



2012 Prepaid Medical Assistance Program Evidence of Coverage



For members in the counties of: Brown, Dodge, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena and Waseca.

January, 2012

South Country Health Alliance Member Services

1-866-567-7242 • TTY 711

Calls to these numbers are free.

8 a.m. – 8 p.m., Monday – Friday

Visit us online at www.mnscha.org

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.

Is the provider accessible to people with disabilities?

If you require special access to obtain services from a provider, you can obtain a listing by calling Member Services at the number listed above. Or, visit www.mnscha.org. This could include (but is not limited to) the following kinds of access for services: availability of flexible hours, wheelchair access, or parking lot access.

Our plan will accept all eligible people who choose or are assigned to the plan. We will not discriminate in regard to your physical or mental condition; health status; need for health services; marital status; age; sex; sexual orientation; national origin; race; color; religion or political beliefs.

Attention. If you want free help translating this information, call the above number.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການເປ່ຍຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງ ໂທອຕາມເລກໂທອທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

This information is available in other forms to people with disabilities by calling 1-866-567-7242 (toll free) or 711 (TTY for the hearing impaired), or through the Minnesota Relay at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

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Welcome to South Country Health Alliance!

We are pleased to welcome you as a member of South Country Health Alliance's Prepaid Medical Assistance Program (referred to as "Plan").

South Country Health Alliance (referred to as "we," "us", or "our") is part of the Prepaid Medical Assistance Program (PMAP). We coordinate and cover your medical services. You will get most of your health services through the Plan's network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which doctor to see.

This Evidence of Coverage or EOC (formerly called Certificate of Coverage or COC), 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 copays
- A listing of covered and non-covered services
- Information on what to do if you have a complaint or want to appeal an action
- Definitions

The counties in the Plan service area are as follows: Brown, Dodge, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena, Waseca.

Please tell us how we're doing. You can call, email, 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.

Section 1. Telephone numbers and contact information

How to contact our Member Services

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

CALL:	Toll Free 1-866-567-7242
TDD:	711
FAX:	1-507-431-6328
WRITE:	South Country Health Alliance Attn: Member Services 110 West Fremont Street Owatonna, MN 55060
WEBSITE:	www.mnscha.org

Our Plan contact information for certain services

Appeals and Grievances	1-866-567-7242 (toll free) or 711 (TTY/TDD), or write to South Country, Attn: Appeals Department, at the address below. See Section 13 for more information.
Chemical Dependency Services	Call MMSI Health Services at 1-800-645-6296 (toll free) or write to South Country at the address at the address below.
Chiropractic Services	Call Clinical Resource Group at 1-866-281-1997 (toll free).
Dental Services	Call DentaQuest at 1-800-516-2940 (toll free) or 1-800-446-7566 (TTY/TDD)
Durable Medical Equipment Coverage Criteria	Contact Member Services.
Interpreter Services	Hearing: 711 (TTY/TDD) Spoken: 1-866-567-7242 (toll free)
Health Questions Phone Line	Ask Mayo Clinic 24 hr Nurse Advice Line: 1-800-504-3451 (toll free) or 1-877-728-3311 (TTY/TDD)
Mental Health Services	Call MMSI Health Services at 1-800-645-6296 (toll free) or write to South Country at the address below.
Prescriptions	Call Member Services
Transportation	Call Member Services
Write to South Country	South Country Health Alliance 110 West Fremont Street Owatonna, MN 55060

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). These calls are toll 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 or 1-800-657-3729 (toll free).

Section 2. Important information on getting the care you need

Each time you get health services, check to be sure the provider is a Plan network provider. 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 select Programs > Medical Assistance (PMAP) > and choose the Provider Directory from the Member Materials on the right side of the page.

You chose or have been assigned to a Plan network doctor or clinic. The name of the doctor or clinic you must go to is on your member identification (ID) card. This is your Primary Care Clinic. The clinic's phone number is also on your member ID card.

Your Primary Care Clinic or doctor will arrange most of your medical care. It is important that one doctor knows about all your medical needs. The doctor can make sure you get the care you need.

You do not need a referral to see a Plan network specialist.

Contact your Primary Care Clinic for information about the clinic's hours, and 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 at any time. To find out how to do this, call Member Services at the phone number in Section 1.

Transition of Care

If you are a newly enrolled member who is currently receiving care from a provider who is not a Plan network provider, we will help you transition to a participating 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.

Almost all health services must be approved by your Primary Care Clinic. Exceptions to this rule are:

- Dental, routine vision care, chiropractic care, and obstetrics and gynecology services. You must get these services from providers in our network.
- 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 [doctor], clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- For chemical dependency services, call the phone number listed in Section 1.
- For mental health services, call the phone number listed in Section 1.
- Emergency and post stabilization care: If you get emergency care from a provider not in the Plan network, you must follow some rules. See Section 7. It tells you what emergency care is covered. It also tells you the rules.

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

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 a non-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 [doctor], clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- Emergency and post-stabilization services

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

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 these 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 doctor 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.

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

You may be required to contribute an amount toward some medical services. This is called cost sharing. Cost sharing consists of a copay or a deductible on certain services. You are responsible to pay your cost sharing amount to your provider. See Section 6 for more information.

Payments to providers

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

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

Interpreter services

We will provide interpreter services to help you access services. This includes spoken language interpreters and hearing 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 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 a program for members who have received medical care and have not followed the rules

or have misused services. Restricted Recipients may not pay out of pocket for services from provider types to whom they are currently restricted. If you are placed in this program, we may replace your regular [member card] with a Restricted Recipient Program card.

You must get health services from one designated doctor, one pharmacy, one hospital or other health service provider. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). You may also be assigned to a home health agency or other providers. You may not be allowed to use the personal care assistance choice or flexible use options or consumer directed services. Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.

At the end of the 24 months, your use of health care services will be reviewed. If you still did not follow the rules, 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

Your coverage with us will be canceled if you are not eligible for Medical Assistance. It will also be canceled if you change health plans.

Section 3. Enrollee Bill of Rights

You have the right to:

- Be treated with respect, dignity, and consideration for privacy.
- Get the services you need 24 hours a day, seven days a week. This includes emergencies.
- Be told about your health problems.
- Get information about treatments, your treatment choices, and how they will help or harm you.
- Participate with providers in making decisions about your health care.
- Refuse treatment and get information about what might happen if you refuse treatment.
- Refuse care from specific providers.
- Know that we will keep your records private according to law.
- 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.
- 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.

- 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.
- Choose where you will get family planning services.
- Get a second opinion for medical, mental health, and chemical dependency services.
- Be free of restraints or seclusion used as a means of: coercion; discipline; convenience; or retaliation.
- Request a copy of this Evidence of Coverage at least once a year.
- Get the following information from us, if you ask for it:
 - 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.

NOTE: South Country Health Alliance (SCHA) makes authorization decisions using evidence-based standards of care, medical necessity criteria and the member’s benefit coverage. SCHA does not reward providers or other individuals for denying services to members, nor does SCHA reward decisions that results in under-utilization of services.

Section 4. Enrollee 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 South Country member ID 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 doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
- Give information asked for by your doctor. Share information about your health history.
- Follow all of your doctor’s instructions. If you have questions about your care, ask your doctor.
- Work with your doctor to understand your total health condition. It is important to 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. If you do, please call Member Services at the phone number in Section 1.

Section 5. Your Health Plan Member ID Card

Each member will receive a South Country member ID card.

Always carry your member ID card with you.

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

You must use your health plan member ID 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 ID 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 member ID card to show what it looks like:

SOUTH COUNTRY HEALTH ALLIANCE		PMAP	
Name: SAMPLE, JOSEPH Q.		Effective Date: 01/01/2012	
ID: XXXXX123401		Medical Acct #: XXXXXXXXXXXXXXXX	
PMI#: 00015281		Service Type: Medical/Rx	
DOB: 02/10/1981		Care Type: SCHA MA	
Rx Bin: 610455		PCC: MY CLINIC	
PCN: SHMCD		PCC Phone: (555) 555-5555	
Preventive Office Visit: \$0.00 Non-Preventive Office Visit: \$3.00 Non-Emergency ER: \$3.50			
		Administered by 	

MEMBER SERVICES 1-866-567-7242 or 711 (TTY) Find a dental provider 1-800-516-2940 or 1-800-466-7566 (TTY) Find a pharmacy 1-800-509-0545 Ask Mayo Clinic 24-hr Nurse Advice Line 1-800-504-3451 or 1-877-728-3311 (TTY) For non-emergency services, contact the clinic on the front of this card. In an emergency, contact the clinic as soon as possible after receiving care.	PROVIDER SERVICES 1-800-995-4543 Dental Provider Services 1-800-241-8478 Pharmacy Help Desk 1-866-325-5233 Medical claims to: MMSI PO Box 4014 Rochester, MN 55903 Dental Claims to: DentaQuest 12121 North Corporate Parkway Mequon, WI 53092
Written appeals mail to: Appeals Office, DHS, PO Box 64941, St Paul, MN 55164 Phone appeals or grievances call: DHS State Ombudsman 1-651-431-2660 or 1-800-657-3729	
www.mnscha.org	

Section 6. Cost Sharing

Cost sharing refers to your responsibility to pay an amount towards your medical costs. Cost sharing consists of copays and a monthly deductible.

If your income is at or below 100 percent of federal poverty guidelines, you will pay no more than 5 percent of your monthly family income for cost sharing. This may reduce the copay and deductible amount to less than the amounts listed here. DHS will tell us each month if you have a reduced cost sharing amount.

Copays

The members listed here **do not** have to pay copays for medical services that are covered by Medical Assistance (MA) under the Plan:

- Pregnant women (If you become pregnant, tell your county worker right away.)
- Members under age 21
- Members receiving hospice care
- Members residing in a nursing home, hospital, or other long-term care facility for more than 30 days

Some services require copays. A copay is an amount that you will be responsible to pay to your provider.

Copays are listed in the following chart:

Service	Copay Amount
Non-preventive visits – (such as visits for a sore throat, diabetes checkup, high fever, sore back, etc.) provided by a physician, physician assistant, advanced practice nurse, certified professional midwife, chiropractor, acupuncturist, podiatrist, audiologist, or eye doctor. There are no copays for mental health services.	\$3.00
Diagnostic procedures (for example, colonoscopy, endoscopy, arthroscopy)	\$3.00
Emergency room visit when it is not an emergency	\$3.50
Brand name prescriptions <ul style="list-style-type: none"> • The most you will have to pay in copays for prescriptions is \$12.00 per month. 	\$3.00
Generic prescriptions <ul style="list-style-type: none"> • The most you will have to pay in copays for prescriptions is \$12.00 per month. 	\$1.00

The most you will have to pay in copays for prescriptions is \$12.00 per month. Copays will not be charged for some mental health drugs and most family planning drugs.

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

You must pay your copay directly to your provider. Some providers require that you pay the copay when you arrive for the

medical service. The hospital may bill you after your non-emergency visit to the emergency room.

If you are unable to pay the copay, the provider must still provide services. This is true even if you have not paid your copay to that provider in the past or if you have other debts to that provider. The provider may still bill you for the unpaid copays.

We get information from the State about which members do not have copays. You may need to pay a copay until you are listed in our system as a person who is exempt from copays.

Examples of services that do not have copays:

- Chemical dependency treatment
- Dental services
- Emergency services
- Eye glasses
- Family planning services
- Home care
- Immunizations
- Inpatient hospital stays
- Interpreter services
- Medical equipment and supplies
- Mental health services
- Rehabilitation therapies
- Preventive care visits, like physicals
- Repair of eyeglasses
- Services covered by Medicare, except for Medicare Part D drugs
- Some mental health drugs (anti-psychotics)
- Tests such as blood work and X-rays
- Medical transportation
- 100% federally funded services at Indian Health Services clinics

This is not a complete list. Call Member Services at the phone number in Section 1 if you have questions.

Deductible

A deductible is an amount you must pay each month toward health care costs. The amount of the deductible will be based on family income. A deductible is separate from copays. The maximum deductible amount is \$2.55 per month.

The members listed here **do not** have to pay a deductible for medical services that are covered by Medical Assistance (MA) under the Plan:

- Pregnant women (If you become pregnant, tell your county worker right away.)
- Members under age 21
- Members receiving hospice care
- Members residing in a nursing home, hospital, or other long-term care facility for more than 30 days

The deductible will not apply to the following services:

- Pharmacy charges
- Emergency services provided in a hospital, clinic, office or other facility
- Family Planning services
- Any service that has a copay applied to it
- Chemical dependency treatment services
- Services paid by Medicare

- Services received by an American Indian from an Indian Health Care Provider or through contracted health services (IHS-CHS) referral from an IHS facility

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

Section 7. Covered Services

This section describes the major services that are covered under the Plan for Medical Assistance enrollees. It is not a complete list. Some services have limitations or require a service authorization. These services are marked with a telephone symbol (☎). 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.

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

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)
- ☎ Room and board determined necessary by chemical dependency assessment

Notes:

See Section 1 for Chemical Dependency Services contact information.

A qualified Plan network assessor 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.

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:

- Birth to 2 years: 0-1, 2, 4, 6, 9, 12, 15, 18 and 24 months
- 3 to 21 years: 3, 4, 5, 6, 8, 10, 12, 14, 16, 18 and 20 years

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
- 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

Covered Services:

- Diagnostic services including:
 - Comprehensive exam (every five years for non-pregnant adults)
 - Periodic exam (once per calendar year for non-pregnant adults)
 - Limited problem focused exams (once per day per facility for non-pregnant adults)
- X-rays are limited to:
 - bitewing (once per calendar year for non-pregnant adults)
 - single x-rays for diagnosis of problems
 - panoramic (for non-pregnant adults – once every five years, 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 (for non-pregnant adults - once every five years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC))
- Preventive services including:
 - Cleaning (once per calendar year for non-pregnant adults)
 - Fluoride varnish (once per calendar year for non-preg-

Services marked with 📞 require a service authorization

- o Sealants **only for members under age 21**, once every five years per permanent molar
- Restorative services including:
- Fillings
 - o Sedative fillings for relief of pain
 - o Individual crowns **only for members under age 21 and pregnant women**, must be made of prefabricated stainless steel or resin, unless medically necessary in specific circumstances
- Endodontics (root canals) (for non-pregnant adults - on anterior teeth and premolars only and once per lifetime, retreatment is not covered)
- Periodontics including:
 - o Gross removal of plaque and tartar (once every five years for non-pregnant adults)
 - o Scaling and root planing (for non-pregnant adults - once every two years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC))
- Dental implant-related services (only covered when medically necessary and for very limited conditions, not covered for non-pregnant adults)
- 📞 Prosthodontics including:
 - o removable prostheses (dentures and partials) once every three years per dental arch (for non-pregnant adults – once every six years per dental arch)
- 📞 Oral surgery (for non-pregnant adults - limited to extractions, biopsies, and incision and drainage of abscesses)
- Orthodontics **only for members under age 21** and only when medically necessary for very limited conditions
- Additional general services including:
 - o Treatment for pain (once per day for non-pregnant adults)
 - o General anesthesia (for non-pregnant adults - only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC))
- Not Covered Services (for non-pregnant adults only):
 - o Relines, repairs, and rebases of removable prostheses (dentures and partials)
 - o Lost, stolen, or damaged and un-repairable prostheses

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 doctor

Doctor and Other Health Services

Covered Services:

- Doctor visits including:
 - o Care for pregnant women
 - o Family planning – **open access service**
 - o Lab tests and x-rays

- o Physical exams
- o Preventive exams
- o Preventive office visits
- o Specialists
- o Telemedicine consultation
- o Vaccines and drugs administered in a doctor's office
- o Visits for illness or injury
- o Visits in the hospital or nursing home
- Immunizations
- 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 (e.g. 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

Not Covered Services:

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

Emergency Medical Services and Post-Stabilization Care

Covered Services:

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

Not Covered Services:

- Emergency care, urgent care, or other health care services

received from providers located outside of the United States

Notes:

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

In all other cases, call your primary care doctor, if possible. The clinic's phone number is also on your member ID card. The number is answered 24 hours a day, seven days a week. The doctor will tell you what to do.

If you are out of town, go to the closest emergency room. Show them your member ID card and ask them to call your primary care doctor.

You must call your Primary Care Clinic 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 due to damage, loss or theft
- 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 (birth control pills, patch, ring, IUD, injections, implants) – **open access service**
- Family planning supplies with prescription (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**
- Treatment for AIDS and other HIV-related conditions - **NOT an open access service**. You must see a provider in the Plan network.
- Voluntary sterilization – **open access service**
Note: You must be age 21 or older 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.

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, even if they are not in the Plan network.

Hearing Aids

Covered Services:

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

Home Care Services

Covered Services:

- 📞 Skilled nursing
- 📞 Rehabilitation therapies to restore function (for example, speech, physical, occupational)
- 📞 Home health aide
- 📞 Private duty nursing
- 📞 Personal Care Assistant (PCA) services

Hospice

Covered Services:

- Doctor, nurse, and other professional services
- Medical social services
- Medical equipment and supplies
- Physical, occupational, and speech therapies
- Short-term inpatient care, including respite care
- Counseling, including dietary counseling
- Home health aide and homemaker services
- Outpatient drugs for symptom management and pain relief

Notes:

You must elect hospice benefits to receive hospice services.

Members under the age of 21 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
- Hearing 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, wigs for people with alopecia areata)
Contact Member Services for more information on coverage 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.

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/doctor'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 Services

Covered Services:

- 📞 Crisis response services including:
 - Assessment
 - Intervention
 - Stabilization
 - Community intervention (*for members over age 18*)
- 📞 Diagnostic assessments including screening for the presence of co-occurring mental illness and substance use disorder
- 📞 Mental Health Targeted Case Management (MH-TCM)
- 📞 Dialectical Behavioral Therapy (DBT) (*for members over age 18 who meet certain criteria*)
- 📞 Inpatient psychiatric hospital stay
 - Subacute psychiatric level of care (*for members under age 21*)
- Outpatient Mental Health Services including:
 - Explanation of findings
 - Mental health medication management
 - 📞 Neuropsychological services
 - Psychotherapy
 - 📞 Psychological testing
- Rehabilitative Mental Health Services including:
 - Assertive Community Treatment (ACT) (*for members over age 18*)
 - Adult Day Treatment (*for members over age 18*)
 - 📞 Adult Rehabilitative Mental Health Services (ARMHS) (*for members over age 18*)
 - Certified Peer Specialist Support Services in some 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*)

📞 Intensive Residential Treatment Services (IRTS) (for members over age 18)

📞 Partial Hospitalization Program

- 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). 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) in bordering states

Notes:

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

Get mental health services from the Plan network of mental health providers.

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.

Obstetrics and Gynecology (OB/GYN) Services

Covered Services:

- Prenatal, delivery, and postpartum care
- Childbirth classes
- Hospital services for newborns
- HIV counseling and testing for pregnant women – **open access service**
- Treatment for HIV-positive pregnant women
- Treatment for newborns of HIV-positive mothers
- 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*)
- Services provided by a licensed health professional at

licensed birth centers including services of certified professional 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.

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 doctor 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 doctor, clinic, hospital, pharmacy, or family planning agency.

Out-of-area Services

Covered Services:

- A service you need when temporarily out of the Plan service area
- A service you need after you move from our service area while you are still a Plan member
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- Medically necessary urgent care when you are outside of the Plan service area. (Call Member Services at the phone number in Section 1 as soon as possible.)

📞 Covered services that are not available in the Plan service area

Not Covered Services:

Emergency care, urgent care, or other health care services received from providers located outside of the United States.

Out-of-network Services

Covered Services:

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

Services marked with 📞 require a service authorization

- Certain over-the-counter drugs (when pre prescribed by a physician or pharmacist)

Not Covered Services:

- Drugs used to treat impotence or erectile 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

Notes:

The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor 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 doctor 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 your doctor prescribes a drug that is not in our formulary, South Country's pharmacy benefits manager, Prime Therapeutics, may deny these drugs or provide another drug from the formulary that will work in the same way. For non-formulary prescriptions, prescribers should call 1-866-325-5322 (toll free) to obtain medical exceptions for the drug.

If a pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. 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 doctor, you can. You can also call Member Services at the phone number in Section 1 for help.

Prescription Drugs (for members who have Medicare)

Covered Services:

- 📞 Benzodiazepines, barbiturates, 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 impotence or erectile 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

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

Surgery

Covered Services:

- Office/clinic visits/surgery
- Removal of port wine stain birthmarks
- 📞 Reconstructive surgery (e.g. 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

Transplants

Covered Services:

- 📞 Organ and tissue transplants, including: kidney, cornea, bone marrow, stem cell, heart, heart-lung, liver, lung, pancreas, pancreas-kidney, pancreatic islet cell, intestine, intestine-liver, and other transplants

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 (e.g., 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 the Plan, 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.

The Plan will provide transportation to your Primary Care Clinic *even 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.

Urgent Care

Covered Services:

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

Not Covered Services:

- Urgent care, emergency care, or other health care services received from providers located outside of the United States

Notes:

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

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

Section 8. Services we do not cover

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

- 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, guest services
- Cosmetic procedures or treatment
- Experimental or investigative services
- Emergency care, urgent care, or other health care services received from providers located outside of the United States
- Autopsies

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

These services are not covered by us 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)
- Nursing home stays
- 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
- 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.

Section 10. When to call your county worker

Call your county worker to report these changes:

- Name or address changes
- Pregnancy begin/end dates
- Addition or loss a household member
- Lost or stolen Minnesota Health Care Program (ID) card
- New insurance or Medicare – begin/end dates
- New job or change in income

Section 11. Using the Plan coverage with other insurance

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

- No-fault car insurance
- Workers’ compensation
- Medicare
- Other 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 payments going to you
- Help us get payments from your other insurance

If your other insurance changes, call your county worker.

Section 12. Subrogation or other claim

This first paragraph applies to certain non-citizens in the Prepaid Medical Assistance Program (PMAP):

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

This second paragraph applies to members in the Prepaid Medical Assistance Program (PMAP), except certain non-citizens:

You may have other sources of payment for your medical care. They might be from another person, group, insurance company or other organization. Federal and state laws provide that Medical Assistance benefits pay only if no other source of payment

exists. If you have a claim against another source for injuries, we will make a separate claim for medical care we covered for you. The laws require you to help us do this. The claim may be recovered from any source that may be responsible for payment of the medical care we covered for you. The amount of the claim will not be more than Federal and State laws allow.

Section 13. Grievance, appeal and State Fair Hearing process

If you disagree with a decision or have a complaint, you can do any of the following:

- You can call Member Services 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 listed under “Appeals and Grievances.”
- You can write to the Minnesota Department of Human Services to request a State Fair Hearing. You may request a State Fair Hearing at any time during the Plan appeal process. You do not have to file an appeal with us before you request a State Fair Hearing.
- You can call or write to the Minnesota Department of Health.

Timelines for filing grievances, appeals, and State Fair Hearings

You must request a State Fair Hearing **within 30 days** after the date on the notice from us. You have up to 90 days if you have a good reason for being late.

You must file a grievance or appeal with us **within 90 days** after the date on the Notice of Action or from the date of the incident about which you are complaining.

For the Restricted Recipient Program, an enrollee who receives a notice of restriction must file an appeal with us **within 30 days** of the date of the notice. You may also request a State Fair Hearing within 30 days of the date on the notice. You have up to 90 days if you have a good reason for being late.

Continuation of services

If we are stopping or reducing a service, you can ask to keep getting the service if you file a health plan appeal or request a State Fair Hearing **within 10 days after we send you the notice, or before the service is stopped or reduced, whichever is later.** The participating treating provider must agree the service should continue. 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.

Personal Care Assistance (PCA) Services during Appeal

If we are stopping or reducing your PCA services, you can ask to keep getting the same amount of services when you file a health plan appeal or a State fair hearing. You must file within 30 days from the date on the notice, or before the service is stopped or reduced, whichever is later. The services 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.

Your Rights

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. The treating provider may appeal utilization review decisions with us without your written 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 during 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 with us or for a State Fair Hearing. We may pay for some expenses such as transportation, childcare, photocopying, etc.

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 of this document 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 of this document for more information.

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.

To file an oral grievance with us

A Grievance is an expression of discontent about any matter other than an action, as defined in Section 14. This includes, but is not limited to, discontent with:

- quality of care or services provided
- failure to respect your rights

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

We will give you a decision within 10 days. We may take up to

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

If your grievance is about our denial of 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.

To file a written grievance with us

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

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

We will notify you within 10 days that the grievance has been received.

We will give you a written decision within 30 days from the day we get your grievance. 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 30 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.

To file an oral or written appeal with us

An Appeal is your oral or written request for review of our action on a request for services or payment. This includes:

- denial or limited authorization in 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

Call Member Services at the phone number in Section 1 and request an oral appeal. Tell us why you disagree with the decision. 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 appeal. We will ask you to sign the written appeal.

You can also send a letter about your appeal. In the letter, explain why you disagree with the decision. Send the letter to the address in Section 1 listed under "Appeals and Grievances."

We can help you write your appeal. Call Member Services at the phone number in Section 1 if you need help.

If your appeal is about an urgently needed service we will give

you a decision within 72 hours. We will try to call you with the decision before we send the written decision.

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 72 hours that we are taking extra time and the reasons why. If we do not grant your request for an expedited review, you may file a grievance.

We will notify you within 10 days that your appeal has been received.

For standard appeals, we will give you a written decision within 30 days from the day we get your appeal. 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 30 days that we are taking extra time and the reasons why.

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

If we are deciding an appeal regarding denial of a service for lack of medical necessity or one that involves clinical issues, the person making the decision will be a health care professional with appropriate clinical expertise in treating the 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. You can also call the Ombudsman for State Managed Health Care Programs for help.

To file a State Fair Hearing with the Minnesota Department of Human Services

A State Fair Hearing is 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:

- 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

You must ask for a State Fair Hearing **within 30 days** of the date of the Notice of Action or the decision in a Plan appeal. You can have up to 90 days to request a State Fair Hearing if you have a good reason for being late.

Write to: Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941
Or fax to: 651- 431-7523

A Human Services Judge from the State Appeals Office will hold a hearing. You may attend the hearing in person or by tele-

phone.

Tell the State why you disagree with the decision made by us.

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

The process can take between 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 medical necessity denial, you may ask for an expert medical opinion. This will be from an outside reviewer. There is no cost to you.

If you do not agree with the Judge's decision, you may ask the Appeals Office to reconsider their decision. To ask for a reconsideration, send a written request to the Appeals Office within 30 days of the date on the decision.

You may also appeal to the district court in your county.

Ombudsman for State Managed Health Care Programs

An Ombudsman for State Managed Health Care Programs may be able to help with your problem. They can help you file a grievance or appeal to us. They can also help you request a State Fair Hearing.

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

Or Call: 651-431-2660 or 1-800-657-3729 (toll free)
or 1-800-627-3529 (TDD)

To 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

Or Call: 651-201-5100 (Twin Cities metro) or toll
free 1-800-657-3916.

Section 14. 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.

Autopsy: An exam that is done on the body of someone who dies. It is done to find out what caused a person's death.

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

Child: Enrollee 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 on 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. Cost sharing amounts include deductibles and copays. See Section 6 for information on cost sharing.

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

Deductible: An amount that you may be responsible to pay each month toward your medical services. See Section 6 for more information on the deductible.

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.

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 doctor.

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 (formerly called the Certificate 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: Expression of discontent about any matter other than an action. This includes, but is not limited to, discontent with:

- quality of care or services provided
- failure to respect your rights

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 65 years of age or older. 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 the 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 telling you about a decision on a claim, a service, or any other action taken by us.

Ombudsman for State Managed Care Health 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 to us or request a State Fair Hearing.

Open Access Services: Federal and state law allow you to choose any physician, 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 which 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 an enrollee by a non-network provider outside of the Plan service area.

Out-of-Network Services: Health care provided to an enrollee by a non-network provider.

Physician Incentive Plan: Special payment arrangements between us and the doctor 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 of coverage. It continues until: the person is discharged; our Plan network doctor begins care; or we, the hospital, and doctor 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. The name of your clinic appears on your member ID card.

Primary Care Provider: The doctor or other health professional you see at your Primary Care Clinic. This person will manage your health care.

Provider: A 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 doctor, one pharmacy, one hospital or other health services 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 a non-network specialist more than one time (for ongoing care.)

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.

Why Choose South Country?

- We have local, responsive customer service.
- We are owned by the counties we serve, and support our local providers.
- We have local staff in every county to better meet your needs.
- We use only one identification card to combine all medical, dental and pharmacy services.
- We promote healthy activities and safety through member communication, education, and Take Charge! rewards.

Questions?

Call Member Services:

1-866-567-7242 (toll free)

711 (TTY)

or visit our web site

www.mnscha.org