Member Handbook

Health Partners Plans Medicaid

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

Health Partners Plans

part of Jefferson

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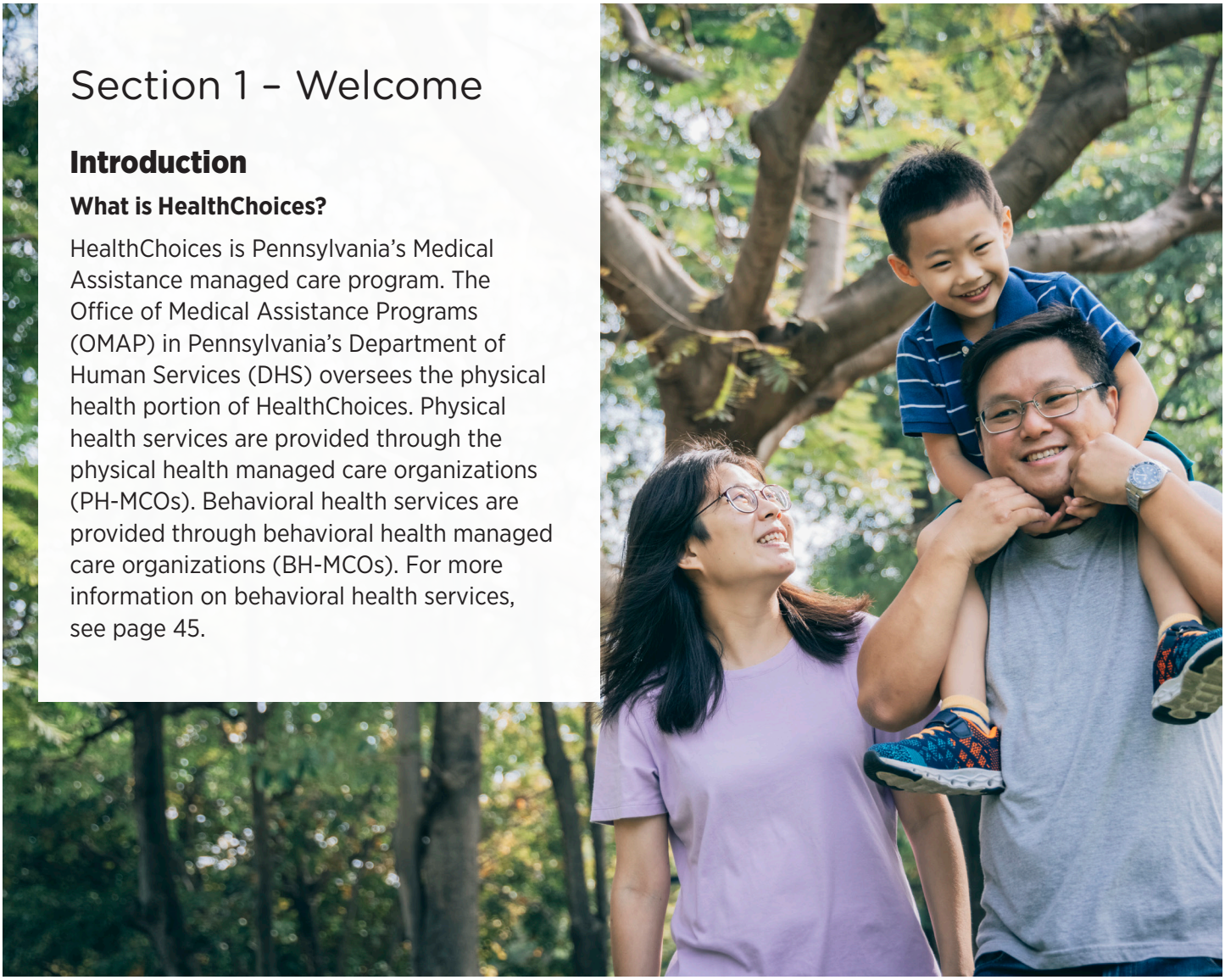
Section 1 – Welcome

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 45.

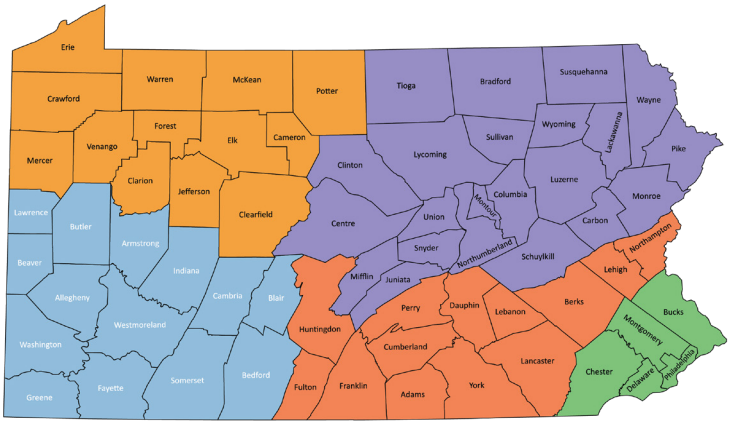


Welcome to Health Partners Plans Medicaid

Health Partners Plans welcomes you as a member in HealthChoices and Health Partners Plans! Health Partners Plans is the health plan that puts your needs first. It has been serving the Medical Assistance population 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 Plans 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 Plans serves members across the Commonwealth:



Health Partners Plans has a network of contracted providers, facilities, and suppliers to provide covered physical health services to members. As a Health Partners Plans 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 Plans 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 Plans 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 Medical Assistance Transportation Program
- Connecting members to Enhanced Member Supports Unit/case management services
- Member Rights and Responsibilities

Health Partners Plans' Member Services are available 24 hours a day, 7 days a week. They 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
1101 Market Street, Suite 3000
Philadelphia, PA 19107

If you receive a call from Health Partners Plans, the representative will advise they are calling on behalf of Health Partners Plans and identify themselves by name and job title

You can also contact us by sending secure messages through our member portal. Once you login, you'll have 24/7 access to your health information, benefits, and much more. Visit www.HPPlans.com/portal to get started.

Member Identification Cards

Your Health Partners Plans membership ID card lets everyone know you are a member of Health Partners Plans. 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 Plans 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/portal. 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 Electronic Benefit Transfer (EBT) card. You will need to present this card along with your Health Partners Plans 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.

The Medical Assistance (MA) cards with the Capitol and cherry blossoms may be used for cash assistance, Supplemental Nutritional Assistance Program (SNAP) and MA. Additionally, if a Member is eligible for cash assistance, they are automatically eligible for MA. Typically, this card is issued to the person who the cash assistance and/or SNAP benefit is directed to, or for MA it is issued to the head of household.

The "Blue Card(s)" are issued only for MA to all other members of the household.

Older MA cards that may still be active are shown here.

The green/blue card with yellow "ACCESS" may also serve as the head of household's EBT card for SNAP and cash assistance, and their MA card. The yellow card is only for MA for all other members of the household. Until you get your Health Partners Plans 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	1-800-440-3989 1-800-618-4225 (TTY)	Pick or change a HealthChoices plan. See page 8 of this Handbook for more information.
Pennsylvania 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
Behavioral Health Services	See page 45
County Assistance Offices	See page 59
Crisis Intervention Services	See page 57
Legal Aid	1-800-322-7572
Medical Assistance Transportation Program	See page 39
Mental Health/Intellectual Disability Services	1-888-565-9435
Suicide and Crisis Lifeline The 988 Suicide and Crisis Lifeline number is available 24/7.	Call: 988 Text: 988 Visit or Chat: 988lifeline.org If mental health care or support is needed, you can learn more about services in PA at www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/default.aspx.

Communication Services

Health Partners Plans can provide this Handbook and other information you need in languages other than English at no cost to you. Health Partners Plans 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 Plans to send you the information.

Health Partners Plans 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 you, Health Partners Plans will work with your provider to provide an interpreter 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 Plans 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 health care needs, which could help you decide which HealthChoices plan to pick
- Give you more information about your HealthChoices plan

To contact the EAP, call 1-800-440-3989 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 1-800-440-3989 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 Plans until then. It can take up to 6 weeks for a change to your HealthChoices plan to take effect. Use your Health Partners Plans 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

Once born, a new baby is automatically assigned to the mother's current HealthChoices plan. You may change your baby's plan by calling the EAP at 1-800-440-3989. 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 Plans also serves your new county you can stay with Health Partners Plans. If Health Partners Plans does not serve your new county, the EAP can help you select a new plan.

If you move out of state, notify your CAO as 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 Plans' provider directory has information about the providers in Health Partners Plans' network. The provider directory is located online here: www.HPPlans.com/HPdocs.

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 Plans 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 Plans' network. If you do not have Medicare, your PCP must be in Health Partners Plans' network.

If you have special health care 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 Plans' network.

Enrollment specialists can help you pick your first PCP with Health Partners Plans. If you do not pick a PCP through the EAP within 14 days of when you picked Health Partners Plans, Health Partners Plans 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. You can also change your PCP using the member portal: HPPlans.com/portal. If you need help finding a new PCP, you can go to www.HPPlans.com/HPdocs, which includes a provider directory, or ask Member Services to send you a printed provider directory.

Health Partners Plans 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 Plans can help coordinate sending your medical records from your old PCP to your new PCP. In emergencies, Health Partners Plans 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 Plans 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 39 of this Handbook or call Health Partners Plans Member Services at the phone number above. If you do not have your Health Partners Plans ID card by the time of your appointment, take your ACCESS card or EBT card with you. You should also tell your PCP that you selected Health Partners Plans as your HealthChoices plan.

Appointment Standards

Health Partners Plans' 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 Plans learning you are pregnant.
  - In your second trimester, your provider must see you within 5 business days of Health Partners Plans learning you are pregnant.
  - In your third trimester, your provider must see you within 4 business days of Health Partners Plans learning you are pregnant.
  - Have a high-risk pregnancy, your provider must see you within 24 hours of Health Partners Plans 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 Plans does not have at least 2 specialists in your area and you do not want to see the specialist in your area, Health Partners Plans will work with you to see an out-of-network specialist at no cost to you. Your PCP must contact Health Partners Plans to let us know you want to see an out-of-network specialist and get approval from Health Partners Plans 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 Plans' network, please see the provider directory on our website at www.HPPlans.com/HPdocs or call Member Services to ask for help or 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 Plans' network provider unless Health Partners Plans 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 your 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 45 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 Plans 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. Visit TeladocHealth.com to set up an account for easier access.

Member Engagement

Suggesting Changes to Policies and Services

Health Partners Plans 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 Plans at 1-800-553-0784 (TTY 1-877-454-8477).

Health Partners Plans Health Education Advisory Committee (HEAC)

Health Partners Plans has a Health Education Advisory Committee (HEAC) that includes members and network providers. The Committee provides advice to Health Partners Plans about the experiences and needs of members like you. For more information about the Committee, please call 1-833-878-2226 or visit the website at www.HPPlans.com/HEAC.

Health Partners Plans Quality Improvement Program

Health Partners Plans' Quality Improvement and Performance (QIP) Program is focused on improving the health outcomes and quality of life for our members.

The Quality Improvement Team develops and oversees a variety of quality initiatives such as outreach to help members schedule appointments, coordination of health events with vendor and provider partners, coordination of in-home visits and kit mailings, linkage to social determinants of health resources, medication management, improvement of health disparities and more. The Quality Improvement Team works directly with providers on initiatives to improve the overall member experience and enhance patient-centered care. To learn more, call Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

Section 2 – Rights and Responsibilities

Member Rights and Responsibilities

Health Partners Plans 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 Plans 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 Plans 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 Plans, 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 Plans' approval.
6. To get information that you can easily understand and talk to your providers about your treatment options, risks of treatment and tests that may be self-administered, without any interference from Health Partners Plans.
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 Plans' 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 Plans 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 Plans, and network providers treat you.
17. To create an advance directive. See Section 6 on page 43 for more information.
18. To make recommendations about the rights and responsibilities of Health Partners Plans' members.

Member Responsibilities

Members need to work with their health care service providers. Health Partners Plans 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 Plans coverage, including all covered and non-covered benefits, and limits.
7. Use only network providers unless Health Partners Plans 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 suspected fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

Privacy and Confidentiality

Health Partners Plans must protect the privacy of your protected health information (PHI). Health Partners Plans 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 Plans can pay your providers. It also includes sharing your PHI with DHS. This information is included in Health Partners Plans' Notice of Privacy Practices. To get a copy of Health Partners Plans' Notice of Privacy Practices, please call 1-800-553-0784 (TTY 1-877-454-8477) 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
- Pregnant women (including 1 year 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 Plans. Please see Section 8, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint, or call Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

Billing Information

Providers in Health Partners Plans' network may not bill you for medically necessary services that Health Partners Plans covers. Even if your provider has not received payment or the full amount of his or her charge from Health Partners Plans, 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 Plans 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 are not covered by Health Partners Plans 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 Plans network provider and you think the provider should not have billed you, you can call Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

Open it right away. Do not pay it. Just write "Health Partners Plans" and your Health Partners Plans 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 Plans pays. Health Partners Plans 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 Plans 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 Plans 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 Plans' network. You also do not have to get prior authorization from Health Partners Plans or referrals from your Medicare PCP to see a specialist. Health Partners Plans 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 Plans, you must get the service from a Health Partners Plans network provider. All Health Partners Plans 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 Plans' network. You need to follow the rules of your other insurance and Health Partners Plans, such as prior authorization and specialist referrals. If your other health insurance covers a specialist referral, or another service that is covered on the Medical Assistance Fee Schedule, with or without prior authorization, you will not need additional approval from the PH-MCO. Your

PH-MCO will accept your third party referral and/or prior authorization if the service is covered by your other health insurance. Health Partners Plans 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 Plans network provider. All Health Partners Plans 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 Plans 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 Plans reviews the health care and prescription drug services you have used. If Health Partners Plans finds overuse or abuse of health care or prescription services, Health Partners Plans asks DHS to approve putting a limit on the providers you can use. If approved by DHS, Health Partners Plans will send you a written notice that explains the limit.

You can pick the providers, or Health Partners Plans will pick them for you. If you want a different provider than the one Health Partners Plans 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 Plans 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 Plans' 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 Plans about the decision to limit your providers.

Every 5 years, while the restriction is in place, Health Partners Plans 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 Plans 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 Plans 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 Plans Fraud and Abuse Hotline at 1-866-477-4848 (TTY 1-877-454-8477), or use this link www.mycompliancereport.com/report?cid=JEFF to give Health Partners Plans 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).

Examples of Member Fraud or Abuse include: someone who receives medical assistance, or other public benefits AND that person is not reporting income, not reporting resources or property they own, not reporting who lives in the household, allowing another person to use their ACCESS/MCO card, forging or making changes to prescriptions, or selling prescriptions or medications.

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 Plans Fraud and Abuse Hotline at 1-866-477-4848 (TTY 1-877-454-8477), email SIUtips@jeffersonhealthplans.com or use an online reporting tool at www.mycompliancereport.com/report?cid=JEFF. You may also report this information

to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

Examples of Provider Fraud or Abuse include: billing for services not provided; misrepresenting the service/supplies rendered (for example, billing brand named for generic drugs; billing for a different service than was rendered; billing for more time or units of service than provided; billing at a service location other than the service location at which services were provided; submitting false information on claims, such as date of service, provider or prescriber of service; double billing for the same service; billing for services provided by unqualified persons; billing for used items as new.

Section 3 – Physical Health Services

Covered Services

The chart below lists the services that are covered by Health Partners Plans 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 Plans. 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.

All medically necessary Medicaid-coverable services in any amount are covered for individual members under the age of 21.

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
Doula Services (Prenatal visit, Postpartum Visit, and Labor & Delivery)	Limit	N/A	12 visits per calendar year (prenatal/ postpartum/labor/delivery) 2 more services per calendar year (preconception counseling/pregnancy/ infant loss/termination of pregnancy)
	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	$0
	Prior Authorization/Referral	No	No
Outpatient Hospital Clinic	Limit	No limits	No limits
	Co-payment	$0	$0
	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	$0
	Prior Authorization/Referral	Yes	Yes
Optometrist Services	Limit	2 exams per calendar year (or more if medically necessary)	2 exams per calendar year (or more if medically necessary)
	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	No limits for basic dental care
	Co-payment	$0	$0
	Prior Authorization/Referral	Prior Authorization may be required based on dental procedure	Prior authorization or Benefit Limit Exception may be required for complex care
Radiology (ex. X-rays, MRIs, CTs)	Limit	No limits	No limits
	Co-payment	$0	$0
	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	$0
	Prior Authorization/Referral	No	No
Outpatient Ambulatory Surgical Center	Limit	No limits	No limits
	Co-payment	$0	$0
	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	$0
	Prior Authorization/Referral	Yes	Yes
Inpatient Rehab Hospital	Limit	No limits	No limits
	Co-payment	$0	$0
	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	$0	$0 generic $0 brand
	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	See Nursing Facility Services on page 33	See Nursing Facility Services on page 33
	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	No limits, but after 4 standard lenses per calendar year, additional lenses in that year must be prior authorized	See Vision Care Services on page 28
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Eyeglass Frames	Limit	No limits, but after 2 standard frames per calendar year, additional frames in that year must be prior authorized	See Vision Care Services on page 28
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Contact Lenses	Limit	No limits, but after 4 lenses per calendar year, additional lenses in that year must be prior authorized.	See Vision Care Services on page 28
	Co-payment	$0	$0
	Prior Authorization/Referral	No	No
Contact Lenses Fitting	Limit	Covered when medically necessarily	Covered when medically necessarily
	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	Fitness club memberships available at no cost. See the Fitness Club Membership section on page 35 or visit HPPlans.com/fitness to learn more.	
	Co-payment		
	Prior Authorization/Referral	No	No

Services That Are Not Covered

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

MCOs may choose to cover experimental medical procedures, medicines and equipment based on your specific situation. MCOs must provide coverage for routine patient care costs for beneficiaries participating in qualifying clinical trials.

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 Plans network provider to get a second opinion. If there are not any other providers in Health Partners Plans' network, you may ask Health Partners Plans 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 Plans before you can get the service. This is called prior authorization. For services that need prior authorization, Health Partners Plans decides whether a requested service is medically necessary before you get the service. You or your provider must make a request to Health Partners Plans 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 of 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).

How to Ask for Prior Authorization

When a service, item, or medicine requires prior authorization from Health Partners Plans before it can be provided to you, typically your provider will submit the prior authorization request with current doctor's orders and supporting clinical documentation through our online provider portal. Your provider may also fax the request to Health Partners Plans at 1-866-240-3712 or call in the request by phone at 1-888-991-9023.

Please talk to your PCP or specialist or call Member Services at 1-800-553-0784 (TTY 1-877-454-8477):

- If you are not sure that your provider has requested prior authorization.
- If you are unsure whether prior authorization is needed for a service, item or medicine.
- If you simply need help to better understand the prior authorization process.

If you need help to better understand the prior authorization process, talk to your health care provider or call Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

If you or your provider would like a copy of the medical necessity guidelines or other rules that were used to decide your prior authorization request, you can call Member Services at 1-800-553-0784 (TTY 1-877-454-8477). Providers should call Provider Services at 1-888-991-9023. You can also visit www.HPPlans.com/providers/prior-authorization.

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

If Health Partners Plans 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 Plans will tell you of our decision within 2 business days after Health Partners Plans 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 Covered Drugs

Health Partners Plans 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 Plans 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 Plans for prior authorization as soon as possible.

What if I Receive a Denial Notice?

If Health Partners Plans 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 Plans must authorize the medication until the Complaint or Grievance is resolved. See Section 8, Complaints, Grievances, and Fair Hearings, starting on page 47 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
1101 Market Street, Suite 3000
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 Plans 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 Plans 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 39 of this Handbook) for emergency medical transportation.

Urgent Care

Health Partners Plans 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 Plans' 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

Health Partners Plans' dental care services are provided by the Avesis network. Tell the dental provider that you are an HPP member using the Avesis network. 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 Plans provides all medically necessary dental services for children under 21 years of age. Children may go to a participating dentist within the Health Partners Plans – Avesis network.

Dental visits for children do not require a referral. If your child's first tooth comes in, or 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. You can choose a participating dentist on your own. For more information on dental services, contact Health Partners Plans 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
- 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 Plans may 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 Plans and there is approved continuity of care prior authorization. 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 Plans covers some dental benefits for members 21 years of age and older through dentists in the Health Partners Plans – Avesis network. Some dental services have limits.

Adult Health Partners Plans 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 for some services.

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 Plans 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 have had 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 Plans 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 Plans 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 Plans to deny the exception.

Your dental service may also be covered by a BLE if you have one of the following underlying medical/dental condition(s).

1. Diabetes
2. Coronary Artery Disease or risk factors for the disease
3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin)
4. Intellectual Disability
5. Current Pregnancy including post-partum period

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

Avēsis Third Party Administrators
LLC Attention: Dental Preauthorization
P.O. Box 38312
Phoenix, AZ 85069

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 Plans will let you know whether or not the BLE is approved within 21 days. If your dentist asks for an exception after you got the service, Health Partners Plans will let you know whether or not the BLE request is approved within 30 days of the date Health Partners Plans gets the request.

If you disagree with or are unhappy with Health Partners Plans' decision, you may file a Complaint or Grievance with Health Partners Plans.

For more information on the Complaint and Grievance process, please see Section 8 of this Handbook, "Complaints, Grievances, and Fair Hearings" on page 47.

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 Health Partners Plans.

Members Under 21 Years of Age

Health Partners Plans covers all medically necessary vision services for children under 21 years of age. Children may go to a participating vision provider within the Health Partners Plans network.

If you choose eyeglass frames, eyeglass lenses, and contact lenses that are not considered standard, you may have to pay out of pocket for these items. Your eye doctor will let you know if you have to pay extra for any of these services. If you have any questions, you can call Health Partners Plans Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

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 Plans 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 Plans vision plan, Health Partners Plans will cover part of the price for the frame up to $100 and you are responsible for the rest of the cost.

Service	Limits	Copayments	Prior Authorization
Vision Examination and Refraction	No limit, but after 2 examinations per calendar year, additional examinations in that year must be prior authorized	$0	No
Standard Eyeglass Lenses	No limited, but after 4 standard lenses per calendar year, additional lenses in that year must be prior authorized	$0	No
Standard Eyeglass Frames	No limits, but after 2 standard frames per calendar year, additional frames in that year must be prior authorized	$0	No
Contact Lenses	No limits, but after 4 standard lenses per calendar year, additional lenses in that year must be prior authorized	$0	No
Low Vision Ads	No limits, but after 1 low vision aid every 2 years, additional low vision ads must be prior authorized	$0	Yes
Eye Prosthesis	No limits, but after 1 prothesis every 2 years, additional prosthesis must be prior authorized	$0	Yes

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 Plans. 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 Plans 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 Plans Member Services at 1-800-553-0784 (TTY 1-877-454-8477) for details.

Members 21 Years of Age and Older

Health Partners Plans 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. Members diagnosed with aphakia and cataracts 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 Plans 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 Plans vision plan, Health Partners Plans 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 Plans. 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 Plans 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.

Pharmacy Benefits

Health Partners Plans covers pharmacy benefits that include prescription medicines and over-the-counter medicines and vitamins with a doctor's prescription.

Prescriptions

When a provider prescribes a medication for you, you can fill your prescription at any pharmacy that is in Health Partners Plans' network. You will need to have your Health Partners Plans prescription ID card with you. Health Partners Plans will pay for any medicine listed on the Statewide PDL and Health Partners Plans' 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 Plans' network, or have any other questions, please call Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

The Health Partners Plans provider directory also contains a list of participating pharmacies. To access the online provider directory, visit HPPlans.com/hpdocs and click on "Find a Pharmacy." 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 Plans prescriptions. Your prescription will be filled if the prescription is covered under your pharmacy benefit.

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 Plans.

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

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

Health Partners Plans covers medicines listed on the Statewide Preferred Drug List (PDL) and the Health Partners Plans 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 Plans 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 Plans' supplemental formulary needs prior authorization. The Statewide PDL and Health Partners Plans' 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 Plans' supplemental formulary, call Member Services at 1-800-553-0784 (TTY 1-877-454-8477) or visit Health Partners Plans' website at HPPlans.com/CoveredDrugs.

Reimbursement for Medication

Health Partners Plans will review all requests for reimbursement. Health Partners Plans 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 Health Partners Plans 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 Health Partners Plans, 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 Plans' supplemental formulary include medicines that are called specialty medicines. A prescription for these medicines needs to be prior authorized. To see the Statewide Preferred Drug List, the Health Partners Plans supplemental formulary, a complete list of specialty medicines and whether your medicine is considered a specialty medicine, call Member Services at 1-800-553-0784 (TTY 1-877-454-8477) or visit Health Partners Plans' website at HPPlans.com/CoveredDrugs.

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 the mailing of 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 Plans' network. For the list of network specialty pharmacies, please call Member Services at1-800-553-0784 (TTY 1-877-454-8477) or see the provider directory on Health Partners Plans' website at www.HPPlans.com/hpdocs. 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 Plans covers over-the-counter medicines when you have a prescription from your provider. You will need to have your Health Partners Plans ID card with you. The following are some examples of over-the-counter medicines that may be covered:

- Sinus and allergy medicine
- Tylenol or aspirin
- Vitamins
- Cough medicine
- Heartburn medicine such as antacids and famotidine

You can find more information about covered over-the-counter medicines by visiting Health Partners Plans' website at www.HPPlans.com/CoveredDrugs 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 Plans 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 Plans 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?
Nicotine Gum/Lozenge	Yes	No
Inhaler	Yes	Yes
Nasal spray	Yes	Yes
Patch	Yes	No
Bupropion (generic for Wellbutrin and Zyban combination)	Yes	No
Varenicline	Yes	No

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 Plans 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 be referred to a quit-smoking program, 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 Plans members are eligible for services to address these side effects, but these services are covered by your BH-MCO. To find the BH-MCO in your county and its contact information:

- See the information that came with your welcome kit, or
- Go to www.healthchoices.pa.gov/providers/about/behavioral/index.htm, or
- Go to page 45 for a listing of the BH-MCO in your county, or
- Call Health Partners Plans 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 Plans 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 Plans 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 Free Quitline: 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 Plans 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 Plans 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 infections, 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 Plans network, you must show your Health Partners Plans 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 member receives throughout 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 Plans 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 Plans learning you are pregnant.
- If you are in your second trimester, within 5 business days of Health Partners Plans learning you are pregnant.
- If you are in your third trimester, within 4 business days of Health Partners Plans learning you are pregnant.
- If you have a high-risk pregnancy, within 24 hours of Health Partners Plans 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 (1 year 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 Plans 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 Plans, you can continue to see that provider even if he or she is not in Health Partners Plans' network. The provider will need to be enrolled in the Medical Assistance Program and must call Health Partners Plans for approval to treat you.

Care for You and Your Baby After Your Baby is Born

You should visit your maternity care provider between 7 to 84 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 Plans 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 or transportation for all your prenatal appointments. 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 Plans covers all these visits and will help you get to each appointment. Staying with Health Partners Plans 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.

Health Partners Plans 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 are available starting in the third trimester or after delivery
- Blood pressure cuffs when ordered by a doctor
- Doula support at the time of delivery
- Home visiting programs for parenting and supporting child's development

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

Durable Medical Equipment and Medical Supplies

Health Partners Plans covers Durable Medical Equipment (DME), including home accessibility 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 Plans network. You may have a co-payment. Health Partners Plans will not be held liable for reimbursement regarding the out of pocket cost for DME (durable medical equipment) purchased from a retail store or online retail dealer (e.g. Amazon). Retail stores and suppliers are not covered by your medical DME benefit for safety reasons. Health Partners Plans offers a wide network of participating DME providers who are credentialed to meet Medicare and Medicaid standards and requirements.

Examples of DME include:

- Oxygen tanks
- Wheelchairs
- Crutches
- Walkers
- Splints
- Special medical beds
- Blood pressure cuffs

Examples of home accessibility DME include:

- Wheelchair lifts
- Stair glides
- Ceiling lifts
- Metal accessibility ramps

Health Partners Plans covers installation of the home accessibility DME, but not home modifications.

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 Plans 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 Plans' network providers.

Nursing Facility Services

Health Partners Plans covers medically necessary nursing facility services. If you need long term nursing facility services (longer than 30 days), you can apply for the Community HealthChoices Program. You will be evaluated to see if you are eligible for participation in the Community HealthChoices Program. If you have any questions or need more information, please call Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

Hospital Services

Health Partners Plans 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 Plans' 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 Plans. To find out if a hospital is in the Health Partners Plans network, please call Member Services at 1-800-553-0784 (TTY 1-877-454-8477) or check the provider directory on Health Partners Plans' website at www.HPPlans.com/hpdocs.

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 Plans' network, you may be transferred to a hospital in Health Partners Plans' network. You will not be moved to a new hospital until you are stable 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, Health Partners Plans 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 Plans 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.

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

Before Health Partners Plans 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 Plans Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

Home Health Care

Health Partners Plans 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.

Health Partners Plans 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. If your doctor's office is a Patient-Centered Medical Home, they have a team committed to helping you. They can assist you with scheduling follow-up care after a hospital discharge, connecting you to community resources

if you need food, housing or financial assistance, and creating a plan of care with follow-up activities and goals.

Disease Management

Health Partners Plans has voluntary care coordination programs to help you take better care of yourself if you have one of the health conditions listed below. Health Partners Plans has care coordinators 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 Plans 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.
- Pediatric Care Coordination 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 and conditions from birth through the age of 21. The Enhanced Member Supports Unit also follows children who require shift care. (See Section 5.)
- Adult Care Coordination provides coordination of services for adult and children under Pediatric Care Coordination with any health condition whether it is asthma, diabetes, COPD, heart disease, HIV or multiple conditions. Staff provides health education, coordination of health care services, connection with community support programs, and connections to behavioral health care needs.
- 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
- 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.
- Connecting you with community programs that can help you with issues that can affect your health and wellness.

By following your provider's plan of care and learning about your condition, you can stay healthier. Health Partners Plans 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 Plans offers fitness club memberships at no cost to members. Visit HPPlans.com/fitness to learn more about programs available to you.

Ready to get started?

Follow these simple steps to get started today:

1. Visit HPPlans.com/fitness to learn more about your fitness membership benefit and to find participating fitness centers in your area.
2. Go to a participating fitness center and show your Health Partners Plans member ID card. The fitness center staff will handle the rest to help you sign up and get started.

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. Once you choose a fitness center, you may not choose a different center for one year. For more information, please call Member Services at 1-800-553-0784 (TTY 1-877-454-8477) or visit HPPlans.com/fitness.

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.

JeffConnect On Demand (non-emergency)

As a Health Partners Plans member, you have 24/7 access to Jefferson providers by using your smartphone, tablet or computer with a webcam. JeffConnect is a quick and easy-to-use option for care for needs like colds, flu, cough, fever, urinary tract symptoms, infections or minor injuries. To get started, download the JeffConnect app from the App Store or Google Play. You can also visit JeffConnect.org. You will need to setup an account before you can use this service. Internet connection is required for this service.

Quality Management Program

Health Partners Plans' Quality Management program monitors and works to improve the care and services you receive as a Health Partners Plans 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 Plans 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 Plans 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).

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 a well-baby or well-child checkup is to detect health problems early so that they can be treated as early as possible. EPSDT includes all Medicaid covered services that are medically necessary to correct or relieve physical or mental illnesses and conditions. Health Partners Plans covers physical health services that are needed to treat health problems that are identified during the checkup. Behavioral health services are provided through your BH-MCO. For more information on behavioral health treatment, see page 45. If you have questions or want more information, contact Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

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

Additional services are available for children with special health care 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 Plans to provide services to Health Partners Plans' members. There may be a time when you need to use a doctor or hospital that is not in the Health Partners Plans network. If this happens, you can ask your PCP to help you. Your PCP has a special number to call to ask Health Partners Plans that you be allowed to go to an out-of-network provider. Health Partners Plans 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 Plans cannot give you a choice of at least 2 providers in your area, Health Partners Plans will cover the medically necessary services provided by an out-of-network provider.

Getting Care While Outside of Health Partners Plans' Service Area

If you are outside of Health Partners Plans' 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 Plans 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 Plans 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 Plans. Below are some services that are available but are not covered by Health Partners Plans. 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 Plans does not cover non-emergency medical transportation for most HealthChoices members. Health Partners Plans can help you arrange transportation to

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

Health Partners Plans 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 and from qualified MA-enrolled medical providers and pharmacies of your choice who are generally available and used by other residents of your community. 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 if you live within 1/4 mile of a fixed route service stop.
- 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 your local MATP to get more information and register for services. A complete list of county MATP contact information can be found here: http://matp.pa.gov/CountyContact.aspx or please see the list on this page

MATP will confirm with Health Partners Plans or your doctor's office that the medical appointment you need transportation for is a covered service. Health Partners Plans 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).

County	Phone	Toll Free
Adams	717-846-7433	800-632-9063
Allegheny	412-350-4476	888-547-6287
Armstrong	724-548-3408	800-468-7771
Beaver	724-375-2895	800-262-0343
Bedford	814-623-9129	800-323-9997
Berks	610-921-2361	800-383-2278
Blair	814-695-3500	800-458-5552
Bradford	570-888-7330	800-242-3484
Bucks	215-794-5554	888-795-0740
Butler	724-431-3663	866-638-0598
Cambria	814-535-4630	888-647-4814
Cameron	866-282-4968	866-282-4968
Carbon	570-669-6380	570-669-6380
Centre	814-355-6807	814-355-6807
Chester	610-344-5545	877-873-8415
Clarion	814-226-7012	800-672-7116
Clearfield	814-765-1551	800-822-2610
Clinton	570-323-7575	800-206-3006
Columbia	717-846-7433	800-632-9063
Crawford	814-333-7090	800-210-6226
Cumberland	717-846-7433	800-632-9063
Dauphin	717-232-7009	800-309-8905
Delaware	610-490-3960	610-490-3960
Elk	866-282-4968	866-282-4968
Erie	814-456-2299	814-456-2299
Fayette	724-628-7433	800-321-7433
Forest	814-927-8266	800-222-1706
Franklin	717-846-7433	800-632-9063
Fulton	717-485-6767	888-329-2376
Greene	724-627-6778	877-360-7433
Huntingdon	814-641-6408	800-817-3383
Indiana	724-465-2140	800-524-2766
Jefferson	814-938-3302	877-411-0585
Juniata	717-242-2277	800-348-2277
Lackawanna	570-963-6482	570-963-6482
Lancaster	717-291-1243	800-892-1122
Lawrence	724-658-7258	888-252-5104
Lebanon	717-273-9328	717-273-9328
Lehigh	610-253-8333	888-253-8333
Luzerne	570-288-8420	800-679-4135
Lycoming	570-323-7575	800-222-2468
Mckean	866-282-4968	866-282-4968

County	Phone	Toll Free
Mercer	724-662-6222	800-570-6222
Mifflin	717-242-2277	800-348-2277
Monroe	570-839-6282 ext 434	888-955-6282
Montgomery	215-542-7433	215-542-7433
Montour	717-846-7433	800-632-9063
Northampton	610-253-8333	888-253-8333
Northumberland	717-846-7433	800-632-9063
Perry	717-846-7433	800-632-9063
Philadelphia	877-835-7412	877-835-7412
Pike	570-296-3408	866-681-4947
Potter	814-544-7315	800-800-2560
Schuykill	570-628-1425	888-656-0700
Snyder	717-846-7433	800-632-9063
Somerset	814-701-3691	800-452-0241
Sullivan	570-888-7330	800-242-3484
Susquehanna	570-278-6140	866-278-9332
Tioga	570-888-7330	800-242-3484
Union	717-846-7433	800-632-9063
Venango	814-432-9767	814-432-9767
Warren	814-723-1874	877-723-9456
Washington	724-223-8747	800-331-5058
Wayne	570-253-4280	800-662-0780
Westmoreland	724-832-2706	800-242-2706
Wyoming	570-278-6140	866-278-9332
York	717-846-7433	800-632-9063

Women, Infants, and Children Program

The Special Supplemental Nutrition Program for 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 benefits to use at grocery stores. WIC also provides breastfeeding information and support to help you succeed on your breastfeeding journey. 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 or to fill out a pre-application, 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 LGBTQIA + 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-LGBTQIA + 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.com. 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 – Enhanced Member Supports

Enhanced Member Supports Unit

Health Partners Plans wants to make sure all of our members get the care they need. We have trained case managers in the Health Partners Plans Enhanced Member Supports Unit that help our members with special healthcare and/or health related social 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 healthcare and/or health related social needs. Health Partners Plans understands that you and your family may need help with issues that may not be directly related to your health care needs. The Enhanced Member Supports Unit is able to assist you with finding programs and agencies in the community that can help you and your family address these needs.

New members are encouraged to complete a health survey. By completing the survey, you are helping us understand your health care and health related social needs, and develop a plan to achieve those needs.

If you think you or someone in your family has a special health care and/or health related social need, and you would like the Enhanced Member Supports Unit to help you, please contact them by calling 1-866-500-4571 and entering your member ID when prompted. TTY users can call 1-877-454-8477.

Enhanced Member Support Unit staff members are available Monday through Friday from 8:00 a.m. to 4:30 p.m. If you need assistance when the Enhanced Member Support Unit staff are not available you may call Member Services at 1-800-553-0784 (TTY 1-877-454-8477).

Care Management

Our Enhanced Member Supports Unit has care coordinators who work with you, your care givers, your care team, and others, as indicated, to assist you in accessing the necessary medical, emotional, social, educational, and other services you need to support your health and make sure you are getting the right care.

Our programs support you at any stage. Our care management programs are:

- Baby Partners – Helps expecting and new mothers get the care they need.
- Pediatric Care Coordination – Helps parents and guardians coordinate the care and social needs for their children.
- Adult Care Coordination – Helps members 21 and older coordinate their care needs and complex care.

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

Coordination of Care

The Health Partners Plans Enhanced Member Supports Unit will help you coordinate care for your family who are members of Health Partners Plans. In addition, Health Partners Plans 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 Plans Enhanced Member Supports Unit for assistance. The Health Partners Plans Enhanced Member Supports 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 safely move back home as soon as possible. We will work with your healthcare team and you during your hospital stay and once you are discharged home. You can also contact the Health Partners Plans Enhanced Member Supports Unit for assistance in help receiving care in your home.

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 Enhanced Member Support Unit at Health Partners Plans.

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, the CHC Helpline at 1-844-824-3655, or request assistance from the Health Partners Plans Enhanced Member Support 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 Enhanced Member Support 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 Plans will tell you in writing what the change is within 90 days of the change. For information on Health Partners Plans' policies on advance directives, call Member Services at 1-800-553-0784 (TTY 1-877-454-8477) or visit Health Partners Plans' 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 Plans 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 Plans 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 47 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.

County	Behavioral Health Provider	Phone
Adams	Community Care Behavioral Health	1-866-738-9849
Allegheny	Community Care Behavioral Health	1-800-553-7499
Armstrong	Carelon Health of Pennsylvania	1-877-688-5969
Beaver	Carelon Health of Pennsylvania	1-877-688-5970
Bedford	Community Care Behavioral Health	1-866-483-2908
Berks	Community Care Behavioral Health	1-866-292-7886
Blair	Community Care Behavioral Health	1-855-520-9715
Bradford	Community Care Behavioral Health	1-866-878-6046
Bucks	Magellan Behavioral Health of PA	1-877-769-9784
Butler	Carelon Health of Pennsylvania	1-877-688-5971
Cambria	Magellan Behavioral Health of PA	1-800-424-0485
Cameron	Community Care Behavioral Health	1-866-878-6046
Carbon	Community Care Behavioral Health	1-866-473-5862
Centre	Community Care Behavioral Health	1-866-878-6046
Chester	Community Care Behavioral Health	1-866-622-4228
Clarion	Community Care Behavioral Health	1-866-878-6046
Clearfield	Community Care Behavioral Health	1-866-878-6046
Clinton	Community Care Behavioral Health	1-855-520-9787

County	Behavioral Health Provider	Phone
Columbia	Community Care Behavioral Health	1-866-878-6046
Crawford	Carelon Health of Pennsylvania	1-866-404-4561
Cumberland	PerformCare	1-888-722-8646
Dauphin	PerformCare	1-888-722-8646
Delaware	Community Care Behavioral Health	1-833-577-2682
Elk	Community Care Behavioral Health	1-866-878-6046
Erie	Community Care Behavioral Health	1-855-224-1777
Fayette	Carelon Health of Pennsylvania	1-877-688-5972
Forest	Community Care Behavioral Health	1-866-878-6046
Franklin	PerformCare	1-866-773-7917
Fulton	PerformCare	1-866-773-7917
Greene	Community Care Behavioral Health	1-866-878-6046
Huntingdon	Community Care Behavioral Health	1-866-878-6046
Indiana	Carelon Health of Pennsylvania	1-877-688-5974
Jefferson	Community Care Behavioral Health	1-866-878-6046
Juniata	Community Care Behavioral Health	1-866-878-6046
Lackawanna	Community Care Behavioral Health	1-866-668-4696
Lancaster	PerformCare	1-888-722-8646
Lawrence	Carelon Health of Pennsylvania	1-877-688-5975
Lebanon	PerformCare	1-888-722-8646
Lehigh	Magellan Behavioral Health of PA	1-866-238-2311
Luzerne	Community Care Behavioral Health	1-866-668-4696
Lycoming	Community Care Behavioral Health	1-855-520-9787
Mckean	Community Care Behavioral Health	1-866-878-6046
Mercer	Carelon Health of Pennsylvania	1-866-404-4561
Mifflin	Community Care Behavioral Health	1-866-878-6046
Monroe	Community Care Behavioral Health	1-866-473-5862
Montgomery	Magellan Behavioral Health of PA	1-877-769-9782
Montour	Community Care Behavioral Health	1-866-878-6046
Northampton	Magellan Behavioral Health of PA	1-866-238-2312
Northumberland	Community Care Behavioral Health	1-866-878-6046
Perry	PerformCare	1-888-722-8646
Philadelphia	Community Behavioral Health	1-888-545-2600
Pike	Community Care Behavioral Health	1-866-473-5862
Potter	Community Care Behavioral Health	1-866-878-6046
Schuykill	Community Care Behavioral Health	1-866-878-6046
Snyder	Community Care Behavioral Health	1-866-878-6046
Somerset	Community Care Behavioral Health	1-866-483-2908
Sullivan	Community Care Behavioral Health	1-866-878-6046
Susquehanna	Community Care Behavioral Health	1-866-668-4696
Tioga	Community Care Behavioral Health	1-866-878-6046
Union	Community Care Behavioral Health	1-866-878-6046
Venango	Carelon Health of Pennsylvania	1-866-404-4561
Warren	Community Care Behavioral Health	1-866-878-6046
Washington	Carelon Health of Pennsylvania	1-877-688-5976
Wayne	Community Care Behavioral Health	1-866-878-6046
Westmoreland	Carelon Health of Pennsylvania	1-877-688-5977
Wyoming	Community Care Behavioral Health	1-866-668-4696
York	Community Care Behavioral Health	1-866-542-0299

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:

- Intensive Behavioral Health Services (IBHS) (children and adolescents)
- 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 Plans does something that you are unhappy about or do not agree with, you can tell Health Partners Plans or the Department of Human Services what you are unhappy about or that you disagree with what the provider or Health Partners Plans 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 Plans you are unhappy with Health Partners Plans or your provider or do not agree with a decision by Health Partners Plans.

Some things you may file a complaint 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 Plans 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 Plans Member Services at 1-800-553-0784 (TTY 1-877-454-8477) and tell Health Partners Plans your Complaint, or
- Write down your Complaint and send it to Health Partners Plans using one of the below methods, or
- If you received a notice from Health Partners Plans telling you Health Partners Plans' decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to Health Partners Plans by using one of the below methods.

Health Partners Plans' contact information for Complaints:

By mail at Health Partners Plans
Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
By fax at 215-991-4105

By secure email* at QuickCGA@jeffersonhealthplans.com.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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 Plans has decided that you cannot get a service or item you want because it is not a covered service or item.
- Health Partners Plans will not pay a provider for a service or item you got.
- Health Partners Plans did not tell you its decision about a Complaint or Grievance you told Health Partners Plans about within 30 days from when Health Partners Plans got your Complaint or Grievance.
- Health Partners Plans has denied your request to disagree with Health Partners Plans' 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 Plans 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 Plans, 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 Plans, 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 Plans.
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 Plans learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of Health Partners Plans learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of Health Partners Plans learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of Health Partners Plans 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 Plans telling you that Health Partners Plans has received your Complaint, and about the First Level Complaint review process.

You may ask Health Partners Plans to see any information Health Partners Plans 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 Plans.

You may attend the Complaint review if you want to attend it. Health Partners Plans 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 Plans 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 clinical issue, a licensed doctor or licensed dentist will be on the committee. Health Partners Plans will mail you a notice within thirty (30) days from the date Health Partners Plans received the Complaint unless you have requested that Health Partners Plans take an additional fourteen (14) days to decide the 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 47.

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 that is postmarked or received by Health Partners Plans within 15 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 Plans' 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 Plans' decision that you cannot get a service or item you want because it is not a covered service or item.
- Health Partners Plans' decision to not pay a provider for a service or item you got, because the service or item is not a covered service for you.
- Health Partners Plans' decision to not pay a provider not enrolled in the Medical Assistance Program for a service or item you got without authorization.

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

You must ask for an external Complaint review by submitting your request in writing to the Pennsylvania Insurance Department's Bureau of Consumer Services within **15 days of the date you got the First Level Complaint decision notice.**

To ask for an external review of your Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the "File a Complaint Page" at https://www.insurance.pa.gov/Consumers/Pages/default.aspx

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

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 55.

For information about external Complaint review, see page 51.

If you need more information about help during the Complaint process, see page 54.

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 Plans Member Services at 1-800-553-0784 (TTY 1-877-454-8477) and tell Health Partners Plans your Second Level Complaint, or
- Write down your Second Level Complaint and send it to Health Partners Plans by one of the below methods, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to Health Partners Plans by using one of the below methods

Health Partners Plans' contact information for Second Level Complaints:

By mail at Health Partners Plans
Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
By fax at 215-991-4105
By secure email* at QuickCGA@jeffersonhealthplans.com.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

What Happens After I File a Second Level Complaint?

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

You may ask Health Partners Plans to see any information Health Partners Plans 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 Plans.

You may attend the Complaint review if you want to attend it. Health Partners Plans 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 Plans, will meet to decide your Second Level Complaint. The Health Partners Plans 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 or licensed dentist will be on the committee. Health Partners Plans 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 54.

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

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care.

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

External Complaint Review

How Do I Ask for an External Complaint Review?

You must send your request for an external review of your Complaint in writing to:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

You can also go to the "File a Complaint" page at https://www.insurance.pa.gov/Consumers/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 Pennsylvania Insurance Department will get your file from Health Partners Plans. 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 your request for an external Complaint review is postmarked or received by the Pennsylvania Insurance Department within 15 days of the date on the notice telling you Health Partners Plans' 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, the services or items will 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 15 days of the date on the notice telling you Health Partners Plans' 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 Plans 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 Plans' decision.

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

What Should I Do if I Have a Grievance?

To file a Grievance:

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

Health Partners Plans' contact information for Grievances:

By mail at Health Partners Plans
Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
By fax at 215-991-4105
By secure email* at QuickCGA@jeffersonhealthplans.com.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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 Plans telling you that Health Partners Plans has received your Grievance, and about the Grievance review process.

You may ask Health Partners Plans to see any information that Health Partners Plans 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 Plans.

You may attend the Grievance review if you want to attend it. Health Partners Plans 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 or licensed dentist, will meet to decide your Grievance. The Health Partners Plans 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 Plans 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 54.

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 that is postmarked or received by Health Partners Plans within 15 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 Plans' 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 Plans.

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 55.

For information about external Grievance review, see below.

If you need more information about help during the Grievance process, see page 54.

External Grievance Review

How Do I Ask for an External Grievance Review?

To ask for an external Grievance review:

- Call Health Partners Plans Member Services at 1-800-553-0784 (TTY 1-877-454-8477) and tell Health Partners Plans your Grievance, or
- Write down your Grievance and send it to Health Partners Plans using one of the below methods.

Health Partners Plans' contact information for External Grievances:

By mail at Health Partners Plans
Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
By fax at 215-991-4105
By secure email* at QuickCGA@jeffersonhealthplans.com

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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

What Happens After I Ask for an External Grievance Review?

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

Health Partners Plans 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 20 days of being notified of the external Grievance reviewer's name.**

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 written request that is postmarked or received by the Pennsylvania Insurance Department within 15 days of the date on the notice telling you Health Partners Plans' Grievance decision, the services or items will continue until a decision is made. If you will be asking for both an external Grievance review and a Fair Hearing, you must request both the external Grievance review and the Fair Hearing within 15 days of the date on the notice telling you Health Partners Plans' Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, services will not continue.

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 Plans for an early decision by calling Health Partners Plans 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@jeffersonhealthplans.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 Plans 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 Plans 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 Plans will decide your Complaint or Grievance in the usual time frame of 30 days from when Health Partners Plans first got your First Level Complaint or Grievance, or 45 days from when Health Partners Plans got your Second Level Complaint.

Expedited Complaint and Expedited External Complaint

A committee of 1 or more people, including a licensed doctor or licensed dentist will review your expedited Complaint. Other providers may participate in the review but, the licensed doctor or licensed dentist will decide your Complaint. The Health Partners Plans 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.

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 Plans 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 Plans will tell you the decision about your Complaint within 48 hours of when Health Partners Plans 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 Plans gets your request for an early decision, whichever is sooner, unless you ask

Health Partners Plans to take more time to decide your Complaint. You can ask Health Partners Plans to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for an 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 Pennsylvania Insurance Department within **2 business days from the date you get the expedited Complaint decision notice.** To ask for an expedited external review of a Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the "File a Complaint Page" at https://www.insurance.pa.gov/Consumers/Pages/default.aspx.

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

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor or licensed dentist, will meet to decide your Grievance. The **Health Partners Plans** 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 Plans 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 Plans will tell you the decision about your Grievance within 48 hours of when Health Partners Plans 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 Plans gets your request for an early decision, whichever is sooner, unless you ask Health Partners Plans to take more time to decide your Grievance. You can ask Health Partners Plans to take up to 14 more days to decide your Grievance. 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 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 Plans** at 1-800-553-0784 and tell Health Partners Plans your Grievance

OR

- Send an email to **Health Partners Plans** at quickCGA@jeffersonhealthplans.com

OR

- Write down your Grievance and send it to **Health Partners Plans** by mail or fax:

Health Partners Plans
Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
215-991-4105 (fax)

Health Partners Plans will send your request to the Pennsylvania Insurance Department 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 Plans 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 Plans, in writing, the

name of that person and how Health Partners Plans can reach him or her.

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

You may call Health Partners Plans' 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 1-800-322-7572 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 Plans will provide the services at no cost to you.

Persons with Disabilities

Health Partners Plans 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 Plans 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 Plans did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after Health Partners Plans 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, faxed, or submitted via email* within **120 days from the date on the notice** telling you Health Partners Plans' 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 Plans' failure to decide a First Level Complaint or Grievance you told Health Partners Plans about within **30 days from when Health Partners Plans got your Complaint or Grievance.**
- The denial of your request to disagree with Health Partners Plans' 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 Plans failed to decide a First Level Complaint or Grievance you told Health Partners Plans about within 30 days from when Health Partners Plans got your Complaint or Grievance.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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 or email.

If you write a letter or email*, 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.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email. You may send a request for a Fair Heating through email and provide your personal identifying information in a letter mailed to the below address.

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
Fax: 1-717-772-6328
Email: RA-PWCGFHteam@pa.gov

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

You may ask Health Partners Plans 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 Plans, not including the number of days between the date on the written notice of Health Partners Plans' 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 Plans did not tell you its decision about a Complaint or Grievance you told Health Partners Plans about within 30 days from when Health Partners Plans 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 Plans, not including the number of days between the date on the notice telling you that Health Partners Plans 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 received by the Department of Human Services within 15 days of the date on the notice telling you Health Partners Plans' 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, by faxing a letter or the Fair Hearing Request Form to 1-717-772-6328, or by submitting a written request electronically via email* to RA-PWCGFHteam@pa.gov. 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.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

You may call **Health Partners Plans'** 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 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

APPENDIX

Crisis Intervention Services

988 Suicide & Crisis LifeLine — Available 24/7

Call: **988**

Text: **988**

Visit or Chat: 988lifeline.org

You can also access this list at https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/Crisis-Intervention.aspx.

Location	Phone number
Allegheny County Department of Human Services	**Phone:** 412-350-5701 **Crisis Services:** 1-888-796-8226 (1-888-7-YOU CAN)
Armstrong/Indiana Behavioral and Developmental Health Program	**Phone:** 724-548-3451 **Crisis Services:** 1-877-333-2470
Beaver County Behavioral Health	**Phone:** 724-891-2827 **Crisis Services:** 1-800-400-6180
Bedford-Somerset Developmental and Behavioral Health Services (DBHS)	**Phone:** **Bedford:** 814-623-5166 **Somerset:** 814-443-4891 **Crisis Services:** 1-866-611-6467
Berks County MH/DD	**Phone:** 610-478-3271 **Crisis Services:** 610-236-0530
Blair County MH/BH/ID Programs	**Phone:** 814-693-3023 **Crisis Services:** 814-889-2141, Choose option 1
Bradford/Sullivan MH/ID	**Phone:** 570-265-1760 **Crisis Services:** 1-800-588-1828 (after hours: 1-877-724-7142
Bucks County Dept. of Mental Health/ Developmental Programs	**Phone:** **Central & Upper Bucks:** 215-345-2273 **Lower Bucks:** 215-785-9765 **Crisis Services:** 1-800-499-7455
Butler County MH/EI/ID Program	**Phone:** 724-284-5114 **Crisis Services:** 1-800-292-3866
Cambria County Behavioral Health/ Intellectual Disabilities Program	**Phone:** 814-535-8531 **Ebensburg Satellite Office:** 814-472-4400 **Crisis Services:** 1-877-268-9463
Cameron/Elk Counties Behavioral & Development Programs	**Phone:** 814-772-8016 **Crisis Services:** 1-800-652-0562
Carbon-Monroe-Pike MH/DS	**Phone:** **Monroe:** 570-421-2901 **Carbon:** 610-377-0773 **Pike:** 570-296-6484 **Crisis Services:** 1-800-849-1868
Centre County MH/ID/EI	**Phone:** 814-355-6786 and 814-355-6744 **Crisis Services:** 1-800-643-5432
Chester County Dept. of Mental Health/Intellectual & Developmental Disabilities	**Phone:** 610-344-6265 **Crisis Services:** 610-344-6265 **Valley Creek Crisis Center:** 610-280-3270
Clarion County MH/DD	**Phone:** 814-226-1080 **Crisis Services:** 1-800-226-7223
CMSU Behavioral Health & Developmental Services	**Phone:** 570-275-5422 **Crisis Services:** 1-800-222-9016
Community Connections of Clearfield/Jefferson Counties	**Phone:** 814-371-5100 **Crisis Services:** 1-800-341-5040
Crawford County Human Services	**Phone:** 814-724-8380 **Crisis Services:** 814-724-2732

Location	Phone number
Cumberland/Perry MH/IDD	**Phone:** **Cumberland:** 717-240-6320 **Perry:** 866-240-6320 **Crisis Services:** **Camp Hill:** 717-763-2222 **Carlisle:** 717-243-6005 **All other areas:** 1-866-350-4357
Dauphin County Mental Health/ Intellectual Disabilities Program	**Phone:** 717-780-7050 **Crisis Services:** 717-232-7511 or 1-888-596-4447
Delaware County BH/ID	**Phone:** 610-713-2365 **Crisis Services:** 1-855-889-7827
Erie County MH/ID	**Phone:** 814-451-6000 **Crisis Services:** 814-456-2014 or 1-800-300-9558
Fayette County Behavioral Health Administration	**Phone:** 724-430-1370 **Crisis Services:** 724-437 1003
Forest/Warren Human Services	**Phone:** **Warren:** 1-866-641-3488 **Forest:** 814-755-7995 **Crisis Services:** **Weekdays 8:30 a.m. – 5 p.m.:** 814-726-2100 / 814-726-8413 After 5 p.m., **weekends/holidays:** 814-723-2800 / 1-800-406-1255
Franklin/Fulton MH/ ID/EI	**Phone:** 800-841-3593 **Crisis Services:** **Keystone:** 717-264-2555 **True North Wellness:** 1-866-918-2555
Greene County Human Services	**Phone:** 1-888-317-7106 **Crisis Services:** 1-800-417-9460
Juniata Valley Behavioral & Developmental Services – HMJ	**Phone:** 717-242-6467 **Crisis Services:** 1-800-929-9583
Lackawanna/ Susquehanna BH/ID/ EI Programs	**Phone:** 570-346-5741 **Crisis Services:** **Lackawanna:** 570-348-6100 **Susquehanna:** 570-278-6822
Lancaster County BH/DS	**Phone:** 717-299-8021 **Crisis Services:** 717-394-2631

Location	Phone number
Lawrence County Mental Health & Developmental Services	**Phone:** 724-658-2538 **Crisis Services:** 724-652-9000
Lebanon County MH/ ID/EI	**Phone:** 717-274-3415 **Crisis Services:** 717-274-3363
Lehigh County MH/ ID/D&A/EI	**Phone:** 610-782-3200 **Crisis Services:** 610-782-3127
Luzerne-Wyoming Counties Mental Health and Developmental Services	**Phone:** 1-800-816-1880 **Crisis Services:** 570-552-6000
Lycoming/Clinton MH/ID	**Phone:** **Lycoming:** 570-326-7895 **Clinton:** 570-748-2262 **Crisis Services:** 570-326-7895
McKean County Mental Health Services	**Phone:** 814-887-3350 **Crisis Services:** 1-800-459-6568
Mercer County MH/DS	**Phone:** 724-662-2230 **Crisis Services:** 724-662-2227
Montgomery County MH/DD/EI Program Office	**Phone:** 610-278-3642 **Crisis Services:** 1-855-634-HOPE (4673)
Northampton County MH/EI/Dev. Prog. Div.	**Phone:** 610-829-4840 **Crisis Services:** 610-252-9060
Northumberland County BH/ID Services	**Phone:** 570-495-2040 **Crisis Services:** 1-855-313-4387
Philadelphia Dept of BH & Intellectual Disability Services	**Phone:** 1-888-545-2600 **Crisis Services:** 215-686-6640
Potter County Human Services	**Phone:** 1-800-800-2560 **Crisis Services:** 1-877-724-7142
Schuylkill County Administrative Offices of MH/ DS/D&A	**Phone:** 570-621- 2890 **Crisis Services:** 1-877-9WE-HELP or 1-877-993-4357
Tioga County Dept. of Human Services	**Phone:** 570-724-5766 **Crisis Services:** 877-724-7142

Location	Phone number
Venango County Mental Health & Developmental Services	**Phone:** 814-432-9100 **Crisis Services:** 814-432-9111
Washington County BH/DS	**Phone:** 724-228-6832 **Crisis Services:** 1-877-225-3567
Wayne County Office of Behavioral & Developmental Programs/EI	**Phone:** 570-253-9200 **Crisis Services:** 570-253-0321
Westmoreland County Behavioral Health & Dev. Services	**Phone:** 1-800-353-6467 **Crisis Services:** 1-800-836-6010

Location	Phone number
York/Adams MH/IDD	**Phone:** 717-771-9618 or 1-800-441-2025 **Crisis Services:** **WellSpan at York Hospital:** 717-851-5320 **WellSpan at Gettysburg Hospital:** 717-334-2121 **TrueNorth at Hanover Hospital:** 717-637-3711 **TrueNorth at Memorial Hospital:** 717-632-4900 **TrueNorth Mobile Crisis Intervention:** 717-637-7633 or 1-866-325-0339

County Assistance Office Contact Information

You can access this list on https://www.dhs.pa.govServices/Assistance/Pages/CAO-Contact.aspx.

County	Location	Phone
Adams	**Adams County Assistance Office** 225 South Franklin Street P.O. Box 4446 Gettysburg, PA 17325	717-334-6241
Allegheny	**Allegheny County Assistance Office Headquarters** Piatt Place - 301 5th Avenue, Suite 470 Pittsburgh, PA 15222	412-565-2146
	Low Income Home Energy Assistance Program (LIHEAP) 5947 Penn Avenue, 4th Floor Pittsburgh, PA 15206	412-562-0330
	Alle-Kiski District 909 Industrial Boulevard New Kensington, PA 15068-0132	1-800-622-3527 724-339-6800 LIHEAP: 724-832-5524
	Institution-Related Eligibility District (IRED) 301 5th Avenue, Suite 420 Pittsburgh, PA 15222	412-565-5604
	Liberty District 332 5th Avenue, Suite 300 Pittsburgh, PA 15222	412-565-2652
	Three Rivers District Warner Center - 332 Fifth Avenue, 2nd Floor Pittsburgh, PA 15222	412-565-7755
	Southeast District 220 Sixth Street McKeesport, PA 15132-2720	412-664-6800 or 6801
	Greater Pittsburgh East District 5947 Penn Avenue Pittsburgh, PA 15206-3844	412-645-7400 or 7401
Armstrong	**Armstrong County Assistance Office** 1280 North Water Street Kittanning, PA 16201-0898	1-800-424-5235 724-543-1651 LIHEAP: 724-543-6076 or 800-543-5105

County	Location	Phone
Beaver	**Beaver County Assistance Office** 171 Virginia Avenue P. O. Box 349 Rochester, PA 15074-0349	1-800-653-3129 724-773-7300 LIHEAP: 724-773-7495
Bedford	**Bedford County Assistance Office** 150 North Street Bedford, PA 15522-1040	1-800-542-8584 814-623-6127 LIHEAP: 814-624-4072
Berks	**Berks County Assistance Office** Reading State Office Building 625 Cherry Street Reading, PA 19602-1188	1-866-215-3912 610-736-4211 LIHEAP: 610-736-4228 or 866-215-3911
Blair	**Blair County Assistance Office** 1100 Green Avenue Altoona, PA 16601-3440	1-866-812-3341 LIHEAP: 814-946-7365
Bradford	**Bradford County Assistance Office** 101 Hawkins Road Towanda, PA 18848	1-800-542-3938 570-265-9186
Bucks	**Bucks County Assistance Office** 1214 Veterans Highway Bristol, PA 19007-2593	1-800-362-1291 215-781-3300 LIHEAP: 215-781-3393 or 1-800-616-6481
Butler	**Butler County Assistance Office** 108 Woody Dr. Butler, PA 16001-5692	1-866-256-0093 724-284-8844
Cambria	**Cambria County Assistance Office** 729 Goucher Street Johnstown, PA 15905	1-877-315-0389 814-533-2491 LIHEAP: 814-533-2253
Cameron	**Cameron County Assistance Office** 411 N. Chestnut Street P.O. Box 71 Emporium, PA 15834-0071	1-877-855-1824 814-486-3757 LIHEAP: 814-486-1206
Carbon	**Carbon County Assistance Office** 101 Lehigh Drive Lehighton, PA 18235	1-800-314-0963 610-577-9020 LIHEAP (cash): 610-577-9073 LIHEAP (crisis): 866-410-2093
Centre	**Centre County Assistance Office** 2580 Park Center Boulevard State College, PA 16801-3005	1-800-355-6024 814-863-6571 LIHEAP: 814-861-1955

County	Location	Phone
Chester	**Chester County Assistance Office** 100 James Buchanan Drive Thorndale, PA 19372-1132	1-888-814-4698 610-466-1000 717-240-2700
Dauphin	**Dauphin County Assistance Office** 2432 N. 7th Street P.O. Box 5959 Harrisburg, PA 17110-0959	1-800-788-5616 717-787-2324 LIHEAP: 717-265-8919
Delaware	**Delaware County Assistance Office Headquarters** 701 Crosby Street, Suite A Chester, PA 19013-6099	610-447-5500 LIHEAP: 610-447-3099
	Crosby District 701 Crosby Street, Suite A Chester, PA 19013-6099	610-447-5500 LIHEAP: 610-447-3099
	Darby District 845 Main Street Darby, PA 19023	610-461-3800
Elk	**Elk County Assistance Office** 145 Race Street P.O. Box F Ridgway, PA 15853-0327	1-800-847-0257 814-776-1101 LIHEAP: 814-772-5215 or 814-776-1101
Erie	**Erie County Assistance Office** 1316 Holland StreetP.O. Box 958 Erie, PA 16512-0958	1-800-635-1014 814-461-2000 LIHEAP: 814-461-2002
Fayette	**Fayette County Assistance Office** 41 West Church Street Uniontown, PA 15401-3418	1-877-832-7545 724-439-7015 LIHEAP: 724-439-7125
Forest	**Forest County Assistance Office** 106 Sherman Street Tionesta, PA 16353	1-800-876-0645 814-755-3552
Franklin	**Franklin County Assistance Office** 620 Norland Avenue Chambersburg, PA 17201-4205	1-877-289-9177 717-264-6121 LIHEAP: 717-262-6579
Fulton	**Fulton County Assistance Office** 539 Fulton Drive McConnellsburg, PA 17233	1-800-222-8563 717-485-3151
Greene	**Greene County Assistance Office** 108 Greene Plaza, Suite 1 Waynesburg, PA 15370-0950	1-888-410-5658 724- 627-8171
Huntingdon	**Huntingdon County Assistance Office** 7591 Lake Raystown Shopping Center Huntingdon, PA 16652-0398	1-800-237-7674 814-643-1170 LIHEAP: 814-643-4098
Indiana	**Indiana County Assistance Office** 2750 West Pike Road Indiana, PA 15701	1-800-742-0679 724-357-2900 LIHEAP: 724-357-2918

County	Location	Phone
Jefferson	**Jefferson County Assistance Office** 100 Prushnok Drive P.O. Box 720 Punxsutawney, PA 15767-0720	1-800-242-8214 814-938-2990 LIHEAP: 814-938-1329
Juniata	**Juniata County Assistance Office** 100 Meadow Lane P.O. Box 65 Mifflintown, PA 17059-9983	1-800-586-4282 717-436-2158
Lackawanna	**Lackawanna County Assistance Office** 200 Scranton State Office Building 100 Lackawanna Avenue Scranton, PA 18503-1972	1-877-431-1887 570-963-4525 LIHEAP: 570-963-4842
Lancaster	**Lancaster County Assistance Office** 832 Manor Street P.O. Box 4967 Lancaster, PA 17604-4967	717-299-7411 LIHEAP (cash): 717-299-7543 LIHEAP (crisis): 717-299-7543
Lawrence	**Lawrence County Assistance Office** 108 Cascade Galleria New Castle, PA 16101-3900	1-800-847-4522 724-656-3000 LIHEAP: 724-656-3021
Lebanon	**Lebanon County Assistance Office** 625 South Eighth Street Lebanon, PA 17042-6762	1-800-229-3926 717-270-3600 LIHEAP: 717-273-1641
Lehigh	**Lehigh County Assistance Office** 555 Union Blvd., Suite 3 Allentown, PA 18109-3389	1-877-223-5956 610-821-6509
Luzerne	**Luzerne County Assistance Office Wilkes-Barre District** 205 South Washington Street Wilkes-Barre, PA 18711-3298	1-866-220-9320 570-826-2100 LIHEAP: 570-826-2041 LIHEAP (crisis): 570-826-0510
	Hazleton District Center Plaza Building 10 West Chestnut Street Hazleton, PA 18201-640	570-459-3800 LIHEAP: 570-459-3834
Lycoming	**Lycoming County Assistance Office** 400 Little League Boulevard P.O. Box 127 Williamsport, PA 17703-0127	1-877-867-4014 570-327-3300 LIHEAP: 570-327-3497
McKean	**McKean County Assistance Office** 68 Chestnut Street, Suite B Bradford, PA 16701-0016	1-800-822-1108 814-362-4671
Mercer	**Mercer County Assistance Office** 2236 Highland Road Hermitage, PA 16148-2896	1-800-747-8405 724-983-5000 LIHEAP: 724-983-5022
Mifflin	**Mifflin County Assistance Office** 1125 Riverside Drive Lewistown, PA 17044-1942	1-800-382-5253 717-248-6746 LIHEAP: 717-242-6095

County	Location	Phone
Monroe	**Monroe County Assistance Office** 1972 W. Main Street, Suite 101 Stroudsburg, PA 18360-0232	1-877-905-1495 570-424-3030 LIHEAP: 570-424-3517
Montgomery	**Montgomery County Assistance Office** Norristown District 1931 New Hope Street Norristown, PA 19401-3191	1-877-398-5571 610-270-3500 LIHEAP: 610-272-1752
	Pottstown District 24 Robinson Street Pottstown, PA 19464-5584	1-800-641-3940 610-327-4280 LIHEAP: 610-272-1752
Montour	**Montour County Assistance Office** 497 Church Street Danville, PA 17821-2217	1-866-596-5944 570-275-7430 LIHEAP: 1-866-410-2093
Northampton	**Northampton County Assistance Office** 201 Larry Holmes Drive P.O. Box 10 Easton, PA 18044-0010	1-800-349-5122 610-250-1700 LIHEAP: 610-250-1785
Northumberland	**Northumberland County Assistance Office** 320 Chestnut Street Sunbury, PA 17801	1-833-299-4361 570-988-5900 LIHEAP: 570-988-5996 or 800-332-8583
Perry	**Perry County Assistance Office** 100 Centre Drive P.O. Box 280 New Bloomfield, PA 17068-0280	1-800-991-1929 717-582-2127 LIHEAP: 717-582-5038
Philadelphia	**Philadelphia County Assistance Office Headquarters** 801 Market Street Philadelphia, PA 19107	215-560-7226 LIHEAP: 215-560-1583
	Low-Income Home Energy Assistance Program (LIHEAP) 1163 S. Broad Street Philadelphia, PA 19147	LIHEAP: 215-560-1583
	Boulevard District 4109 Frankford Avenue Philadelphia, PA 19124-4508	215-560-6500
	Chelten District 301 East Chelten Avenue, 1st Flr. Philadelphia, PA 19144-5751	215-560-5200
	Delancey District 5740 Market Street 2nd Floor Philadelphia, PA 19139-3204	215-560-3700
	Elmwood District 5740 Market Street 1st Floor Philadelphia, PA 19139-3204	215-560-3800

County	Location	Phone
Philadelphia	**Liberty District** 219 East Lehigh Avenue Philadelphia, PA 19125-1099	215-560-4000
	Long Term and Independent Services District 5070 Parkside Avenue Philadelphia, PA 19131	215-560-5500
	Ridge/Tioga District 1350 West Sedgley Avenue Philadelphia, PA 19132-2498	215-560-4900
	Somerset District 2701 N. Broad Street, 2nd Flr. Philadelphia, PA 19132-2743	215-560-5400
	South District 1163 S. Broad Street Philadelphia, PA 19147	Phone: 215-560-4400 FAX: 215-218-4650
	Unity District 4111 Frankford Avenue Philadelphia, PA 19124	215-560-6400
	West District 5070 Parkside Avenue Philadelphia, PA 19131-4747	215-560-6100
Pike	**Pike County Assistance Office** Milford Professional Park Suite 101 10 Buist Road	1-866-267-9181 570-296-6114 LIHEAP: 570-296-6114
Potter	**Potter County Assistance Office** 269 Route 6 West, Room 1 Coudersport, PA 16915-8465	1-800-446-9896 814-274-4900
Schuylkill	**Schuylkill County Assistance Office** 2640 Woodglen Road P.O. Box 1100 Pottsville, PA 17901-1100	1-877-306-5439 570-621-3000 LIHEAP: 570-621-3072
Snyder	**Snyder County Assistance Office** 83 Maple Lane Selinsgrove, PA 17870-1302	1-866-713-8584 570-374-8126 LIHEAP: 570-372-1721
Somerset	**Somerset County Assistance Office** 164 Stayrook Street Somerset, PA 15501	1-800-248-1607 814-443-3681 LIHEAP: 814-443-3683
Sullivan	**Sullivan County Assistance Office** 918 Main Street, Suite 2 P.O. Box 355 Laporte, PA 18626-0355	1-877-265-1681 570-946-7174 LIHEAP: 570-946-7174
Susquehanna	**Susquehanna CountyAssistance Office** 111 Spruce StreetP.O. Box 128 Montrose, PA 18801-0128.	1-888-753-6328 570-278-3891 LIHEAP: 1-866-410-2093
Tioga	**Tioga County Assistance Office** 11809 Route 6 Wellsboro, PA 16901-6764	1-800-525-6842 570-724-4051 LIHEAP: 570-724-4051

County	Location	Phone
Union	**Union County Assistance Office** Suite 300 1610 Industrial Boulevard Lewisburg, PA 17837-1292	1-877-628-2003 570-524-2201 LIHEAP: 570-522-5274
Venango	**Venango County Assistance Office** 530 13th Street Franklin, PA 16323-0391	1-877-409-2421 814-437-4341/4342 LIHEAP: 814-437-4354
Warren	**Warren County Assistance Office** 210 North Drive, Suite A N. Warren, PA 16365	1-800-403-4043 814-723-6330 LIHEAP: 814-726-2540
Washington	**Washington County Assistance Office** 90 W Chestnut Street, Suite 300 East Wing Washington, PA 15301	1-800-835-9720 724-223-4300 LIHEAP: 724-223-5246
	Valley District 595 Galiffa Drive P.O. Box 592 Donora, PA 15033-0592	1-800-392-6932 724-379-1500 LIHEAP: 724-379-1549
	Donora/Valley District 595 Galiffa Drive P.O. Box 592 Donora, PA 15033-0592	1-800-238-9094 724-379-1500 LIHEAP: 724-832-5524
Wayne	**Wayne County Assistance Office** 15 Innovation Drive Lake Ariel, PA 18436-8800	1-877-879-5267 570-253-7100 LIHEAP: 570-253-7118
Westmoreland	**Westmoreland County Assistance Office - Main Office** 587 Sells Lane Greensburg, PA 15601-449	1-800-905-5413 724-832-5200 LIHEAP: 724-832-5524
Wyoming	**Wyoming County Assistance Office** 608 Hunter Highway, Suite 6 P.O. Box 490 Tunkhannock, PA 18657-0490	1-877-699-3312 570-836-5171 LIHEAP: 570-836-5171
York	**York County Assistance Office** 130 N. Duke Street P.O. Box 15041 York, PA 17405-7041	1- 800-991-0929 717-771-1100 LIHEAP: 1-800-991-0929

Discrimination is Against the Law

Health Partners Plans 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 Plans 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 Plans 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 Plans 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 Health Partners Plans at **1-800-553-0784 (TTY 1-877-454-8477).**

If you believe that Health Partners Plans 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
1101 Market Street, Suite 3000
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 Plans 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, phone or email at:

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

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

January 1, 2025

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-553-0784 (TTY 1-877-454-8477) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-553-0784 (TTY 1-877-454-8477) hable con su proveedor.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-553-0784（文本电话：1-877-454-8477）或咨询您的服务提供商。

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-553-0784 (TTY 1-877-454-8477) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-553-0784 (TTY 1-877-454-8477) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-553-0784 (1-877-454-8477) أو تحدث إلى مقدم الخدمة.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-553-0784 (TTY 1-877-454-8477) oswa pale avèk founisè w la.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-553-0784 (Người khuyết tật: 1-877-454-8477) hoặc trao đổi với người cung cấp dịch vụ của bạn.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-553-0784 (TTY 1-877-454-8477) або зверніться до свого постачальника».

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-553-0784（TTY：1-877-454-8477）或與您的提供者討論。

ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-553-0784 (TTY 1-877-454-8477) ou fale com seu provedor.

January 1, 2025

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসেযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-553-0784 (TTY 1-877-454-8477) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-553-0784 (TTY : 1-877-454-8477) ou parlez à votre fournisseur.

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់ហាន ក៏អាចរកហានដោយ ឥតគិតថ្លៃផែងដែរ។ ហៅទូរសព្ទទៅ 1-800-553-0784 (TTY 1-877-454-8477) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-553-0784 (TTY 1-877-454-8477)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબિલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-553-0784 (TTY 1-877-454-8477) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

HP-810MR-6364
January 1, 2025

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