MEMBER HANDBOOK

Health Partners

1-800-553-0784 (TTY: 1-877-454-8477)

Health Partners Plans

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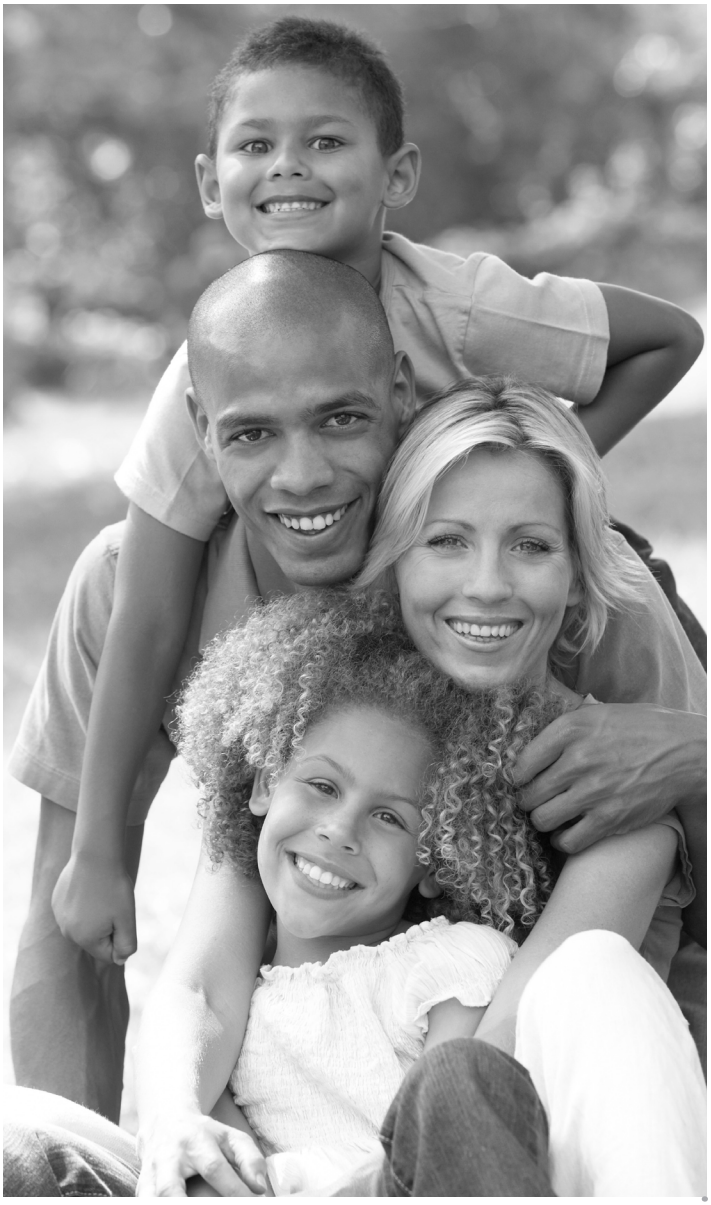


Section – 1
Welcome

Introduction

What is HealthChoices?

HealthChoices is Pennsylvania's Medical Assistance managed care program. The Office of Medical Assistance Programs (OMAP) in Pennsylvania's Department of Human Services (DHS) oversees the physical health portion of HealthChoices. Physical health services are provided through the physical health managed care organizations (PH-MCOs). Behavioral health services are provided through behavioral health managed care organizations (BH-MCOs). For more information on behavioral health services, see page 44.

Welcome to Health Partners (Medicaid)

Health Partners welcomes you as a member in HealthChoices and Health Partners! Health Partners is the health plan that puts your needs first. It has been serving the Medical Assistance population in Bucks, Chester, Delaware, Montgomery and Philadelphia counties since 1985.

We give you the health care benefits you need for you and your family and the quality service you expect — all delivered with the respect you deserve. In fact, Health Partners is consistently one of the highest rated Medicaid plans in Pennsylvania. We will continue to maintain this high level of quality in care and in customer service.

Health Partners has a network of contracted providers, facilities, and suppliers to provide covered physical health services to members. As a Health Partners member, you must use our participating providers, hospitals and pharmacies, in most situations, for all your health care (except if you are out of the area, need emergency care or family planning services). These participating providers include PCPs and specialists and are part of the Health Partners network. We have carefully screened these providers, specialists, hospitals and pharmacies to make sure they work together to give you the health care services you need.

Member Services

Staff at Member Services can help you with:

- Explaining Health Partners operations and benefits
- Assisting members in the selection/changing of a PCP
- Assisting members with making appointments and obtaining services
- Assisting Limited English Proficiency members with interpreter services
- Assisting members with arranging transportation for members through MATP
- Receiving, identifying and fielding emergency member Issues, including educating staff on prohibition in providing health-related advice to members requesting clinical information
- Connecting members to case management services
- Member Rights and Responsibilities

Health Partner's Member Services are available by phone or email:

24 hours a day, 7 days a week

And can be reached at 1-800-553-0784
(TTY: 1-877-454-8477) or contact@hpplans.com.

Member Services can also be contacted in writing at:

Health Partners Plans
901 Market Street, Suite 500
Philadelphia, PA 19107

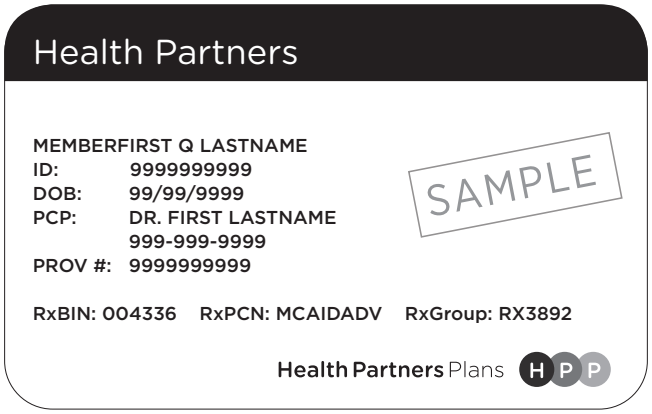
And

Member Walk-in Services are available Monday-Friday, 8:30 a.m. - 4:00 p.m.

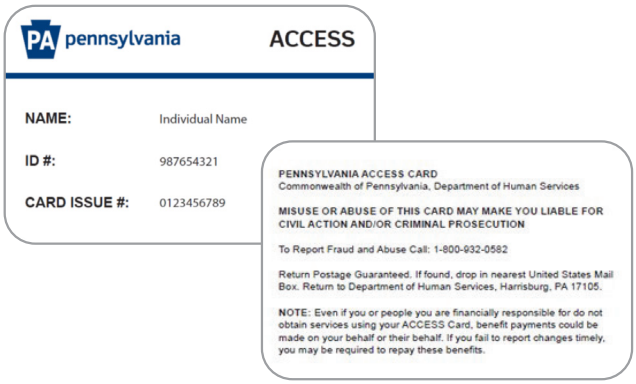
You can also contact us through our member portal, HP Connect, at www.HPPlans.com.

Member Identification Cards

Your Health Partners membership ID card lets everyone know you are a member of Health Partners. The name and telephone number of your PCP are on your card. Your card is important. You must show it when you go for provider visits, to get prescriptions filled and to get other benefits and services. If you do not have your card, your provider can call us. We'll let him or her know that you are a Health Partners member.
If your card is lost or stolen, please call our Member Services department. Someone is available to help you 24 hours a day, seven days a week. You can also order a replacement card via the member portal at www.HPPlans.com. If your card is lost or stolen all services you are receiving will continue and all services will continue to be available while you wait for a new card to be delivered.



You will also get an ACCESS or EBT card. You will need to present this card along with your Health Partners ID card at all appointments. If you lose your ACCESS or EBT card, call your County Assistance Office (CAO). The phone number for the CAO is listed later in the **Important Contact Information** section. You will receive the following card.



Until you get your Health Partners ID card, use your ACCESS or EBT card for your health care services that you get through HealthChoices.

Important Contact Information

The following is a list of important phone numbers you may need. If you are not sure who to call, please contact Member Services for help: 1-800-553-0784 (TTY: 1-877-454-8477).

Emergencies

Please see Section 3, Physical Health Services, beginning on page 16, for more information about emergency services. If you have an emergency, you can get help by going to the nearest emergency department, calling 911, or calling your local ambulance service.

Important Contact Information – At a Glance

Name	Contact Information: Phone or Website	Support Provided
Pennsylvania Department of Human Services Phone Numbers		
County Assistance Office/COMPASS	1-877-395-8930 or 1-800-451-5886 (TTY/TTD) or www.compass.state.pa.us or myCOMPASS PA mobile app for smart phones	Change your personal information for Medical Assistance eligibility. See page 8 of this Handbook for more information.
Fraud and Abuse Reporting Hotline, Department of Human Services	1-844-DHS-TIPS (1-844-347-8477)	Report member or provider fraud or abuse in the Medical Assistance Program. See page 15 of this Handbook for more information.
Other Important Phone Numbers		
Teladoc®	1-800-Teladoc (835-2362) 1-800-877-8973 (TTY)	Talk with a doctor or nurse 24 hours a day, 7 days a week, about urgent health matters. See page 11 of this Handbook for information.
Enrollment Assistance Program	1-800-844-3989 1-800-618-4255 (TTY)	Pick or change a HealthChoices plan. See page 8 of this Handbook for more information.
Insurance Department, Bureau of Consumer Services	1-877-881-6388	Ask for a complaint form, file a complaint, or talk to a consumer services representative.
Protective Services	1-800-490-8505	Report suspected abuse, neglect, exploitation, or abandonment of an adult over age 60 and an adult between age 18 and 59 who has a physical or mental disability.

Other Phone Numbers

Childline	1-800-932-0313

County Assistance Offices

Bucks	215-781-3300
Chester	610-466-1000
Delaware	610-447-5500
Montgomery	610-270-3500
Philadelphia	215-560-7266
Boulevard	215-560-6500
Chelten	215-560-5200
Delancey	215-560-3700
Elmwood	215-560-3800
Glendale	215-560-4600
Liberty	215-560-4000
LTIS	215-560-5500
Ridge/Tioga	215-560-4900
Somerset	215-560-5400
South	215-560-4400
Unity	215-560-6400
West	215-560-6100

Crisis Intervention Services	1-800-499-7455 (Bucks) 1-877-918-2100 (Chester) 1-855-889-7827 (Delaware) 610-279-6100 (Montgomery) 215-686-4420 (Philadelphia)
Legal Aid	1-877-429-5994 (Bucks, Chester, Delaware and Montgomery) 215-227-2400 (Philadelphia)
Medical Assistance Transportation Program	1-888-795-0740 (Bucks) 484-696-3854 (Chester) 610-490-3960 (Delaware) 215-542-7433 (Montgomery) 1-877-835-7412 (Philadelphia)
Mental Health/ Intellectual Disability Services	1-888-565-9435
National Suicide Prevention Lifeline	1-800-273-8255

Communication Services

Health Partners can provide this Handbook and other information you need in languages other than English at no cost to you. Health Partners can also provide your Handbook and other information you need in other formats such as compact disc, Braille, large print, DVD, electronic communication, and other formats if you need them, at no cost to you. Please contact Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) to ask for any help you need. Depending on the information you need, it may take up to 5 business days for Health Partners to send you the information.

Health Partners will also provide an interpreter, including for American Sign Language or TTY services, if you do not speak or understand English or are deaf or hard of hearing. These services are available at no cost to you. If you need an interpreter, call Member Services at 1-800-553-0784 and Member Services will connect you with the interpreter service that meets your needs. For TTY services, call our specialized number at 1-877-454-8477 or call Member Services who will connect you to the next available TTY line.

If your PCP or other provider cannot provide an interpreter for your appointment, Health Partners will provide one for you. Call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) if you need an interpreter for an appointment.

Enrollment

In order to get services in HealthChoices, you need to stay eligible for Medical Assistance. You will get paperwork or a phone call about renewing your eligibility. It is important that you follow instructions so that your Medical Assistance does not end. If you have questions about any paperwork you get or if you are unsure whether your eligibility for Medical Assistance is up to date, call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or your CAO.

Enrollment Services

The Medical Assistance Program works with the Enrollment Assistance Program (EAP) to help you enroll in HealthChoices. You received information about EAP with the information you received about selecting a HealthChoices plan. Enrollment specialists can give you information about all of the HealthChoices plans available in your area so that you can decide which one is best for you. If you do not pick a HealthChoices plan, a HealthChoices plan will be chosen for you. Enrollment specialists can also help you if you want to change your HealthChoices plan or if you move to another county.

Enrollment specialists can help you:

- Pick a HealthChoices plan
- Change your HealthChoices plan
- Pick a PCP when you first enroll in a HealthChoices plan
- Answer questions about all of the HealthChoices plans
- Determine whether you have special needs, which could help you decide which HealthChoices plan to pick
- Give you more information about your HealthChoices plan

To contact the EAP, call 1-800-844-3989 or 1-800-618-4225 (TTY).

Changing Your HealthChoices Plan

You may change your HealthChoices plan at any time, for any reason. To change your HealthChoices plan, call the EAP at 1-800-844-3989 or 1-800-618-4225 (TTY). They will tell you when the change to your new HealthChoices plan will start, and you will stay in Health Partners until then. It can take up to 6 weeks for a change to your HealthChoices plan to take effect. Use your Health Partners ID card at your appointments until your new plan starts.

Changes in the Household

Call your CAO and Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) if there are any changes to your household.

For example:

- Someone in your household is pregnant or has a baby
- Your address or phone number changes
- You or a family member who lives with you gets other health insurance
- You or a family member who lives with you gets very sick or becomes disabled
- A family member moves in or out of your household
- There is a death in the family

A newborn baby is automatically assigned to the mother's current HealthChoices plan. You may change your baby's plan by calling the EAP at 1-800-844-3989. Once the change is made you will receive a new HealthChoices member ID card for your baby.

Remember that it is important to call your CAO right away if you have any changes in your household because the change could affect your benefits.

What Happens if I Move?

If you move out of your county you may need to choose a new HealthChoices plan. Contact your CAO if you move. If Health Partners also serves your new county you can stay with Health Partners. If Health Partners does not serve your new county, the EAP can help you select a new plan.

If you move out of state, you will no longer be able to get services through HealthChoices. Your caseworker will end your benefits in Pennsylvania. You will need to apply for benefits in your new state.

Loss of Benefits

There are a few reasons why you may lose your benefits completely.

They include:

- Your Medical Assistance ends for any reason. If you are eligible for Medical Assistance again within 6 months, you will be re-enrolled in the same HealthChoices plan unless you pick a different HealthChoices plan.
- You go to a nursing home outside of Pennsylvania.
- You have committed Medical Assistance fraud and have finished all appeals.
- You go to prison or are placed in a youth development center.

There are also reasons why you may no longer be able receive services through a physical health MCO and you will be placed in the fee-for-service program.

They include:

- You are placed in a juvenile detention center for more than 35 days in a row.
- You are 21 years of age or older and begin receiving Medicare Part D (Prescription Drug Coverage).
- You go to a state mental health hospital.

You may also become eligible for Community HealthChoices. If you become eligible for Medicare coverage or become eligible for nursing facility or home and community based services, you will be eligible for Community HealthChoices. For more information on Community HealthChoices visit www.healthchoices.pa.gov.

You will receive a notice from DHS if you lose your benefits or if you are no longer able to receive services through a physical health MCO and will begin to receive services through the fee-for-service system or Community HealthChoices.

Information About Providers

The Health Partners' provider directory has information about the providers in Health Partners' network. The provider directory is located online here: www.HPPlans.com/providers/resources. You may call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) to ask that a copy of the provider directory be sent to you or to request information about where a doctor went to medical school or their residency program.

You may also call Member Services to get help finding a provider. The provider directory includes the following information about network providers:

- Name, address, website address, email address, telephone number
- Whether or not the provider is accepting new patients
- Days and hours of operation
- The provider's credentials and board certifications
- The provider's specialty and services offered by the provider
- Whether or not the provider speaks languages other than English and, if so, which languages
- Whether or not the provider locations are wheelchair accessible

*The information in the printed directory may change. You can call Member Services to check if the information in the provider directory is current. Health Partners updates the printed provider directory every month. The online directory is updated at least monthly.

Picking Your Primary Care Provider (PCP)

Your PCP is the doctor or doctors' group who provides and works with your other health care providers to make sure you get the health care services you need. Your PCP refers you to specialists you need and keeps track of the care you get by all of your providers.

A PCP may be a family doctor, a general practice doctor, a pediatrician (for children and teens), or an internist (internal medicine doctor). You may also pick a certified registered nurse practitioner (CRNP) as a PCP. A CRNP works under the direction of a doctor and can do many of the same things a doctor can do such as prescribing medicine and diagnosing illnesses.

Some doctors have other medical professionals who may see you and provide care and treatment under the supervision of your PCP.

Some of these medical professionals may be:

- Physician Assistants
- Medical Residents
- Certified Nurse-Midwives

If you have Medicare, you can stay with the PCP you have now even if your PCP is not in Health Partners' network. If you do not have Medicare, your PCP must be in Health Partners' network.

If you have special needs, you can ask for a specialist to be your PCP. The specialist needs to agree to be your PCP and must be in Health Partners' network.

Enrollment specialists can help you pick your first PCP with Health Partners. If you do not pick a PCP through the EAP within 14 days of when you picked Health Partners, Health Partners will pick your PCP for you.

Changing Your PCP

If you want to change your PCP for any reason, call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) to ask for a new PCP. If you need help finding a new PCP, you can go to www.HPPlans.com, which includes a provider directory, or ask Member Services to send you a printed provider directory.

Health Partners will send you a new ID card with the new PCP's name and phone number on it. The Member Services representative will tell you when you can start seeing your new PCP.

When you change your PCP, Health Partners can help coordinate sending your medical records from your old PCP to your new PCP. In emergencies, Health Partners will help to transfer your medical records as soon as possible.

If you have a pediatrician or pediatric specialist as a PCP, you may ask for help to change to a PCP who provides services for adults.

Office Visits

Making an Appointment with Your PCP

To make an appointment with your PCP, call your PCP's office. If you need help making an appointment, please call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

If you need help getting to your doctor's appointment, please see the Medical Assistance Transportation Program (MATP) section on page 38 of this Handbook or call Health Partners Member Services at the phone number above.

If you do not have your Health Partners ID card by the time of your appointment, take your ACCESS card with you. You should also tell your PCP that you selected Health Partners as your HealthChoices plan.

Appointment Standards

Health Partners' providers must meet the following appointment standards:

- Your PCP should see you within 10 business days of when you call for a routine appointment.
- You should not have to wait in the waiting room longer than 30 minutes, unless the doctor has an emergency.
- If you have an urgent medical condition, your provider should see you within 24 hours of when you call for an appointment.
- If you have an emergency, the provider must see you immediately or refer you to an emergency room.
- If you are pregnant and
  - In your first trimester, your provider must see you within 10 business days of Health Partners learning you are pregnant.
  - In your second trimester, your provider must see you within 5 business days of Health Partners learning you are pregnant.
  - In your third trimester, your provider must see you within 4 business days of Health Partners learning you are pregnant.
  - Have a high-risk pregnancy, your provider must see you within 24 hours of Health Partners learning you are pregnant.

Referrals

A referral is when your PCP sends you to a specialist. A specialist is a doctor (or a doctor's group) or a CRNP who focuses his or her practice on treating one disease or medical condition or a specific part of the body. If you go to a specialist without a referral from your PCP, you may have to pay the bill.

If Health Partners does not have at least 2 specialists in your area and you do not want to see the specialist in your area, Health Partners will work with you to see an out-of-network specialist at no cost to you. Your PCP must contact Health Partners to let us know you want to see an out-of-network specialist and get approval from Health Partners before you see the specialist.

Your PCP will help you make the appointment with the specialist. The PCP and the specialist will work with you and with each other to make sure you get the health care you need.

Sometimes you may have a special medical condition where you need to see the specialist often. When your PCP refers you for several visits to a specialist, this is called a standing referral.

For a list of specialists in Health Partners' network, please see the provider directory on our website at www.HPPlans.com/members/health-partners/find-a-doctor or call Member Services to ask for a printed provider directory.

Self-Referrals

Self-referrals are services you arrange for yourself and do not require that your PCP arrange for you to receive the service. You must use a Health Partners' network provider unless Health Partners approves an out-of-network provider.

The following services do not require referral from your PCP:

- Prenatal visits
- Routine obstetric (OB) care
- Routine gynecological (GYN) care
- Routine family planning services (may see out-of-network provider without approval)
- Routine dental services
- Routine eye exams
- Emergency services

You do not need a referral from you PCP for behavioral health services. You can call your behavioral health managed care organization for more information. Please see section 7 of the Handbook, on page 44 for more information.

After-Hours Care

You can call your PCP for non-emergency medical problems 24 hours a day, 7 days a week. On-call health care professionals will help you with any care and treatment you need.

Health Partners works with Teladoc to connect you with doctors who can help you with many non-emergency medical conditions. Teladoc is a toll-free advice line at 1-800-Teladoc (835-2362), 1-800-877-8973 (TTY) that you can also call 24 hours a day, 7 days a week. A doctor or nurse will talk with you about your urgent health matters.

Member Engagement

Suggesting Changes to Policies and Services

Health Partners would like to hear from you about ways to make your experience with HealthChoices better. If you have suggestions for how to make the program better or how to deliver services differently, please contact Health Partners at 1-800-553-0784 (TTY: 1-877-454-8477).

Health Partners Health Education Advisory Committee (HEAC)

Health Partners has a Health Education Advisory Committee (HEAC) that includes members and network providers. The Committee provides advice to Health Partners about the experiences and needs of members like you. For more information about the Committee, please call 215-967-4514, email CommEd@HPPlans.com or visit the website at www.HPPlans.com/in-the-community.

Health Partners Quality Improvement Program

HPP has a program that includes home health care visits directly relating to a special health care need for our medically complex children and adults. These services are provided once approved for medical necessity in coordination with the member's requesting provider.

Section – 2
Rights and Responsibilities

Member Rights and Responsibilities

Health Partners and its network of providers do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

As a Health Partners member, you have the following rights and responsibilities.

Member Rights

You have the right:

1. To be treated with respect, recognizing your dignity and need for privacy, by Health Partners staff and network providers.
2. To get information in a way that you can easily understand and find help when you need it.
3. To get information that you can easily understand about Health Partners, its services, and the doctors and other providers that treat you.
4. To pick the network health care providers that you want to treat you.
5. To get emergency services when you need them from any provider without Health Partners' approval.
6. To get information that you can easily understand and talk to your providers about your treatment options, risks of treatment and test that may be self-administered, without any interference from Health Partners.
7. To make all decisions about your health care, including the right to refuse treatment. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.
8. To talk with providers in confidence and to have your health care information and records kept confidential.
9. To see and get a copy of your medical records and to ask for changes or corrections to your records.
10. To ask for a second opinion.
11. To file a grievance if you disagree with Health Partners' decision that a service is not medically necessary for you.

12. To file a complaint if you are unhappy about the care or treatment you have received.
13. To ask for a DHS Fair Hearing.
14. To be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.
15. To get information about services that Health Partners or a provider does not cover because of moral or religious objections and about how to get those services.
16. To exercise your rights without it negatively affecting the way DHS, Health Partners, and network providers treat you.
17. To create an advance directive. See Section 6 on page 42 for more information.
18. To make recommendations about the rights and responsibilities of Health Partners' members.

Member Responsibilities

Members need to work with their health care service providers. Health Partners needs your help so that you get the services and supports you need.

These are the things you should do:

1. Provide, to the extent you can, information needed by your providers.
2. Follow instructions and guidelines given by your providers.
3. Be involved in decisions about your health care and treatment.
4. Work with your providers to create and carry out your treatment plans.
5. Tell your providers what you want and need.
6. Learn about Health Partners coverage, including all covered and non-covered benefits and limits.
7. Use only network providers unless Health Partners approves an out-of-network provider or you have Medicare.
8. Get a referral from your PCP to see a specialist.
9. Respect other patients, provider staff, and provider workers.
10. Make a good-faith effort to pay your co-payments.
11. Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

Privacy and Confidentiality

Health Partners must protect the privacy of your protected health information (PHI). Health Partners must tell you how your PHI may be used or shared with others. This includes sharing your PHI with providers who are treating you or so that Health Partners can pay your providers. It also includes sharing your PHI with DHS. This information is included in Health Partners' Notice of Privacy Practices. To get a copy of Health Partners' Notice of Privacy Practices, please call 1-800-553-0784 (TTY: 1-877-454-8477), email PrivacyOfficial@HPPlans.com or visit www.HPPlans.com/privacy-practices

Co-payments

A co-payment is the amount you pay for some covered services. It is usually only a small amount. You will be asked to pay your co-payment when you get the service, but you cannot be denied a service if you are not able to pay a co-payment at that time. If you did not pay your co-payment at the time of the service, you may receive a bill from your provider for the co-payment.

Co-payment amounts can be found in the Covered Services chart on page 17 of this Handbook.

The following members do not have to pay co-payments:

- Members under age 18 (under 21 for prescriptions)
- Pregnant women (including 60 days after the child is born: the post-partum period)
- Members who live in a long-term care facility, including Intermediate Care Facilities for the Intellectually Disabled and Other Related Conditions or other medical institution
- Members who live in a personal care home or domiciliary care home
- Members eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program
- Members eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance

The following services do not require a co-payment:

- Emergency services
- Laboratory services
- Family planning services, including supplies
- Hospice services
- Home health services
- Tobacco cessation services

What if I Am Charged a Co-payment and I Disagree?

If you believe that a provider charged you the wrong amount for a co-payment or for a co-payment you believe you should not have had to pay, you can file a Complaint with Health Partners. Please see Section 8, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint, or call Member Services at 1-800-553-0874 (TTY: 1-877-454-8477).

Billing Information

Providers in Health Partners' network may not bill you for medically necessary services that Health Partners covers. Even if your provider has not received payment or the full amount of his or her charge from Health Partners, the provider may not bill you. This is called balance billing.

When Can a Provider Bill Me?

Providers may bill you if:

- You did not pay your co-payment.
- You received services from an out-of-network provider without approval from Health Partners and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received services that is not covered by Health Partners and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received a service from a provider that is not enrolled in the Medical Assistance Program.

What Do I Do if I Get a Bill?

If you get a bill from a Health Partners network provider and you think the provider should not have billed you, you can call Member Services at 1-800-553-0874 (TTY: 1-877-454-8477).

Open it right away. Do not pay it. Just write "Health Partners" and your Health Partners identification number from your ID card on the bill. Mail the bill back to the office that sent it to you. The address of the office is usually in the upper left-hand corner or lower right-hand corner of the bill.

If you get a bill from a provider for one of the above reasons that a provider is allowed to bill you, you should pay the bill or call the provider.

Third-Party Liability

You may have Medicare or other health insurance. Medicare or your other health insurance is your primary insurance. This other insurance is known as "third party liability" or TPL. Having other insurance does not affect your Medical Assistance eligibility. In most cases, your Medicare or other insurance will pay your PCP or other provider before Health Partners pays. Health Partners can only be billed for the amount that your Medicare or other health insurance does not pay.

You must tell both your CAO and Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) if you have Medicare or other health insurance. When you go to a provider or to a pharmacy, you must tell the provider or pharmacy about all forms of medical insurance you have and show the provider or pharmacy your Medicare card or other insurance care, ACCESS or EBT card, and your Health Partners ID card. This helps make sure your health care bills are paid timely and correctly.

Coordination of Benefits

If you have Medicare and the service or other care you need is covered by Medicare, you can get care from any Medicare provider you pick. The provider does not have to be in Health Partners' network. You also do not have to get prior authorization from Health Partners or referrals from your Medicare PCP to see a specialist. Health Partners will work with Medicare to decide if it needs to pay the provider after Medicare pays first, if the provider is enrolled in the Medical Assistance Program.

If you need a service that is not covered by Medicare but is covered by Health Partners, you must get the service from a Health Partners network provider. All Health Partners rules, such as prior authorization and specialist referrals, apply to these services.

If you do not have Medicare but you have other health insurance and you need a service or other care that is covered by your other insurance, you must get the service from a provider that is in both the network of your other insurance and Health Partners' network. You need to follow the rules of your other insurance and Health Partners, such as prior authorization and specialist referrals. Health Partners will work with your other insurance to decide if it needs to pay for the services after your other insurance pays the provider first.

If you need a service that is not covered by your other insurance, you must get the services from a Health Partners network provider. All Health Partners rules, such as prior authorization and specialist referrals, apply to these services.

Recipient Restriction/Lock-in Program

The Recipient Restriction/Member Lock-In Program requires a member to use specific providers if the member has abused or overused his or her health care or prescription drug benefits. Health Partners works with DHS to decide whether to limit a member to a doctor, pharmacy, hospital, dentist, or other provider.

How Does it Work?

Health Partners reviews the health care and prescription drug services you have used. If Health Partners finds overuse or abuse of health care or prescription services, Health Partners asks DHS to approve putting a limit on the providers you can use. If approved by DHS, Health Partners will send you a written notice that explains the limit.

You can pick the providers, or Health Partners will pick them for you. If you want a different provider than the one Health Partners picked for you, call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477). The limit will last for 5 years even if you change HealthChoices plans.

If you disagree with the decision to limit your providers, you may appeal the decision by asking for a DHS Fair Hearing, within 30 days of the date of the letter telling you that Health Partners has limited your providers.

You must sign the **written** request for a Fair Hearing and send it to:

Department of Human Services
Office of Administration
Bureau of Program Integrity - DPPC
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

If you need help asking for a Fair Hearing, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or contact your local legal aid office.

If your appeal is postmarked within 10 days of the date on Health Partners' notice, the limits will not apply until your appeal is decided. If your appeal is postmarked more than 10 days but within 30 days from the date on the notice, the limits will be in effect until your appeal is decided. The Bureau of Hearings and Appeals will let you know, in writing, of the date, time, and place of your hearing. You may not file a Grievance or Complaint through Health Partners about the decision to limit your providers.

After 5 years, Health Partners will review your services again to decide if the limits should be removed or continued and will send the results of its review to DHS. Health Partners will tell you the results of the review in writing.

Reporting Fraud or Abuse

How Do I Report Member Fraud or Abuse?

If you think that someone is using your or another member's Health Partners card to get services, equipment, or medicines, is forging or changing their prescriptions, or is getting services they do not need, you can call the Health Partners Fraud and Abuse Hotline at 1-866-477-4848 (TTY: 1-877-454-8477), email compliance@hpplans.com or use the EthicsPoint online reporting tool at hpplans.ethicspoint.com to give Health Partners this information. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

How Do I Report Provider Fraud or Abuse?

Provider fraud is when a provider bills for services, equipment, or medicines you did not get or bills for a different service than the service you received. Billing for the same service more than once or changing the date of the service are also examples of provider fraud. To report provider fraud you can call the Health Partners Fraud and Abuse Hotline at 1-866-477-4848 (TTY: 1-877-454-8477), email compliance@hpplans.com or via the EthicsPoint online reporting tool at hpplans.ethicspoint.com. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

Section 3 – Physical Health Services

Covered Services

The chart below lists the services that are covered by Health Partners when the services are medically necessary. Some of the services have limits or co-payments, or need a referral from your PCP or require prior authorization by Health Partners. If you need services beyond the limits listed below, your provider can ask for an exception, as explained later in this section. Limits do not apply if you are under age 21 or pregnant.

Service		Children	Adults
Primary Care Provider	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Specialist	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Certified Registered Nurse Practitioner	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Federally Qualified Health Center/Rural Health Center	Limit	No limits	No limits
	Co-payment	No	No
	Prior Authorization/Referral	No	No
Outpatient Non-Hospital Clinic	Limit	No limits	No limits
	Co-payment	$0	$1
	Prior Authorization/Referral	No	No
Outpatient Hospital Clinic	Limit	No limits	No limits
	Co-payment	$0	$1
	Prior Authorization/Referral	No	No
Podiatrist Services	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Chiropractor Services	Limit	No limits	No limits
	Co-payment	$0	$1
	Prior Authorization/Referral	Yes	Yes
Optometrist Services	Limit	2 exams per calendar year (or more if medically necessary)	2 exams per calendar year
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Hospice Care	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes	Yes
Respite Care (related to hospice)	Limit	5 days covered every 60 certified days	5 days covered every 60 certified days
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes	Yes

Service		Children	Adults
Dental Care Services	Limit	Routine dental care and braces if medically necessary	Routine dental care and annual allowance for some procedures, limits apply
	Co-payment	$0	$0
	Prior Authorization/Referral	Prior Authorization may be required based on dental procedure	Prior Authorization may be required based on dental procedure
Radiology (ex. X-rays, MRIs, CTs)	Limit	No limits	No limits
	Co-payment	$0	$1
	Prior Authorization/Referral	Required for CT/ PET/MRI and other high-tech services	Required for CT/ PET/MRI and other high-tech services
Outpatient Hospital Short Procedure Unit	Limit	No limits	No limits
	Co-payment	$0	$3
	Prior Authorization/Referral	No	No
Outpatient Ambulatory Surgical Center	Limit	No limits	No limits
	Co-payment	$0	$3
	Prior Authorization/Referral	No	No
Non-Emergency Medical Transport *(Only to and from Medical Assistance covered services)*	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes	Yes
Family Planning Services	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
EPSDT Services	Limit	No limits	Not Covered
	Co-payment	$0	
	Prior Authorization/Referral	No	
Renal Dialysis	Limit	No limits for outpatient and in-home dialysis	No limits for outpatient and in-home dialysis
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Emergency Services	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Urgent Care Services	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No

Service		Children	Adults
Ambulance Services	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Inpatient Hospital	Limit	No limits	No limits
	Co-payment	$0	$3 per day up to $21 per stay
	Prior Authorization/Referral	Yes	Yes
Inpatient Rehab Hospital	Limit	No limits	No limits
	Co-payment	$0	$3 per day up to $21 per stay
	Prior Authorization/Referral	Yes	Yes
Gender Confirmation Services and Surgery	Limit	No limits	No limits
	Co-payment	$0	Co-pay applies for inpatient services
	Prior Authorization/Referral	Yes	Yes
Maternity Care	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Prescription Drugs	Limit	No limits	No limits
	Co-payment *(Some drugs do not have a copay.)*	$0	$1 generic $3 brand *(Begins at age 21.)*
	Prior Authorization/Referral	Prior Authorization may apply	Prior Authorization may apply
Nutritional Supplements	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	Prior Authorization required if over $500	Prior Authorization required if over $500
Enteral Parenteral Nutritional Supplements	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes, if over $500	Yes, if over $500
Nursing Facility Services	Limit	30 days (stays longer than 30 consecutive days are covered under Medical Assistance Fee-for-Service, not Health Partners	30 days (stays longer than 30 consecutive days are covered under Medical Assistance Fee-for-Service, not Health Partners
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes	Yes

Service		Children	Adults
Home Health Care, including Nursing Aide, and Therapy Services	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes	Yes
Durable Medical Equipment	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes, if over $500	Yes, if over $500
Prosthetics and Orthotics	Limit	No limits	Low vision aids and eye ocular limited to one per every two calendar years
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes over $500	Yes over $500
Eyeglass Lenses	Limit	Up to 4 lenses per calendar year (More are available if medically necessary.)	Lenses covered only for aphakia or cataracts: Up to 4 lenses per calender year or more if medically necessary
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Eyeglass Frames	Limit	2 pairs of eyewear per year: May include two pairs of eyeglasses, two pairs of contact lenses, or one pair of each (one pair of eyeglasses and one pair of contact lenses)	Eyeglasses covered only for aphakia or cataracts: Up to 2 frames per calendar year or more if medically necessary
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Contact Lenses	Limit	2 pairs of eyewear per year: May include two pairs of eyeglasses, two pairs of contact lenses, or one pair of each (one pair of eyeglasses and one pair of contact lenses)	Contact lenses covered only for aphakia or cataracts: 4 lenses per calendar year
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No

Service		Children	Adults
Medical Supplies	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	Required over $500	Required over $500
Therapy (Physical, Occupational, Speech)	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	Yes	Yes
Laboratory	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Tobacco Cessation	Limit	No limits	No limits
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Fitness Center	Limit	Must complete 6 visits in the first 90 days	Must complete 12 visits in the first 90 days
	Co-payment	No	$2 first 12 visits, $0 afterward
	Prior Authorization/Referral	No	No

Services That Are Not Covered

There are physical health services that Health Partners does not cover. If you have any questions about whether or not Health Partners covers a service for you, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

MCOs may not cover experimental medical procedures, medicines, and equipment.

Second Opinions

You have the right to ask for a second opinion if you are not sure about any medical treatment, service, or non-emergency surgery that is suggested for you. A second opinion may give you more information that can help you make important decisions about your treatment. A second opinion is available to you at no cost other than a co-pay.

Call your PCP to ask for the name of another Health Partners network provider to get a second opinion. If there are not any other providers in Health Partners' network, you may ask Health Partners for approval to get a second opinion from an out-of-network provider.

What is Prior Authorization?

Some services or items need approval from Health Partners before you can get the service. This is called prior authorization. For services that need prior authorization, Health Partners decides whether a requested service is medically necessary before you get the service. You or your provider must make a request to Health Partners for approval before you get the service.

What Does Medically Necessary Mean?

Medically necessary means that a service, item, or medicine does one of the following:

- It will, or is reasonably expected to, prevent an illness, condition, or disability;
- It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
- It will help you to get or keep the ability to perform daily tasks, taking into consideration both your abilities and the abilities or someone of the same age.

If you need any help understanding when a service, item, or medicine is medically necessary or would like more information, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Utilization Review Process

Utilization Management (UM) is how health plans make sure members get the right care at the right time. UM helps prevent over treatment of our members, as well as helping them get the care they need. HPP utilization management decisions are based only on how appropriate the care is and to make sure the care is covered. Health Partners never offers incentives to reduce or deny access to needed care. We do not reward doctors or other individuals for encouraging members to not get treatment and service.

The Health Partners UM department reviews and evaluates all aspects of members' care, including preventive care and medical treatments. Health Partners does these reviews prior to members getting services and after services have been provided. Health Partners looks for how severe the member's condition is and how much and how long medical services are being requested for members.

All of this is done to improve the quality and appropriateness of care and service provided to Health Partners' members.

What Services, Items, or Medicines Need Prior Authorization?

The following chart identifies some, but not all services, items and medicines that require prior authorization.

Services that require prior authorization include, but are not limited to:	You may also need to receive approval or prior authorization to receive certain medications. The following kinds of medications may require prior authorization:
• All scheduled hospital admissions and acute rehab admissions • CT scans, MRIs, PETs and certain other radiology services when received as an outpatient and not an emergency • Durable medical equipment like wheelchairs, and hospital beds • Medical oncology (chemotherapy) services • Nurse visits and other home health services • Physical/occupational/speech therapy	• Medications not on the state-wide preferred drug list or benefit exceptions required by medical necessity • Medications and/or treatments under clinical investigation • Medications used for non-FDA approved uses • Medications that exceed $1,000 per claim • All brand name medications when there is an A-rated generic equivalent available • Prescriptions that exceed plan limits (day's supply, quantity or cost) • Prescriptions processed by non-network pharmacies • New-to-market products • Medications that have treatment guidelines approved by our Pharmacy and Therapeutics Committee • Orphan drugs • Selected injectable products (self-administered and/or physician office administration)

For those services that have limits, if you or your provider believes that you need more services than the limit on the service allows, you or your provider can ask for more services through the prior authorization process.

If you are or your provider is unsure about whether a service, item, or medicine requires prior authorization, call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Prior Authorization of a Service or Item

Health Partners will review the prior authorization request and the information you or your provider submitted. Health Partners will tell you of its decision within 2 business days of the date Health Partners received the request if Health Partners has enough information to decide if the service or item is medically necessary.

If Health Partners does not have enough information to decide the request, we must tell your provider within 48 hours of receiving the request that we need more information to decide the request and allow 14 days for the provider to give us more information. Health Partners will tell you of our decision within 2 business days after Health Partners receives the additional information.

You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

Prior Authorization of Outpatient Drugs

Health Partners will review a prior authorization request for outpatient drugs, which are drugs that you do not get in the hospital, within 24 hours from when Health Partners gets the request. You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

If you go to a pharmacy to fill a prescription and the prescription cannot be filled because it needs prior authorization, the pharmacist will give you a temporary supply unless the pharmacist thinks the medicine will harm you. If you have not already been taking the medicine, you will get a 72-hour supply. If you have already been taking the medicine, you will get a 15-day supply. Your provider will still need to ask Health Partners for prior authorization as soon as possible.

The pharmacist will not give you the 15-day supply for a medicine that you have been taking if you get a denial notice from Health Partners 10 days before your prescription ends telling you that the medicine will not be approved again and you have not filed a Grievance.

What if I Receive a Denial Notice?

If Health Partners denies a request for a service, item, or drug or does not approve it as requested, you can file a Complaint or a Grievance. If you file a Complaint or a Grievance for denial of an ongoing medication, Health Partners must authorize the medication until the Complaint or Grievance is resolved. See Section 8, Complaints, Grievances, and Fair Hearings, starting on page 46 of this Handbook for detailed information on Complaints and Grievances.

Program Exception Process

For those services that have limits, if you or your provider believes that you need more services than the limits on the service allows, you or your provider can ask for a program exception (PE). The PE process is different from the Dental Benefit Limit Exception process described on page 26.

To ask for a PE, your or your provider can call the Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or send a request to:

Health Partners Plans
Member Services
501 Market Street, Suite 500
Philadelphia, PA 19107

PE requests must include the following information:

- Your name
- Your address
- Your phone number
- The service you need
- The reason you need the service
- Your provider's name
- Your provider's phone number

Service Descriptions

Emergency Services

Emergency services are services needed to treat or evaluate an emergency medical condition. An emergency medical condition is an injury or illness that is so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person's life or long-term health. If you have an emergency medical condition, go to the nearest emergency room, dial 911, or call your local ambulance provider. You **do not** have to get approval from Health Partners to get emergency services and you may use any hospital or other setting for emergency care.

Below are some examples of emergency medical conditions and non-emergency medical conditions:

Emergency medical conditions

- Heart attack
- Chest pain
- Severe bleeding
- Intense pain
- Unconsciousness
- Poisoning

Non-emergency medical conditions

- Sore throat
- Vomiting
- Cold or flu
- Backache
- Earache
- Bruises, swelling, or small cuts

If you are unsure if your condition requires emergency services, call your PCP or Teladoc at 1-800-Teladoc (TTY: 1-800-877-8973), 24 hours a day, 7 days a week.

Emergency Medical Transportation

Health Partners covers emergency medical transportation by an ambulance for emergency medical conditions. If you need an ambulance, call 911 or your local ambulance provider. Do not call MATP (described on page 38 of this Handbook) for emergency medical transportation.

Urgent Care

Health Partners covers urgent care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition. This is when you need attention from a doctor, but not in the emergency room.

If you need urgent care, but you are not sure if it is an emergency, call your PCP or Teladoc at 1-800-Teladoc (TTY: 1-800-877-8973), 24 hours a day, 7 days a week

first. Your PCP or a Teladoc doctor or nurse will help you decide if you need to go to the emergency room, the PCP's office, or an urgent care center near you. In most cases if you need urgent care, your PCP will give you an appointment within 24 hours. If you are not able to reach your PCP or your PCP cannot see you within 24 hours and your medical condition is not an emergency, you may also visit an urgent care center or walk-in clinic within Health Partners' network. Prior authorization is not required for services at an urgent care center.

Some examples of medical conditions that may need urgent care include:

- Vomiting
- Coughs and fever
- Sprains
- Rashes
- Earaches
- Diarrhea
- Sore throats
- Stomach aches

If you have any questions, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Dental Care Services

Dental care services are provided by an outside vendor. If you have questions, please contact Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Members Under 21 Years of Age

Health Partners provides all medically necessary dental services for children under 21 years of age. Children may go to a participating dentist within the Health Partners network.

Dental visits for children do not require a referral. If your child is 1 year old or older and does not have a dentist, you can ask your child's PCP to refer your child to a dentist for regular dental checkups. For more information on dental services, contact Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Dental services that are covered for children under the age of 21 include the following, when medically necessary:

- Anesthesia
- Checkups
- Cleanings
- Crowns
- Dental emergencies
- Dental surgical procedures
- Dentures
- Extractions (tooth removal)
- Fillings
- Fluoride treatments (these can also be performed by some CRNPs and physicians)
- Orthodontics (braces)*
- Periodontal services
- Root canals
- Sealants
- X-rays

There are no copays for the above services and prior authorization is required.

Your child's PCP may be able to apply fluoride treatments as well. For more information, just ask your child's PCP.

**If braces were put on before the age of 21, Health Partners will continue to cover services until treatment for braces is completed or age 23, whichever comes first, as long as the member remains with Health Partners. If the member changes to another Managed Care Organization (MCO), coverage will be provided by that MCO.*

For more information on your child's dental benefits, please call our Member Services department at 1-800-553-0784 (TTY: 1-877-454-8477).

Members 21 Years of Age and Older

Health Partners covers some dental benefits for members 21 years of age and older through dentists in the Health Partners network. Some dental services have limits.

Adult Health Partners members are eligible for the following dental services, when medically necessary:

- Anesthesia
- Checkups
- Cleanings

- Dental emergencies
- Dental surgical procedures
- Dentures
- Extractions (tooth removal)
- Fillings
- X-rays

There are no copays for the above services and prior authorization is required.

The following limits apply for adult members for the dental benefits listed above:

- You can get one dental exam and one cleaning every six months by a Health Partners participating dentist.
- In your lifetime, you can get:
  - One partial upper denture or one full upper denture.
  - One partial lower denture or one full lower denture.

If you got a partial or full upper and/or lower denture paid by the Medical Assistance program since April 27, 2015, you can get another one only if you get special approval called a benefit limit exception.

Adult members can request a benefit limit exception for additional dental services. If approved, Health Partners will cover these additional dental services for adults:

- Crowns and similar services
- Periodontal services
- Root canals or other endodontic services

These limits do not apply to you if you live in a nursing home or an intermediate care facility.

Dental Benefit Limit Exception

Some dental services are only covered with a Benefit Limit Exception (BLE). You or your dentist can also ask for a BLE if you or your dentist believes that you need more dental services than the limits allow.

Health Partners will approve a BLE if:

- You have a serious or chronic illness or health condition and without the additional service your life would be in danger; OR
- You have a serious or chronic illness or health condition and without the additional service your health would get much worse; OR
- You would need more expensive treatment if you do not get the requested service; OR
- It would be against federal law for Health Partners to deny the exception.

To ask for a BLE before you receive the service, you or your dentist can call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or send the request to:

Health Partners Plans
Member Services
901 Market Street, Suite 500
Philadelphia, PA 19107

BLE requests must include the following information:

- Your name
- Your address
- Your phone number
- The service you need
- The reason you need the service
- Your provider's name
- Your provider's phone number

Time Frames for Deciding a Benefit Limit Exception

If you or your provider asks for an exception before you get the service, Health Partners will let you know whether or not the BLE is approved within 2 business days of the date Health Partners gets the request.

If your dentist asks for an exception after you got the service, Health Partners will let you know whether or not the BLE request is approved within 30 days of the date Health Partners gets the request.

If you disagree with or are unhappy with Health Partners' decision, you may file a Complaint or Grievance with Health Partners. For more information on the Complaint and Grievance process, please see Section 8 of this Handbook, "Complaints, Grievances, and Fair Hearings" on page 46.

Vision Care Services

Your basic vision benefits are managed by an outside vendor. If you have questions, please contact Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Vision services, such as diagnostic testing, vision interventions, eye treatments, or eye surgeries are managed by HPP.

Members Under 21 Years of Age

Health Partners covers all medically necessary vison services for children under 21 years of age. Children may go to a participating vision provider within the Health Partners network. Your basic vision benefit includes two annual vision exams and two pairs of eyeglasses or contact lenses a year (4 sets of lenses per year). Additional vision exams and replacement eyeglasses can be authorized for you if medically necessary. You can select from a wide variety of fashionable eyeglass frames from a participating provider.

Your Health Partners basic vision coverage includes:

- Choice of metal or plastic frames
- Choice of plastic or glass lenses
- Oversized lenses
- Fashion and gradient tinting of plastic lenses
- One year breakage warranty on all plan glasses

There are no copays for the above services.

If you choose a frame that is not on the Health Partners vision plan, Health Partners will cover part of the price for the frame up to $100 and you are responsible for the rest of the cost.

If you need eye care, just call Member Services for help finding a convenient vision care provider. When you call to make an appointment, be sure to tell the office you are a member of Health Partners. Remember to take your membership ID card, ACCESS card and any other insurance cards with you to the appointment.

If you need eyeglasses or contacts, the eye doctor may be able to fill your eyeglass prescription in the same office. If not, the doctor will write a prescription for you to take to an eyewear center that accepts your Health Partners ID card. Call Member Services for help with finding a convenient vision care provider. Remember to take your membership card, ACCESS card and the prescription.

If you need special lenses for eye problems, such as cataracts, you can see a participating specialist. Additional coverage for eyeglasses and contact lenses is available for members with aphakia or cataracts. Please call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) for details.

Members 21 Years of Age and Older

Health Partners members age 21 and over have routine coverage for exams, eyeglasses or contact lenses. Your vision benefit includes two annual vision exams and one pair of eyeglasses or contact lenses a year Member diagnosed with aphakia also have coverage for a second pair of glasses or contact lenses.

Additional vision exams and replacement eyeglasses can be authorized for you if medically necessary. You can select from a wide variety of fashionable eyeglass frames from a participating provider. Your Health Partners basic vision coverage includes:

- Choice of metal or plastic frames
- Choice of plastic or glass lenses
- Oversized lenses
- Fashion and gradient tinting of plastic lenses
- One year breakage warranty on all plan glasses

There are no copays for the above services. If you choose a frame that is not on the Health Partners vision plan, Health Partners will cover part of the price for the frame up to $100 and you are responsible for the rest of the cost.

If you need eye care, just call Member Services for help finding a convenient vision care provider. When you call to make an appointment, be sure to tell the office you are a member of Health Partners. Remember to take your membership ID card, ACCESS card and any other insurance cards with you to the appointment.

If you need eyeglasses or contacts, the eye doctor may be able to fill your eyeglass prescription in the same office. If not, the doctor will write a prescription for you to take to an eyewear center that accepts your Health Partners ID card. Call Member Services for help with finding a convenient vision care provider. Remember to take your membership card, ACCESS card and the prescription.

Prescriptions

When a provider prescribes a medication for you, you can take it to any pharmacy that is in Health Partners' network. You will need to have your Health Partners prescription ID card with you and you may have a co-payment if you are 21 or older. Health Partners will pay for any medicine listed on the Statewide PDL and Health Partners' supplemental formulary and may pay for other medicines if they are prior authorized. Either your prescription or the label on your medicine will tell

you if your doctor ordered refills of the prescription and how many refills you may get. If your doctor ordered refills, you may only get 1 refill at a time. If you have questions about whether a prescription medicine is covered, need help finding a pharmacy in Health Partners' network, or have any other questions, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

The Health Partners provider directory also contains a list of participating pharmacies. To access the online provider directory, visit HPPlans.com and click on "Find a Doctor." If you need assistance, please contact Member Services.

If you need medicine, your PCP or specialist will write a prescription. Simply take the prescription to one of the more than 1,000 area pharmacies (drug stores) that fill Health Partners prescriptions. Your prescription will be filled if the prescription is covered under your pharmacy benefit. Copays apply beginning at age 21.

If you are asked to pay a copayment for your prescription and think you should not have to, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) from the pharmacy for assistance. If the pharmacist tries to charge you for a prescription, please ask him or her to contact Health Partners.

All Health Partners (Medicaid) members under the age of 21 are eligible for full pharmacy services at no charge.

Statewide Preferred Drug List (PDL) and Health Partners Supplemental Formulary

Health Partners covers medicines listed on the Statewide Preferred Drug List (PDL) and the Health Partners supplemental formulary. This is what your PCP or other doctor should use when deciding what medicines you should take. Both the Statewide PDL and Health Partners supplemental formulary cover both brand name and generic drugs. Generic drugs contain the same active ingredients as brand name drugs. Any medicine prescribed by your doctor that is not on the Statewide PDL and Health Partners' supplemental formulary needs prior authorization. The Statewide PDL and Health Partners' supplemental formulary can change from time to time, so you should make sure that your provider has the latest information when prescribing a medicine for you.

If you have any questions or to get a copy of the Statewide PDL and Health Partners' supplemental formulary, call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or visit Health Partners' website at www.HPPlans.com.

Reimbursement for Medication

HPP will review all requests for reimbursement. HPP does not require a specific form, but a receipt is necessary to process the request.

Age of Reimbursement Claim

Some prescriptions require review for medical necessity before HPP will pay for them. This is called Prior Authorization (PA). Others do not. If the prescription requires no review, in other words, it would have been paid without any intervention from HPP, then the prescription may be reviewed for reimbursement. Prescriptions older than 1 year will not be reviewed regardless if it requires a PA or not.

Age of Prior Authorization

Prior authorization of medications requires clinical review at the time of the request. Due to the nature of the medical review, older requests can result in inadequate and incomplete records. Therefore, any reimbursement request that requires a prior authorization that was not approved previously, and is older than 30 days from the time the prescription was filled, will not be reviewed.

Specialty Medicines

The Statewide PDL and Health Partners' supplemental formulary include medicines that are called specialty medicines. A prescription for these medicines needs to be prior authorized. You may have a co-payment for your medicine. To see the Statewide Preferred Drug List, the Health Partners supplemental formulary and a complete list of specialty medicines, call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or visit Health Partners' website at www.HPPlans.com.

You will need to get these medicines from a specialty pharmacy. A specialty pharmacy can mail your medicines directly to you and will not charge you for sending you your medicines. The specialty pharmacy will contact you before sending your medicine. The pharmacy can also answer any questions you have about the process. You can pick any specialty pharmacy that is in Health Partners' network. For the list of network specialty pharmacies, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or see the provider directory on Health Partners' website at www.HPPlans.com. For any other questions or more information please call Member Services at

1-800-553-0784 (TTY: 1-877-454-8477).

Over-the-Counter Medicines

Health Partners covers over-the-counter medicines when you have a prescription from your provider. You will need to have your Health Partners prescription ID card with you and you may have a copayment. The following are some examples of covered over-the-counter medicines:

- Sinus and allergy medicine
- Tylenol or aspirin
- Vitamins
- Cough medicine
- Heartburn medicine

You can find more information about covered over-the-counter medicines by visiting Health Partners' website at www.HPPlans.com or by calling Member Services at 1-800-553-0784 (TTY: 1-877-454-8477)

Tobacco Cessation

Do you want to quit smoking? Health Partners wants to help you quit!

If you are ready to be smoke free, no matter how many times you have tried to quit smoking, we are here to help you.

Medicines

The Statewide PDL covers the following medicines to help you quit smoking.

Health Partners covers many quit-smoking products. We do not cover brand name drugs that can be gotten as generics, unless your doctor gets prior authorization (approval).

Product	Covered	Prior Authorization Needed?
Gum	Yes	No
Inhaler	Yes	No
Lozenges	Yes	No
Nasal spray	Yes	No
Patch	Yes	No
Budeprion (generic for Wellbutrin)	Yes	No
Buproban (generic for Zyban)	Yes	No
Bupropion (generic for Wellbutrin and Zyban combination)	Yes	No
Chantix (Varenicline)	Yes	No
Wellbutrin (brand only)	Yes	Yes
Zyban (brand only)	Yes	Yes

Contact your PCP for an appointment to get a prescription for a tobacco cessation medicine.

Counseling Services

Counseling support may also help you to quit smoking. Health Partners covers counseling to members who are trying to quit smoking.

A Health Educator provides guidance and support to members who use tobacco products. The Health Educator works with members to identify triggers, establish goals, address barriers, and develop an attainable plan to decrease and ultimately stop the use of tobacco products. The program provides a platform that is comprehensive and encourages members to lead healthy lifestyles.

For more information or to enroll and get quit-smoking counseling, call 1-866-500-4571 (TTY: 1-877-454-8477).

Behavioral Health Treatment

Some people may be stressed, anxious, or depressed when they are trying to become smoke-free. Health Partners members are eligible for services to address these side effects, but these services are covered by your BH-MCO. You can find the BH-MCO in your county and its contact information on page 44 in this Handbook. You can also call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) for help in contacting your BH-MCO.

Care Coordination Services as You Quit Smoking

All Health Partners members who are working with a care coordinator for any health care need may also receive support as the try to quit smoking. For additional information about all of the Health Partners programs, please review Section 5 in this Handbook.

Other Tobacco Cessation Resources

Here are free support services and tools available to anyone trying to quit smoking:

- PA Department of Health: 1-800-QUIT-NOW
- American Lung Association Help Line: 1-800-LUNG-USA and their Freedom from Smoking online quit tool at www.freedomfromsmoking.org
- Philadelphia Department of Public Health at www.smokefreephilly.org

Remember Health Partners is here to help support you in becoming healthier by becoming smoke-free. Do not wait! Please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) so we can help to get you started.

Family Planning

Health Partners covers family planning services. You do not need a referral from your PCP for family planning services. These services include pregnancy testing, testing and treatment of sexually transmitted diseases, birth control supplies, and family planning education and counseling. You can see any doctor that is a Medical Assistance provider, including any out-of-network provider that offers family planning services. There is no co-payment for these services. When you go to a family planning provider that is not in the Health Partners network, you must show your Health Partners and ACCESS or EBT ID card.

For more information on covered family planning services or to get help finding a family planning provider, call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Maternity Care

Care During Pregnancy

Prenatal care is the health care a woman receives through her pregnancy and delivery from a maternity care provider, such as an obstetrician (OB or OB/GYN) or a nurse-midwife. Early and regular prenatal care is very important for you and your baby's health. Even if you have been pregnant before, it is important to go to a maternity care provider regularly through each pregnancy.

If you think you are pregnant and need a pregnancy test, see your PCP or a family planning provider. If you are pregnant, you can:

- Call or visit your PCP, who can help you find a maternity care provider in the Health Partners network.
- Visit a network OB or OB/GYN or nurse-midwife on your own. You do not need a referral for maternity care.
- Visit a network health center that offers OB or OB/GYN services.
- Call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) to find a maternity care provider.

You should see a doctor as soon as you find out you are pregnant. Your maternity care provider must schedule an appointment to see you:

- If you are in your first trimester, within 10 business days of Health Partners learning you are pregnant.

- If you are in your second trimester, within 5 business days of Health Partners learning you are pregnant.
- If you are in your third trimester, within 4 business days of Health Partners learning you are pregnant.
- If you have a high-risk pregnancy, within 24 hours of Health Partners learning you are pregnant.

If you have an emergency, go to the nearest emergency room, dial 911, or call your local ambulance provider.

It is important that you stay with the same maternity care provider throughout your pregnancy and postpartum care (60 days after your baby is born). They will follow your health and the health of your growing baby closely. It is also a good idea to stay with the same HealthChoices plan during your entire pregnancy.

Health Partners has specially trained maternal health coordinators who know what services and resources are available for you. (See Baby Partners section below.)

If you are pregnant and are already seeing a maternity care provider when you enroll in Health Partners, you can continue to see that provider even if he or she is not in Health Partners' network. The provider will need to be enrolled in the Medical Assistance Program and must call Health Partners for approval to treat you.

Care for You and Your Baby After Your Baby is Born

You should visit your maternity care provider between 21 to 56 days after your baby is delivered for a check-up unless your maternity care provider wants to see you sooner.

Your baby should have an appointment with the baby's PCP when he or she is 3 to 5 days old, unless the doctor wants to see your baby sooner. It is best to pick a doctor for your baby while you are still pregnant. If you need help picking a doctor for your baby, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Baby Partners

Health Partners has a special program for pregnant women called Baby Partners.

Baby Partners is staffed by nurses and social workers who are available to assist members throughout their pregnancy and after delivery.

Our staff works with your OB/GYN or midwife by answering questions, reminding you about important appointments and offering health care tips.

Health Partners Plans is committed to supporting and helping you throughout your pregnancy, whether it is through assistance with appointment scheduling, transportation for all your prenatal appointments or health education resources through our interactive member portal at HPPrewards.com. Additionally you may qualify for an incentive to help you stay on track. Please call, 1-866-500-4571 (TTY: 1-877-454-8477) to find out more.

Care During Pregnancy

Prenatal care is the care that you need when you are pregnant. It is important for your health and the health of your unborn child. Even if you have been pregnant before, it is important to go to the doctor or other prenatal care provider regularly during each pregnancy. You should expect to go for prenatal visits between 12 and 15 times before your baby is born. Health Partners covers all these visits and will help you get to each appointment. Staying with Health Partners throughout your pregnancy is usually best for the health of you and your baby.

If you think you are pregnant and need a pregnancy test, see your PCP or a family planning provider. If you are pregnant, you can:

- Call a certified midwife or OB/GYN for an appointment.

  OR

- Call the Baby Partners team to find a certified midwife or OB/GYN that is close to your home. Our provider network includes both male and female doctors and certified nurse midwives to provide your maternity care.

Care after the Birth of Your Baby — Postpartum Care

After the excitement of bringing your baby home, there are still some things to remember so your baby and you can stay healthy. You should visit your health care provider for a checkup between 21 and 56 days after your baby was delivered.

Health Partners Maternity Benefits

The following benefits are covered for all moms:

- Prenatal care appointments
- Vitamins
- Hospital stays
- Hospital delivery and nursery care

- Tests recommended by your health care provider
- Dental exams, X-rays/radiographs and other medically necessary dental services
- Home care visits for mom and baby after delivery
- Breast pumps for breastfeeding moms after delivery
- 24-hour breastfeeding helpline at 215-307-6791

For more information, call Baby Partners at 1-866-500-4571 (TTY: 1-877-454-8477).

Durable Medical Equipment and Medical Supplies

Health Partners covers Durable Medical Equipment (DME) and medical supplies. DME is a medical item or device that can be used many times in your home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury. Medical supplies are usually disposable and are used for a medical purpose. Some of these items need prior authorization, and your physician must order them. DME suppliers must be in the Health Partners network. You may have a co-payment.

Examples of DME include:

- Oxygen tanks
- Wheelchairs
- Crutches
- Walkers
- Splints
- Special medical beds

Examples of medical supplies include:

- Diabetic supplies (such as syringes, test strips)
- Gauze pads
- Dressing tape
- Incontinence supplies (such as pull ups, briefs, underpads)

If you have any questions about DME or medical supplies, or for a list of network suppliers, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Outpatient Services

Health Partners covers outpatient services such as physical, occupational and speech therapy as well as X-rays and laboratory tests. Your PCP will arrange for these services with one of Health Partners' network providers.

Nursing Facility Services

Health Partners covers up to 30 days of nursing facility services. If you need nursing facility services for more than 30 days and the Community HealthChoices Program is available in the area where you live, you will be evaluated to see if you are eligible for participation in the Community HealthChoices Program. If Community HealthChoices is not available in the area where you live you will be disenrolled from Health Partners and will receive your services through the Medical Assistance fee-for-service system.

Hospital Services

Health Partners covers inpatient and outpatient hospital services. If you need inpatient hospital services and it is not an emergency, your PCP or specialist will arrange for you to go to a hospital in Health Partners' network and will follow your care even if you need other doctors during your hospital stay. Inpatient hospital stays must be approved by Health Partners. To find out if a hospital is in the Health Partners network, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or check the provider directory on Health Partners' website at www.HPPlans.com/providers/resources.

If you have an emergency and are admitted to the hospital, you or a family member or friend should let your PCP know as soon as possible but no later than 24 hours after you were admitted to the hospital. If you are admitted to a hospital that is not in Health Partners' network, you may be transferred to a hospital in Health Partners' network. You will not be moved to a new hospital until you are strong enough to be transferred to a new hospital.

Sometimes you may need to see a doctor or receive treatment at a hospital without being admitted overnight. These services are called outpatient hospital services.

It is very important to make an appointment to see your PCP within 7 days after you leave the hospital. Seeing your PCP right after your hospital stay will help you follow any instructions you got while you were in the hospital and prevent you from having to be readmitted to the hospital.

For Medicaid transplant services, HPP will pay for transplants to the extent that the Medical Assistance Fee-for-Service program pays for such transplants. Any transplant considered to be reasonable or necessary by CMS will be covered when medical necessity

criteria is met. Transplants considered experimental or investigational by CMS will not be covered. Covered CMS transplants include bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas and small bowel/multi-visceral.

Except for emergency care, prior authorization is required for inpatient hospital services. If you have any other questions about hospital services, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Preventive Services

Health Partners covers preventive services, which can help keep you healthy. Preventive services include more than just seeing your PCP once a year for a check-up. They also include immunizations (shots), lab tests, and other tests or screenings that let you and your PCP know if you are healthy or have any health problems. Visit your PCP for preventive services. He or she will guide your health care according to the latest recommendations for care.

Women can also go to a participating OB/GYN for their yearly Pap test and pelvic exam, and to get a prescription for a mammogram.

Physical Exam

You should have a physical exam by your PCP at least once a year. This will help your PCP find any problems that you many not know about. Your PCP may order tests based on your health history, age, and sex. Your PCP will also check if you are up to date on immunizations and preventive services to help keep you healthy.

If you are unsure about whether or not you are up to date with your health care needs, please call your PCP or Member Services at 1-800-553-0784 (TTY: 1-877-454-8477). Member Services can also help you make an appointment with your PCP.

New Medical Technology

Health Partners may cover new medical technologies such as procedures and equipment if requested by your PCP or specialist. Health Partners wants to make sure that new medical technologies are safe, effective, and right for you before approving the service.

Before Health Partners approves new treatments, drugs, or equipment that are still considered experimental, the request goes through the following processes:

- We request that the provider submit a detailed narrative description of the service or item.
- We check to ensure that existing Federal and State Regulations do not preclude coverage.
- We research available data via online medical resources to obtain more detailed information on the service or item including, but not limited to:
  - FDA approval status
  - Peer-Review Literature

If you need more information on new medical technologies, please call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Home Health Care

Health Partners covers home health care provided by a home health agency. Home health care is care provided in your home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy. Your physician must order home health care.

If you are over age 21, there are no limits on the number of home health care visits that you can get.

HPP has a program that includes home health care visits directly relating to a special health care need for our medically complex children and adults. These services are provided once approved for medical necessity in coordination with the member's requesting provider.

You should contact Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) if you have been approved for home health care and that care is not being provided as approved.

Patient Centered Medical Homes

A patient-centered medical home or health home is a team approach to providing care. It is not a building, house, or home health care service.

Disease Management

Health Partners has voluntary programs to help you take better care of yourself if you have one of the health conditions listed below. Health Partners has care managers who will work with you and your providers to make sure you get the services you need. You do not need a referral from your PCP for these programs, and there is no co-payment.

Health Partners has care coordination (case management) programs in place to help you manage your health care needs. The team, includes nurses, social workers and non-clinical staff. You do not need a referral for any program, there is no copay and all the programs are voluntary.

- Baby Partners is the maternity program that follows mothers-to-be from the first notification of pregnancy through 60 days post-delivery.
- Healthy Kids is the program for children under the age of 21 where assistance is offered to parents and guardians to promote all the important health care milestones from birth through the age of 21, in addition to disease education and coordination of service for disease conditions including asthma, diabetes, lead poisoning, and developmental delay.
- Care Coordination and the Special Needs Unit (SNU) provide coordination of services for adult members with any disease condition whether it is asthma, diabetes, COPD, heart disease, HIV or multiple conditions. Staff provides disease education, connections to behavioral health care needs, community resources and benefit explanations. The SNU also follows children who require shift care. (See Section 5.)
- Clinical Connections is responsible for discharge screenings to make sure that members safely transition home and assists members with scheduling the important 7 day post discharge PCP or specialist visit. This unit will also provide disease specific education and health risk assessment follow up and can connect members to additional care coordination services as needed.

All staff in these programs can assist with:

- Coordination of PCP and specialist appointments as well as selection
- Transportation
- Food resources
- Dietary counseling
- Understanding some important tests
- Review of discharge instructions
- Coordination of home care services and durable medical equipment
- Behavioral health referrals and coordination of needed services
- Medication delivery
- Prior authorization needs
- Explanation of Medicaid benefits including complaint and grievance filing
- Life planning needs
- Smoking cessation counseling and resource education
- Participation in interagency team meetings as requested.

By following your provider's plan of care and learning about your disease or condition, you can stay healthier. Health Partners Care Coordinators are here to help you understand how to take better care of yourself by following your doctor's orders, teaching you about your medicines, helping you to improve your health, and giving you information to use in your community. If you have any question or need help, please call Clinical Connections at 1-866-500-4571 (TTY: 1-877-454-8477).

Expanded Services

- **Fitness Club Membership**
  Exercise is key to staying healthy and feeling good about yourself. That's why Health Partners offers special memberships at participating YMCAs and other fitness centers. To qualify for a yearlong membership at a participating center, adult members must complete 12 visits within the first three months. For these visits, a $2 copayment is required. After completing these visits, no copayment is required for the rest of the year. Members under the age of 18 need to complete six visits within the first three months and do not have to pay a copay. We cannot grant time extensions to complete required visits.

  You must sign a fitness enrollment form during your first visit to the fitness center. You must also follow the rules of the fitness center. You cannot change fitness centers after signing up for this benefit. Members who sign up at a Greater Philadelphia YMCA may visit any Greater Philadelphia YMCA location. For more information, please call Health Partners Member Services.

- **Fit Kids Program**
  The Fit Kids program provides families with education and support that emphasizes healthy lifestyle choices. This program is for children at risk of developing chronic diseases and for children

needing weight management services. The program encourages good nutrition and exercise. Care coordination services are provided by phone by nurses and a registered dietitian. To arrange services, call our Clinical Connections Helpline at 215-967-4690 (TTY: 1-877-454-8477).

- **24-Hour Teladoc Medical Assistance Line**
  You can also call Teladoc, 24 hours a day, if you have a non-urgent medical question. The doctors may be able to answer your health question and give you tips to care for the condition yourself. If you have a more serious health concern, they may suggest that you call your PCP. To reach Teladoc, call toll free at 1-800-Teladoc (835-2362). Remember, if your concern is life threatening or you need medical help right away, call 911 or go to the nearest emergency room.
- **Diabetes and Hypertension**
  Health Partners Plans is committed to supporting and helping you meet your health care goals, whether it is through assistance with appointment scheduling, transportation services to a specialist or health education resources through our interactive member portal at HPPrewards.com.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT services are available for children under the age of 21. They are sometimes also referred to as well-baby or well-child checkups. Your child may be seen by a pediatrician, family practice doctor, or CRNP. The provider you choose for your child will be your child's PCP. The purpose of this service is to detect potential health problems early and to make sure your child stays healthy. If you have questions or want more information, contact Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

- **Quality Management Program**
  Health Partners' Quality Management program monitors and works to improve the care and services you receive as a Health Partners member. This includes the care you receive from our network providers as well as the services we provide as a health plan. In order to make sure that you receive safe, quality health care that is respectful of your needs, we:
  - Send out surveys to find out what you think of Health Partners services and our provider network
  - Monitor member complaints about meeting access to care requirements
  - Provide preventive care services by offering you important health tips based on your age
  - Check the credentials of our network providers and those applying to become part of our network

Each year, Health Partners makes information about our Quality Management program available to our members and providers. For more information about our Quality Management program, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or visit "How the Plan Helps Improve Your Health" in the "Frequently Asked Questions" section of our website at HPPlans.com.

When Should an EPSDT Exam be Completed?

Recommended Screening Schedule			
3-5 Days	0-1 Months	2-3 Months	4-5 Months
6-8 Months	9-11 Months	12 Months	15 Months
18 Months	24 Months	30 Months	
Children ages 3-20 should be screened yearly			

Children and young adults should have their examinations completed based on the schedule listed above. It is important to follow this schedule even if your child is not sick. Your provider will tell you when these visits should occur. Infants and toddlers will need several visits per year, while children between the ages of 3 to 20 will need just 1 visit per year.

What Will the Provider Do During the EPSDT Exam?

Your provider will ask you and your child questions, perform tests, and check how much your child has grown.

The following services are some of the services that may be performed during an exam depending on the child's age and needs of the child:

- A complete physical exam
- Immunizations
- Vision test
- Urinalysis screening
- Blood lead screening test
- Developmental screening
- Depression screening starting at age 12
- Maternal depression screening
- Hearing test
- Autism screening
- Tuberculosis screening
- Oral health examination
- Blood pressure check
- Health and safety education
- Check of the child's body mass index (BMI)
- Screen and/or counsel for tobacco and alcohol use and substance use starting at age 11

Health Partners covers services that are needed to treat health problems that are identified during the EPSDT exam.

Additional services are available for children with special needs. Talk to your provider about whether or not your child may need these additional services.

Section 4 – Out-of-Network and Out-of-Plan Services

Out-of-Network Providers

An out-of-network provider is a provider that does not have a contract with Health Partners to provide services to Health Partners' members. There may be a time when you need to use a doctor or hospital that is not in the Health Partners network. If this happens, you can ask your PCP to help you. Your PCP has a special number to call to ask Health Partners that you be allowed to go to an out-of-network provider. Health Partners will check to see if there is another provider in your area that can give you the same type of care you or your PCP believes you need. If Health Partners cannot give you a choice of at least 2 providers in your area, Health Partners will cover the medically necessary services provided by an out-of-network provider.

Getting Care While Outside of Health Partners' Service Area

If you are outside of Health Partners' service area and have a medical emergency, go to the nearest emergency room or call 911. For emergency medical conditions, you do not have to get approval from Health Partners to get care. If you need to be admitted to the hospital, you should let your PCP know.

If you need care for a non-emergency condition while outside of the service area, call your PCP or Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) who will help you to get the most appropriate care.

Health Partners will not pay for services received outside of the United States and its territories.

Out-of-Plan Services

You may be eligible to get services other than those provided by Health Partners. Below are some services that are available but are not covered by Health Partners. If you would like help in getting these services, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Non-Emergency Medical Transportation

Health Partners does not cover non-emergency medical transportation for most HealthChoices members. Health Partners can help you arrange transportation to

covered service appointments through programs such as Shared Ride or the MATP described below.

Health Partners does cover non-emergency medical transportation if:

- You live in a nursing home, and need to go to any medical appointment or an urgent care center or a pharmacy for any Medical Assistance service, DME or medicine
- You need specialized non-emergency medical transportation, such as if you need to use a stretcher to get to your appointment

If you have questions about non-emergency medical transportation, please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Medical Assistance Transportation Program

MATP provides non-emergency transportation to medical appointments and pharmacies. This service is provided at no cost to you. The MATP in the county where you live will determine your need for the program, and provide the right type of transportation for you. Transportation services are typically provided in the following ways:

- Where public transportation such as buses, subways or trains is available, MATP provides tokens or passes or repays you for the public transportation fare.
- If you or someone else has a car that you can use to get to your appointment, MATP may pay you an amount per mile plus parking and tolls with valid receipts.
- Where public transportation is not available or is not right for you, MATP provides rides in paratransit vehicles, which include vans, vans with lifts, or taxis. Usually the vehicle will have more than 1 rider with different pick-up and drop-off times and locations.

If you need transportation to a medical appointment or the pharmacy, contact MATP to get more information and register for services.

Bucks County	1-888-795-0740
Chester County	1-484-696-3854
Delaware County	1-610-490-3960
Montgomery County	215-542-7433
Philadelphia County	1-877-835-7412

A complete list of county MATP contact information can be found here: http://matp.pa.gov/CountyContact.aspx.

MATP will confirm with Health Partners or your doctor's office that the medical appointment you need transportation for is a covered service. Health Partners works with MATP to help you arrange transportation. You can also call Member Services for more information at 1-800-553-0784 (TTY: 1-877-454-8477).

Women, Infants, and Children Program

The Women, Infants, and Children Program (WIC) provides healthy foods and nutrition services to infants, children under the age of 5, and women who are pregnant, have given birth, or are breastfeeding. WIC helps you and your baby eat well by teaching you about good nutrition and giving you food vouchers to use at grocery stores. WIC helps babies and young children eat the right foods so they can grow up healthy. You can ask your maternity care provider for a WIC application at your next visit or call 1-800-WIC-WINS (1-800-942-9467). For more information visit the WIC website at www.pawic.com

Domestic Violence Crisis and Prevention

Domestic violence is a pattern of behavior where one person tries to gain power or control over another person in a family or intimate relationship.

There are many different types of domestic violence. Some examples include:

- Emotional abuse
- Physical violence
- Stalking
- Sexual violence
- Financial abuse
- Verbal abuse
- Elder Abuse
- Intimate partner violence later in life
- Intimate partner abuse
- Domestic Violence in the LGBTQ+ Community

There are many different names used to talk about domestic violence. It can be called: abuse; domestic violence; battery; intimate partner violence; or family, spousal, relationship or dating violence.

If any of these things are happening to you, or have happened, or you are afraid of your partner, you may be in an abusive relationship.

Domestic violence is a crime and legal protections are available to you. Leaving a violent relationship is not easy, but you can get help.

Where to get help:
National Domestic Violence Hotline
1-800-799-7233 (SAFE)
1-800-787-3224 (TTY)

Pennsylvania Coalition Against Domestic Violence
The services provided to domestic violence victims include: crisis intervention; counseling; going along to police, medical, and court appointments; and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are also provided to lower the risk of domestic violence in the community.
1-800-932-4632 (in Pennsylvania)

Sexual Violence and Rape Crisis

Sexual violence includes any type of unwanted sexual contact, words or actions of a sexual nature that is against a person's will. A person may use force, threats, manipulation, or persuasion to commit sexual violence. Sexual violence can include:

- Rape
- Sexual assault
- Incest
- Child sexual assault
- Date and acquaintance rape
- Grabbing or groping
- Sexting without permission
- Ritual abuse
- Commercial sexual exploitation (for example: prostitution)
- Sexual harassment
- Anti-LGBTQ+ bullying
- Exposure and voyeurism (the act of being viewed, photographed, or filmed in a place where one would expect privacy)
- Forced participation in the production of pornography

Survivors of sexual violence can have physical, mental or emotional reactions to the experience. A survivor of sexual violence may feel alone, scared, ashamed, and fear that no one will believe them. Healing can take time, but healing can happen.

Where to get help:
Pennsylvania rape crisis centers serve all adults and children. Services include:

- Free and confidential crisis counseling 24 hours a day.
- Services for a survivor's family, friends, partners or spouses.
- Information and referrals to other services in your area and prevention education programs.

Call 1-888-772-7227 or visit the link below to reach your local rape crisis center.

Pennsylvania Coalition Against Rape
(www.pcar.org/)

Early Intervention Services

While all children grow and develop in unique ways, some children experience delays in their development. Children with developmental delays and disabilities can benefit from the Early Intervention Program.

The Early Intervention Program provides support and services to families with children birth to the age of 5 who have developmental delays or disabilities. Services are provided in natural settings, which are settings where a child would be if the child did not have a developmental delay or disability.

Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family. These services and supports address the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

Parents who have questions about their child's development may contact the CONNECT Helpline at 1-800-692-7288 or visit www.papromiseforchildren.org. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children from birth to age 5. In addition, CONNECT can help parents with contacting their county Early Intervention Program or local preschool Early Intervention Program.

Section 5 – Special Needs

Special Needs Unit

Health Partners wants to make sure all of our members get the care they need. We have trained case managers in the Health Partners Special Needs Unit that help our members with special needs have access to the care they need. The case managers of the unit help members with physical or behavioral disabilities, complex or chronic illnesses, and other special needs. Health Partners understands that you and your family may need help with issues that may not be directly related to your health care needs. The Special Needs Unit is able to assist you with finding programs and agencies in the community that can help you and your family address these needs.

If you think you have or someone in your family has a special need, and you would like the Special Needs Unit to help you, please call 1-866-500-4571, enter your member ID and when prompted press 1. TTY users can call 1-877-454-8477. The Special Needs Unit staff members are available Monday through Friday from 8:00 a.m. to 4:30 p.m. If you need assistance when the Special Needs Unit staff are not available you may call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Coordination of Care

The Health Partners Special Needs Unit will help you coordinate care for your family who are members of Health Partners. In addition, Health Partners can assist in connecting you with other state and local programs.

If you need help with any part of your care, your child's care, or coordinating that care with another state, county, or local program; please contact the Health Partners Special Needs Unit for assistance.

The Health Partners Special Needs Unit will also assist members in transitioning care from services received in a hospital or temporary medical setting to care received at home. We want our members to be able to move back home as soon as possible. Please contact the Health Partners Special Needs Unit for assistance in help receiving care in your home.

Care Management

Our health and wellness programs help you get the care you need. We work with your doctors to make sure you're getting the right care. Our care coordinators can help you manage your health, set health care goals and even schedule appointments with your doctors. Our programs include:

- Baby Partners – helps expecting and new mothers get the care they need.
- Healthy Kids – helps parents and guardians learn about their children's health needs.
- Care Coordination/Special Needs Unit – offers extra help for members who might need help reaching their health goals.

You may be eligible to participate in these programs. Participation is voluntary.

What is a Care Coordinator?

A care coordinator is a social worker or nurse who can help you:

- Reach your health goals
- Schedule doctors' appointments
- Remember important screenings/doctor appointments
- Get information about your health conditions
- Connect you with resources

For more information about any of these programs, call Member Relations at 1-800-553-0784 (TTY 1-877-454-8477).

Home and Community-Based Waivers and Long-Term Services and Supports

The Office of Developmental Programs (ODP) administers the Consolidated Waiver, Community Living Waiver, Person/Family Directed Supports Waiver, Adult Autism Waiver, and the Adult Community Autism Program (ACAP) for individuals with intellectual disabilities or autism. If you have questions regarding any of these programs, you may contact ODP's Customer Service Hotline at 1-888-565-9435, or request assistance from the Special Needs Unit at Health Partners.

The Office of Long-Term Living (OLTL) administers services for seniors and individuals with physical disabilities. This includes the Community HealthChoices Program (CHC).

The CHC Program is a Medical Assistance manged care program for individuals who also have Medicare coverage or who need the services of a nursing facility or home-and community-based waiver.

If you have questions regarding what services are available and how to apply, you may contact OLTL's Participant Helpline at 1-800-757-5042 or request assistance from the Health Partners Special Needs Unit at 1-866-500-4571 (TTY: 1-877-454-8477).

Medical Foster Care

The Office of Children Youth and Families has oversight of medical foster care for children under the authority of county children and youth programs. If you have questions about this program, please contact the Special Needs Unit at 1-866-500-4571 (TTY: 1-877-454-8477).

Section 6 – Advance Directives

Advance Directives

There are 2 types of advance directives: Living Wills and Health Care Powers of Attorney. These allow for your wishes to be respected if you are unable to decide or speak for yourself. If you have either a Living Will or a Health Care Power of Attorney, you should give it to your PCP, other providers, and a trusted family member or friend so that they know your wishes.

If the laws regarding advance directives are changed, Health Partners will tell you in writing what the change is within 90 days of the change. For information on Health Partners' policies on advance directives, call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) or visit Health Partners' website at www.HPPlans.com.

Living Wills

A Living Will is a document that you create. It states what medical care you do, and do not, want to get if you cannot tell your doctor or other providers the type of care you want. Your doctor must have a copy and must decide that you are unable to make decisions for yourself for a Living Will to be used. You may revoke or change a Living Will at any time.

Health Care Power of Attorney

A Health Care Power of Attorney is also called a Durable Power of Attorney. A Health Care or Durable Power of Attorney is a document in which you give someone else the power to make medical treatment decisions for you if you are physically or mentally unable to make them yourself. It also states what must happen for the Power of Attorney to take effect. To create a Health Care Power of Attorney, you may but do not have to get legal help. You may contact your Health Partners care coordinator for more information or direction to resources near you. Call 1-866-500-4571 (TTY: 1-877-454-8477) if you do not have a care coordinator.

What to Do if a Provider Does Not Follow Your Advance Directive

Providers do not have to follow your advance directive if they disagree with it as a matter of conscience. If your PCP or other provider does not want to follow your advance directive, Health Partners will help you find a provider that will carry out your wishes. Please call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) if you need help finding a new provider.

If a provider does not follow your advance directive, you may file a Complaint. Please see page 46 in Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint or call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477).

Section 7 – Behavioral Health Services

Behavioral Health Care

Behavioral health services include both, mental health services and substance use disorder services. These services are provided through behavioral health managed care organizations (BH-MCOs) that are overseen by the Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS). Contact information for the BH-MCO is listed below. You can also call Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) to get contact information for your BH-MCO.

Bucks
Magellan Behavioral Healthcare
1-877-769-9784

Chester
Community Care Behavioral Health Organization
1-866-622-4228

Delaware
Magellan Behavioral Healthcare
1-888-207-2911

Montgomery
Magellan Behavioral Healthcare
1-877-769-9782

Philadelphia
Community Behavioral Health
1-888-545-2600

You can call your BH-MCO toll-free 24 hours a day, 7 days a week.

You do not need a referral from your PCP to get behavioral health services, but your PCP will work with your BH-MCO and behavioral health providers to help get you the care that best meets your needs. You should let your PCP know if you, or someone in your family, is having a mental health or drug and alcohol problem.

The following services are covered:

- Behavioral health rehabilitation services (BHRS) (children and adolescent)
- Clozapine (Clozaril) support services
- Drug and alcohol inpatient hospital-based detoxification services (adolescent and adult)

- Drug and alcohol inpatient hospital-based rehabilitation services (adolescent and adult)
- Drug and alcohol outpatient services
- Drug and alcohol methadone maintenance services
- Family based mental health services
- Laboratory (when related to a behavioral health diagnosis and prescribed by a behavioral health practitioner)
- Mental health crisis intervention services
- Mental health inpatient hospitalization
- Mental health outpatient services
- Mental health partial hospitalization services
- Peer support services
- Residential treatment facilities (children and adolescent)
- Targeted case management services

If you have questions about transportation to appointments for any of these services, contact your BH-MCO.

Section 8 – Complaints, Grievances, and Fair Hearings

Complaints, Grievances, and Fair Hearings

If a provider or Health Partners does something that you are unhappy about or do not agree with, you can tell Health Partners or the Department of Human Services what you are unhappy about or that you disagree with what the provider or Health Partners has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell Health Partners you are unhappy with Health Partners or your provider or do not agree with a decision by Health Partners.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Health Partners has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) and tell Health Partners your Complaint, or
- Write down your Complaint and send it to Health Partners by mail or fax, or
- If you received a notice from Health Partners telling you Health Partners' decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to Health Partners by mail or fax.

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that:

- Health Partners has decided that you cannot get a service or item you want because it is not a covered service or item.
- Health Partners will not pay a provider for a service or item you got.
- Health Partners did not tell you its decision about a Complaint or Grievance you told Health Partners about within 30 days from when Health Partners got your Complaint or Grievance.
- Health Partners has denied your request to disagree with Health Partners' decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New member appointment for your first examination...	**We will make an appointment for you...**
members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in Health Partners unless you are already being treated by a PCP or specialist.
members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a member in Health Partners, unless you are already being treated by a PCP or specialist.
members under the age of 21	with PCP for an EPSDT exam no later than 45 days after you become a member in Health Partners, unless you are already being treated by a PCP or specialist.
all other members	with PCP no later than 3 weeks after you become a member in Health Partners.
Members who are pregnant:	**We will make an appointment for you...**
pregnant women in their first trimester	with OB/GYN provider within 10 business days of Health Partners learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of Health Partners learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of Health Partners learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of Health Partners learning you are pregnant.
Appointment with...	**An appointment must be scheduled . . . . .**
PCP urgent medical condition routine appointment health assessment/general physical examination	 within 24 hours. within 10 business days. within 3 weeks.
Specialists (when referred by PCP) urgent medical condition	 within 24 hours of referral.

routine appointment with one of the following specialists: • Otolaryngology • Dermatology • Pediatric Endocrinology • Pediatric General Surgery • Pediatric Infectious Disease • Pediatric Neurology • Pediatric Pulmonology • Pediatric Rheumatology • Dentist • Orthopedic Surgery • Pediatric Allergy & Immunology • Pediatric Gastroenterology • Pediatric Hematology • Pediatric Nephrology • Pediatric Oncology • Pediatric Rehab Medicine • Pediatric Urology • Pediatric Dentistry	within 15 business days of referral
routine appointment with all other specialists	within 10 business days of referral
You may file **all other Complaints at any time.**	

What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from Health Partners telling you that Health Partners has received your Complaint, and about the First Level Complaint review process.

You may ask Health Partners to see any information Health Partners has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Health Partners.

You may attend the Complaint review if you want to attend it. Health Partners will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more Health Partners staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a denial decision by the plan, a licensed doctor will be on the committee. Health Partners will mail you a notice within 30 days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 46.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like Health Partners' Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- Health Partners' decision that you cannot get a service or item you want because it is not a covered service or item.

- Health Partners' decision to not pay a provider for a service or item you got.
- Health Partners' failure to decide a Complaint or Grievance you told Health Partners about within 30 days from when Health Partners got your Complaint or Grievance.
- You not getting a service or item within the time by which you should have received it.
- Health Partners' decision to deny your request to disagree with Health Partners' decision that you have to pay your provider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice.**

You must ask for a Fair Hearing within **120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice.**

For information about Fair Hearings, see page 54.

For information about external Complaint review, see page 50.

If you need more information about help during the Complaint process, see page 53.

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) and tell Health Partners your Second Level Complaint, or
- Write down your Second Level Complaint and send it to Health Partners by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to Health Partners by mail or fax.

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from Health Partners telling you that Health Partners has received your Complaint, and about the Second Level Complaint review process.

You may ask Health Partners to see any information Health Partners has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to Health Partners.

You may attend the Complaint review if you want to attend it. Health Partners will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for Health Partners, will meet to decide your Second Level Complaint. The Health Partners staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. Health Partners will mail you a notice within 45 days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 53.

What if I Do Not Like Health Partners' Decision on My Second Level Complaint?

You may ask for an external review by either the Department of Health or the Insurance Department.

You must ask for an external review within **15 days of the date you got the Second Level Complaint decision notice.**

External Complaint Review

Send your written request for an external review of your Complaint to the following:

Pennsylvania Insurance Department

Bureau of Consumer Services

Room 1209, Strawberry Square

Harrisburg, PA 17120

Telephone Number: 1-877-881-6388

You can also go to the "File a Complaint Page" at https://www.insurance.pa.gov/Consumers/insurance-complaint/Pages/default.aspx

If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

What Happens After I Ask for an External Complaint Review?

The Department of Health or the Insurance Department will get your file from Health Partners. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you want to continue getting services, you must ask for an external Complaint review or a Fair Hearing within 10 days of the date on the notice telling you Health Partners' First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you for the services or items to continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you must request both the external Complaint review and the Fair Hearing within 10 days of the date on the notice telling you Health Partners' First Level Complaint decision. If you wait to request a Fair Hearing until after receiving a decision on your external Complaint, services will not continue.

Grievances

What is a Grievance?

When Health Partners denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you Health Partners' decision.

A Grievance is when you tell Health Partners you disagree with Health Partners' decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call Health Partners at 1-800-553-0784 (TTY: 1-877-454-8477) and tell Health Partners your Grievance, or
- Write down your Grievance and send it to Health Partners by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from Health Partners and send it to Health Partners by mail or fax.

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from Health Partners telling you that Health Partners has received your Grievance, and about the Grievance review process.

You may ask Health Partners to see any information that Health Partners used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to Health Partners.

You may attend the Grievance review if you want to attend it. Health Partners will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The Health Partners staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. Health Partners will mail you a notice within 30 days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page 53.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like Health Partners' Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for Health Partners.

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice.**

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page 54.

For information about external Grievance review, see below.

If you need more information about help during the Grievance process, see page 53.

External Grievance Review

How Do I Ask for an External Grievance Review?

To ask for an external Grievance review:

- Call Health Partners Member Services at 1-800-553-0784 (TTY: 1-877-454-8477) and tell Health Partners your Grievance, or
- Write down your Grievance and send it to Health Partners by mail to:

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107

Health Partners will send your request for external Grievance review to the Department of Health.

What Happens After I Ask for an External Grievance Review?

The Department of Health will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

Health Partners will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to

the reviewer within 15 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:
If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within 10 days of the date on the notice telling you Health Partners' Grievance decision, the services or items will continue until a decision is made.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting 30 days to get a decision about your First Level Complaint or Grievance, or 45 days to get a decision about your Second Level Complaint could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask Health Partners for an early decision by calling Health Partners at 1-800-553-0784 (TTY: 1-877-454-8477), faxing a letter or the Complaint/Grievance Request Form to 215-991-4105, or sending an email to quickCGA@hpplans.com.
- Your doctor or dentist should fax a signed letter to 215-991-4105 within 72 hours of your request for an early decision that explains why Health Partners taking 30 days to tell you a decision about your First Level Complaint or Grievance, or 45 days to tell you a decision about your Second Level Complaint could harm your health.

If Health Partners does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, Health Partners will decide your Complaint or Grievance in the usual time frame of 30 days from when Health Partners first got your First Level Complaint or Grievance, or 45 days from when Health Partners got your Second Level Complaint.

Expedited Complaint and Expedited External Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference because Health Partners has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

Health Partners will tell you the decision about your Complaint within 48 hours of when Health Partners gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when Health Partners gets your request for an early decision, whichever is sooner. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Department of Health within **2 business days from the date you get the expedited Complaint decision notice.** To ask for expedited external review of a Complaint:

- Call Health Partners at 1-800-553-0784 (TTY: 1-877-454-8477) and tell Health Partners your Complaint

  OR

- Send an email to Health Partners at quickCGA@hpplans.com

  OR

- Write down your Complaint and send it to Health Partners by mail or fax:

  Health Partners Plans
  Complaints, Grievances & Appeals Unit
  901 Market Street, Suite 500
  Philadelphia, PA 19107
  215-991-4105 (fax)

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The Health Partners staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference because Health Partners has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

Health Partners will tell you the decision about your Grievance within 48 hours of when Health Partners gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when Health Partners gets your request for an early decision, whichever is sooner. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review by the Department of Health within **2 business days from the date you get the expedited Grievance decision notice.** To ask for expedited external review of a Grievance:

- Call Health Partners at 1-800-553-0784 and tell Health Partners your Grievance

  OR

- Send an email to Health Partners at quickCGA@hpplans.com

  OR

- Write down your Complaint and send it to Health Partners by mail or fax:

Health Partners Plans
Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
215-991-4105 (fax)

Health Partners will send your request to the Department of Health within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of Health Partners will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell Health Partners, in writing, the name of that person and how Health Partners can reach him or her.

You or the person you choose to represent you may ask Health Partners to see any information Health Partners has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call Health Partners' toll-free telephone number at 1-800-553-0784 (TTY: 1-877-454-8477) if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at 215-981-3700 (Philadelphia County); 1-877-429-5994 (Bucks, Chester, Delaware and Montgomery counties) or call the Pennsylvania Health Law Project at 1-800-274-3258.

Persons Whose Primary Language Is Not English

If you ask for language services, Health Partners will provide the services at no cost to you.

Persons with Disabilities

Health Partners will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by Health Partners at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

Department of Human Services Fair Hearings

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something Health Partners did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after Health Partners decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you Health Partners' decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- Health Partners' failure to decide a First Level Complaint or Grievance you told Health Partners about within 30 days from when Health Partners got your Complaint or Grievance.
- The denial of your request to disagree with Health Partners' decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that Health Partners failed to decide a First Level Complaint or Grievance you told Health Partners about within 30 days from when Health Partners got your Complaint or Grievance.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter, it needs to include the following information:

- Your (the member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs –
HealthChoices Program
Complaint, Grievance and Fair Hearings
PO Box 2675
Harrisburg, PA 17105-2675

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

Health Partners will also go to your Fair Hearing to explain why Health Partners made the decision or explain what happened.

You may ask Health Partners to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Health Partners, not including the number of days between the date on the written notice of the Health Partners' First

Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because Health Partners did not tell you its decision about a Complaint or Grievance you told Health Partners about within 30 days from when Health Partners got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with Health Partners, not including the number of days between the date on the notice telling you that Health Partners failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:
If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 10 days of the date on the notice telling you Health Partners' First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 1-717-772-6328. Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call **Health Partners**' toll-free telephone number at **1-800-553-0784 (TTY: 1-877-454-8477)** if you need help or have questions about Fair Hearings, you can contact your local legal aid office at 215-981-3700 (Philadelphia County); 1-877-429-5994 (Bucks. Chester, Delaware and Montgomery counties) or call the Pennsylvania Health Law Project at 1-800-274-3258.

Health Partners Plans

Discrimination is Against the Law

Health Partners (Medicaid) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation. Health Partners does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Health Partners provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Health Partners provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Member Relations at 1-800-553-0784 (TTY 1-877-454-8477).

If you believe that Health Partners has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Health Partners Plans
Attn: Complaints, Grievances & Appeals Unit
901 Market Street, Suite 500
Philadelphia, PA 19107
Phone: 1-800-553-0784 (TTY 1-877-454-8477)
Fax: 1-215-991-4105

The Bureau of Equal Opportunity
Room 223, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675
Phone: (717) 787-1127 (TTY/PA RELAY: 711)
Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Health Partners and the Bureau of Equal Opportunity are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call: 1-800-553-0784 (TTY 1-877-454-8477).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-553-0784 (TTY 1-877-454-8477**)**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-553-0784 (телетайп 1-877-454-8477**)**.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-553-0784 (TTY 1-877-454-8477)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-553-0784 (TTY 1-877-454-8477).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-553-0784 (رقم هاتف الصم والبكم:1-877-454-8477).

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-553-0784 (टिटिवाइ 1-877-454-8477) ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-553-0784 (TTY 1-877-454-8477) 번으로 전화해 주십시오.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-553-0784 (TTY 1-877-454-8477)។

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposes gratuitement. Appelez le 1-800-553-0784 (ATS 1-877-454-8477).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-553-0784 (TTY 1-877-454-8477) သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-553-0784 (TTY 1-877-454-8477).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-553-0784 (TTY 1-877-454-8477).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-553-0784 (TTY 1-877-454-8477)।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-553-0784 (TTY 1-877-454-8477).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-553-0784 (TTY 1-877-454-8477).

Health Partners Plans
901 Market Street, Suite 500
Philadelphia, PA 19107

24-hour Member Services: 1-800-553-0784

(TTY: 1-877-454-8477) for plan information and member help

24-hour Teladoc medical assistance line at

1-800-Teladoc (835-2362)

Visit us at HPPlans.com

Health Partners Plans

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