you get from a Plan network provider, you have the right to get an opinion from another provider. We will pay for this. For medical conditions, the second opinion will be from another Plan network provider. For mental health services, the second opinion will be from an out-of-network provider. For chemical dependency services, the second opinion will be from a different qualified assessor who is not in the Plan network.

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.

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

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

State Fair Hearing: A hearing at the state to review a decision made by us. You must request a hearing in writing. You may ask for a hearing if you disagree with any of the following:

- a denial, termination, or reduction of services
- enrollment in the Plan
- denial in full or part of a claim for a service
- our failure to act within required timelines for service 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.

United States: For the purpose of this Evidence of Coverage, 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.

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

Hennepin Health

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400 South Fourth Street, Suite 201
Minneapolis, Minnesota 55415

Call: 612-596-1507 or 1-888-562-8000 (toll-free)

TTY: 1-800-627-3529 or 711

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