

## 2010 Certificate of Coverage

# Prepaid Medical Assistance Program (PMAP) Prepaid General Assistance Medical Care (PGAMC)

Effective Date: January 1, 2010



READ THIS **CERTIFICATE OF COVERAGE** CAREFULLY. This **Certificate of Coverage** describes PrimeWest Health PMAP and PGAMC. It also explains your rights and responsibilities and those of PrimeWest Health.

If you do not know which Minnesota Health Care Program you are receiving, ask your county worker or call PrimeWest Health.

**PrimeWest Health Service Area:** Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, and Traverse counties

### **Member Services:**

For help or information, please call Member Services at **1-866-431-0801** or for TTY, call **1-800-627-3529** or **711**. Calls to these numbers are free. Hours are Monday – Friday, 8 a.m. – 5 p.m. Or, go to our plan website at [www.primewest.org](http://www.primewest.org).

# PrimeWest Health

Member Services 1-866-431-0801

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

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

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

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

ກໍ່ມາດສໍາສາດ ເມີນຜູ້ກວດສອບຜູ້ຍ່ອມກໍ່ມາດສໍາສາດນີ້ເພື່ອເຊື່ອມຕໍ່ກັບບໍລິສັດທີ່ເຮົາເຮັດວຽກຢູ່ ສູ່ບໍລິສັດນີ້ ເຮົາເລືອກເຊື່ອມຕໍ່ເຮົາເຮັດວຽກຢູ່

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

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

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

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

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

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American Indians can continue or begin to use tribal and Indian Health Service (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. If a health care provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your Plan network primary care provider prior to the referral.

This information is available in other forms to people with disabilities by calling PrimeWest Health at the numbers below.

## TOLL FREE

1-866-431-0801

## TOLL FREE MINNESOTA RELAY

TTY, Voice, ASCII, or Hearing Carry Over:  
1-800-627-3529 or 711

## TOLL FREE SPEECH-TO-SPEECH RELAY SERVICE

1-877-627-3848

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

## ADDRESS

PrimeWest Health  
2209 Jefferson St, Ste 101  
Alexandria, MN 56308  
1-320-335-5357  
1-866-431-0801 (toll free)

## WEBSITE

[www.primewest.org](http://www.primewest.org)

## MEMBER SERVICES HOURS

Monday – Friday, 8 a.m. – 5 p.m.

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## Welcome to PrimeWest Health

Welcome

We are pleased to welcome you as a member of PrimeWest Health (referred to as “Plan”).

PrimeWest Health (referred to as “we,” “us,” or “our”) is part of the Prepaid Medical Assistance Program (PMAP) and the Prepaid General Assistance Medical Care program (PGAMC). We coordinate and cover your medical services. You will get most of your health services through the Plan’s network of providers. When you need health care or have questions about your health services, you can call us. We will help you decide what to do next and which health care provider to see.

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

This *Certificate of Coverage* includes the following:

- Contact information
- Information on how to get the care you need
- Your rights and responsibilities as a member of the Plan
- Information about copays
- A listing of covered and non-covered services
- Information on what to do if you have a complaint or want to Appeal an Action
- Definitions

The counties in the Plan service area are as follows: Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, and Traverse.

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

If you ask, we will give you this *Certificate of Coverage* in one of these languages: Spanish, Hmong, Laotian, Russian, Somali, Vietnamese, or Cambodian. Call PrimeWest Health Member Services at **1-866-431-0801** (toll free) or **1-800-627-3529** or **711** (toll free TTY).

## Section 1: Telephone Numbers and Other Contact Information

### How to contact our Member Services

If you have any questions or concerns, please call or write to Member Services. We will be happy to help you.

#### Member Services

##### CALL

**1-866-431-0801**

Calls to this number are free.

Monday – Friday, 8 a.m. – 5 p.m.

##### TTY

**1-800-627-3529 or 711**

Calls to these numbers are free. These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.

Monday – Friday, 8 a.m. – 5 p.m.

##### FAX

**1-320-335-5223**

Calls to this number are *not* free.

##### WRITE

PrimeWest Health  
2209 Jefferson St, Ste 101  
Alexandria, MN 56308

##### WEBSITE

[www.primewest.org](http://www.primewest.org)

#### Appeals and Grievances (see Section 13 for more information)

##### CALL

**1-866-431-0801**

Calls to this number are free.

##### FAX

**1-877-600-4912**

Calls to this number are free.

##### WRITE

Appeals and Grievances  
PrimeWest Health  
2209 Jefferson St, Ste 101  
Alexandria, MN 56308

#### For the following services, call Member Services at 1-866-431-0801 (toll free)

Chemical Dependency Services  
Chiropractic Services  
Dental Services  
Durable Medical Equipment Coverage Criteria  
Mental Health Services  
Prescriptions

#### Interpreter Services

Hearing **1-800-627-3529 or 711**

Spoken Language **1-866-431-0801**

Calls to these numbers are free.

#### Health Questions Phone Line

Ask Mayo Clinic nurse line **1-888-668-4336**

Calls to this number are free.

7 days a week, 24 hours a day

**To Request Health Care Transportation**

COUNTY	AGENCY	CALL
Beltrami	Human Services	1-218-333-8300
Big Stone	Family Services	1-320-839-2555
Clearwater	Human Services	1-218-694-6164 1-800-245-6064
Douglas	Social Services	1-320-762-2302
Grant	Social Services	1-218-685-4417 1-800-291-2827
Hubbard	Social Services	1-218-732-9328 1-800-660-1666
McLeod	Social Services	1-320-864-3144 1-800-247-1756
Meeker	Social Services	1-320-693-5300 1-877-915-5300
Pipestone	Family Services	1-507-825-6720 1-888-632-4325
Pope	Family Services	1-320-634-5750
Renville	Human Services	1-320-523-2202 1-800-363-2533
Stevens	Human Services	1-320-589-7400 1-800-950-4429
Traverse	Social Services	1-320-563-8255 1-800-721-8277

Rev. 10/01/09

**Other important contact information**

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

**Minnesota Department of Human Services**

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

**Ombudsman for State Managed Health Care Programs**

The Ombudsman for State Managed Health Care Programs at the Minnesota Department of Human Services (DHS) helps people enrolled in a health plan in resolving service and billing problems. They can help you file a Grievance or Appeal with us. The Ombudsman can also help you request a State Fair Hearing. Call **1-800-657-3729** (toll free) or **1-651-431-2660**.

**Section 2: Important Information on Getting the Care You Need****Primary care**

Each time you get health services, check to be sure the provider is a Plan network provider. Members receive a *Provider Directory*. It lists Plan network providers. It is current as of the date it is printed. To verify current information, you can call the provider, call Member Services at the phone number in *Section 1*, or visit our website listed in *Section 1*.

You chose or have been assigned to a Plan network health care provider or clinic. The name of the health care provider or clinic is on your membership card. This is your primary care clinic.

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

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

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

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

## Service Authorizations

Our approval is needed for some services to be covered. This is called a Service Authorization. The approval must be obtained before you get the services or before we pay for them. Many of these services are noted in *Section 7*. For more information, call Member Services at the phone number in *Section 1*.

If you need a covered service that you cannot get from a Plan network provider, you must get a Service Authorization from us to see an out-of-network provider. Exceptions to this rule are as follows:

- **Open access services:** Family planning, diagnosis of infertility, testing and treatment of sexually transmitted diseases (STDs), and testing for AIDS or other HIV-related conditions are **open access services**. You can go to any health care provider, clinic, pharmacy, or family planning agency, even if it is not in our network, to get these services.
- **Dental services:** You can get dental services from any dental provider who is willing to accept our payment as payment in full and not bill you for the difference.
- **Emergency care, urgent care, and post-stabilization services**

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

If we are unable to find you a qualified Plan network provider, we must give you a standing Service Authorization for you to see a qualified specialist for any of the following conditions:

- A chronic (ongoing) condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first 3 months (first trimester)
- A degenerative disease or disability
- Any other condition or disease that is serious or complex enough to require treatment by a specialist

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

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

- An acute condition
- A life-threatening mental or physical illness
- A pregnancy that is beyond the first 3 months (first trimester)
- A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least 1 year, or is likely to result in death.
- A disabling or chronic condition that is in an acute phase

If your health care provider certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

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

## Covered and non-covered services

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

Some services and supplies are not covered. All health services must be medically necessary for them to be covered services. Read this *Certificate of Coverage* carefully. It lists many services and supplies that are not covered. See *Sections 7 and 8*.

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

We may cover additional or substitute services under some conditions.

## Copays and payments

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You may be required to pay a copay for certain services. A copay is an amount that you will be responsible to pay to your provider. See *Section 6* for more information.

We cannot pay you back for most medical bills that you pay. State and Federal laws prevent us from paying you directly. If you paid for a service that you think we should have covered, call Member Services at the phone number in *Section 1*.

## Interpreter services

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We will provide interpreter services to help you access services. This includes spoken language interpreters and hearing interpreters. If you need assistance to help you access services, call Member Services at the phone number in *Section 1*.

## Other health insurance

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

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

## Private information

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

## Restricted Recipient Program

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The Restricted Recipient Program is a program for members who have received medical care and have not followed the rules or have misused services. You must get health services from 1 designated primary care provider, 1 drug store, 1 hospital, or other designated health services provider(s) located in your local trade area. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). You may also be assigned to a home health agency or other providers. You may not be allowed to use the personal care assistance choice or flexible use options or consumer directed services. Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.

At the end of the 24 months, your health care services will be reviewed. If you still do not follow the rules, you will be placed in the program for an additional 36 months of eligibility. You have the right to Appeal placement in the Restricted Recipient Program. See *Section 13*.

## Cancellation

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

## Section 3: *Member Bill of Rights*

**As a PrimeWest Health member, you have the right to:**

- Be treated with respect, dignity, and consideration for privacy
  - Get the services you need 24 hours a day, 7 days a week. This includes emergencies.
  - Be told about your health problems
  - Get information about treatments, your treatment choices, and how they will help or harm you
  - Participate with providers in making decisions about your health care
  - Refuse treatment and get information about what might happen if you refuse treatment
  - Refuse care from specific providers
  - Know that we will keep your records private according to law
  - Request and receive a copy of your medical records. You also have the right to ask to correct the records.
  - Get notice of our decisions if we deny, reduce or stop a service, or deny payment for a service
  - File a Grievance or Appeal with us. You can also file a complaint with the Minnesota Department of Health.
  - Request a State Fair Hearing with the Minnesota Department of Human Services (also referred to as “the State”). You may request a State Fair Hearing before or at any time during our Appeal process. You do not have to file an Appeal with us before you request a State Fair Hearing.
  - A clear explanation of covered nursing home and home care services
  - Give written instructions that inform others of your wishes about your health care. This is called a “health care directive.” It allows you to name a person (agent) to decide for you if you are unable to decide, or if you want someone else to decide for you.
  - Choose where you will get family planning services
  - Get a second opinion for medical, mental health, and chemical dependency services
  - Be free of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation
  - Request a copy of this *Certificate of Coverage* at least once a year
  - Make recommendations about our rights and responsibilities policy
  - Get the following information from us, if you ask for it:
    - Whether we use a physician incentive plan that affects the use of referral services
    - The type(s) of incentive arrangement used
    - Whether stop-loss protection is provided
    - Results of a member survey if one is required because of our physician incentive plan
    - Results of an external quality review study from the State
- Note:** There are no incentives offered to Plan providers to give less care than your condition requires. Decisions about your health care are based only on the following:
- Appropriateness of care
  - The covered benefits you have
- For more information about the plan’s physician incentive plan, contact our Corporate Compliance Officer at **1-888-588-4420**. Calls to this number are free.
- Exercise the rights listed here

## Section 4: *Member Responsibilities*

As a PrimeWest Health member, you have the responsibility to:

- Read this *Certificate of Coverage* and know which services are covered under the Plan and how to get them
- Show your health plan membership card and your Minnesota Health Care Program ID card every time you go for health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.
- Establish a relationship with a Plan network primary care provider before you become ill. This helps you and your primary care provider understand your total health condition.
- Give information asked for by your health care provider. Share information about your health history.
- Follow all your health care provider's instructions. If you have questions about your care, ask your health care provider.
- Work with your health care provider to understand your total health condition. It is important to know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.
- Practice preventive health care. Have tests, exams, and shots recommended for you based on your age and gender.

**Let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number in Section 1.**

## Section 5: *Your PrimeWest Health Membership Card*

Each member will receive a membership card.

Always carry your membership card with you.

You must show your membership card whenever you get health care.

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

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

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

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

**PrimeWest HEALTH**

Grp: (80840)  
 Issuer: (80840)  
 ID #:  
 Name:  
 RxBIN: 610455  
 RxPCN:  
 Care Type:  
 PCC:

Svc Type:  
 Medical  
 Dental  
 RX

**For Members** (calls to these numbers are free)  
 Member Services: 1-866-431-0801  
 TTY: 1-800-627-3529 or 711  
 Medical Questions: 1-888-668-4336 (Ask Mayo Clinic nurse line)  
 For life-threatening emergencies, call 911  
 Complaints: 1-866-431-0801 State Ombudsman: 1-800-657-3729  
 Appeals: Dept. of Human Services, P.O. Box 41, St. Paul, MN 55164-0941

**For Providers** (calls to these numbers are free)  
 Provider Services: 1-866-431-0802  
 Pharmacists: 1-800-821-4795, option 4 for pharmacy questions  
 Utilization Review: 1-866-431-0803  
 Submit claims to: Attn: Claims, PrimeWest Health, PO Box 369, Alexandria, MN 56308  
 Hospital admissions require PrimeWest Health notification. Notify PrimeWest Health within 48 hours if you are hospitalized in or out of the PrimeWest Health network.

## Section 6: Copays

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

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

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

Copays are listed in the following chart. **Be sure you are reading the copay chart for the program in which you are enrolled. If you do not know which program you are enrolled in, call your county worker to find out.**

	Medical Assistance	General Assistance Medical Care
Emergency room visit when it is not an emergency	\$6 copay	\$25 copay
Brand name prescriptions	\$3 copay	\$3 copay
Generic prescriptions	\$1 copay	\$1 copay

The most you will have to pay in copays for prescriptions is \$7 per month. Copays will not be charged for some mental health drugs and most family planning drugs.

**For PMAP members only:** If your income is at or below 100 percent of Federal poverty guidelines, you will pay no more than 5 percent of your monthly income for copays. This may reduce the \$7 monthly prescription copay limit to less than \$7.

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

You must pay your copay to your hospital or pharmacy. Most pharmacies require that you pay the copay when you arrive to pick up your prescription. The hospital may bill you after your non-emergency visit to the emergency room.

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

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

## Section 7: *Covered Services*

This section describes the major services that are covered under the Plan for Medical Assistance and General Assistance Medical Care members. It is not a complete list. Some services have limitations or require a Service Authorization. These services will be marked with an asterisk and a note. Get the Service Authorization before you get the service. All health care services must be medically necessary for them to be covered. Call Member Services at the phone number in *Section 1* for more information.

Some services require copays. A copay is an amount that you will be responsible to pay to your provider. See *Section 6* for information about copays and exceptions to copays.

### Chemical Dependency Services

A Rule 25 assessment performed by a qualified CD assessor at your county must be completed prior to receiving services. **Some services may require a Service Authorization.**

#### Covered Services

- Assessment/diagnosis
- Outpatient treatment\*
- Inpatient hospital\*
- Residential non-hospital treatment\*
- Outpatient methadone treatment\*
- Detoxification only if required for medical treatment\*
- Room and board determined necessary by chemical dependency assessment\*

*\*All chemical dependency treatment services require a Service Authorization*

#### Notes

- See Chemical Dependency Services in *Section 1* for information on where you should call or write.
- A qualified Rule 25 county assessor will decide what type of chemical dependency care you need. You may get a second assessment if you do not agree with the first one. Both the Rule 25 assessor and the second assessor (when applicable) must provide us with a Client Placement Assessment (CPA) with the treatment plan. To get a second assessment, you must send us a request. We must get your request within 5 working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor not in the Plan network. We will do this within 5 working days of when we get your request. If you agree with the second assessment, we will authorize services according to chemical dependency standards and the second assessment. You have the right to Appeal. See *Section 13* of this *Certificate of Coverage*.

## Child and Teen Checkups (C&TCs)

**Child and Teen Checkups are NOT covered for PGAMC members.**

### Covered Services

- Child and Teen Checkup (C&TC) visits
  - Growth measurements
  - Developmental screening
  - Mental health screening
  - Physical exam
  - Immunizations
  - Laboratory tests
  - Vision checks
  - Hearing checks
  - Regular dental checks

### Notes

- C&TC is a health care program of well-child visits for members under age 21. C&TC visits help find and treat health problems early. How often a C&TC is needed depends on age:
  - Birth to 2 years: 0 – 1, 2, 4, 6, 9, 12, 15, 18, and 24 months
  - 3 to 21 years: 3, 4, 5, 6, 8, 10, 12, 14, 16, 18, and 20 years
- Ask your primary care clinic for information about scheduling C&TC visits.

## Chiropractic Care

**Some services may require a Service Authorization.**

### Covered Services

- Manual manipulation (adjustment) of the spine to treat subluxation\*
- X-rays when needed to support a diagnosis of subluxation of the spine

*\*Requires a Service Authorization for more than 24 treatments in a calendar year*

### Not Covered Services

- Other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor
- Chiropractic exams and consultations
- Chiropractic visits that do not include manual manipulation of the spine

## Dental Services (for adults except pregnant women)

**Some services may require a Service Authorization.**

### Covered Services

- Diagnostic services
  - Comprehensive exam every 5 years
  - Periodic exam once per calendar year
  - Problem-focused exams (once per day, per facility)
  - X-rays, limited to:
    - o Bitewing once per calendar year
    - o Single X-rays for diagnosis of problems
    - o Panoramic:
      - Once every 5 years
      - As medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma
      - Once every 2 years in limited situations
    - o Full mouth X-rays once every 5 years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)
- Preventive services
  - Cleaning once per calendar year
  - Fluoride varnish once per calendar year
- Restorative services
  - Fillings
  - Sedative fillings for relief of pain
- Endodontics (root canals) on anterior teeth and premolars only\*
- Periodontics\*
  - Gross removal of plaque and tartar once every 5 years
  - Scaling and root planing once every 2 years only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)
- Prosthodontics\*
  - Removable prostheses (dentures and partials) once every 6 years per dental arch
- Oral surgery limited to extractions, biopsies, and incision and drainage of abscesses
- Additional general services
  - Treatment for pain (once per day)
  - General anesthesia only when provided in an outpatient hospital or freestanding Ambulatory Surgery Center (ASC)

*\*Some services require a Service Authorization. Call Member Services at the phone number in Section 1 if you need more information about dental coverage or Service Authorizations.*

### Not Covered Services

- Relines, repairs, and rebases of removable prostheses (dentures and partials)
- Replacement of lost, stolen, or damaged and irreparable prostheses

### Notes

- See *Section 1* for Dental Services contact information.

## Dental Services (for children and pregnant women)

Some services may require a Service Authorization.

### Covered Services

- Diagnostic services
  - Comprehensive exam
  - Periodic exam
  - Problem-focused exams
  - X-rays, limited to:
    - o Bitewing
    - o Single X-rays for diagnosis of problems
    - o Panoramic
    - o Full mouth X-rays
- Preventive services
  - Cleaning
  - Fluoride varnish once every 6 months
  - Sealants for children under 21, once every 5 years per permanent molar
- Restorative services
  - Fillings
  - Sedative fillings for relief of pain
  - Individual crowns, must be made of prefabricated stainless steel or resin, unless medically necessary in specific circumstances
- Endodontics (root canals)\*
- Periodontics\*
  - Gross removal of plaque and tartar
  - Scaling and root planing
- Implants only when medically necessary for very limited conditions\*
- Prosthodontics\*
  - Removable prostheses (dentures and partials) once every 3 years per dental arch
- Oral surgery
- Orthodontics only when medically necessary for very limited conditions\*
- Additional general services
  - Treatment for pain
  - General anesthesia

*\*Some services require a Service Authorization. Call Member Services at the phone number in Section 1 if you need more information about dental coverage or Service Authorizations.*

### Notes

- See *Section 1* for Dental Services contact information.

## Diagnostic Services (lab and X-ray)

Some services may require a Service Authorization.

### Covered Services

- Lab tests and X-rays
- Other medical diagnostic tests ordered by your health care provider\*

*\*Some medical diagnostic tests may require a Service Authorization. You need a prescription/health care provider's order for diagnostic tests. Call Member Services at the phone number in Section 1 if you need more information about diagnostic services coverage or Service Authorizations.*

## Doctor and Other Health Services

Some services may require a Service Authorization.

### Covered Services

- Health care provider visits
  - Care for pregnant women
  - Family planning – **open access service**
  - Lab tests and X-rays
  - Physical exams
  - Preventive exams
  - Preventive office visits
  - Specialists
  - Telemedicine consultation
  - Vaccines and drugs administered in a health care provider's office\*
  - Visits for illness or injury
  - Visits in the hospital or nursing home
- Immunizations
- Clinical trial coverage: Routine care that is: 1) provided as part of the Protocol Treatment of a cancer Clinical Trial; 2) is usual, customary, and appropriate to your condition; and 3) would be typically provided outside of a Clinical Trial. This includes services and items needed for the treatment of effects and complications of the Protocol Treatment.
- Podiatry services (debridement of toenails and infected corns and calluses and other non-routine foot care)
- Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit
- Advanced practice nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist
- Community health worker care coordination and patient education services
- Health education and counseling (e.g., smoking cessation, nutrition counseling, diabetes education)
- Blood and blood products
- Cancer screenings (including mammography, Pap test, prostate cancer screening, colorectal cancer screening)
- Tuberculosis care management and direct observation of drug intake (**Tuberculosis care management and direct observation of drug intake is NOT covered for PGAMC members.**)
- Counseling and testing for sexually transmitted diseases (STDs), AIDS, and other HIV-related conditions – **open access service**

## Doctor and Other Health Services *continued*

- Treatment for AIDS and other HIV-related conditions – **not an open access service**. You must see a provider in the Plan network.
- Treatment for sexually transmitted diseases (STDs) – **open access service**

*\*Some vaccines and drugs administered in a health care provider's office may require a Service Authorization. Call Member Services at the phone number in Section 1 if you need more information about Service Authorizations.*

### Not Covered Services

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

## Emergency Medical Services and Post-Stabilization Care

### Covered Services

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

### Not Covered Services

- Emergency care, urgent care, or other health care services received from providers located outside the United States and Canada

### Notes

- In an emergency that needs treatment right away, either call **911** or go to the closest emergency room. Show them your membership card and ask them to call your primary care provider.
- If you are out of town, go to the closest emergency room. Show them your membership card and ask them to call your primary care provider.
- An **urgent** condition is not as serious as an emergency, but it is a condition that needs prompt attention. If you have an urgent condition, call your primary care provider, if possible.
- If your clinic is closed, call the *Ask Mayo Clinic* nurse line at **1-888-668-4336** (toll free). This number is answered 24 hours a day, 7 days a week. The nurse will tell you what to do.

## Eye Care Services

**Some services may require a Service Authorization.**

### Covered Services

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

*\*May require a Service Authorization. Call Member Services at the phone number in Section 1 if you need more information about eye care coverage or Service Authorizations.*

## Eye Care Services *continued*

### Not Covered Services

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

## Family Planning Services

Some services may require a **Service Authorization**.

### Covered Services

- Family planning exam and medical treatment – **open access service**
- Family planning lab and diagnostic tests – **open access service**
- Family planning methods (birth control pills, patch, ring, IUD, injections, implants) – **open access service**
- Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) – **open access service**
- Counseling and diagnosis of infertility, including related services – **open access service**
- Treatment for medical conditions of infertility – **not an open access service**. You must see a provider in the Plan network. **Note:** This service does not include artificial ways to become pregnant.
- Counseling and testing for sexually transmitted disease (STDs), AIDS, and other HIV-related conditions – **open access service**
- Treatment for sexually transmitted diseases (STDs) – **open access service**
- Treatment for AIDS and other HIV-related conditions – **not an open access service**. You must see a provider in the Plan network.
- Voluntary sterilization – **open access service**. **Note:** You must be age 21 or over and you must sign a Federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.
- Genetic counseling – **open access service**
- Genetic testing\* – **not an open access service**. You must see a provider in the Plan network.

\*Genetic testing may require a Service Authorization. Call Member Services at the phone number in Section 1 if you need more information about family planning coverage or Service Authorizations.

### Not Covered Services

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

### Notes

- Federal and State law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency to get **open access services**. You can get **open access services** from any provider, even if they are not in the Plan network.

## Hearing Services

**Some services may require a Service Authorization.**

### Covered Services

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

*\*May require a Service Authorization. Call Member Services at the phone number in Section 1 if you need more information about hearing services coverage or Service Authorizations.*

## Home Care Services

**Home care services are NOT covered for PGAMC members.**

**All services require a Service Authorization.**

### Covered Services

- Skilled nursing\*
- Rehabilitation therapies\* (e.g., speech, physical, occupational, respiratory)
- Home health aide\*
- Private duty nursing\*
- Personal Care Assistant (PCA) services\*

*\*Skilled nursing and rehabilitation therapies require a Service Authorization after 9 visits; home health aide, private duty nursing, and PCA services always require a Service Authorization.*

## Hospice

**Hospice services are NOT covered for PGAMC members.**

**All services require a Service Authorization.**

### Covered Services

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

*\*All hospice services require Service Authorization*

### Notes

- You must elect hospice benefits to receive hospice services.
- If you are interested in using hospice services, please call Member Services at the phone number in Section 1.

## Hospital – Inpatient

**A Service Authorization is required for all admissions.** Ask the facility to contact the Plan within 24 hours of admission. If the admission is for Long-term Acute Care (LTAC), Acute Rehabilitation, or Swing Bed, the hospital should contact our Plan before the admission.

### Covered Services

- Inpatient hospital stay\*
- Your semi-private room and meals
- Private room when medically necessary\*
- Tests and X-rays
- Surgery\*
- Drugs
- Medical supplies
- Therapy services (e.g., physical, occupational, speech, respiratory)

*\*Requires a Service Authorization*

### Not Covered Services

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

## Hospital – Outpatient

**Some services may require a Service Authorization.**

### Covered Services

- Urgent care for conditions that are not as serious as an emergency
- Outpatient surgical center\*
- Tests and X-rays\*
- Dialysis
- Emergency room services
- Post-stabilization care

*\*May require a Service Authorization. Call Member Services at the phone number in Section 1 if you need more information about outpatient hospital coverage or Service Authorizations.*

## Interpreter Services

### Covered Services

- Spoken language interpreter services
- Hearing interpreter services

### Notes

- Interpreter services are available to help you get services.
- Oral interpretation is available for any language.
- See Interpreter Services in *Section 1* for contact information.

## Medical Equipment and Supplies

**You need a prescription/health care provider's order for medical equipment and supplies.** Call Member Services if you need more information on our Plan's durable medical equipment coverage criteria or to determine if a Service Authorization is needed.

### Covered Services

- Prosthetics or orthotics\*
- Durable medical equipment\* (e.g., wheelchair, hospital bed, walker, crutches, wigs for people with alopecia areata)
- Repairs of medical equipment\*
- Batteries for medical equipment
- Some shoes when part of a leg brace or when custom molded\*
- Oxygen and oxygen equipment
- Supplies you may need to take care of a medical problem\*
- Diabetic equipment and supplies
- Nutritional/enteral products when specific criteria are met\*
- Incontinence products
- Family planning supplies – **open access service**. See Family Planning Services in *Section 7*.

\*May require Service Authorization

### Not Covered Services

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

### Notes

- You need a prescription/health care provider's order.
- Please call the Durable Medical Equipment Coverage Criteria phone number in *Section 1* if you need more information on our durable medical equipment coverage criteria.

## Mental Health Services

**Some services may require a Service Authorization.**

### Covered Services

- Adult Mental Health Crisis Services (non-residential and residential): assessment, mobile intervention, treatment planning, and stabilization services
- Children's Mental Health Crisis Services (non-residential): mobile assessment, intervention, and stabilization
- Adult Rehabilitative Mental Health Services (ARMHS): basic living/social skills, community intervention, medication education, and services to help you stay in the community
- Assertive Community Treatment (ACT)
- Children's Therapeutic Services and Supports (CTSS): rehabilitative services including individual, group, and family psychotherapy; individual, group, and family skills training; mental health behavioral aides (MHBA); and crisis assistance
- Consultation between your primary care provider and a psychiatrist about your care
- Crisis assessment and intervention provided in an emergency or urgent care setting
- Day treatment and partial hospitalization\*

Mental Health Services *continued*

## Section 7

- Diagnostic assessment including screening for the presence of co-occurring mental illness and substance use disorder
- Dialectical Behavioral Therapy (DBT) for people 18 or over who have been diagnosed with borderline personality disorder. **This service will be covered upon Federal approval.**
- Explanation of findings
- Inpatient psychiatric hospital stay\*
- Intensive Residential Treatment Services (IRTS)\*
- Medication management
- Mental health services provided via two-way interactive video, which would otherwise be covered as direct face-to-face services
- Mental Health Targeted Case Management for people with serious and persistent mental illness (SPMI) or serious emotional disturbance (SED)\*
- Neuropsychological services
- Psychological testing
- Psychotherapy: individual, family, multi-family, and group
- Subacute psychiatric care for people under age 21\*
- Treatment services at children's residential mental health treatment facilities (Rule 5).\* Treatment services do not include coverage for room and board. Room and board may be covered by your county. Call your county for information.

*\*Requires a Service Authorization. Ask the facility to contact the Plan within 24 hours of admission to inpatient, residential, subacute, or partial hospitalization care. Targeted case management requires a Service Authorization before the service starts.*

### Not Covered Services

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

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

### Notes

- See Mental Health Services in *Section 1* for information on where you should call or write.
- Get mental health services from the Plan network of mental health providers.
- If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to go to any qualified health professional who is not in the Plan network. We will pay for this. The out-of-network provider should notify PrimeWest Health of the services provided in order to facilitate payment of these services. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to Appeal our decision.
- We will not determine medical necessity for court-ordered mental health services. Use a Plan network provider for your court-ordered mental health assessment.

## Obstetrics and Gynecology (OB/GYN) Services

### Covered Services

- Prenatal, delivery, and postpartum care
- Childbirth classes
- Hospital services for newborns
- HIV counseling and testing for pregnant women – **open access service**
- Treatment for HIV-positive pregnant women
- Treatment for newborns of HIV-positive mothers
- Testing and treatment of sexually transmitted diseases (STDs) – **open access service**
- Pregnancy-related services received in connection with an abortion (does not include abortion-related services)

### Not Covered Services

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

### Notes

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

## Out-of-Area Services

**Out-of-area services provided by out-of-network providers (except for emergency services, urgent care, post-stabilization care, renal dialysis, and open access services) require a Service Authorization.**

### Covered Services

- A service you need when you are temporarily out of the Plan service area\*
- A service you need after you move from our service area while you are still a Plan member\*
- Emergency services for an emergency that needs treatment right away
- Post-stabilization care
- Medically necessary urgent care when you are outside of the Plan service area
- Covered services that are not available in the Plan service area\*

*\*Requires a Service Authorization*

### Not Covered Services

- Emergency care, urgent care, or other health care services received from providers located outside the United States and Canada

## Out-of-Network Services

**All out-of-network services, except emergency services, urgent care, post-stabilization care, renal dialysis, and open access services, require a Service Authorization.**

### Covered Services

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

\*Requires a Service Authorization

## Prescription Drugs for People Who Do Not Have Medicare

### Covered Services

- Prescription drugs
- Medication therapy management (MTM) services
- Certain over-the-counter drugs (when prescribed by a health care provider or pharmacist)

### Not Covered Services

- Drugs used to treat impotence
- Drugs used to enhance fertility
- Drugs used for cosmetic purposes including drugs to treat hair loss
- Drugs or products to promote weight loss
- Drugs not clinically proven to be effective

### Notes

- The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your health care provider shows us that: 1) the drug that is normally covered has caused a harmful reaction to you; 2) there is a reason to believe the drug that is normally covered would cause a harmful reaction; or 3) the drug prescribed by your health care provider is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered.
- We will cover an antipsychotic drug, even if it is not on our drug list, if your provider certifies this is best for you. There is no copay for antipsychotic drugs. In certain cases, we will also cover other drugs used to treat a mental illness or emotional disturbance even if the drug is not on our approved drug list. We will do this for up to one year if your provider certifies the drug is best for you and you have been treated with the drug for 90 days before: 1) we removed the drug from our drug list; or 2) you enrolled in the Plan. For most drugs, you can get only a 34-day supply at one time.
- Your health care provider can request a non-formulary drug by contacting PrimeWest Health's Pharmacy Benefits Administrator at **1-800-711-9866** (toll free). If you have been receiving the prescribed non-formulary drug at the time of the request, a 34-day supply will be covered during the review process. You and your health care provider will be notified of the decision.
- If pharmacy staff tell you the drug is not covered and ask you to pay, ask them to call your health care provider. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by us under the Plan. If the pharmacy won't call your health care provider, you can. You can also call Member Services at the phone number in *Section 1* for help.

## Prescription Drugs for People Who Do Have Medicare

### Covered Services

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

### Not Covered Services

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

### Notes

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

## Rehabilitation

**Some services may require a Service Authorization.**

### Covered Services

- Physical, occupational, speech, and respiratory therapies and audiology\*

*\*Some services may require Service Authorization before rehabilitation is provided and some physical, occupational, and speech therapy services have a threshold. Call Member Services at the phone number in Section 1 if you need more information about rehabilitation services thresholds or Service Authorizations.*

### Not Covered Services

- Vocational rehabilitation
- Health clubs and spas

## Surgery

**Some services may require a Service Authorization.**

### Covered Services

- Office/clinic visits/surgery\*
- Removal of port wine stain birthmarks
- Reconstructive surgery\* (e.g., following mastectomy; following surgery for injury, sickness, or other diseases; for birth defects)
- Anesthesia services
- Circumcision when medically necessary\*

*\*Circumcision and reconstructive surgery always require a Service Authorization. Other surgeries may require a Service Authorization. Call Member Services at the phone number in Section 1 if you need more information about surgery coverage or Service Authorizations.*

## Surgery *continued*

### Not Covered Services

- Cosmetic surgery
- Sex reassignment surgery

## Transplants

All transplants require a Service Authorization.

### Covered Services

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

\*Requires a Service Authorization

### Notes

- The type of transplant must be: 1) listed in the Minnesota Department of Human Services *Provider Manual*; 2) a type covered by Medicare; or 3) approved by the State's medical review agent.
- Transplants must be done at transplant centers that meet the United Network for Organ Sharing (UNOS) standards or at Medicare-approved transplant centers.
- Stem cell or bone marrow transplant centers must meet the standards set by the Foundation for the Accreditation of Cellular Therapy (FACT).

## Transportation

Some services may require a Service Authorization.

### Covered Services

- Emergency ambulance (air or ground)\*
- Non-emergency ambulance
- Special transportation\* (for people who, because of physical or mental impairment, cannot safely use a common carrier and do not need an ambulance). **Special transportation is NOT covered for PGAMC members.**
- Common carrier transportation (e.g., bus or cab)

\*Out-of-state air ambulance to or from a non-contracted facility requires a Service Authorization. When air ambulance is provided due to an emergency, the Service Authorization can be obtained after the service is provided. Special transportation by an out-of-network provider requires a Service Authorization.

### Not Covered Services

- Mileage reimbursement (e.g., when you use your own car), meals, lodging, and parking. These services are not covered under the Plan, but may be available through another source. Call your county for more information.

### Notes

- If you need transportation to and from health services that we cover, call the Transportation phone number in *Section 1*.
- The Plan is not required to provide transportation to your primary care clinic if it is over 30 miles from your home. Call the Transportation phone number in *Section 1* if you do not have a primary care clinic that is available within 30 miles of your home.

## Urgent Care

### Covered Services

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

### Not Covered Services

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

### Notes

- An urgent condition is not as serious as an emergency. This is care for a condition that needs prompt treatment to stop the condition from getting worse. Urgent care is available 24 hours a day.
- Call Member Services at the phone number in *Section 1* as soon as possible when you get urgent care outside the Plan service area.

## Section 8: *Services We Do Not Cover*

If you get services or supplies that are **not** covered, you may have to pay for them yourself. Some “not covered” services and supplies are listed under each category in *Section 7*. Below is a list of other services and supplies that are not covered under the Plan. This is not a complete list. Call Member Services at the phone number in *Section 1* for more information.

- Health care services or supplies that are not medically necessary
- Supplies that are not used to treat a medical condition
- Hospital inpatient and nursing home incidental services, such as TV, phone, barber and beauty services, or guest services
- Cosmetic procedures or treatment
- Experimental or investigative services
- Emergency care, urgent care, or other health care services received from providers located outside the United States and Canada
- Autopsies

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## Section 9: *Services That Are Not Covered under the Plan but May Be Covered through Another Source*

These services are **not** covered by us under the Plan, but may be covered through another source, such as the State, county, Federal government, tribe, or a Medicare prescription drug plan. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at **1-800-657-3739** (toll free) or **1-651-431-2670**.

- Child welfare targeted case management
- Case management for people with developmental disabilities
- Intermediate care facility for people with developmental disabilities (ICF/MR)
- Nursing home stays
- Abortion services
- Medically necessary services specified in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) that are provided by a school district and covered under Medical Assistance
- Prescriptions covered under the Medicare Prescription Drug Program (Medicare Part D). You must be enrolled in a Medicare prescription drug plan to get these services.
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a State regional treatment center, a State-owned long-term care facility, or an institution for mental disease (IMD), unless approved by us or the service is ordered by a court under conditions specified in law
- Services provided by Federal institutions
- Waiver services provided under Home and Community Based Services waivers
- Job training and educational services
- Day training and habilitation services
- Mileage reimbursement (e.g., when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Room and board associated with treatment services at children’s residential mental health treatment facilities (Rule 5). Room and board may be covered by your county. Call your county for information.

## Section 10: *When to Call Your County Worker*

Call your county worker to report the following changes:

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

## Section 11: *Using the Plan Coverage with Other Insurance*

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

- No-fault car insurance
- Workers’ compensation
- Medicare
- Other HMO coverage
- Other commercial insurance

When you become a member of the Plan, you agree to do the following:

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

If your other insurance changes, call your county worker.

## Section 12: *Subrogation or Other Claim*

This first paragraph applies to members in Prepaid General Assistance Medical Care (PGAMC) and certain non-citizens in the Prepaid Medical Assistance Program (PMAP)

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

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

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

## Section 13: *Grievance, Appeal, and State Fair Hearing Process*

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

- You can call Member Services at the phone number in *Section 1* to file a Grievance or Appeal.
- You can write to us to file a Grievance or Appeal. Write to the address in *Section 1* listed under Appeals and Grievances.
- You can write to the Minnesota Department of Human Services to request a State Fair Hearing. You may request a State Fair Hearing at any time during the Plan Appeal process. You do not have to file an Appeal with us before you request a State Fair Hearing.
- You can call or write to the Minnesota Department of Health.

### Timelines for filing Grievances, Appeals, and State Fair Hearings

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

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

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

### Continuation of services

If we are stopping or reducing a service, you can keep getting the service if you file a health plan Appeal or request a State Fair Hearing **within 10 days after we send you the notice, or before the service is stopped or reduced, whichever is later**. The participating treating provider must agree the service should continue. The service can continue until the Appeal or State Fair Hearing is resolved. If you lose the Appeal or State Fair Hearing, you may have to pay for these services yourself.

### Your rights

If you decide to file a Grievance or Appeal or request a State Fair Hearing, it will not affect your eligibility for medical services. It will also not affect your enrollment in the health plan.

Your provider may file a Grievance or Appeal or request a State Fair Hearing on your behalf. The provider must have your written consent. The treating provider may Appeal utilization review decisions with us without your written consent.

You can have a relative, friend, advocate, provider, or lawyer help with your Grievance, Appeal, or State Fair Hearing.

You may request a State Fair Hearing at any time during the Plan Appeal process. You do not have to file an Appeal with us before you request a State Fair Hearing.

There is no cost to you for filing an Appeal with us or for a State Fair Hearing. We may pay for some expenses such as transportation, child care, photocopying, etc.

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

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

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

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

### To file an oral Grievance with us

A Grievance is an expression of discontent about any matter other than an Action. This includes, but is not limited to, discontent with the following:

- Quality of care or services provided
- Failure to respect your rights

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

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

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

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help.

### To file a written Grievance with us

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

We can help you put your Grievance in writing. Call Member Services at the phone number in *Section 1* if you need help. We will notify you within 10 days that the Grievance has been received.

We will give you a written decision within 30 days from the day we get your Grievance. We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 30 days that we are taking extra time and the reasons why.

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

If you do not agree with our decision, you can file a complaint with the Minnesota Department of Health. You can also call the Ombudsman for State Managed Health Care Programs for help.

### To file an oral or written Appeal with us

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

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

Call Member Services at the phone number in *Section 1* and request an oral Appeal. Tell us why you disagree with the decision. Oral Appeals must be followed by a written and signed Appeal, unless you are requesting an expedited resolution. We will help you complete a written and signed Appeal.

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

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

If your Appeal is about an urgently needed service, we will give you a decision within 72 hours. We will try to call you with the decision before we send the written decision.

We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 72 hours that we are taking extra time and the reasons why. If we do not grant your request for an expedited review, you may file a Grievance.

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

For standard Appeals, we will give you a written decision within 30 days from the day we get your Appeal. We may take up to 14 more days to make a decision if we need more information and it will be in your best interest. We will tell you within 30 days that we are taking extra time and the reasons why.

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

If we are deciding an Appeal regarding denial of a service for lack of medical necessity or one that involves clinical issues, the person making the decision will be a health care professional with appropriate clinical expertise in treating the condition or disease.

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

You or your representative may examine the case file, including medical records and any other documents and records considered by us during the Appeal process. If you do not agree with our decision, you can request a State Fair Hearing with the Minnesota Department of Human Services. You can also call the Ombudsman for State Managed Health Care Programs for help.

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

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

- A denial, termination, or reduction of services
- Enrollment in the plan
- Denial in full or part of a claim for a service
- Our failure to act within required timelines for Service Authorizations and Appeals
- Any other Action

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

Write to: Minnesota Department of Human Services  
Appeals Office  
PO Box 64941  
Saint Paul, MN 55164-0941

Or fax to: **1-651-431-7523**

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

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

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

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

If your hearing is about a medical necessity denial, you may ask for an expert medical opinion. This will be from an outside reviewer. There is no cost to you.

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

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

## Ombudsman for State Managed Health Care Programs

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

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

Or call: **1-800-657-3729** (toll free) or  
**1-800-627-3529** or **711** (toll free TTY) or  
**1-651-431-2660**

## To file a complaint with the Minnesota Department of Health

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Write to: Minnesota Department of Health  
Health Policy and Systems Compliance  
Division – Managed Care Systems  
PO Box 64882  
Saint Paul, MN 55164-0882

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

## Section 14: *Definitions*

These are the meanings of some words in this *Certificate of Coverage*.

**Action** – This includes any of the following:

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

**Anesthesia** – Drugs that make you fall asleep for an operation

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

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

**Certificate of Coverage** – What the document you are reading is called. This *Certificate of Coverage* tells you what services are covered under the Plan. It tells what you must do to get covered services. It tells your rights and responsibilities. It also tells our rights and responsibilities.

**Chemical Dependency** – Using alcohol or drugs in a way that harms you

**Child** – Person under age 21

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

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

**Copay** – An amount that you are responsible to pay to the provider. Some adult members must pay a part of the provider’s charges for some services. Copays are usually paid at the time service is provided. See *Section 6* for required copay amounts.

**Covered Services** – The health care services that are eligible for payment

**Direct Access Services** – You can go to any provider in the Plan network to get these services. You do not need a referral or Service Authorization before getting services.

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

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

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

**Experimental** – A service that has not been proven to be safe and effective

**External Quality Review Study** – A study about how quality, timeliness, and access of care are provided by us. This study is external and independent.

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

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

**Formulary** – The list of drugs covered under the Plan

**General Assistance Medical Care (GAMC)** – Minnesota’s health care coverage program for adults who do not have dependent children, but have limited incomes and do not qualify for other State or Federal programs

**Grievance** – Expression of discontent about any matter other than an Action. This includes, but is not limited to, discontent with the following:

- Quality of care or services provided
- Failure to respect your rights

**Hospice** – A special program for members who are terminally ill and not expected to live more than 6 months. It offers special services for the member and his/her family.

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

**Investigative** – A service that has not been proven to be safe and effective

**Medical Assistance (MA)** – Minnesota’s Medicaid program. The Federal Centers for Medicare & Medicaid Services (CMS) administers Medicaid nationwide. In Minnesota, the Department of Human Services (DHS) oversees the program, and eligibility is administered by the counties.

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

- Be the service that other providers would usually order
- Help you get better or stay as well as you are
- Help stop the condition from getting worse
- Help prevent and find health problems

**Medicare** – The Federal health insurance program for people 65 years of age or over. It is also for some people under age 65 with disabilities and people with End Stage Renal Disease.

**Medicare Prescription Drug Plan** – An insurance plan that offers the Medicare Prescription Drug Program (Medicare Part D) drug benefits

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

**Network** – Our contracted health care providers for the Plan

**Notice of Action** – A form or letter we send you telling you about a decision on a claim, a service, or any other Action taken by us

**Ombudsman for State Managed Health Care Programs** – A person at the Minnesota Department of Human Services who can help you with access, service, or billing problems. He/she can also help you file a Grievance or Appeal to us or request a State Fair Hearing.

**Open Access Services** – Federal and State law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency—even if not in our network—to get these services

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

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

**Out-of-Network Services** – Health care provided to a member by an out-of-network provider

**Physician Incentive Plan** – Special payment arrangements between us and the health care provider that may affect the use of referrals. It may also affect other services that you might need.

**Post-stabilization Care** – A hospital service needed to help a person's condition stay stable after having emergency care. It starts when the hospital asks for our approval of coverage. It continues until: the person is discharged; our Plan network health care provider begins care; or we, the hospital, and the health care provider agree to a different arrangement.

**Prepaid General Assistance Medical Care (PGAMC)** – A program in which the State contracts with health plans to cover and manage health care services for General Assistance Medical Care enrollees

**Prepaid Medical Assistance Program (PMAP)** – A program in which the State contracts with health plans to cover and manage health care services for Medical Assistance enrollees

**Prescriptions** – Medicines and drugs ordered by a health care provider

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

**Primary Care Clinic** – The clinic you choose for your routine care. This clinic will provide or approve most of your care. The name of your clinic appears on your membership card.

**Primary Care Provider** – The health care provider you see at your primary care clinic. This person will manage your health care.

**Provider** – A health care professional or facility approved under State law to provide health care

**Restricted Recipient Program** – A program for members who have received medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from 1 designated primary care provider, 1 drug store, 1 hospital, or other designated health services provider(s) located in your local trade area. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months.

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

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

**Service Authorization** – Our approval that is needed for some services before you get them

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

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

- A denial, termination, or reduction of services
- Enrollment in the plan
- Denial in full or part of a claim for a service
- Our failure to act within required timelines for Service Authorizations and Appeals
- Any other Action

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

**United States** – For the purpose of this *Certificate of Coverage*, the United States includes the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, The Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands

**Urgent Care** – Care for a condition that needs prompt treatment to stop the condition from getting worse. An urgent condition is not as serious as an emergency. In areas that do not have “Urgent Care,” “After Hours,” or “Extended Hours” clinics, you may need to go to the emergency room for this care. Urgent care is available 24 hours a day.



*Why*  
**choose**  
PrimeWest Health?

- **Quality Health Coverage** – You get coverage for the health care you need, including many services to help you stay healthy: checkups, immunizations, care coordination, and disease management programs
- **Access to Specialists** – You can see network specialists without a referral
- **Large Network of Providers** – We have an extensive network of primary and specialty care providers
- **Cooperation** – We work closely with local providers to better meet your needs
- **Local Ownership** – We're owned by the residents of the counties we serve
- **Local Customer Service** – We have trained and dedicated Member Services staff

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Reduce Reuse Recycle

