BlueCross BlueShield Minnesota

2024

MEMBER HANDBOOK

Blue Plus Families and Children

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

January 1, 2024

This booklet contains important information about your health care services.

Blue Plus, 3400 Yankee Drive, Eagan, MN 55121
Open hours for visiting the facility are from 8 a.m. to 5 p.m., Monday to Thursday
Website: **bluecrossmn.com/publicprograms**
Blue Plus Member Services: Call **1-800-711-9862**, TTY **711**, this call is free.
Hours of service: Monday through Friday, 8 a.m. to 5 p.m., Central Time

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M08043R01

Blue Advantage[SM] and MinnesotaCare
Toll Free 1-800-711-9862, TTY 711

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.

ဟ်သူဉ်ဟ်သးဘဉ်တကှ်၊ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ဝ် တီလ်ဝ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂ်ၢ်လၢထးအံၤနူဉ်တကှ်၊

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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

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

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

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

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

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Civil Rights Notice

Discrimination is against the law. Blue Plus does not discriminate on the basis of any of the following:

- Race
- Color
- National origin
- Creed
- Religion
- Sexual orientation
- Public assistance status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex Stereotypes and gender identity)
- Marital status
- Political beliefs
- Medical condition
- Health status
- Receipt of health care services
- Claims experience
- Medical history
- Genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Blue Plus. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:
Blue Plus
1800 Yankee Doodle Road, Eagan, MN 55122
Toll Free: **1-800-711-9862** TTY: **711**
Fax: **651-662-9478** Email: Civil.Rights.Coord@bluecrossmn.com

Auxiliary Aids and Services: Blue Plus provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Advantage[SM] and MinnesotaCare Member Services at **1-800-711-9862** (this call is free), or your preferred relay services.

Language Assistance Services: Blue Plus provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Advantage[SM] and MinnesotaCare Member Services at **1-800-711-9862** (this call is free), or your preferred relay services.

Civil Rights Complaints

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

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion (in some cases)

Contact the **OCR** directly to file a complaint:

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

Minnesota Department of Human Rights (MDHR)
In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Religion
- Creed
- Sex
- Sexual orientation
- Marital status
- Public assistance status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201, St. Paul, MN 55104
651-539-1100 (voice), 800-657-3704 (toll-free), 711 or 800-627-3529 (MN Relay), 651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)
You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National origin
- Religion (in some cases)
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

Table of Contents

Welcome to Blue Plus

We are pleased to welcome you as a member of Blue Plus Blue Advantage[SM] program (referred to as “plan” or “the plan”).

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

If you are new to Blue Plus, you will be receiving a New Enrollee survey to complete by mail. This is a voluntary survey. It will take only a few minutes to fill out. We encourage you to complete this survey. The survey will help us connect you to health care services or other services available to you as a member. Based on your answers, we may contact you for additional information. If you have questions about this survey, please call Member Services.

This Member Handbook is our contract with you. It is an important legal document.

This Member Handbook includes:

- Contact information
- Information on how to get the care you need
- Your rights and responsibilities as a member of the plan
- Information about cost sharing
- A listing of covered and not covered health care services
- When to call your county worker
- Using the plan coverage with other insurance or other sources of payment
- Information on what to do if you have a grievance (complaint) or want to appeal a plan action, as defined in Section 13
- Definitions

The counties in the plan service area are as follows: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac Qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Sherburne, Sibley, St. Louis, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright and Yellow Medicine.

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

Section 1. Telephone Numbers and Contact Information

How to contact our Member Services

If you have any questions or concerns, call or write to Member Services. We will be happy to help you. Member Services' hours of service are 8 a.m. to 5 p.m., Central Time, Monday through Friday.

CALL: **(651) 662-5545** or toll free at **1-800-711-9862.** This call is free.
TTY: **711**
WRITE: Blue Plus, P.O. Box 982817, El Paso, TX 79998-2817
VISIT: Blue Plus, 3400 Yankee Drive, Eagan, MN 55121
WEBSITE: **bluecrossmn.com/shop-plans/minnesota-health-careprograms/blue-advantage-families-and-children**

Our plan contact information for certain services

Appeals and Grievances Call Blue Plus Member Services at **1-800-711-9862**, TTY call **711**, (this call is free), or write to us at Blue Plus, P.O. Box 982816, El Paso, TX 79998-2816. Refer to Section 13 for more information.

Chiropractic Services Call Blue Plus Member Services at **1-800-711-9862**, **TTY 711**. This call is free.

Dental Services Call Minnesota Select Dental Customer Service at **(651) 406-5907** or toll free at **1-800-774-9049**, TTY call **711**. This call is free. Delta Dental of Minnesota is independent from Blue Cross. Delta Dental provides administrative services for dental benefits.

Durable Medical Equipment Coverage Criteria Call Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free.

Health Questions Telephone Line Members may call 24/7 NurseLine (toll free) at **1-888-275-3974** anytime they are experiencing symptoms or need health care information. The service is staffed by registered nurses who will assess your symptoms and direct you to the best possible care. This service is available for you 24 hours a day, seven days a week to speak with a registered nurse. TTY call **711**. This call is free.

Interpreter Services
American Sign Language (ASL) **711** (TTY)
Spoken Language **1-800-711-9862.** This call is free.

Mental Health Services Call Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free.

Prescriptions Call Prime Member Services at **1-844-765-5939** for pharmacy services. TTY call **711**. This call is free.

Substance Use Disorder Services Call Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free.

Transportation Call BlueRide at **(651) 662-8648** or toll free at **1-866-340-8648**. TTY call **711**. This call is free.

Other important contact information

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

For information and to learn more about health care directives and how to exercise an advance directive, contact Blue Plus Members Services at **1-800-711-9862**. TTY call **711**. This call is free. More information about health care directives can be found: **bluecrossmn.com/publicprograms**. You may also visit the Minnesota Department of Health (MDH) website at: **https://www.health.state.mn.us/facilities/regulation/infobulletins/advdir.html**

To Report Fraud and Abuse call Blue Plus Member Services at **1-800-711-9862**. TTY call **711**. This call is free. To report fraud or abuse directly to the State, contact the Surveillance and Integrity Review Section (SIRS) at the Minnesota Department of Human Services (DHS) by phone at **651-431-2650** or **800-657-3750** or **711** (TTY), or use your preferred relay services (This call is free); by fax at 651-431-7569; or by email at DHS.SIRS@state.mn.us.

Minnesota Department of Human Services

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

Ombudsperson for Public Managed Health Care Programs

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

Section 2. Important Information on Getting the Care You Need

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

When you are a member or become a member of Blue Plus you chose or were assigned to a primary care provider (PCP)/primary care clinic (PCC). Your primary care provider (PCP)/primary care clinic (PCC) can provide most of the health care services you need and will help coordinate your care. This provider will also advise you if you need to use specialists. You may change your primary care provider (PCP)/primary care clinic (PCC). We can help you find a new PCP or PCC. You can change your PCC or PCP at any time.

Call Blue Plus Member Services at **1-800-711-9862**, TTY call **711** for selecting and changing a primary care provider/primary care clinic. This call is free.

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

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

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

Transition of Care:

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

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

Utilization management:

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

Prior authorizations:

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

Almost all health services must be approved by your primary care clinic. Exceptions to this rule are:

- Routine dental care, 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 acquired immune deficiency syndrome (AIDS) or other human immunodeficiency virus (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 substance use disorder 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. Refer to 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.

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

- Open access services: family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for acquired immune deficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related conditions. You can use any 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.

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

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

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

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

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

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

If your 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.

At Blue Plus, 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 **1-800-711-9862,** Monday through Friday, 8 a.m. to 5 p.m. This call is free. If you need language assistance to talk about these issues, Blue Plus can give you information in your language through an interpreter. For sign language services, call **TTY 711**. For other language assistance, call **1-800-711-9862**. This call is free.

Covered and not covered services:

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

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

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

We may cover additional or substitute services under some conditions.

Requests to cover new medical procedures, devices, or drugs are reviewed by physicians or specialists. This group includes doctors and other health care experts. They use national guidelines and medical and scientific evidence to decide whether Blue Plus should approve new equipment, procedures, or drugs.

Payments to providers:

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

What to do if you get a bill from a provider:

In most cases, you should not get a bill from a provider. But you may have to pay charges if:

You agreed in writing ahead of time to pay for care that is not offered by us after you asked for an OK from us.

You agreed ahead of time in writing to pay for care from a provider who does not work with us, and you did not get our OK ahead of time.

If you get a bill and you do not think you should have to pay for the charges, call Member Services at **1-800-711-9862**, TTY **711**, this call is free. Have the bill with you when you call and tell us:

- The date of service
- The amount being charged
- Why you're being billed

Sometimes, you may get a statement from a provider that is not a bill. Call us if you have any questions and we will help you know if you have to pay the bill.

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

Cultural awareness:

We understand that your beliefs, culture, and values play a role in your health. We want to help you maintain good health and good relationships with your doctor. We want to ensure you get care in a culturally sensitive way.

Interpreter services:

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

Other health insurance:

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

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

Private information:

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

Restricted Recipient Program:

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

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

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

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

At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility. You have the right to appeal placement in the Restricted Recipient Program. You must file an appeal within 60 days from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. You may request a State Appeal (Fair Hearing with the state) after receiving our decision that we have decided to enforce the restriction. Refer to Section 13.

Cancellation:

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

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

Section 3. Member Bill of Rights

You have the right to:

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

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

Be told about your health problems.

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

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

Participate with providers in making decisions about your health care.

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

Refuse care from specific providers.

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

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

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

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

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

Receive a clear explanation of covered home care services.

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

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

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

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

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

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

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

Make recommendations about our rights and responsibilities policy.

Exercise the rights listed here.

Section 4. Member Responsibilities

You have the responsibility to:

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

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

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

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

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

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

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

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

Section 5. Your Health Plan Member Identification (ID) Card

Each member will receive a plan member ID card.

Always carry your plan member ID card with you.

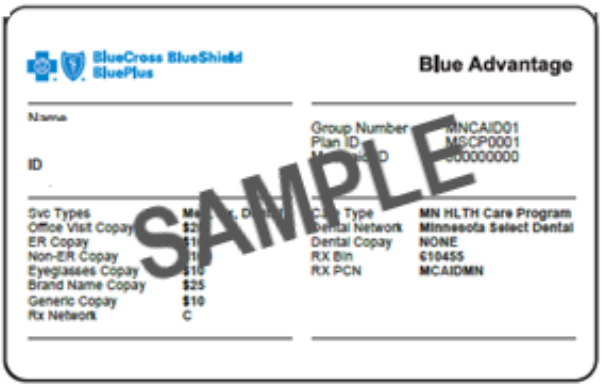
You must show your plan member ID card whenever you get health care.

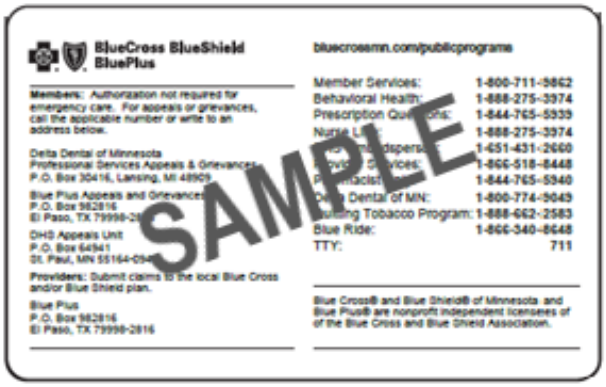
You must use your plan member ID card along with your Minnesota Health Care Program card. Also show the cards of any other health coverage you have, such as Medicare or private insurance.

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

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

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





Section 6. Cost Sharing

Cost sharing is an amount that health plan members may be responsible to pay to their providers for their medical or pharmacy services. It includes deductibles and copays. As of January 1, 2024, **you do not have cost sharing for medical or pharmacy services covered under Medical Assistance.**

Copays

Copays are listed in the following chart:

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

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

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

Section 7. Covered Services

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

Acupuncture Services

Covered services:

- Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing.*
- Up to 20 units of acupuncture services are allowed per calendar year without authorization. Ask for prior authorization if additional units are needed.
- Acupuncture services are covered for the following:
  - acute and chronic pain
  - depression
  - anxiety
  - schizophrenia
  - post-traumatic stress syndrome
  - insomnia
  - smoking cessation
  - restless legs syndrome
  - menstrual disorders
  - xerostomia (dry mouth) associated with the following:
    - Sjogren’s syndrome
    - radiation therapy

*Requires or may require a prior authorization.

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

Child and Teen Checkups (C&TC)

Covered Services:

- Child and Teen Checkups (C&TC) preventive health visits.

  These visits provide children, teens and young adults with regular age-appropriate preventative, dental, mental health, developmental, and when needed, specialty services.

  Depending on age, these visits may include:
  - growth measurements
  - health education
  - health history including nutrition
  - developmental screening
  - social-emotional or mental health screening
  - head-to-toe physical exam
  - immunizations
  - lab tests
  - vision checks
  - hearing checks
  - oral health, including fluoride varnish application

Notes:

C&TC is a health care program of health visits for members birth up to 21 years old.

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

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

- Birth to 2-1/2 years: 0-1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months
- 3 to 21 years: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20 years

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

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

Chiropractic Care

Covered Services:

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

Not Covered Services:

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

Dental Services

Covered Services:

- Diagnostic services:
  - comprehensive exam (once per five years) (cannot be performed on same date as a periodic or limited evaluation)
  - periodic exam (cannot be performed on same date as a limited or comprehensive evaluation)
  - limited (problem-focused) exams (cannot be performed on same date as a periodic or comprehensive oral evaluation, or dental cleaning)
  - oral evaluation for patients under age three (3) (once per lifetime) (cannot be performed on same date as oral hygiene instruction service)

*Requires or may require a prior authorization.

  - detailed oral evaluation (cannot be performed on same date as full mouth debridement)
  - periodontal evaluation (cannot be performed on same date as full mouth debridement)
  - teledentistry for diagnostic services
  - imaging services, limited to:
    - bitewing (once per calendar year) (pregnant member limited to once per five years)
    - single X-rays for diagnosis of problems (four per date of service) (pregnant member limited to once per five years)
    - panoramic (once in a five-year period except when medically necessary; once every two years in limited situations; or with a scheduled outpatient hospital facility or freestanding Ambulatory Surgery Center (ASC) procedure)
    - full mouth X-rays (once in a five-year period)
- Preventive services:
  - dental cleanings (limited to twice per calendar year; up to four per year with Prior authorization) (limited to twice per calendar year for children; up to four per year as medically necessary)
  - fluoride varnish (once every six months) (cannot be performed on same date as emergency treatment of dental pain service)
  - sealants (one every five years per permanent molar)
  - cavity treatment (once per tooth per six months)
  - oral hygiene instruction (cannot be performed on same date as oral evaluation for children under age three) (prior authorization is required for additional service)
- Restorative services:
  - fillings (limited to once per 90 days per tooth)
  - sedative fillings for relief of pain (cannot be performed on same date as emergency treatment of dental pain service)
  - individual crowns (must be made of prefabricated stainless steel or resin) (with prior authorization)
- Endodontics (root canals) (once per tooth per lifetime)
- Oral surgery* (with Prior Authorization)

- Orthodontics only when medically necessary for very limited conditions (with prior authorization)
- Periodontics:
  - gross removal of plaque and tartar (full mouth debridement) (once per five years) (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation, or periodontal evaluation service)
  - scaling and root planing (with prior authorization) (cannot be performed on same day as dental cleaning or full mouth debridement) (once every two years for each quadrant)
    - Follow-up procedures (periodontal maintenance) (with prior authorization) (up to four per calendar year following the completion of scaling and root planing)
- Prosthodontics:
  - removable appliances (dentures, partials, overdentures) (one appliance every six years per dental arch; partials always require a prior authorization)
  - adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials) (repairs to missing or broken teeth are limited to five teeth per 180 days)
  - replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances (with prior authorization)
  - replacement of partial appliances if the existing partial cannot be altered to meet dental needs (with prior authorization)
  - tissue conditioning liners
  - precision attachments and repairs
- Additional general dental services:
  - emergency treatment of dental pain (once per day)
  - general anesthesia, deep sedation (when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery.)
    - General anesthesia may be covered in a clinic setting under certain circumstances:
      - Coverage for a child under age five;
      - A person who is severely disabled;
      - A person who has a medical condition and requires hospitalization or general anesthesia for dental care treatment

- extended care facility/house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), nursing facilities, school or Head Start program, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital) (cannot be performed on same date as oral hygiene instruction service)
- behavioral management when necessary to ensure that a covered dental service is correctly and safely performed
- medications (only when medically necessary for very limited conditions)
- Nitrous oxide (only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)
- oral bite adjustments (complete adjustments with prior authorization) (limited to once per day)
- Oral or IV sedation (only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)

Notes:

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

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

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

Refer to Section 1 for Dental Services contact information.

Diagnostic Services

Covered Services:

- Lab tests and X-rays
- Other medical diagnostic tests ordered by your doctor*

*Requires or may require a prior authorization.

Notes:

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

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

Doctor and Other Health Services

Covered Services:

- Doctor visits including:
  - allergy immunotherapy and allergy testing
  - care for pregnant women
  - family planning – **open access service**
  - lab tests and X-rays
  - physical exams
  - preventive exams
  - preventive office visits
  - specialists
  - telemedicine consultation
  - vaccines and drugs administered in a doctor's office
  - visits for illness or injury
  - visits in the hospital or nursing home
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Behavioral Health Home: coordination of primary care, mental health services, and social services
- Blood and blood products
- Clinical trial coverage: Routine care that is: 1) provided as part of the protocol treatment of a Clinical Trial; 2) is usual, customary and appropriate to your condition; and 3) would be typically provided outside of a Clinical Trial. This includes services and items needed for the treatment of effects and complications of the protocol treatment.*

- Cancer screenings (including mammography, pap test, prostate cancer screening, colorectal cancer screening)
- Clinical Services*
- Community health worker care coordination and patient education services
- Community Medical Emergency Technician (CMET) services
    - post-hospital/post-nursing home discharge visits ordered by your primary care provider
    - safety evaluation visits ordered by Primary Care Provider/Physician (PCP)
- Community Paramedic Services: certain services are provided by a community paramedic. The services must be a part of a care plan by your primary care provider. The services may include:
    - health assessments
    - chronic disease monitoring and education
    - help with medications
    - immunizations and vaccinations
    - collecting lab specimens
    - follow-up care after being treated at a hospital
    - other minor medical procedures
- Counseling and testing for sexually transmitted diseases (STDs), AIDS and other HIV-related conditions - **open access service**
- Enhanced asthma care services (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma, when specific criteria are met)
    - Home visits to determine if there are asthma-triggers in the member's home
    - Must be provided by a registered environmental health specialist, healthy homes specialist, and lead risk assessor. Your local public health agency can help you find one of these health care professionals to help you or you can contact Member Services.
- Health Care Home services: care coordination for members with complex or chronic health care needs
- Health education and counseling (for example, smoking cessation, nutrition counseling, diabetes education)
- Hospital In-Reach Community-Based Service (IRSC) Coordination: coordination of services targeted at reducing hospital emergency room (ER) use under certain

circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services.

- Immunizations
- Podiatry services (debridement of toenails, infected corns and calluses, and other non-routine foot care)
- Respiratory therapy
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must use a provider in the plan network
- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Tuberculosis care management and direct observation of drug intake

Not Covered Services:

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

Early Intensive Developmental and Behavioral Intervention (EIDBI) Services *(for members under age 21)*

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

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

The benefit is also intended to:

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

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

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

Covered Services:

- Comprehensive Multi-Disciplinary Evaluation (CMDE) which is needed to determine eligibility and medical necessity for EIDBI services
- Individual Treatment Plan (ITP) Development (Initial)
  - Individual Treatment Plan (ITP) Development and Progress Monitoring
- Direct Intervention: Individual, Group, and/or higher intensity
- Observation and Direction
- Family/Caregiver Training and Counseling: Individual and/or Group
- Coordinated Care Conference
- Travel time*

Emergency Medical Services and Post-Stabilization Care

Covered Services:

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

Not Covered Services:

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

Notes:
If you have an emergency and need treatment right away, call **911** or use 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. You can call the number 24 hours a day, seven days a week and get instructions about what to do.

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

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

Family Planning Services

Covered Services:

- Family planning exam and medical treatment – **open access service**
- Family planning lab and diagnostic tests – **open access service**
- Family planning methods (for example, birth control pills, patch, ring, Intrauterine Device (IUD), injections, implants) – **open access service**
- Family planning supplies with prescription (for example, condom, sponge, foam, film, diaphragm, cap) – **open access service**
- Counseling and diagnosis of infertility, including related services – **open access service**
- Treatment for medical conditions of infertility – **NOT** an open access service. You must use a provider in the plan network. Note: This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS, and other HIV-related conditions – **open access service**
- Treatment for sexually transmitted diseases (STDs) - **open access service**
- Voluntary sterilization – **open access service**

  Note: You must be age 21 or over and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.

- Genetic counseling - **open access service**
- Genetic testing – **NOT** an open access service**.** You must use a provider in the plan network.
- Treatment for AIDS and other HIV-related conditions - **NOT** an open access service. You must use a provider in the plan network.

Not Covered Services:

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

Notes:

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

Hearing Aids

Covered Services:

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

Home Care Services

Covered Services:

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

Hospice*

Covered Services:

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

- Physician services
- Nursing services
- Medical social services

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

Notes:

Medicare Election

You must elect hospice benefits to receive hospice services.

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

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

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

Hospital – Inpatient

Covered Services:

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

- Inpatient hospital stay
- Your semi-private room and meals
- Private room when medically necessary
- Tests and X-rays

- Surgery
- Drugs
- Medical supplies
- Professional services
- Therapy services (for example: physical, occupational, speech, respiratory)

Not Covered Services:

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

Notes:

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

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

Hospital – Outpatient

Covered Services:

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

observation services up to 72 hours for unusual circumstances when submitted with additional documentation.

Notes:

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

Housing Stabilization Services (for members 18 years old and older)

Covered Services:

The plan will pay for the following services for members eligible for Housing Stabilization Services:

- Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services
- Housing transition services to help you plan for, find, and move into housing
    - Housing transition - moving expenses (limited to $3000 per year)
        - Only for people leaving a Medical Assistance funded institution or provider-controlled setting who are moving into their own home
        - Applications, security deposits, and the cost of securing documentation that is required to obtain a lease on an apartment or home
        - Essential household furnishings required to live in and use in the home, including furniture, window coverings, food preparation items, and bed or bath linens
        - Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water
        - Services necessary for the individual's health and safety such as pest removal and one time cleaning prior to moving in
        - Necessary home accessibility adaptations
- Housing sustaining services to help you maintain housing
- Transportation to receive Housing Stabilization Services (within a 60 mile radius)

Not Covered Services:

- Rent or mortgage payments

- Food
- Clothing
- Recreational items, including streaming devices, computers, televisions, cable television access, speakers and so forth
- Any items, expenses or supports that duplicate any other service or are owned or leased by a provider

Notes:

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

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

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

Interpreter Services

Covered Services:

- Spoken language interpreter services
- Sign language interpreter services

Notes:

Interpreter services are available to help you get covered services.

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

Medical Equipment and Supplies

Covered Services:

- Prosthetics or orthotics*
- Durable medical equipment (for example, wheelchairs, hospital beds, walkers, crutches, standers, bath and toilet equipment, and wigs for people with hair loss due to any medical condition). Contact Member Services for more information on coverage and benefit limits for wigs*
- Repairs of medical equipment*
- Batteries for medical equipment
- Some shoes, including therapeutic stack shoes when specific criteria are met and when custom molded or part of a leg brace*
- Oxygen and oxygen equipment*
- Airway clearance devices
- Electrical stimulation devices
- Medical supplies you need to take care of your illness, injury, or disability*
- Diabetic equipment and supplies
- Nutritional/enteral products, when specific criteria are met
- Incontinence products
- Family planning supplies — open access service. (Refer to Family Planning Services in this section.)
- Augmentative communication devices, including electronic tablets*
- Allergen-reducing products (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma)
- Seizure detection devices

Not Covered Services:

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

Notes:

You will need to use your doctor and get a prescription for medical equipment and supplies to be covered.

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

Mental Health/Behavioral Health Services*

Covered Services:

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

  - Neuropsychological services
  - Psychotherapy (patient and/or family, family, crisis, and group)
  - Psychological testing
- Physician Mental Health Services including:
  - Health and behavior assessment/intervention
  - Inpatient visits
  - Psychiatric consultations to primary care providers
  - Physician consultation, evaluation, and management
- Rehabilitative Mental Health Services including:
  - Assertive Community Treatment (ACT) (for members age 18 or older)
  - Adult day treatment (for members age 18 or older)
  - Adult Rehabilitative Mental Health Services (ARMHS) is available to members age 18 or older
  - Certified family peer specialists (for members under age 21)
  - Certified Peer Specialist (CPS) support services in limited situations
  - Children's mental health residential treatment services (for members under age 21)
  - Children's Therapeutic Services and Supports (CTSS) including Children's Day Treatment (for members under age 21)
  - Family psychoeducation services (for members under age 21)
  - Intensive Residential Treatment Services (IRTS) (for members over age 18)
  - Intensive Treatment Foster Care Services (for members under age 21)
  - Partial Hospitalization Program (PHP)
  - Intensive Rehabilitative Mental Health Services (IRMHS)/Youth Assertive Community Treatment (Youth ACT): intensive non-residential rehabilitative mental health services (for members ages 8 through 20)
- Psychiatric Residential Treatment Facility (PRTF) for members age 21 and under
- Telehealth

Not Covered Services:

- Conversion therapy

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

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

Notes:

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

Use a plan network provider for mental health services.

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

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

Obstetrics and Gynecology (OB/GYN) Services

Covered Services:

- Prenatal, delivery, and postpartum care
- Childbirth classes
- Hospital services for newborns
- HIV counseling and testing for pregnant 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)*

- Doula services by a certified doula
- Services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives

Not Covered Services:

- Abortion: This service is not covered under the plan. It may be covered by the state. Call DHS Health Care Consumer Support at **(651) 297-3862** or **800-657-3672** or **711** (TTY), or use your preferred relay services for coverage information. Also refer to Section 9. This call is free.
- Planned home births

Notes:

You have “direct access” to OB-GYN providers for the following services: annual preventive health exam, including follow-up exams that your doctor says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must use a provider in the plan network. For services labeled as **open access**, you can use any doctor clinic, hospital, pharmacy, or family planning agency.

Optical Services

Covered Services:

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

Not Covered Services:

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

- Contact lens supplies

Out-of-Area Services

Covered Services:

- A service you need when temporarily out of the plan service area. Call Member Services at the phone number in Section 1 as soon as possible when you get care outside 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, urgent, or other health care services or items supplied from providers located outside of the United States (U.S.). We will not make payment for health care to a provider or any entity outside of the U.S.

Notes:

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

Out-of-Network Services

Covered Services:

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

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

Notes:

Sometimes members need to see a very specialized type of doctor. We will work with your doctor to make sure you get the specialist or service when you need it, for as long as you need it, even if the provider is not currently a network provider. There is no cost to you when we authorize the care or service before you see the provider.

Prescription Drugs (for members who do NOT have Medicare)

Covered Services:

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

Not Covered Services:

- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved or authorized by the Food and Drug Administration (FDA)
- Medical cannabis

Notes:

The list of covered drugs (formulary) includes the prescription drugs covered by Blue Plus. The drugs on the list are selected by the plan with the help of a team of doctors and pharmacists. The list has to be similar to the list covered by Fee-for-Service Medical

Assistance (Medicaid). The list also must include drugs listed in the Department of Human Services' Preferred Drug List (PDL).

In addition to the prescription drugs covered by Blue Plus, some over-the-counter drugs are covered under your Medical Assistance (Medicaid) benefits. A list of covered drugs (formulary) is also posted on the website. You can also call Member Services and ask for a written copy of our list of covered drugs (formulary).

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

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

- **Prior Authorization (PA):** Blue Plus requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval from Blue Plus before you fill your prescriptions. If you don't get approval, Blue Plus may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, Blue Plus limits the amount of the drug that Blue Plus will cover.
- **Preferred/Non-Preferred (P/NP):** For some groups of drugs, Blue Plus requires you to try the preferred drugs before paying for the non-preferred drugs. To receive a non-preferred drug, your doctor or health care provider will have to get prior authorization.
- **Age Requirements:** In some cases, there are age requirements for you to try certain drugs. A prior authorization is needed depending on your age and the specific drug prescribed.
- **Brand-name Drugs:** Brand-name version of the drug will be covered by Blue Plus only when:
    1. Your prescriber informs Blue Plus in writing that the brand name version of the drug is medically necessary; OR
    2. Blue Plus prefers the dispensing of the brand-name version over the generic version of the drug; OR
    3. Minnesota Law requires the dispensing of the brand-name version of the drug

You can find out if your drug requires prior authorization, has quantity limits, has Preferred/Non-Preferred status, or has an age requirement by contacting Customer Services or visiting our website at **https://www.bluecrossmn.com/members/shop-plans/minnesota-health-care-programs/blue-advantage-families-and-children**. A drug

restriction or limit can be removed if your doctor submits a statement or documentation supporting the request. You can also get more information about the restrictions applied to specific covered drugs by contacting Customer Services or visiting our website at **https://www.bluecrossmn.com/members/shop-plans/minnesota-health-care-programs/blue-advantage-families-and-children**.

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

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

Most drugs and certain supplies are available up to a 34-day supply. Certain drugs you take on a regular basis for a chronic or long-term condition are available up to a 90-day supply and are listed on the 90-Day Supply Program.

If Blue Plus 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 Blue Plus to make an "exception" and cover the drug for you or remove the restrictions or limits. If your exception request is approved, the drug will be covered at the appropriate generic or brand name copay level.

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

Formulary Exception Process

As a new member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription.

You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug during the first 90 days you are a member of our plan. Please contact Member Services if you have questions regarding this coverage.

If the doctor believes that you need coverage for a drug that is not on the covered drug list, you may request an exception. The doctor must submit a written Formulary Exception request to us. The request must certify that the covered drug is not working for you, and that the non-covered drug must be "dispense as written" (DAW) to benefit you. For most drugs, you can get only a 34-day supply at one time. Contact Blue Plus Member Services for additional information.

If 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.

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

Specialty drugs are used by people with complex or chronic diseases. These drugs often require special handling, dispensing, or monitoring by a specially trained pharmacist.

If you are prescribed a drug that is on the Blue Plus Specialty Drug List, your prescriber will need to send the prescription of that specialty drug to one of Blue Plus' Specialty Pharmacies.

Accredo Health Group, Inc.
Toll free: **1-866-470-2245, TTY 1-800-716-3231** This call is free.
Fax: **1-888-302-1028**
Customer service line is open 24 hours a day, seven days a week

Children's Home Care (for hemophilia medications only)
Toll free **1-866-656-1020, TTY 711** This call is free.
Fax: **(877) 828-3939**
Monday through Friday from 8 a.m. to 5 p.m., Central Time

Fairview Specialty Pharmacy Service
1-800-595-7140, TTY 711 This call is free.
Fax: **(877) 828-3939**
Monday through Friday from 8 a.m. to 7 p.m., Saturday from 8 a.m. to 4 p.m., Central Time

North Memorial Health Pharmacy – Specialty Center
3435 W. Broadway Ave.
Robbinsdale, MN 55422

Pharmacists available by phone 24/7 at **1-877-520-5307** (toll free),
TTY 711 or **(763) 581-6333** This call is free.
Fax: **763-581-2814**
Monday through Friday from 8 a.m. to 5 p.m., Central Time

Thrifty White Specialty Pharmacy
Pharmacists available by phone 24/7 at **(855) 611-3399, TTY 711** This call is free.
Fax: **855-423-8300**
Monday through Friday, 8 a.m. to 8 p.m.; Saturday, 9 a.m. to 5 p.m. Central Time; Sunday: Closed

You will also need to call the Specialty Pharmacy that receives your prescription to set up an account. You will need to have your Blue Plus Member ID card when you call the Specialty Pharmacy.

Prescription Drugs (for members who have Medicare)

Covered Services:

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

Not Covered Services:

- Prescription drugs that are eligible to be covered under the Medicare Prescription Drug Program (Medicare Part D)
- Drugs used to treat erectile or sexual dysfunction
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs excluded from coverage by federal or state law
- Experimental drugs, investigational drugs, or drugs not approved or authorized by the FDA
- Medical cannabis

Notes:

Medicare pays for most of your prescription drugs through the Medicare Prescription Drug Program (Medicare Part D). **You must enroll in a Medicare prescription drug plan** to receive most of your prescription drug services. You will get your prescription drug services

through your Medicare prescription drug plan – not through our plan. You may have to pay a copay for prescriptions covered by your Medicare prescription drug plan.

Rehabilitation

Covered Services:

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

Not Covered Services:

- Vocational rehabilitation
- Health clubs and spas

School Based Community Services (for members under age 21)

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

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

Covered Services:

- Rehabilitative Services
    - Audiology
    - Occupational Therapy
    - Physical Therapy
    - Speech Language Pathology

*Requires or may require a prior authorization.

- Mental Health Services
- Children's Therapeutic Services and Supports
- Diagnostic Assessments
- Explanation of Findings
- Family Psychoeducation
- Health Behavior Assessment/Intervention
- Outpatient Mental Health Services
- Psychological Testing
- Psychotherapy
- Psychotherapy for Crisis

Not Covered Services:

- Personal care assistance
- Assistive Technology
- Home Care Nursing
- Special Transportation
- IEP services that are required to be covered through the school

Substance Use Disorder Services (SUD)

Covered Services:

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

*Requires or may require a prior authorization.

- Peer recovery support
- Withdrawal Management

Not Covered Services:

Payment for room and board determined necessary by substance use disorder assessment is the responsibility of the Minnesota Department of Human Services.

Notes:

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

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

Surgery*

Covered Services:

- Office or clinic visits and surgery*
- Removal of port wine stain birthmarks
- Reconstructive surgery (for example, following mastectomy, following surgery for injury, sickness or other diseases; for birth defects)*
- Anesthesia services
- Circumcision when medically necessary*
- Gender affirming surgery*

Not Covered Services:

- Cosmetic surgery

Telehealth Services

Covered Services:

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

Telemonitoring

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

Covered Services:

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

Tobacco and Nicotine Cessation

Covered Services:

- An initial call to talk about your history of nicotine use and your efforts to quit
- Four additional calls with a wellness coach at times that work for you
- A personal quit plan
- A workbook sent to your home with tips to help you stick with the plan and deal with stress and cravings
- Two additional calls to support you after you complete the program (30- and 90-day follow-ups)

- Online tools and resources for support and to track your progress between calls
- If you want to use a quit aid (patch, gum or lozenge), your wellness coach will help you figure out which would work best for you. Call the customer service number on the back of your member ID card to find out about health plan coverage for any quit aids.

Traditional Healing Services

Cultural practices are central to restoring and improving the health of Indigenous peoples. The Traditional Healing Services benefit reimburses providers dedicated to serving Indigenous communities. These services improve access to traditional forms of healing, culturally based care, and cultural activities. Traditional healing covers diverse practices that are based on Indigenous knowledge and wisdom.

Covered Services

Traditional Healing Services are covered for members who access holistic and Indigenous culturally based care from a provider contracted to provide these services. Examples include:

- Working with an Indigenous elders in residence.
- Participating in culturally based activities that improve health and wellbeing.
- Participating in a ceremony.
- Traditional Medicine services for individuals, families, and groups based upon appropriate needs.
- Consultations with traditional health experts.
- Blue Plus pays up to $500 per year per member.

Transplants*

Covered Services:

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

Notes:

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

Transplants must be done at a transplant center that is a Medicare approved transplant center.

Stem cell or bone marrow transplants centers must meet the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT).

Blue Plus' Transplant Process members must use Blue Distinction Centers® of Excellence for the transplants below. Medically necessary procedures that are covered include:

- Cellular Immunotherapy (Car-T)
- Transplants for:
    - Adult Heart
    - Adult Kidney Deceased Donor
    - Adult Kidney Living Donor
    - Adult Lung
    - Adult Liver Deceased Donor
    - Adult Liver Living Donor
    - Adult Bone Marrow / Stem Cell
    - Pediatric Heart
    - Pediatric Kidney
    - Pediatric Liver
    - Pediatric Bone Marrow/Stem Cell

Members may use Blue Distinction Centers® of Excellence for the following surgeries:

- Bariatric Surgery
- Cancer Care
- Cardiac Care
- Spine Surgery
- Knee and Hip Replacement

Eligible providers:

- All organ transplants must be performed at transplant centers meeting United Network for Organ Sharing (UNOS) criteria or be a Medicare approved heart, heart-lung, lung, liver, or intestinal (small bowel) transplant center.
- Stem cell and bone marrow transplants must be performed in a tissue transplant center which is certified by and meets the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT), or be approved by the Advisory Committee on Organ and Tissue Transplants.
- For all transplants, the provider must have a current Blue Plus transplant contract for the specific transplant type being performed.
- As technology changes, the covered transplants listed above will be subject to modifications in the form of additions or deletions, when appropriate.
- Kidney, cornea, and autologous pancreatic islet cell transplants are eligible procedures that are covered on the same basis as any other eligible service and are not subject to the special requirements for transplants listed above. See “Doctor and Other Health Services” and “Hospital Inpatient.”
- Prior authorization is required for all transplant procedures. All requests for prior authorization must be submitted in writing to Blue Plus’ Transplant Coordinator, P.O. Box 64179, St. Paul, MN 55164, or fax to **(651) 662-1624, TTY 711**.

If you have specific questions on transplants, call the Transplant Coordinator, Monday through Friday, from 8 a.m. to 4:30 p.m. Central Time at **(651) 662-9936** or toll free **1-866-309-6564**, (This call is free) TTY 711.

Not Covered:

- Reimbursement for meals and lodging expenses
- Services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- Services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered
- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow transplant and peripheral stem cell support procedures that are considered investigative or not medically necessary
- Living donor organ and/or tissue transplants unless otherwise specified in this plan
- Services for the collection and storage of infant cord blood
- Transplantation of animal organs and/or tissue

Transportation to and from Medical Services

Covered Services:

- Ambulance (air or ground includes transport on water)
- Volunteer driver transport
- Unassisted transport (taxicab or public transit)
- Assisted transport*
- Lift-equipped/ramp transport*
- Protected transport*
- Stretcher transport

Not Covered Services:

- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking also including out of state travel. These services are not covered under the plan but may be available through the local county or tribal agency. Call your local county or tribal agency for more information.

Notes:

If you need transportation to and from health services that we cover, call the transportation phone number in Section 1. We will provide the most appropriate and cost-effective form of transportation.

The plan is not required to provide transportation to your primary care clinic if it is more than 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Call the transportation phone number in Section 1 if you do not have a primary care clinic that is available within 30 miles of your home and/or if you do not have a specialty provider that is available within 60 miles of your home.

The Blue Plus transportation program, BlueRide, is available to those who do not have other means of transportation to their medical and dental appointments. For a ride, please call at least two business days in advance before your appointment. If your appointment changes, call at least four hours before your pickup time to change or cancel your ride. BlueRide is for medical or dental appointments. Do not ask the driver to drop you off at another location. Call BlueRide for more information at **1-866-340-8648, TTY 711** (This call is free). Hours of operation are Monday through Friday, 8 a.m. to 5 p.m. Central Time.

*Requires or may require a prior authorization.

Urgent Care

Covered Services:

- Urgent care within the plan service area*
- Urgent care outside of the plan service area*

Not Covered Services:

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

Notes:

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

You may also call the NurseLine at **1-888-275-3974, TTY 711**, this call is free. NurseLine provides clinical support 24 hours per day, 7 days a week.

It's good to know what in-network urgent care clinic is nearest to you. You can find an urgent care clinic here: **bluecrossmn.com/FamiliesAndChildrenFAD**. Or you can call Member Services.

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

*Requires or may require a prior authorization.

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. The following is a list of other services and supplies that are not covered under the plan. This is not a complete list. Call Member Services for more information.

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

Section 9. Services That Are Not Covered Under the Plan but May Be Covered Through Another Source

These services are not covered under the plan, but may be covered through another source, such as the state, county, federal government, tribe, or a Medicare prescription drug plan. To find out more about these services, call DHS Health Care Consumer Support at **651-297-3862** or **800-657-3672** or **711** (TTY), or use your preferred relay services. This call is free.

- Abortion services
- Case management for members with developmental disabilities
- Child welfare targeted case management
- Day training and habilitation services
- HIV case management
- Home Care Nursing (HCN): To learn more about HCN services, contact a home care agency for an assessment. To find a home care agency in your area, call the HCCS number previously listed.
- Intermediate care facility for members with developmental disabilities (ICF/DD)
- Job training and educational services
- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance (Medicaid)
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays
- Personal Care Assistance (PCA). Community First Services and Supports (CFSS) will replace PCA services, upon federal approval. Contact your county of residence intake for long-term care services and supports to learn more about PCA services and to arrange for an assessment.
- Post-arrest Community-Based Services Coordination
- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.
- Room and board associated with Intensive Residential Treatment Services (IRTS)

- Room and board associated with treatment services at children's residential mental health treatment facilities. Room and board may be covered by your county. Call your county for information.
- Services provided by federal institutions
- Services provided by a state regional treatment center, a state-owned long term care facility unless approved by us or the service is ordered by a court under conditions specified in law
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Home and Community-Based Services waivers

Section 10. When To Call Your County Worker

Call your county worker to report these changes:

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

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
- Tricare
- Other Health Maintenance Organization (HMO) coverage
- Other commercial insurance

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

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

If your other insurance changes, call your county worker.

Section 12. Subrogation or Other Claim

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

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

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

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

Section 13. Grievance, Appeal, and State Appeal (Fair Hearing with the state) Process

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

Call Member Services at the phone number in Section 1 if you have questions or want help filing a grievance or appeal.

Grievance and appeal system terms to know:

A grievance is when you are not satisfied with the services you have received and may include any of the following:

- quality of care or services provided
- failure to respect your rights
- rudeness of a provider or health plan employee
- delay in appropriate treatment or referral
- not acting within required time frames for grievances and appeals

A denial, termination, or reduction (DTR) (notice of action) is a form or letter we send you to tell you about a decision we made on a request for service, payment of a claim, or any other request. The notice will tell you how to file an appeal with the health plan or request a State Appeal (Fair Hearing with the state) if you disagree with our decision.

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

- denial or limited authorization of the type or level of service requested by your provider
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of payment for a service
- not providing services (including transportation) in a reasonable amount of time
- denial of a member’s request to get services out of network for members living in a rural area with only one health plan
- not providing a response to your grievance or appeal in the required timelines

- denial of your request to dispute your financial liability including copayments and other cost sharing

Your provider may Appeal on your behalf with your written consent. Your treating provider may Appeal a prior authorization decision without your consent.

A State Appeal (Fair Hearing with the state) is your request for the state to review a decision we made. You must appeal to Blue Plus before asking for a State Appeal. If we take more than 30 days to decide your appeal and you have not requested an extension or we did not add an extension, you do not need to wait for our decision to ask for a State Appeal. You may appeal any of these actions (decisions):

- denial or limited authorization of the type or level of service
- reduction, suspension, or stopping of a service that was approved before
- denial of all or part of a payment for a service
- not providing services in a reasonable amount of time
- our failure to act within required timelines for prior authorizations and appeals
- financial liability including copayments or other cost sharing
- any other action

Important timelines for appeals

You must follow the timelines for filing health plan appeals, and State Appeals (Fair Hearings with the state). If you go over the time allowed, we may not review your appeal and the state may not accept your request for an appeal.

You must appeal to us **within 60 days** from the date of the DTR (notice of action). We can give you more time if you have a good reason for missing the deadline. You must file an appeal with us **before** you request a State Appeal. If we take more than 30 days to decide your appeal and you have not requested an extension or we did not add an extension, you can request a State Appeal without waiting for us.

You must request a State Appeal **within 120 days** of our appeal decision.

If we are stopping or reducing a service, you can keep getting the service if you file a health plan appeal **within 10 days** from the date on the notice, or before the service is stopped or reduced, whichever is later. **You must ask to keep getting the service when you file an appeal.** The service can continue until the appeal is decided. If you lose the appeal, you may be billed for these services, but only if state policy allows it.

If you lose the appeal, you may keep getting the service during a State Appeal if you request a State Appeal within 10 days from the date of the decision on your plan appeal.

For the Restricted Recipient Program, a member who receives a notice of restriction may file an appeal with us. You must file an appeal **within 60 days** from the date on the notice. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. You may request a State Appeal after receiving our decision.

To file an oral or written appeal with us:

You may appeal by phone, writing, fax, or in person. The contact information and address is found in Section 1 under “Appeals and Grievances.”

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

Your appeal request should include:

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

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

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

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

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

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

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

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

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

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

You must file a health plan Appeal with us **before** you ask for a State Appeal. You must ask for a State Appeal **within 120 days** from the date of our appeal decision (resolution).

Your appeal to the state must be in writing. You can write to the Minnesota Department of Human Services to request a State Appeal.

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

File online at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG
Or fax to: **(651) 431-7523**

Tell the state why you disagree with the decision we made. You can ask a friend, relative, advocate, provider, or lawyer to help you. Your provider must have your written permission to request a State Appeal for you.

A human services judge from the state Appeals Office will hold a hearing. You may ask to attend the hearing by telephone, by video, or in person. You can ask your providers or others to give testimony. You can provide documents for the judge to consider.

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

If your hearing is about a service that was denied because it was not medically necessary, you may ask for review by a medical expert. The medical expert is independent of both the state and Blue Plus. The state pays for this review. There is no cost to you.

If you do not agree with the human service judge's decision, you may ask the state to reconsider their decision. Send a written request for reconsideration to the Minnesota Department of Human Services Appeals Office within 30 days from the date of the decision. The contact information is listed earlier in this section.

If you do not agree with the state's decision, you may appeal to the district court in your county.

Grievances (Complaints)

You may file a Grievance with us **at any time.** There is no timeline for filing a grievance with us. **To file an oral grievance with us:**

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

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

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

To file a written grievance with us:

Send a letter to us about your grievance. Write to the address listed in Section 1 under "Appeals and Grievances." Or you can fax the letter to us using the fax number listed in Section 1.

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

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

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

If you do not agree with our decision, you can file your complaint with the Minnesota Department of Health.

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

Call: **1-800-657-3916** (this call is free) **or (651) 201-5100**
711 (TTY), or use your preferred relay services.

Visit: health.state.mn.us/facilities/insurance/clearinghouse/complaints.html

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

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

If you decide to file a grievance or appeal, or request a State Appeal, it will not affect your eligibility for medical services. It will also not affect your enrollment in our health plan.

You can have a relative, friend, advocate, provider, or lawyer help with your grievance, appeal, or a State Appeal.

There is no cost to you for filing a health plan appeal, grievance, or a State Appeal. We may pay for some expenses such as transportation, childcare, photocopying, etc.

If you ask for your medical records or other documents we used to make our decision or want copies, we or your provider must provide them to you at no cost. If you ask, we must give you a copy of the guidelines we used to make our decision, at no cost to you. You may need to put your request in writing.

If you need help with your grievance, appeal, or a State Appeal, you can call or write to the Ombudsperson for Public Managed Health Care Programs. They may be able to help you

with access, service, or billing problems. They can also help you file a grievance or appeal with us or request a State Appeal.

Call: **(651) 431-2660**,
800-657-3729, or **711** (TTY), or use your preferred relay services.
This call is free. Hours of service are Monday through Friday, 8 a.m. to 4:30 p.m., Central Time.

Or

Write to: Ombudsperson for Public Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249
Fax to: **(651) 431-7472**

Section 14. Definitions

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

Action: This includes:

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

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

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

Child: Member under age 21.

Child and Teen Checkups (C&TC): A special health care program of well-child visits for members under age 21. It includes screening to check for health problems. It also includes referrals for diagnosis and treatment, if necessary.

Clinical Trial: A qualified medical study test that is: subject to a defined peer review; sponsored by a clinical research program that meets federal and state rules and approved standards; and whose true results are reported.

Copay/Copayment: A fixed amount you may pay as your share of the cost each time you get certain services, supplies, or prescription drugs. Co-pays are usually paid at the time services, supplies, or prescription drugs are provided.

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

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

Cultural Competency: Cultural and language competence is the ability of managed care organizations and the providers within their network to provide care to members with diverse values, beliefs, and behaviors, and to tailor the delivery of care to meet members' social, cultural, and language needs. The goal is a health care delivery system and workforce that

can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, sexual orientation, disability, religion, or socioeconomic status.

Denial, Termination or Reduction (DTR) (Notice of Action): A form or letter we send you to tell you about a decision on a claim, service, or any other action taken by us.

Direct Access Services: You can use any provider in the plan network to get these services. You do not need a referral or prior authorization from your PCP or PCC before getting services.

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

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

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

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

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

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

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

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

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

Fee-for-Service (FFS): A method of payment for health services. The medical provider bills the Minnesota Department of Human Services (DHS) directly. DHS pays the provider for the

medical services. This method is used when you are eligible for MHCP but are not enrolled in a health plan.

Formulary: The list of drugs covered under the plan.

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

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

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

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

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

Inpatient Hospital Stay: A stay in a hospital or treatment center that usually lasts 24 hours or more.

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

Medically Necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and behavioral health (including Mental Health and Substance Use Disorder). It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

- be the services, supplies and prescription drugs other providers would usually order.
- help you get better or stay as well as you are.
- help stop your condition from getting worse.
- help prevent or find health problems.

Medicare: The federal health insurance program for people age 65 or over. It is also for some people under age 65 with disabilities, and people with End-Stage Renal Disease.

Medicare Prescription Drug Plan: An insurance plan that offers Medicare Prescription Drug Program (Medicare Part D) drug benefits.

Medicare Prescription Drug Program: The prescription drug benefit for Medicare members. It is sometimes called Medicare Part D. Drug coverage is provided through a Medicare prescription drug plan.

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

Member Handbook: This is the document you are reading. This document tells you what services are covered under the plan. It tells what you must do to get covered services. It tells your rights and responsibilities. It also tells our rights and responsibilities.

Network: Our contracted health care providers for the plan.

Network Providers: These are providers who agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called plan providers or participating providers.

Ombudsperson for Public Managed Health Care Programs: A person at the Minnesota Department of Human Services who can help you with access, service or billing problems. The Ombudsperson can also help you file a grievance or appeal or request a State Appeal (Fair Hearing with the state).

Open Access Services: Federal and state law allow you to choose any 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 that are not at an inpatient level of care. These services may also be available at your clinic or another health facility.

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

Out-of-Network Provider or Out-of-Network Facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. This is also known as a non-participating provider.

Out-of-Network Services: Health care provided to a member by a provider who is not part of the plan network.

Physician Incentive Plan: Special payment arrangements between us and the doctor or doctor group that may affect the use of referrals. It may also affect other services that you might need.

Physician Services: Services provided by an individual licensed under state law to practice medicine or osteopathy. Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: An organization that has a network of doctors, hospitals, pharmacies, providers of long- term services, and other providers. It also has care coordinators to help you.

Post-stabilization Care: A hospital service needed to help a person’s conditions stay stable after having emergency care. It starts when the hospital asks for our approval for coverage. It continues until: the person is discharged; our plan network doctor begins care; or we, the hospital, and doctor agree to a different arrangement.

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prepaid Medical Assistance Program (PMAP): A program in which the state contracts with health plans to cover and manage health care services for Medical Assistance (Medicaid) enrollees.

Prescriptions: Medicines and drugs ordered by a medical provider.

Prescription Drug Coverage: A health plan that helps pay for prescription drugs and medications. Also refer to “Medicare Prescription Drug Program.”

Preventive Services: Services that help you stay healthy, such as routine physicals, immunizations, and well-person care. These services help find and prevent health problems. Follow-up on conditions that have been diagnosed (like a diabetes checkup) are ***not*** preventive.

Primary Care Clinic: The primary care clinic (PCC) you choose for your routine care. This clinic will provide most of your care.

Primary Care Provider: Your primary care provider (PCP) is the doctor or other qualified health care provider you use at your primary care clinic. This person will manage your health care.

Prior Authorization: Our approval that is needed for some services before you get them. This is also known as preauthorization or service authorization.

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

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

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

Rehabilitation Services and Devices: Treatment and equipment you get to help you recover from an illness, accident, or major operation.

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

Second Opinion: If you do not agree with an opinion you get from a plan network provider, you have the right to get an opinion from another provider. We will pay for this. For mental health services, the second opinion may be from an out-of-network provider. For substance use disorder services, the second opinion will be from a different qualified assessor who does not need to be in the plan network. We must consider the second opinion but do not have to accept a second opinion for substance use disorder or mental health services.

Service Area: The area where a person must live to be able to become or remain a member of the plan. Contact Member Services at the phone number in Section 1 for details about the service area.

Service Authorization: Our approval that is needed for some services before you get them. This is also known as preauthorization or prior authorization.

Skilled Nursing Care: Care or treatment that can only be done by licensed nurses.

Specialist: A doctor who provides health care for a specific disease or part of the body.

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

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

- a denial, termination, or reduction of services
- enrollment in the plan
- denial of part or all of a claim for a service
- our failure to act within required timelines for prior authorizations and appeals
- any other action

Subrogation: Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this plan for a service that is covered by another source or third-party payer.

Substance Use Disorder: Using alcohol or drugs in a way that harms you.

United States: For the purpose of this Member Handbook, the United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, The Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Urgently Needed Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. This is also known as Urgent Care.

Section 15. Additional Information

This section tells you about different topics: health care directives, case management, provider payment methods, women's health and cancer rights, how we protect your privacy, quality improvement, and if you are sick or hurt, where do you go?.

Health care directives

What is a health care directive?

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

How do I make a health care directive?

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

- It must be in writing and dated
- It must state your legal name
- It must be signed by you or someone you authorize to sign for you in the event that you cannot understand or communicate your health care wishes
- You must have your signature verified by a notary public or two witnesses
- You must include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider.

Why should I have a health care directive?

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

Must I have a health care directive?

No. You don't have to have a health care directive. But writing one helps to make sure your wishes are followed.

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

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

Do I have to use the Blue Cross and Blue Shield of Minnesota advance health care directive form?

No, only if you wish. Other forms are available through hospitals and attorneys. The form provided is for Minnesota use only. Other states have different forms for advance directives.

How do I choose a health care agent?

The person you choose to make the health care decisions for you in the event that you cannot make decisions for yourself is called your health care agent or proxy. Some forms use the term durable power of attorney for health care. The person you choose as your agent should be:

- at least 18 years old (a legal requirement)
- willing to follow your wishes and preferences about your case
- not easily intimidated by medical professionals or the medical system
- able to make difficult, emotional decisions in a time of crisis
- nearby or readily available when needed

You may name anyone to be your agent.

Can I choose more than one health care agent?

You may name one or more people to act as your agents. If you do this, you may identify one person to be the primary agent and the others(s) to be alternate agent(s). Or, you may indicate that you want your agents to act together.

It is very important that you talk to each person you want to name as an agent before you complete your directive so that you can:

- Find out if the person is willing to accept the responsibility
- Tell the person about your wishes and preferences for care

- Be sure the person is willing and able to follow your wishes

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

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

What can I put in a health care directive?

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

- The person or persons you trust as your agent(s) to make health care decisions for you
- Your goals, values and preferences about health care
- The types of medical treatment you would want (or not want)
- How you want your agent or agents to decide
- Where you want to receive care
- Instructions about artificial nutrition and hydration
- Mental health treatments
- Instructions if you are pregnant
- Donations of organs, tissues, and eyes
- Funeral arrangements
- Who you would like as your guardian or conservator if there is a court action

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

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

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

- Your agent must be at least 18 years of age
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reason for the naming of the agent in your directive
- You cannot request health care treatment that is outside of reasonable medical practice
- You cannot request assisted suicide

In my health care directive, can I designate my health care agent to make financial decisions for me?

No. The person you choose as your health care agent can only make health care decisions. If you want to appoint someone to handle your financial or legal affairs, you should consult an attorney.

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

Your health care directive lasts until you change or cancel it. Any changes must meet the health care directive requirements. You may cancel your directive by any of the following:

- Writing a statement saying you want to cancel your existing health care directive
- Destroying your existing health care directive
- Telling at least two other people you want to cancel your existing health care directive
- Writing a new health care directive

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

Your health care provider will generally follow your health care directive or any instructions from your agent, as long as the health care follows reasonable medical practice. However, neither you, nor your agent can request treatment that will not help you or that the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agent to arrange to transfer you to another provider who will follow the agent's directions.

What if I believe Blue Cross and Blue Shield of Minnesota or Blue Plus has not followed health care directive requirements?

Complaints of this type can be filed with the Minnesota Department of Health at:

Health Policy and Systems Compliance
Monitoring Division Manage Care System
P.O. Box 64882
St. Paul, MN 55164-0882
Phone: **(651) 201-5100** or **1-800-657-3916** (This call is free)
TTY **711**

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

You should inform others of your health care directive and give people copies of it. You may wish to inform family members, your health care agent(s) and your health care providers

that you have a health care directive. You should give them a copy. It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.

How can I get more information about health care directives?

You can discuss your health care directive and your wishes with your primary care physician, or if you live in Minnesota, contact the Minnesota Board on Aging at **(651) 431-2500** or toll free at **1-800-882-6262**, TTY Service at **1-800-627-3529** or visit mnaging.org.

Case management

Providers, nurses, social workers, and members or their representative may make a referral to case management by calling the following number:

Phone: **1-800-711-9862, TTY 711**

Case management
Health care can be overwhelming, so we're here to help you stay on top of it. Your case manager will help you:

- Figure out your care plan
- Answer questions
- Help you receive the services you need
- Coordinate with your doctors and support system

If you've experienced a critical event or health issue that is complex, we'll help you learn more about your illness and develop a plan of care through our complex case management program.

Access to complex case management

We use data to find out which members qualify for our complex case management program. You can be referred to complex case management through our:

- 24/7 NurseLine
- Disease Management program
- Discharge planner

- Utilization management
- Member or care giver referral
- Your doctor or other provider

If you have one of these health issues or another complex or special health issue and want to learn more about case management, call Member Services at **1-800-711-9862, TTY 711**, Monday through Friday, 8 a.m. to 5 p.m. Central Time. This call is free.

Condition Care

A Condition Care (CC) program can help you receive more out of life. As part of your Blue Plus benefits, we are here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called CC case managers. They will help you learn how to better manage your condition, or health issue. You can choose to join a CC program at no cost to you.

What programs do we offer?

You can join a CC program to get health care and support services if you have any of these conditions:

- Asthma
- Substance use disorder
- Bipolar disorder
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult
- Major depressive disorder — child and adolescent
- Schizophrenia
- Coronary artery disease (CAD)
- Diabetes

How it works

When you join one of our CC programs, a CC case manager will:

- Help you create health goals and make a plan to reach them.

- Coach you and support you through one-on-one phone calls.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition and/or treatment plan (ways to help health issues).
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your health care providers, like helping you with:
  - Making appointments.
  - Transportation to health care provider visits.
  - Referring you to specialists in our health plan, if needed.
  - Receiving any medical equipment you may need.
- Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco, like quitting smoking).

Our CC team and your primary care provider (PCP) are here to help you with your health care needs.

How to join

We will send you a letter welcoming you to a CC program, if you qualify. Or call us toll free at **1-888-830-4300 (TTY 711)**, Monday through Friday from 8:30 a.m. to 5:30 p.m. local time.

When you call, we will:

- Set you up with a CC case manager to get started
- Ask you some questions about your or your child's health
- Start working together to create your or your child's plan

You can choose to opt out (we will take you out of the program) of the program at any time. Please call us toll free at **1-888-830-4300 (TTY 711)** from 8:30 a.m. to 5:30 p.m. local time, Monday through Friday to opt out. You may also call this number to leave a private message for your CC case manager 24 hours a day.

Access to Utilization Management Staff

If you have Utilization Management (UM) questions, call Member Services at **1-800-711-9862**, **TTY 711**, Monday through Friday from 8 a.m. to 5 p.m. Central Time. This call is free. They can also help if you need help in another language.

You can leave a voice message with UM questions outside of working hours and the UM associate will return your call. The UM associate will identify themselves when initiating or returning calls by their name, title, and health plan name. Communications received after normal business hours are returned on the next business day, and communications received after midnight on Monday – Friday are responded to on the same business day.

UM procedures include, but are not limited to:

- Preservice review
- Urgent concurrent review
- Postservice review
- Filing an appeal

Provider payment methods

Participating Providers

Blue Plus contracts with a large majority of doctors, hospitals, and clinics in Minnesota to be part of its network. Each provider is an independent contractor and is not an agent or employee of Blue Plus. These health care providers are referred to as “Participating Providers.” They have agreed to accept as full payment (less deductibles, coinsurance and copayments) an amount that a Blue Cross and/or Blue Shield plan has negotiated with its participating providers (the “Allowed Amount”). The Allowed Amount may vary from one provider to another for the same service. Several methods are used to pay participating health care providers. If the provider is “participating” they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

Non-Institutional or Professional (i.e., doctor visits, office visits) Provider Payments

- **Fee-for-Service** – Providers are paid for each service or bundle of services. Payment is based on the amount of the provider’s billed charges.
- **Discounted Fee-for-Service** – Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.
- **Discounted Fee-for-Service, Withhold and Bonus Payments** – Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5-20%) of the provider’s payment is withheld. As an incentive to

promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per member per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

- **Minnesota Health Care Programs Fee Schedule** – Providers may be paid at a certain percent of the public program fee schedule. Payment for high-cost cases and preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.

Institutional (i.e., hospital and other facility) Provider Payments

- **Inpatient Care**
- **Payments for each Case (case rate)** – Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
- **Payments for each Day** – Providers are paid a fixed amount for each day the patient spends in the hospital or facility.
- **Percentage of Billed Charges** – Providers are paid a percentage of the hospital's or facility's billed charges for inpatient or outpatient services, including home services.
- **Outpatient Care**
- **Payments for each Category of services** – Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
- **Payments for each Visit** – Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
- **Payments for each Patient** – Providers are paid a fixed amount per patient per calendar year for certain categories of outpatient services.

- **Minnesota Health Care Programs Fee Schedule** – Providers may be paid at a certain percent of the public program fee schedule. The Minnesota Department of Human Services publishes its fee schedule for public programs from time to time.

Pharmacy Payment

Four kinds of pricing are compared and the lowest amount of the four is paid:

- the average wholesale price of the drug, less a discount, plus a dispensing fee; or
- the pharmacy's retail price; or
- the maximum allowable cost we determine by comparing market prices (for generic drugs only); or
- the amount of the pharmacy's billed charge.

Nonparticipating Provider

Generally, there is no coverage for services you receive from a Nonparticipating Provider, that is, a non-network provider. There are certain exceptions to this rule that are described in your Member Handbook. To the extent Blue Plus covers services you receive from a Nonparticipating Provider, payment will be based on a payment methodology Blue Plus uses to pay a similar type of Participating Provider. In certain circumstances, payment may be limited to the Minnesota Health Care Programs Fee Schedule, the amount upon which payment is based for a given covered service of a specific provider.

The Allowed Amount may vary from one provider to another for the same service. All benefits are based on the Allowed Amount, except as noted in the "Benefit Chart."

Blue Plus participates in the Integrated Health Partnership (IHP) program with the MN Department of Human Services. Through the IHP program, providers are given a cost target for an attributed population. Providers who met quality goals may be paid a portion of the savings from reducing the overall total cost of care. This payment methodology incentivizes well-coordinated, high-quality care at lower costs.

The above is a general summary of our provider payment methodologies only. Provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Please note that some of these payment methodologies may not apply to your particular plan. Detailed information about payment allowances for services rendered by Nonparticipating Providers in particular is available on our website at ***bluecrossmn.com****.*

What to do if you get a bill from a provider

In most cases, you should not receive a bill from a provider. But you may have to pay charges if:

- You agreed in writing ahead of time to pay for care that is not offered by us after you asked for an OK from us
- You agreed ahead of time in writing to pay for care from a provider who does not work with us, and you did not receive our OK ahead of time

If you receive a bill and you do not think you should have to pay for the charges, call Member Services at **1-800-711-9862, TTY 711**. This call is free. Have the bill with you when you call and tell us:

- The date of service
- The amount being charged
- Why you're being billed

You can also send a letter saying you have been sent a bill. Send the letter and the bill to the address below:

Claims
Blue Cross and Blue Shield of Minnesota
P.O. Box 982816
El Paso, TX 79998-2816

Sometimes, you may get a statement from a provider that is not a bill. Call us if you have any questions, and we will help determine if you have to pay the bill.

To verify current information or to get more information on a provider, you can call the provider, call Member Services at the phone number in Section 1, or visit our website listed in Section 1.

Women's health and cancer rights

Under the Women's Health and Cancer Rights Act of 1998, health plans are required to provide coverage for breast reconstruction following a mastectomy. The benefit includes:

- reconstruction of the breast on which the mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and

- prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Care is to be coordinated with your primary care physician and is covered under your medical/surgical benefits.

How we protect your privacy

Our privacy rules protect your personal health information. We obey federal and state laws that protect your information, whether on paper, the Internet, by phone, written, electronic or orally. In most cases, we need your approval before we can share your personal medical information. This includes health records, claims data and anything else that identifies you.

You have the right to choose “yes” or “no” when we ask to share your information. If you approve our request, we will describe what we will share. We will tell you how it will be used and how long your consent lasts.

By law, there are cases when we do not need your approval before we share personal information. For example, we can share data with:

- Blue Plus employees or contractors who handle applications and claims
- Providers — if they need to confirm your benefits or if we need to review their work. (We have strict privacy rules with all providers.)
- Health researchers or people doing health plan studies. When we take part in research studies that use your information, we write to you to explain the study. Then you can choose if you want to share information. Please note: Researchers can only see data that does not identify you.

If you can’t sign the form to approve sharing your information, Blue Plus will ask your legally authorized representative (parent, guardian or conservator who holds your power of attorney) to sign. Proof of identity is required.

You can request in writing a copy of your personal health information. However, if your doctor believes that your records are sensitive, we may not share them with you. If you think your privacy rights were violated, or you disagree with a decision regarding your personal health information,
you can:

1. Call the Member Services number on the back of your member ID card.
2. Write to the Blue Plus address on the back of your member ID card.
3. Write to the Minnesota Department of Health:

Minnesota Department of Health
Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882

To learn more about our privacy procedures, go to **bluecrossmn.com** (click on “Legal & Privacy” at the bottom) or call Member Services.

Quality improvement

You deserve high quality medical and behavioral health care. Our Quality Improvement (QI) program reviews the services that you get from our doctors, hospitals and other health care services. This ensures that you receive care that is good quality, helpful and right for you. Your health is important to us, and we believe quality work yields quality results. We make information about our Quality Improvement program available every year on our website and in writing to members upon request. We work hard to make sure you have access to great care.

We do this by:

- Having programs and services to help improve your quality of health care
- Providing learning tools on pregnancy and newborn care for all pregnant members and new moms
- Finding local programs in your community that help you get these services if you need them
- Hosting learning events to answer your questions and concerns and help you make the most of your health care
- Following state and federal guidelines
- Looking at our quality results to find new ways to provide better care

Want to know more about our how our Quality Improvement program works? Call us at **1-800-711-9862, TTY 711**, Monday through Friday, 8 a.m. to 5 p.m. Central Time. This call is free. Ask us to mail you a copy of our program flier. We can also tell you more about the ways we make sure you get quality health care services.

You can review the quality and cost of care, as well. This can help you make the best decisions about your care. Visit these sites online to help you find out more:

The Leapfrog Group — leapfroggroup.org

Hospital Compare — https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Hospital Inpatient Quality Reporting Program — https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program

Your opinion is important to us. You will receive a member satisfaction survey each year to tell us how we're doing. Your answers are anonymous. This information is used to improve our services and your care. If we helped you, please tell us in the survey.

You can also be part of our Community Member Advisory Committee (CMAC). As part of this group, you can tell us your views and ideas to help us understand what our members need. It will also help us to find out how we can improve the quality and cost of health care. For more information about CMAC, call Member Services at **1-800-711-9862, TTY 711**, Monday through Friday, 8 a.m. to 5 p.m., Central Time. This call is free.

Additional rights and responsibilities

You have the right to:

Get information about the health plan, its services, its doctors and other providers and member rights and responsibilities.

Get information about treatments, your treatment choices, and how treatments will help or harm you, regardless of cost or benefit coverage.

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

Candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

Voice complaints or appeals about the organization or the care it provides. Recommendations regarding the organization's member rights and responsibilities policy.

You are responsible for following plans and instructions for care that you have agreed to with your doctors.

We want you to know your rights and responsibilities as a Blue Plus member. We will tell you about them when you enroll and once a year after that. If you have questions about your rights, responsibilities, or how to request information, call Member Services at **1-800-711-9862, TTY 711** (this call is free).

Important information on getting the care you need

Members have access to a Provider Directory that lists the address, phone number, and special training of plan network providers. You may ask for a printed copy of the Provider Directory at any time by calling Member Services at **1-800-711-9862, TTY 711** (this call is free), or by visiting our website at **bluecrossmn.com/publicprograms**.

Making benefit decisions

We care about you and want to help you get the health care you need. We don't give incentives for service denials and we only make decisions based on appropriateness of care and available benefits. Your doctors and other health providers work with you to decide what's best for you and your health. Your doctor may ask us for our OK to pay for a certain health care service. We base our decision on two things:

- Whether or not the care is medically necessary*
- What health care benefits you have

We don't pay or reward doctors or other health care workers to:

- Deny you care
- Say you do not have benefits
- Approve less care than you need

*Medically necessary means we will pay for services needed to:

- Protect your life
- Keep you from getting seriously ill or disabled
- Reduce severe pain through the diagnosis or treatment of disease, illness or injury

These services meet the standards of good medical practice within the organized medical community. To learn more about how medical benefit decisions are made, call Member Services toll free at **1-800-711-9862, TTY 711**, Monday through Friday, 8 a.m. to 5 p.m. Central Time. This call is free.

Fairness is a priority

Know your doctors or your other health care providers cannot treat you differently for these reasons:

- Your age
- Your sex or gender identity
- Your race

- Your national origin
- Your language needs
- The degree of your illness or health condition

Important note

Some hospitals and providers may choose not to perform a service because of their beliefs. They can choose this even if the health care service is an approved service. Some examples are:

- Family planning
- Contraceptive services (includes emergency contraception) to prevent pregnancy
- Sterilization (includes tubal ligation at the time of labor and delivery) to prevent pregnancy
- Infertility treatments (to help a family have children)
- Abortion (choosing to end a pregnancy)

You can find out more before you select a provider. You can call us or the doctor or clinic you plan to use.

New medical treatments

We want you to benefit from new treatments, so we review them on a routine basis. A group of PCPs, specialists and medical directors decide if a treatment:

- Is approved by the government
- Has shown in a reliable study how it affects patients
- Will help patients as much as, or more than, treatments we use now
- Will improve the patient's health

The review group looks at all of the details. The group decides if the treatment is medically necessary. If your doctor asks us about a treatment the review group has not looked at yet, the reviewers will learn about the treatment. They'll let your doctor know if the treatment is medically necessary and if we approve it.

If you are sick or hurt, where do you go?

You do not need a referral to see plan network specialists, or for behavioral health services, and hospital services who are in network. However, your primary care clinic can provide most of the health care services you need and will help coordinate your care.

After-hours care/when your PCP's office is closed

After-hours care is when you have an urgent health issue that you want to discuss with a health practitioner but your provider's office is closed. If you need after-hours care, call your provider to hear what to do when the office is closed. Provider offices have answering machines or answering services to help with after-hours health issues. You may also call 24/7 NurseLine at **888-275-3974, TTY 711**. This is a free call.

Urgent care

An urgent medical condition is not an emergency, but needs medical care within 24 hours. It is not the same as a true emergency. Call your PCP or PCC if your condition is urgent, and you need medical help within 24 hours. If you can't reach your PCP or PCC, call 24/7 NurseLine, even on holidays, at **1-888-275-3974, TTY 711**. This call is free.

Emergency care

An emergency is a medical condition with such severe symptoms that you reasonably believe not getting medical attention right away may be life threatening or cause serious damage to you or your unborn child. If you have an emergency, call 911 or go to the nearest ER.

Call your PCP or PCC within 24 hours after you go to the ER or if you've checked into the hospital. Your PCP will set up a visit with you for follow-up care.

How to find additional information about your benefits and access to medical services

You can visit **bluecrossmn.com/publicprograms** to find information on benefits or medical services you may need including:

- A member handbook that includes your benefits and how to access your benefits and providers
- A provider directory that includes the provider's specialty, address and phone number, professional qualifications, medical school attended, residency completion, and board certification
- How to file a grievance or appeal
- What to do if you get a bill
- How to obtain language assistance or a copy of the member handbook or other member materials in a language other than English