Member Handbook

Health Partners Essential

Healthy PA
PRIVATE COVERAGE OPTION

Health Partners Plans

WELCOME TO HEALTH PARTNERS PLANS

This Member Handbook will help you understand all of the benefits, services and programs you can use as a member of the Health Partners Essential plan.

Health Partners Plans makes it very easy for you to get health care and services. If you ever have questions about the Health Partners Essential plan or the care you are receiving, just call our Member Relations department at 1-855-215-7077. We're here 24 hours a day, seven days a week to help you!

No matter what language you speak, we can help. Through a special service, you have access to over 140 different languages to speak to us. Just call Member Relations for help.

If you need help reading the information contained in this Member Handbook, please call the 24-hour Health Partners Essential Member Relations line at 1-855-215-7077. If you are a TTY user, please call 711.

You may also visit our website at **HealthPartnersPlans.com** for more information on how to help stay healthy.

For help with this information, call our 24-hour helpline.
Si necesita ayuda con esta información, llámenos a nuestra línea de ayuda disponible las 24 horas • Nếu cần giúp đỡ về thông tin này, hãy gọi số điện thoại trực 24-giờ sau đây của chúng tôi • Если вам нужна помощь относительно этой информации, звоните в нашу круглосуточную справочную службу • 如果對這訊息有疑問，請致電我們的24小時幫助熱線 • ដើម្បីជាជំនួយ ទទួលបានកិច្ចការនេះ សូមទំនាក់ទំនងខ្សែសង្គ្រោះរបស់យើងមានបំណើការ ២៤ម៉ោង តាមរយៈលេខ:

1-855-215-7077 (TTY 711)

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Section 1: Getting Started

What is Health Partners Essential?

Health Partners Essential is the health plan through Health Partners Plans that puts your needs first. We give you the healthcare benefits you need and the quality service you expect, all delivered with the respect you deserve.

Health Partners Essential is a Private Coverage Option (PCO) plan available through the State's *Healthy PA* program for qualified residents of Philadelphia, Bucks, Chester, Delaware and Montgomery counties.

The Health Partners Plans Pledge to Give You the Medical Care You Need

At Health Partners Plans, we want to keep you healthy. That's why we pledge to give you the care you need, when you need it. Health Partners Plans does not directly or indirectly give financial rewards or incentives to doctors or staff to limit or deny approvals for care. In this way, Health Partners Plans makes sure that you get the care that is best for your medical needs.

In some cases, you will need to pay a copayment. More information on copayments can be found on page 18. If you do receive a bill for covered services, you can send it back. Just follow the instructions on page 52 under the section titled "What to Do if You Receive a Bill."

Definition of Managed Care

We think of managed care as going back to the basics. This means that you pick a provider. Your personal provider is known as a PCP, or primary care provider. Your PCP will be in our network of providers who contract with us to provide you with covered services. Your PCP will set up all of your health care. He or she will keep all your medical records and know your medical history. It's that simple.

Remember, prevention is important in staying healthy. That means you should get all the shots, regular checkups and screenings you need. This helps to prevent sickness and to keep you healthy.

Membership ID Card

Your Health Partners Essential membership ID card lets everyone know you are a member of Health Partners Essential. The name and telephone number of your primary care provider (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 your card is lost or stolen, please call our Member Relations department at 1-855-215-7077 (TTY 711). Someone is available to help you 24 hours a day, seven days a week.

If you also have other insurance coverage, you must take that information with you to the doctor's office and present that along with your Health Partners Essential membership ID card.

Using Health Partners Essential Participating Providers for Your Healthcare Needs

As a Health Partners Essential member, you must use our participating providers, in most situations, for all your health care (except if you are out of the area, need urgent/emergency care, OB/GYN services or family planning services). We have carefully screened these PCPs, specialists, hospitals, pharmacies and other network providers to make sure they work together to give you the healthcare services you need.

For most services, you must call your PCP first to get a referral for the service. Your PCP will watch over all of your health care. He or she will refer you to a participating specialist or hospital if needed. Remember, you can call your PCP at any time to follow up after a visit or hospital stay.

Your PCP is there to make sure you get the medical care you need. He or she will always be your number one support in getting proper treatment and staying healthy.

You can get some services without a referral from your PCP. These include:

- Emergency services (You may want to call your PCP first if you are unsure whether emergency services are needed.)
- Family planning
- Mammograms (some sites still require a prescription from the provider)
- OB/GYN services

Keep in mind that you must use Health Partners Essential participating providers for these services (except if you are out of the area and need urgent/emergency care or services). **If you don't use participating providers, Health Partners Essential may not pay for your services and you may have to pay for them.**

If you become sick when you are away from home and it is not an emergency, call your PCP. Your PCP will tell you what to do and if you need to see a provider. If your PCP says you need to see another provider, your Health Partners Essential plan will cover the visit, as long as the service is covered under your benefit plan. Make sure you tell your PCP about any treatment that you receive when you are away from home. This way, your PCP can provide any needed follow-up care.

If it is an emergency, call 911 right away or go to the nearest emergency room.

Choosing a Provider

When you sign up for Health Partners Essential, pick a Primary Care Provider (PCP) in our network. To find PCPs in our network, visit our website at HealthPartnersPlans.com, click on "Find a Doctor" and then "PCO" to look up Health Partners Essential providers.

You can also find information here about other providers, including specialists and ancillary providers. If you would like a printed list of participating providers, please call Member Relations.

The Benefit of Having a PCP

Think of your PCP as your family doctor. He or she is your advocate, the person you can count on to support you and help you get the healthcare services you need. Your PCP works with a long list of quality doctors and will handle all of your health care.

Your PCP is Part of a Bigger Picture

Your PCP is part of a network of hospitals, specialists and other healthcare providers. Your PCP will help you get the care you need from the hospitals or specialists that he or she works closely with. This helps you get more personal care.

Health Partners Plans is proud that many of our doctors are teachers in medical schools. Some offices have resident doctors who see and treat patients under the supervision of a senior doctor. A resident doctor is someone who has finished medical school and may be learning a specialty, like treating heart conditions or skin problems.

Some Health Partners Essential offices have special staff, such as medical residents, certified nurse practitioners and physician assistants to help care for you. These special staff members are always supervised by senior doctors who are responsible for all of your medical care.

For More Information about Your PCP

If you want more information about your PCP's training, education or experience, please contact our Member Relations department at 1-855-215-7077 (TTY 711).

Changing Your PCP

If you want to change your PCP for any reason, here's how:

1. Visit our website at HealthPartnersPlans.com**,** click on "Find a Doctor" and then "PCO."
2. Select a new PCP.
3. Call our Member Relations department, 24 hours a day, seven days a week at 1-855-215-7077 (TTY 711).
4. Tell the Member Relations representative that you want to change your PCP.

The representative will ask for needed information, including your reason for the change. In most cases, the change will be effective on the first day of the following month (or the first day of the second following month, if you make your request late in the month). This provides time for your new PCP to be notified and prepared to provide care. In cases of medical or other urgency, Health Partners Plans will make special arrangements to make this change sooner.

Your Member Relations representative will provide you with the date when you will start with your new PCP. You can make an appointment to see your new PCP any time after that date. (Before this date, please call your current PCP if healthcare services are needed.)

Continuity of Care

Health Partners Essential is responsible for working with you to make sure that you will be able to keep getting the care you need, no matter which providers you see or services you receive. Health Partners Essential follows certain guidelines when providing continuity of care. Those guidelines are outlined below.

If you are a new Health Partners Essential member receiving ongoing treatment for a specific health condition from a provider not in the Health Partners Essential network, you have the right to ask to continue seeing that provider for up to 90 days after you become a Health Partners Essential member.

If you are a new Health Partners Essential member, Health Partners Plans must continue to provide the same services that you received under your previous health plan, whether they needed to be prior authorized (approved) or not, for up to 90 days after you become a Health Partners Essential member. If your new PCP decides that you need the services beyond the 90 days, Health Partners Plans will require a new authorization to continue these services.

If you are a new Health Partners Essential member who is pregnant and you are already under the care of an OB/GYN doctor not in the Health Partners Essential network, you may continue to receive services from that specialist throughout your pregnancy and for a period of time after you have your baby. You can also decide to change to an OB/GYN doctor who is in the Health Partners Essential network.

We will try to work with you to make sure you are able to be treated by the PCP, specialist or other provider that you want. However, there may be a situation where Health Partners Plans cannot honor your request for a particular provider. This includes situations where a federal or state government agency like the Department of Human Services (DHS) prohibits a provider from participating. Health Partners Plans will not cover the cost of any services given by that provider.

If your PCP ever leaves Health Partners Plans, we will notify you so that you can select a new PCP. In most cases you have the right to ask to continue seeing your PCP for up to 90 days from the date the provider stops participating with us, or 90 days from the date we notify you, whichever is later. To ask to continue seeing your PCP for up to 90 days, call Member Relations.

If in any case it is found by the Health Partners Plans Medical Director to be clinically appropriate, the transitional periods noted above may be extended.

If you have any questions about continuity of care or if you would like to continue receiving services from a particular provider after you enroll in Health Partners Essential, please call our Member Relations department at 1-855-215-7077 (TTY 711).

24-Hour Access to Your PCP

Health Partners Plans believes that being able to see your PCP is the most important part of your care. For health concerns, you can contact your PCP 24 hours a day, seven days a week. It is part of our total commitment to you. If you have a medical problem or question, call your PCP.

24-Hour Health Advice Line

Health Partners Essential members can also call our 24-hour health advice line, Teledoc. If you have a medical question and are not sure if you need to call your PCP, Teledoc can help. Teledoc may be able to answer your health question and give you tips to care for the problem yourself. If you have a more serious health concern, they may suggest that you call your PCP. To reach our Teledoc health advice line, call toll free, 1-800-Teledoc (1-800-835-2362). Remember, if your concern is life threatening or you need medical help right away, call 911 or go to the nearest Emergency Room.

Making an Appointment with Your PCP

For regular checkups or for care when you are sick, just call your PCP to make an appointment. There is no charge for office visits.

To visit your PCP, all you have to do is:

1. Call your PCP's office to find out when it is open. Your PCP's office name and telephone number are listed on your membership card.
2. Make an appointment.
3. Take your Health Partners Essential membership card when you go.

If you need help making an appointment, please contact our Member Relations department at 1-855-215-7077 (TTY 711).

Appointment Standards

Health Partners Essential participating PCPs, OB/GYN doctors and other specialists must meet the time frames for appointments shown on the next page. Health Partners Plans calls new pregnant members to help set up recommended appointments.

When you are waiting for a doctor to see you, the average waiting time should be no more than thirty (30) minutes or no more than one (1) hour when the physician has another patient with an Urgent Medical Condition or a difficult medical need.

Appointment Standards

Appointment Type **New member appointment for your first examination . . .**	**Appointment Standard** **Must be scheduled . . .**
PCP or Specialist – for members with HIV/AIDS	within seven (7) days from the effective date of enrollment for any person known to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the member is already in active care with a PCP or specialist
PCP or Specialist – for members who receive Supplemental Security Income (SSI)	within forty-five (45) days of enrollment, unless the member is already in active care with a PCP or specialist
PCP – for all other members	within three (3) weeks from the effective date of enrollment
Members who are pregnant	**Must be scheduled**
OB/GYN – High Risk Pregnancy Visit	within twenty-four (24) hours of identification of high risk pregnancy
OB/GYN – First Trimester (pregnant 1-3 months)	within ten (10) business days of being identified as pregnant
OB/GYN – Second Trimester (pregnant 4-6 months)	within five (5) business days of being identified as pregnant
OB-GYN – Third Trimester (pregnant 7-9 months)	within four (4) days of being identified as pregnant
Appointment with…	**You must be seen…**
PCP – Emergency Medical Condition	immediately or referred to an emergency facility
PCP – Urgent Medical Condition	within twenty-four (24) hours
PCP – Routine Appointment	within ten (10) business days
PCP – Health Assessment/General Physical Examination and First Examination	within three (3) weeks of enrollment
Specialist – Emergency Medical Condition	immediately upon referral

Specialist – Urgent Medical Condition	within twenty-four (24) hours of referral
Specialist – Routine Appointment With one of the following specialists: Otolaryngology, Dermatology, Orthopedic Surgery	within fifteen (15) business days of referral
Specialist – Routine Appointment With all other specialists	within ten (10) business days of referral

Urgent Care

Urgent care is care needed for an illness, pain or injury that, if left untreated, could become a crisis or emergency. If you need urgent care, your PCP will see you within 24 hours. You should call your PCP or have someone call for you. Remember, your PCP is available to you 24 hours a day, seven days a week. He or she is there to help you and will give you advice or direction. Taking this step could save you a trip to the emergency room! To learn more, please call our Member Relations department at 1-855-215-7077 (TTY 711).

If for some reason 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. Urgent Care Centers and Walk-in Clinics are facilities that provide basic medical care for walk-in patients that do not require emergency care. Examples are care for minor illnesses, or injuries such as muscle sprains or minor cuts requiring stitches. To learn more about Urgent Care Centers and Walk-in Clinics and the services they provide, please call our Member Relations department at 1-855-215-7077 (TTY 711).

Help If You Speak a Language Other than English

If you would like to request a Member Handbook or other Health Partners Essential information in a language other than English, at no cost, just call our Member Relations department at 1-855-215-7077 (TTY 711).

Help in Alternative Formats

If you would like to request a Member Handbook or other Health Partners Essential information in an alternative format (such as CD, Braille or large print), at no cost, please call Member Relations at 1-855-215-7077 (TTY 711).

Help If You Need an Interpreter or TTY Services

If you need an interpreter for any language, including sign language, or if you require TTY services for your healthcare needs, our Member Relations department can help you. Just call 1-855-215-7077 (TTY 711).There is no cost to you for these services.
If you need an interpreter and you call Member Relations, we have an online interpreter service that can help you. This service provides help in over 140 languages and is available 24 hours a

day, seven days a week. You will not have to make another telephone call to get this service. Member Relations will do this for you and will stay on the telephone with you.

Community Outreach Office

Set up with you in mind, our Community Outreach Office offers another way to get help and information. Member Relations staff there can help with any questions you have about using the plan. You can come there to:

- Pick up Member Handbooks and other Health Partners Essential materials
- Get help finding a doctor
- Order replacement member ID cards
- Take part in Health Partners Plans community education programs

Our community office is at 826 E. Allegheny Avenue in Philadelphia, just east of Kensington Avenue. SEPTA's Market-Frankford line (Allegheny station) and bus routes 3, 60 and 89 all stop nearby. You can call our community office at 215-426-4372, Monday – Friday, 8:00 a.m. to 4:30 p.m., except holidays.

Section 2: Seeing a Specialist

Definition of a Specialist

Specialists are doctors who treat specific problems. Examples of specialists include heart doctors, skin doctors or cancer doctors.

When You Should See a Specialist

Your PCP may feel that you have a sickness that needs to be treated by a doctor who has had special training so he or she can treat your sickness more effectively. If so, your PCP will give you a referral. A referral is written permission from your PCP for you to see a specialist. With a referral, any care you receive from that specialist is covered. You need a referral form to see most specialists.

For a list of specialists, visit our website at HealthPartnersPlans.com, click on "Find a Doctor" and then select "Healthy PA PCO" to look up Health Partners Essential participating providers. If you need a printed list of participating specialists, contact our Member Relations at 1-855-215-7077 (TTY 711).

If a specialist ever leaves Health Partners Plans while you are under his or her care, in most cases you have the right to request to continue seeing him or her for up to 90 additional days. Please call Member Relations to make such a request. (Please see section on Continuity of Care, page 9.)

Members with special needs can request that an appropriate specialist serve as their PCP. This is possible only if the specialist agrees to serve as a PCP, and if Health Partners Plans approves. In some situations, members with special needs may not qualify to have a specialist as their PCP. Call Member Relations at 1-855-215-7077 (TTY 711).

How to Get a Second Opinion

You may get a second opinion by asking your PCP to send you to another participating specialist. Your Health Partners Essential plan covers the cost of the visit. Before going to another specialist for a second opinion, always check with your PCP.

Section 3: Out-of-Plan Services

What is an Out-of-Plan Provider?

An out-of-plan provider is a provider that does not have an agreement with Health Partners Plans to provide services to Health Partners Essential members.

Out-of-Plan Facilities

An out-of-plan facility is a hospital or other facility that does not have an agreement with Health Partners Plans to provide services to Health Partners Essential members.

Coverage of Out-of-Plan Services

If a participating Health Partners Plans hospital or provider does not offer a service you need, your Health Partners Essential plan will cover the out-of-plan services. When there are fewer than two specialists in the network that are trained to do the service, your PCP may choose to send you to see an out-of-plan specialist. He or she can do this by asking for approval from Health Partners Plans. If Health Partners Plans denies this request, you may file a complaint. To file a complaint, just call our Member Relations department at 1-855-215-7077 (TTY 711).

Health Partners Essential must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries. If no contracted Private Coverage Organization (PCO) rate exists or if the provider of the service is an out-of-plan provider, Health Partners Essential must pay deductibles and coinsurance up to the applicable PCO fee schedule for the service.

Section 4: Emergencies

Definition of an Emergency

An emergency is an acute medical condition where you have severe pain or other symptoms and you or your caretakers believe that you cannot wait to get an appointment with your PCP because it could place your health or that of an unborn child in serious jeopardy or could cause further harm by waiting to see your PCP. Some examples of emergencies are:

- Blackouts
- Broken bones
- Chest pain
- Choking
- Drug overdose
- Heavy bleeding
- Poisoning
- Serious cuts or burns
- Sudden inability to move or talk
- Trouble breathing

Remember: If it is a life-threatening situation, call 911 for help immediately. If you are not sure whether you need immediate medical attention, you may call our 24-hour health advice line, Teledoc, toll-free at 1-800-Teledoc (1-800-835-2362).

If you have an emergency, your Health Partners Essential plan will cover any care you receive at the hospital. After an emergency, always call your Health Partners Plans PCP within 24 hours or as soon as possible. Do not go back to the emergency room for follow-up care that is not an emergency. Instead, make an appointment with your PCP.

Sometimes in an emergency, you may be admitted to an out-of-plan hospital. Health Partners Plans may request that you transfer to a participating hospital. This will take place after your condition is stable. Your PCP and the doctor at the hospital will discuss your condition. They will decide when you can be moved.

When your PCP and the provider at the hospital decide you can be moved, they will arrange for you to be transported under medical supervision to a Health Partners Essential participating hospital. There will be no charge for this transportation.

You do not have to go to another hospital if you do not want to. However, if the hospital you are in is not in the Health Partners Essential network and you choose to stay in that hospital, you may be responsible for any hospital costs above and beyond the initial emergency and post-stabilization treatment.

If you are denied treatment at an emergency room, you should call your PCP or our Member Relations department right away. Your PCP's telephone number is on your Health Partners Essential ID card. Our Member Relations department can be reached 24 hours a day, seven days a week at 1-855-215-7077 (TTY 711).

Out-of-Area Emergencies

If you have an emergency and you are outside the Health Partners Plans service area, you should seek medical care from the nearest hospital or healthcare provider. Call your PCP within 48 hours, or as soon as possible to arrange follow-up care.

The hospital or provider may not be a Health Partners Essential participating provider. This means that you might need to transfer to a participating hospital or provider. This transfer cannot take place until your condition is stable. Your PCP will discuss your condition with the doctor who is treating you. They will decide when you can be moved.

Ambulance Services

Your Health Partners Essential plan covers only emergency ambulance transportation.

Remember: If it is a life-threatening situation, call 911 immediately.

Section 5: Coverage, Benefits, Services and Copayments

Coverage includes certain benefit limits and copayments for some services. A copayment is your out-of-pocket cost and is due at the time services are provided.

Preventive Care and Wellness Benefits

1. The recommendations and guidelines of the following organizations are referenced throughout this Preventive Care Benefit section and may be updated periodically:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - Health Resources and Services Administration
   - United States Preventive Services Task Force

   This plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

2. If any *diagnostic* X-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the Preventive Care benefits described below, these diagnostic X-rays, lab or other tests or procedures will not be covered as Preventive Care Benefits. Those that are **Covered Benefits** will be subject to the cost-sharing that applies to those specific services under this plan.

Routine Physical Exam Benefit

Covered Benefits include office visits to your Primary Care Provider (PCP) for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by your PCP for a reason other than to diagnose or treat a suspected or identified illness or injury.

These services may include but are not limited to:

- Screening and counseling services, such as those on:
  - Interpersonal and domestic violence
  - Sexually transmitted diseases
  - Human Immune Deficiency Virus (HIV) infections
- Screening for gestational diabetes
- High-risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
- X-rays, lab and other tests given in connection with the exam

For details on the frequency and age limits that apply to the Routine Physical Exam Benefit, contact your PCP or call Member Relations at 1-855-215-7077 (TTY 711).

Preventive Care Immunizations Benefit

Covered Benefits include:

- Immunizations for infectious diseases
- Materials for administration of immunizations

The immunizations must be recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and must be provided by your PCP or a participating facility.

Benefit Limitations:

Immunizations that are not considered preventive care, such as those required due to your employment or travel, are not covered under this benefit.

Well Woman Preventive Visits Benefit

Covered Benefits include a routine well woman preventive exam office visit, including Pap smears, provided by your PCP, physician, CRNP, obstetrician, or gynecologist in accordance with the recommendations of the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

Screening and Counseling Services Benefit

Covered Benefits include the following services provided by your PCP or other physician or CRNP, as applicable, in an individual or group setting:

Obesity Benefit

Covered Benefits include:

- Screening and counseling services to aid in weight reduction
- Preventive counseling visits and/or risk factor reduction intervention
- Medical nutrition therapy
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

Misuse of Alcohol and/or Drugs Benefit

Covered Benefits include screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Use of Tobacco Products Benefit

Covered Benefits include screening and counseling services to aid in the cessation of the use of tobacco products.

Coverage includes:

- Preventive counseling visits
- Treatment visits
- Class visits

Benefits for the screening and counseling services above may be subject to visit maximums.

Routine Cancer Screenings Benefit

Covered Benefits include, but are not limited to, the following routine cancer screenings:

- Mammograms
- Fecal occult blood tests
- Digital rectal exams
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies
- Double contrast barium enema (DCBE)
- Colonoscopies

For details on the frequency and age limits that apply to the Routine Cancer Screenings Benefit, contact your PCP or call Member Relations at 1-855-215-7077 (TTY 711).

As to routine gynecological exams performed as part of a routine cancer screening, you may go directly to a participating obstetrician (OB), gynecologist (GYN), or obstetrician/gynecologist (OB/GYN) without a referral from your PCP.

Prenatal Care Benefit

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a PCP, physician, CRNP, obstetrician, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this benefit is limited to pregnancy-related physician office visits, including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Comprehensive Lactation Support and Counseling Services Benefit

Covered Benefits include lactation support (assistance and training in breastfeeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider. The "postpartum period" means the 60-day period directly following the child's date of birth. **Covered Benefits** incurred during the postpartum period also include the rental or purchase of breastfeeding equipment as described below.

Lactation support and lactation counseling services are **Covered Benefits** when provided in either a group or individual setting. Benefits for lactation counseling services may be subject to the visit maximum shown later in the schedule of benefits.

Breastfeeding Durable Medical Equipment

Covered Benefits include the rental or purchase of breastfeeding **Durable Medical Equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pumps

Covered Benefits include the purchase of an electric breast pump once every calendar year following the date of the birth

Health Partners Plans reserves the right to limit **Covered Benefits** to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Health Partners Plans.

Family Planning Services - Female Contraceptives Benefit

For females with reproductive capacity, **Covered Benefits** include those services and supplies that are provided to a member to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a PCP, obstetrician, gynecologist or other physician. Such counseling services are **Covered Benefits** when provided in either a group or individual setting. The following contraceptive methods are **Covered Benefits** under this benefit:

Voluntary Sterilization

Covered Benefits include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered Benefits under this benefit would not include a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of the confinement.

Contraceptives

Covered Benefits include contraceptive drugs and devices obtainable from a pharmacy, including formulary generic FDA-approved women's contraceptives.

Benefit Limitations:

Unless specified above, not covered under this benefit are:

- Services and supplies incurred for an abortion except for reason of rape, incest or mother's medical stability
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Services that are not given by a physician or CRNP or under his or her direction
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care

Hospitalization

If you need to be admitted to a hospital, your PCP will arrange for you to go to a participating hospital and continue to follow your care even if you need other doctors. Except in an emergency, the hospital needs to notify us about a hospitalization, and the services need to be authorized in advance by Health Partners Plans.

Skilled Nursing Facility

In any plan year, Health Partners Essential must provide members with up to 120 days of skilled nursing facility care. (This includes hospital reserve or bed hold days.) The days need not be consecutive.

Outpatient Services

Outpatient services, such as X-rays and laboratory tests, are also covered. Your PCP will arrange for these services at a participating hospital or outpatient center.

Home Health Care

If you become sick or hurt, medical care may be available in your home. Health Partners Plans will talk about this with you and your doctor to make sure you get the right care.

Home health care is covered when medically necessary. Prior authorization is required except for the initial evaluation. Members are covered for up to 60 home health care visits per year.

Chiropractic Services

Services of a state-licensed chiropractor who is a participating provider with Health Partners Essential are covered when medically necessary. Chiropractors can provide spinal manipulation to correct subluxation which is shown by diagnostic X-rays. Members are covered for up to 20 chiropractic visits per year. Referral from your PCP is required.

Quality Management Program

The Health Partners Plans Quality Management program monitors and works to improve the care and services you receive as a Health Partners Essential 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 cultural needs, we:

- Send out surveys to find out what you think of Health Partners Essential plan 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 Relations at 1-855-215-7077 (TTY 711).

Healthier YOU Programs

These programs help you manage your healthcare needs. Health Partners Plans sends out educational information concerning specific diseases, pregnancy, weight management and age-based preventive screenings. We also provide phone messages about important healthcare topics.

In addition, care coordinators are available to work with you and your doctor to help you self-manage your specific healthcare needs. Our Healthier You programs include:

- Asthma Program
- Diabetes Program
- Healthy Heart Program

- Chronic Obstructive Pulmonary Disease (COPD) Program
- Baby Partners Maternity Care Program

Interpreter services are available for non-English speaking members enrolled in the Healthier You Programs. TTY services are also available for our hearing impaired members.
For more information about these programs, please call our Healthcare Management department at 1-866-500-4571 (TTY 711) or visit our website at HealthPartnersPlans.com.

Health Partners Plans also has a 24-hour health advice line, Teledoc, staffed by medical doctors, available to answer your healthcare questions and concerns. Call the Teledoc line at 1-800-Teledoc (1-800-835-2362).

Baby Partners Maternity Program

- The Baby Partners program is staffed by nurses and social workers who are available to assist mothers throughout their entire pregnancy and after delivery. Our staff works together with your OB/GYN or midwife to provide you with education, offer referrals to community resources to help you prepare for the baby, and coordinate required services for high-risk pregnancies.

- Health Partners Essential offers a 24-hour breastfeeding helpline at 215-307-6791 (TTY 711) through our Baby Partners program.
- Visits to your OB/GYN or midwife can be covered even if he/she leaves the network or if the provider you visit before you are enrolled in Health Partners Essential is not in the network. (See Continuity of Care section on page 9 for details.)

Call our Baby Partners helpline at 1-866-500-4571 to enroll in the program.

If you become pregnant, you have the right to leave a *Healthy PA* Private Coverage Option (PCO) plan like Health Partners Essential and be covered by Medical Assistance during your pregnancy or you can also choose to stay a member of Health Partners Essential and receive the services described in this section. Contact our Member Relations for more information.

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 14 to 15 times before your baby is born. Your Health Partners Essential plan covers all of these visits and will help you get to each appointment.

If you think you are pregnant and need a pregnancy test, see your PCP or a family planning provider. You can also call our Baby Partners helpline for a no cost pregnancy testing kit. The kit can be mailed to you or picked up from Health Partners Plans main office.

If you are pregnant, you can:

- Call a certified midwife or OB/GYN for an appointment. No referral is needed.

OR

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

Care after the birth of your baby — Postpartum care

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

Newborn Care

Your newborn is covered by Health Partners (Medicaid) automatically for the first 30 days. Your newborn should be seen by a pediatrician within a week of discharge unless directed otherwise on discharge from the hospital.

Vision Care

Health Partners Essential covers a routine vision exam and up to $100 for prescription eyeglasses or contact lenses every two years.

Fitness Club Membership

Exercise is a key to staying healthy and feeling good about yourself. That's why Health Partners Plans offers special memberships at participating YMCAs and other fitness centers. To qualify for a year-long membership at a participating center, you must complete 12 visits within the first three months of joining. For these visits, a $2 copayment is required. After completing these visits, no copayment is required for the rest of the year. We cannot grant time extensions to complete required visits.

You must sign a fitness enrollment form during your first visit to the fitness center. You must also follow the rules of the fitness center. For more information, please call our Member Relations department at 1-855-215-7077 (TTY 711).

Weight Watchers® Benefit

When you're overweight, those extra pounds can contribute to heart disease, high blood pressure and diabetes. They can also make you unhappy. That's why Health Partners Plans wants to help you get the weight loss help you need – from Weight Watchers of Philadelphia, Inc. As a Health Partners Essential member, you pay a $2 weekly meeting fee when you enroll in the Health Partners Plans Weight Watchers program and meet program requirements.

To qualify, you must be at least five pounds overweight. You then must (1) attend 10 consecutive weekly meetings and (2) lose at least one pound a month. As long as you meet

program requirements, you can continue for the rest of the benefit year. You are also eligible to earn a supermarket gift card when you continue in the program. For additional information about the program, call our Member Relations department at 1-855-215-7077 (TTY 711).

Education Classes

Health Partners Plans has educational classes. Most are offered at our community outreach office. Classes include health-related computer classes addressing diabetes and asthma. We also offer health and wellness classes about nutrition, exercise and how to have a healthy pregnancy. For information about how to participate in a class, call our Member Relations department.

Prescriptions

If you have questions about prescription drug coverage, need help finding a pharmacy, or would like a complete list of participating pharmacies, call our Member Relations department at 1-855-215-7077 (TTY 711). We are here to help you 24 hours a day, seven days a week.

The Health Partners Essential Provider Directory also contains a list of participating pharmacies. To access the online Provider Directory, visit our website at HealthPartnersPlans.com and click on "Find a Doctor," then on "PCO." If you need assistance, please contact Member Relations.

If you need medicine, your PCP or specialist will write a prescription. Simply take the prescription slip to one of the nearly 1,000 area pharmacies (drug stores) that fill Health Partners Essential plan prescriptions. Your prescription will be filled if the prescription is covered under your pharmacy benefit. Copayments for your prescriptions are due at the time you receive them from the pharmacy.

If any question about copayments or coverage comes up while you are at the pharmacy, you or the pharmacist can contact our Member Relations department for assistance.

Formulary

Your Health Partners Essential plan has a formulary. A formulary is a list of medicines that a health plan approves for use. Your doctor uses our formulary when choosing medicines for you. The formulary contains two kinds of drugs: brand name drugs and generic drugs. Generic drugs contain the same active ingredients as brand name drugs. Since they work the same way as the brand name drugs, you can be assured that these drugs are high quality and safe for you to take.

If the medicine your doctor wants to use is not part of the formulary, he or she can make a request through the prior authorization process. Your doctor will need to send a prior authorization request to the Health Partners Plans Pharmacy department. Health Partners Plans has easy-to-use Prior Authorization forms located in the Providers section of the Health Partners Plans website at HealthPartnersPlans.com.

The prior authorization request must explain why you need the medicine and why formulary alternatives (if available) cannot be used. Health Partners Plans will review your doctor's request and make a decision within 24 hours of receiving the request.

If your doctor makes his/her request for Health Partners Plans approval after you have already taken the prescription to the pharmacy, Health Partners Plans, while reviewing the request, will in most cases cover a 5-day supply of the medicine if you have not already been taking the medicine, and a 15-day supply if you have already been taking the medication.

We will let you and your doctor know whether we will approve the medicine for you. If we deny your doctor's request, you have the right to file a complaint or grievance. (See Section 9 for more information.) Since new drugs and treatments are put into use all the time, Health Partners Plans will make changes to the formulary as needed.
If you would like a copy of the Health Partners Essential plan formulary, please call our Member Relations department at 1-855-215-7077 (TTY 711) or visit our website at HealthPartnersPlans.com. Go to the "Tools and Resources" section in the Members area, and click on "Drug Formulary."

What's Not Covered

There are some healthcare services that are not covered by Health Partners Essential. Services and situations not covered include the following:

- Abortions, except in cases of rape, incest, or when the life of the member is in danger
- Ambulance – when non-emergent and/or for routine medical transportation
- Any service that is not ordered by an appropriate Health Partners Essential provider (including your PCP, specialist or vision care provider) except for family planning visits and prescription drugs, and emergency or covered out-of-area care. (Note, however, that prescriptions must be issued by an appropriately licensed healthcare professional that is not on the federal list of excluded providers.)
- Applied behavior analysis
- Chelation therapy, primal therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetics therapy, and vision perception training
- Contraceptives and over-the-counter supplies such as condoms, foams, jellies and ointments
- Cosmetic surgery such as face lifts, tummy tucks, or breast reductions
- Custodial care
- Dental care and X-rays
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Eyeglasses/contacts
- Habilitation services
- Hair analysis
- Hearing aids
- Home births

- Home modifications
- Home uterine activity monitoring
- Household equipment such as water purifiers, hypo-allergenic pillows, mattress purifiers
- Hypnotherapy
- Immunizations for travel or work
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ART, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents
- Implantable drugs and certain injectable drugs, including injectable infertility drugs
- Long-term care
- Medications for hair loss, weight loss or gain, fertility treatment, cosmetic purposes (except acne treatments), smoking cessation, and erectile or sexual dysfunction
- Missed appointment charges
- Non-medically necessary services or supplies
- Non-emergency care when traveling outside the U.S.
- Non-standard allergy services and supplies such as Rinkel Test, Bryan's Test
- Orthotics, except when necessary for diabetic members
- Outpatient supplies such as disposable syringes, incontinence pads, elastic stockings and reagent strips
- Over-the-counter medications (except as provided in a hospital) and supplies
- Paternity testing
- Performance enhancing steroids
- Personal comfort or convenience items
- Private duty nursing
- Radial keratotomy or related procedures
- Recreational, educational and sleep therapy
- Religious, marital and sex counseling
- Renal dialysis
- Respite care
- Reversal of sterilization, reversal of voluntary sterilization (e.g. Tubal Ligation Reversal, Vasectomy Reversal)
- Routine foot/hand care

- Services offered and covered by other programs, such as Worker's Compensation or Veterans Administration
- Services for the treatment of sexual dysfunction, erectile dysfunction, or inadequacies, including therapy, supplies, counseling and prescription drugs
- Services provided outside the United States and its territories, with limited exceptions in Canada, Mexico and U.S. territorial waters
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Thermography, Thermograms
- TMJ – non-surgical treatment
- Tobacco use – any treatment, drug, service or supply to stop or reduce smoking (e.g. hypnosis, nicotine patches or gum)
- Transgender surgery
- Vision services, except routine eye exams
- Weight control services and supplements, bariatric surgery, appetite suppressants and other medications; food or food supplements, exercise programs (except for coverage provided by the Health Partners Essential fitness benefit), exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity (except for coverage provided by the Health Partners Essential Weight Watchers benefit), including Morbid Obesity or for the purpose of weight reduction, regardless of the existence of comorbid conditions

If you are not sure if a particular service is covered by the Health Partners Essential plan, it is important to check with your PCP or our Member Relations department at 1-855-215-7077 (TTY 711).

Section 6: Coverage Guidelines

Prior Authorization

Sometimes there are services or items that your PCP (primary care provider) must ask Health Partners Plans to approve for you. This is known as prior authorization. These services include, but are not limited to:

- Acute inpatient rehabilitation admissions
- Advanced radiology services (CT, MRI, PET scans, stress echocardiography, echocardiography, cardiac nuclear medicine imaging and radiation therapy)
- Durable Medical Equipment (DME) over $500
- Elective hospitalizations
- Homecare services
- Inpatient hospice admissions
- Outpatient hospice
- Outpatient rehab therapies
- Prescription drugs specified in our Formulary, and non-Formulary drugs (refer to HealthPartnersPlans.com or the Medication Prior Authorization section in this handbook for more information)
- Prosthetics/Orthotics
- Services, procedures, items or drugs considered to be new or emerging technology
- Services/procedures performed by non-participating providers
- Skilled nursing facility admissions
- Transfers to non-participating facilities

When Health Partners Plans receives a complete request for prior authorization, we will contact your provider and you by phone within two business days from the date we received the request to tell him or her if we approved the service or item requested. A written decision notice will be mailed to your provider and you within two business days from the date of our decision. You and your provider can ask that we delay our decision by up to 14 days in order to provide additional information to support the request.

If Health Partners Plans believes that we do not have all the information needed to make a decision, we will ask for the additional information needed from your provider within 48 hours of when we get the request. Health Partners Plans will let you know that we asked your provider for this additional information. Your provider has 14 calendar days to submit the additional information requested. Health Partners Plans will contact your provider by phone with our decision within two business days after we get the additional information. If your provider does not send the additional information within 14 calendar days of our request, then we will base our decision on the information available.

If we do not provide written notice of our decision within 21 calendar days from the date Health Partners Plans first received the prior authorization request, the service or item is automatically approved. You have the right to appeal any prior authorization request that is denied. Our written decision notice will tell you what you have to do to appeal.

Health Partners Plans follows set standards when making a decision about prior authorization or whether a procedure is medically necessary. These standards are called utilization review guidelines and clinical criteria. Your provider can get a copy of these guidelines and criteria used in reaching our decision by calling us.

You may also get a copy of these materials by contacting our Member Relations department at 1-855-215-7077 (TTY 711).

If your provider calls for an authorization for a service and it is not approved, Health Partners Plans will not pay for that service. However, you may still receive the service if you are willing to pay out of pocket. Your provider will have you sign a form saying you are aware you are responsible for paying for this unauthorized service.

If your provider fails to call Health Partners Plans for a service requiring prior authorization, and you receive the service anyway, you are not responsible for payment unless it is not a service covered by Health Partners Essential. You may be responsible for payment when you sign a form from your provider, clearly stating your responsibility for payment if not covered by Health Partners Essential.

Payment Denials

When Health Partners Plans denies payment to a provider after you have already received the service, we will send you a notice that tells you that payment was denied for one of the following reasons:

- The service(s)/item(s) were provided without required authorization.
- The service(s)/item(s) were not a covered benefit for you.

The purpose of these notices is to tell you of our decision to deny payment and to tell you whether the provider may or may not bill you for those services.

Medication Prior Authorization

You may also need to receive approval or “prior authorization” to receive certain medications. The following kinds of medications may require prior authorization:

- Non-formulary medications, or benefit exceptions required by medical necessity
- Medications and/or treatments under clinical investigation
- Medications used for non-FDA-approved uses
- Medications that exceed $1,000 per claim
- All brand name medications when there is an A-rated generic equivalent available

- Prescriptions that exceed plan limits (day's supply, quantity, or cost)
- Prescriptions processed by non-network pharmacies
- New-to-market products
- Medications that have treatment guidelines approved by the Health Partners Plans Pharmacy & Therapeutics Committee
- Orphan drugs
- Selected injectable products (self-administered and/or physician office administration)
- Also, any limits or copay overrides may be reviewed for prior authorization

To request prior authorization, your doctor or a designated member of his or her staff must contact the Health Partners Plans Pharmacy department either by fax or telephone and submit a prior authorization request form or a letter of request that includes an explanation of why you need a particular medication.

After receiving the prior authorization request from your doctor, Health Partners Plans will make a decision within 24 hours and send your doctor an approval or denial letter via fax. You will also receive an approval or denial letter in the mail and a notice by phone.

If the prior authorization request is denied, your doctor can submit a written appeal to the Health Partners Plans Pharmacy department or our medical director, explaining the medical necessity of the medication in question. At any time during normal business hours, your doctor can discuss the denial with a clinical pharmacist or can request a peer to peer discussion with the medical director by contacting the Pharmacy department.

If you have been receiving medicine that is being reduced, changed or denied, and you file a complaint, grievance, or request for a fair hearing that is hand-delivered or postmarked **within 10 days of the date on the denial notice we send you** coverage of the medicine will continue until a decision is made. (See section 9 of this handbook for information on how to file a complaint/grievance or appeal, or request a fair hearing.)

Medical Necessity

Your Health Partners Essential plan will pay for healthcare services and benefits not generally covered by Health Partners Plans if they meet any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or lessen the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

The request for the service(s) or benefit(s) must be put into writing. This is called a Letter Of Medical Necessity (LOMN). Your PCP or provider will prepare the LOMN and provide Health Partners Plans with the supporting information. The decision whether to cover the services that you request will be made by Health Partners Plans. Health Partners Plans may need additional information from you or other doctors who have treated you in order to make our decision.

How Health Partners Plans Covers New Services

New advances in medicine can help us stay healthy. Before Health Partners Plans approves a new service or item, we want to make sure that these new advances are safe and helpful. That's why we are careful when we decide if we should cover a new service or item. Here's how we make our decision:

1. We receive a provider's request for a service or item.
2. We ask the provider to give us a letter that tells us all the details about the service or item and that also explains why the member needs the service or item.
3. We perform a web-based literature search to find out more details about the service or item. These details could include:
   - Whether the service or item was approved by the Food and Drug Administration;
   - If other providers have used the service or item and wrote about how it worked for them;
   - Whether the service or item is accepted as useful by other providers. If a literature search does not yield relevant information about the service or item, we contact medical experts directly to get details about the service or item.
4. After the details of the service or item are provided to us from either the literature search or the medical expert, one of our Medical Directors here at Health Partners Plans reviews the details about the service or item. After review, the Health Partners Plans Medical Director makes a decision about whether the service or item should be covered.

These steps help ensure that the service or item is both safe and helpful for you. Experimental services or procedures are not covered under the Health Partners Essential benefit package.

If You Move or Change Your Phone Number

If you change your address or phone number, you should notify the Department of Human Services (DHS) about the change by calling their Customer Service Center toll free at 1-877-395-8930.

Please also notify Health Partners Plans by calling our Member Relations department at 1-855-215-7077 (TTY 711). (Please see information on Member Responsibilities in section 8.) In general, however, we must continue to use your "official" address supplied by DHS until you correct your address.

You may stay with Health Partners Essential, however, if you move to an area within Bucks, Chester, Delaware, Montgomery or Philadelphia counties. Even if you move to another location within the same county, you must tell your case worker as soon as possible.

Section 7: Case Management Services

Special Needs Unit

The Special Needs Unit at Health Partners Plans ensures that members with special needs have access to the care they need. The case managers of the unit help members with physical or behavioral disabilities, complex or chronic illnesses and other special needs. The staff makes sure that these members receive the care they need through Health Partners Plans. The unit also works with various outside agencies to arrange for other necessary services in the community. If you would like the Special Needs Unit to help you, please call us at 1-866-500-4571 (TTY 711) to discuss your needs.

Services for Members with HIV/AIDS

A case manager in the Health Partners Plans Special Needs Unit works full-time to meet the special needs of members with HIV/AIDS. The case manager ensures that these members receive necessary medical care, arranges for needed social services and helps coordinate their overall care. For information about how to get these services, please call our Special needs Unit at 1-866-500-4571 (TTY 711).

Drug and Alcohol Treatment and Mental Health Services

Health Partners Essential members receive mental health and substance abuse treatment through Magellan of PA for the services listed below. Members can be referred to Magellan by their PCP. Members also can call Magellan at 1-800-424-3707 (TTY 1-800-424-3703).

Mental Health Services

- Inpatient treatment
- Outpatient treatment
- Partial hospitalization

Alcohol/Drug Abuse Services

- Inpatient detoxification
- Outpatient detoxification
- Inpatient rehabilitation
- Outpatient rehabilitation
- Residential treatment facility

Social Services Available to Members

Health Partners Plans can give you information about social services that are available in the community. The Health Partners Plans Special Needs Unit can help identify and refer you to a social service agency that may be able to assist you with services not covered by your Health Partners Essential plan.

Services that are offered include: mother/child service agencies, housing agencies, the

Department of Human Services, the Women, Infants and Children (WIC) program, Head Start and Early Intervention Services. If you would like additional information about any of these or other social service programs, please call our Special Needs Unit at 1-866-500-4571 (TTY 711).

Supplemental Security Income

Do you or your child have a disability or serious health problem? You may be eligible to receive Supplemental Security Income (SSI). Health Partners Plans has a contract with Human Arc, a company that can help you apply for SSI. This is a free service to all Health Partners Essential members. You may be contacted by Human Arc to find out if you qualify for this program. We encourage you to work with Human Arc because you may be eligible for cash assistance. For more information, call our Member Relations at 1-855-215-7077 (TTY 711).

Section 8: Member Rights and Responsibilities

As a Health Partners Essential member, you have the right to know about your Rights and Responsibilities. Exercising these rights will not negatively affect the way you are treated by Health Partners Plans, its participating providers or other State agencies. You have the right to make healthcare decisions without feeling as though Health Partners Plans is restraining, isolating, bullying, punishing or retaliating against you.

Member Rights

As a member of Health Partners Essential, you have many rights including:

1. You have the right to receive information about Health Partners Essential, the benefits provided to you by Health Partners Plans and our practitioners and providers. You also have the right to receive information about your rights and responsibilities.
2. You have the right to be treated fairly and to have your right to respect, dignity and privacy protected.
3. You have the right to be a part of decisions made by Health Partners Plans and its participating doctors that affect your personal health care and your membership.
4. You have the right to talk openly with your doctor about all treatments that may be right for your health condition, whether or not Health Partners Essential covers them and without regard to cost.
5. You have the right to receive information on available treatment options and alternatives. Your treatment options should be presented in a way that is clear to you. You also have the right to refuse treatment options from your doctor.
6. You have the right to be free from inappropriate restraint or seclusion while in any healthcare facility.
7. You have the right to voice a complaints about Health Partners Essential or care provided.
8. You have the right to make recommendations regarding the member's rights and responsibilities.
9. You have the right to expect that information you provide to Health Partners Plans, your medical records and anything you discuss with your doctor will be treated confidentially, and will not be released to others without your permission.
10. You have the right to request a specialist to help meet your special needs by serving as your primary care provider.
11. If a problem comes up, you have the right to question decisions made by Health Partners Plans or its participating doctors.
12. You have the right to basic information about doctors and other providers who participate with Health Partners Plans. You have the right to choose from these providers and to refuse care from specific doctors. You have the right to voice complaints and grievances about Health Partners Plans or care provided.

13. You have the right to file a Department of Human Services (DHS) Fair Hearing appeal if you are not satisfied with Health Partners Plans' decision of a complaint/grievance or appeal.
14. You have the right to be present either in person or by telephone at the appeal hearing and to bring a family member, friend, lawyer or other person to help you.
15. You have the right to use an Advance Directive to say how you want your medical care handled. This written statement will be used if you are too sick to speak for yourself.
16. You have the right to have access to your medical records in accordance with Federal and State laws, and to request that we amend or correct your records. If you would like a copy of your records, or want to request that changes be made, please call Member Relations.

Member Responsibilities

You also have many duties as a member of Health Partners Essential, including:

1. You have the duty to tell Health Partners Plans and its participating doctors about information that may affect your membership or your right to program benefits. For example, if you move to another address, you must call Health Partners Plans and your PCP and tell us your new address.
2. You have the duty to inform your doctor about your health history.
3. You have the duty to help with your health care by following the membership rules. For example, you must call your PCP when you need urgent care and after getting emergency care.
4. You have the duty to learn about your health problems and work with your doctor to develop a plan of care. Once you have agreed upon treatment, you have the duty to follow the instructions for care that you have agreed upon.
5. You have the duty to sign a consent form so your doctor can receive a copy of your medical records. This information may be shared with other healthcare providers.
6. You have the duty to make and keep appointments, to be on time, and to call to cancel an appointment or to report that you will be late.
7. You have the duty to treat your PCP, other healthcare providers and Health Partners Plans staff with respect and dignity.
8. You have the duty to use our participating providers for all your healthcare needs. This includes PCPs, specialists, hospitals, pharmacies and any other providers you use as a Health Partners Essential member.

Provider Conscientious Objection

Health Partners Plans and its subcontractors must respect the conscience rights of individual providers and provider organizations, as long as these conscience rights are made known to Health Partners Plans in advance and comply with the current Pennsylvania laws prohibiting discrimination on the basis of the refusal or willingness to provide healthcare services on moral or religious grounds.

Additionally, if Health Partners Essential elects not to provide or reimburse a counseling or referral service based on its moral or religious objection to the service, it must comply with state requirements and is responsible for providing alternative arrangements for these services to members.

Patient Self-Determination Act

The Patient Self-Determination Act is a federal law. This law gives you the right to decide for the future which type of medical treatment you will accept, refuse or end if you become too sick to speak for yourself. Your medical wishes must be put in writing and given to your doctor or other healthcare providers before you get sick. This written document is called an Advance Directive.

In Pennsylvania, Act 169 went into effect in January of 2007, and it governs Advance Healthcare Directives.

Advance Directives

We all expect to stay healthy. And we hope you do for a long, long time. However, there may come a time when you are not healthy and can't make decisions about your health care. This is why it is important to have an Advance Directive.

Before writing an Advance Directive, you should think about the questions below. Discuss them with your family, friends and clergy.

- How important is it for you to die without a long period of pain and suffering?
- How important is it for you to follow your religious beliefs?
- How important is it to have your choices respected and followed?

There are two types of Advance Directives in Pennsylvania: Living Wills and Healthcare Power of Attorney documents (these are also called Durable Power of Attorney documents). Both are treated as legal documents.

Living Wills

A Living Will is a document containing your wishes on how you would like to be treated if you have a terminal illness (illness resulting in death) or a very serious operation. If you are ill and cannot speak for yourself and/or make decisions for yourself, your Living Will document will tell your doctor what life-sustaining treatments (treatments to help keep you alive) you may want and which treatments you do not want.

Examples of life sustaining treatments are:

- Cardiopulmonary resuscitation (CPR) – a way to get your heart beating again
- Intravenous therapy (IV) – a way to keep you medicated when you can't take medicine by mouth
- Feeding tubes – a way to feed you if you can no longer feed yourself

- Respirators – a way to help you breathe if you can't breathe for yourself
- Dialysis – a way to clean your blood if your kidneys can't do it
- Pain relief – either requesting or refusing it

In order for your wishes to be carried out, your Living Will must be written before you become ill or have an operation. Your doctor must have a copy of it. Your doctor must also determine, at the time the life-sustaining treatment decision is being made, that you are incompetent (in no condition to speak your wishes) and that your condition is either terminal (you will die) or that you are permanently unconscious (in a coma).

Healthcare Power of Attorney or Durable Power of Attorney

A Healthcare or Durable Power of Attorney is a written statement that gives the name of a person (called a "proxy" or a "healthcare agent") who can make certain medical decisions for you if you are not able to express yourself physically or mentally (if you cannot think, make decisions, or speak). This written list of instructions is done before medical services are needed. Your doctor will follow these instructions if you cannot communicate these wishes for yourself.

Your proxy/healthcare agent can be an adult friend or family member and does not need to be a lawyer or medical professional. Some examples of the decisions or authority given to your proxy/healthcare agent through a Healthcare/Durable Power of Attorney are:

- Admitting you to a hospital, residential or nursing facility
- Signing healthcare contracts for your medical services
- Authorizing medical or surgical procedures

Just like with the Living Will, you must write down your wishes in a Healthcare/Durable Power of Attorney ahead of time and give it to your doctor and others who need to know your wishes, such as your proxy/healthcare agent. Under Pennsylvania law, you can change or end ("revoke") your Living Will or Healthcare/Durable Power of Attorney at any time as long as you are competent.

Just make sure to let your doctor know if you are revoking it. If you make changes to your Living Will or Healthcare/Durable Power of Attorney, be sure your doctor has a copy of the new document with your changes.

You can also combine your Healthcare Power of Attorney document with your Living Will, and have just one document which covers both topics (the Living Will and the Healthcare Power of Attorney), or you can keep both documents separate.

To get help writing an Advance Directive, you can call a lawyer, social worker, your doctor's office, or the State Attorney General's office. You can also call our Special Needs Unit at 1-866-500-4571 (TTY 711) for further resources.

Will My Wishes Always be Followed?

The law does not ensure that a provider must follow your wishes in every case. However, it does say that if the doctor cannot in good conscience carry out your wishes, or if there are other policies which prevent the doctor from following your wishes, that the doctor must inform you. Your doctor must also help you locate another provider who is able to follow your wishes, if your wishes are permitted under Pennsylvania law. This is another reason it is so important that you give your Advance Directive decisions to your doctor in writing ahead of time, so that if he or she is not able to carry out your wishes, you can be transferred to a doctor who can. If you believe that your doctor or Health Partners Plans did not follow your Advance Directive, you have the right to file a complaint or a grievance. The section in this Handbook titled "Complaints, Grievances and Fair Hearings" lists all of the steps that you can take to file a complaint or a grievance.

How Does Health Partners Plans Protect Your Health Information?

Health Partners Plans must make reasonable efforts to protect member privacy regarding Protected Health Information (PHI). We use appropriate safeguards to limit PHI used or disclosed to the minimum necessary to accomplish the intended purpose. We will identify the persons or departments within Health Partners Plans that require access to PHI to carry out their job responsibilities. We also review the categories or types of PHI that each person or department requires access to, and under what conditions they require this access. This is done before allowing any access to PHI. Any conversations about PHI are conducted in a confidential way and in private.

All new Health Partners Plans employees must read and sign a Confidentiality Statement of Understanding before starting work at Health Partners Plans. All employees must sign a new statement once a year. This requirement ensures that each employee is reminded of the importance of always maintaining confidentiality. We also require all Health Partners Plans staff to undergo confidentiality training every year.

As a general rule, Health Partners Plans will not use the entire health record of a member. Access to the entire health record will be allowed only if this is specifically identified as reasonably necessary to satisfy the purpose. When Health Partners Plans receives an internal request for PHI, we will share information on a need-to-know basis. This helps to protect confidentiality and ensure a member's privacy. Management is responsible to enforce and document the minimum necessary standard for such uses. Protected health information is destroyed at Health Partners Plans so it is not used inappropriately. Any questions about PHI or the access to such information by the workforce will be directed to Health Partners Plans' Privacy Official or designee.

Notice of Privacy Practices

We are required by law to maintain the privacy of your PHI. In accordance with the Health Insurance Portability and Accountability (HIPAA) Privacy Regulations, we have the right to use and disclose your PHI for treatment, payment activities, healthcare operations, public health activities, legal proceedings or law enforcement purposes — as explained in the Notice of Privacy Practices found on our website and in this section. We are most likely to use and/or

disclose your PHI for these functions. Additionally, with your approval, we may use or disclose your PHI outside of treatment, payment and operations. For example, we may share your information with a person or entity that you gave access to through our HIPAA Authorization form.

We have HIPAA procedures for protecting your health information and demographic (race, ethnicity, age, zip, language, etc.) information in all forms (electronic, written, or verbal). Some of these safeguards include:

- Verifying who you are and obtaining your consent before disclosing your information.
- Only sharing the minimum amount of information necessary to accomplish care.
- Identifying employees that require access to information and when.
- Reviewing all categories of information that is used and disclosed on an annual basis.
- Limiting where conversations about members take place and shredding papers that include PHI.

We are committed to protecting your privacy and the confidentiality of your personally identifiable information. The "Notice of Privacy Practices" mailed to all members explains your HIPAA privacy rights, how your medical information may be used, how you can get access to your PHI and how our employees protect your information. Our website and this handbook explain your member "bill of rights" and how we collect and use member demographic data (i.e. zip code, race, language, ethnicity and age). This handbook and other privacy information can be found at HealthPartnersPlans.com, or you can request it from Member Relations at 1-855-215-7077 (TTY 711).

What Are Your Rights?

The following are your rights with respect to your health information. If you would like to exercise the following rights, please contact our Member Relations department at 1-855-215-7077 (TTY 711).

- **You have the right to ask us to restrict or limit how we use or disclose your information** for treatment, payment, or healthcare operations. You also have the right to ask us to restrict information that we have been asked to give family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your request, we are not required to agree to these restrictions.

- **You have the right to ask to receive confidential communications** of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to a different or additional address. We will work with you on any reasonable request by you as explained above.

- **You have the right to inspect and obtain a copy of information** that we maintain about you in your designated record set. A "designated record set" is a group of records maintained by or for Health Partners Plans that is (i) the medical records and billing records about you; (ii) the

enrollment, payment, claims adjudication, and case or medical management record; (iii) and any information we use to make decisions about you and your health care.

However, you do not have the right to access certain types of information and we may decide not to provide you with copies of information that is:

- Contained in psychotherapy notes;
- Gathered for possible use for or in connection with a civil, criminal or administrative action or proceeding; and
- Subject to certain federal laws governing biological products and clinical laboratories.

Additionally, in certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

- **You have the right to ask us to amend information** we maintain about you in your designated record set. We may require that your request be in writing and that you provide a reason for your request. We will respond to your request no later than 30 days after we receive it. If we are unable to act within 30 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay and the date by which we will complete the action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to contest (argue) your statement. However, you have the right to request that your written request, our denial and your statement of disagreement be included with your information for any future disclosures.

- **You have the right to receive an "accounting" or a summary/report of certain disclosures** of your information made by us during the six years prior to your request. **Please note that we are not required to provide you** with an accounting of the following information:
  - Any information disclosed before April 14, 2003;
  - Information disclosed for treatment, payment, and healthcare operations purposes;
  - Information disclosed to you or pursuant to your authorization;
  - Information that is incidental to a use or disclosure otherwise permitted;
  - Information disclosed for a facility directory or to persons involved in your care or other nonfiction purposes;
  - Information disclosed for national security or intelligence purposes;

- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies; and
- Information that was disclosed or used as part of a limited data set for research, public health, or healthcare operations purposes.

We require that your request be in writing. We will act on your request for an accounting within 30 days. We may need additional time to act on your request, and therefore, may take up to an additional 30 days. Your first accounting will be free, and we will continue to provide to you one free accounting upon request every 12 months. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Exercising Your Rights

- **You have a right to receive a copy of this notice upon request at any time.**
- You can also view a copy of the notice on our website at HealthPartnersPlans.com. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by direct mail and post it on our website.
- If you have any questions about this notice or about how we use or share information, please contact Member Relations at 1-855-215-7077 (TTY 711).You can also send us questions by e-mail using the Contact Us link at HealthPartnersPlans.com.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Member Relations department at 1-855-215-7077 (TTY 711). You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.

We will not take any action against you for filing a complaint.

Section 9: Help with Problems

At Health Partners Plans, we work very hard to keep you healthy and to make sure that you are happy with the services we provide. Sometimes, however, you may have a concern about your health care or Health Partners Essential plan services. We want to work out any concerns you have, and will work hard to resolve any problems you may have. Many times, our Member Relations department can help you with these questions or concerns. Our Member Relations representatives are available around-the-clock, seven days a week, by calling 1-855-215-7077 (TTY 711).

Loss of Benefits

The process which results in ending your Health Partners Essential coverage is called disenrollment. Reasons for being disenrolled include but are not limited to:

- Moving out of the Private Coverage Option (PCO) service area
- Losing eligibility
- Spending more than 30 days in a nursing home
- Imprisonment

During the first 90 days of a member's enrollment in Health Partners Essential, we will not restrict you from changing to another Private Coverage Option plan for any reason. The Department of Human Services will determine when you may disenroll from Health Partners Essential for cause.

If you choose to leave the Health Partners Essential plan during your first 90 days of enrollment, you should call 1-800-440-3989 (TTY 1-800-618-4225). However, we value you as a Health Partners Essential member, and hope that you will call the Member Relations department if you are thinking about leaving. This way, you can give us the chance to help fix any problems you may be having. You are important to us!

What to Do If You Receive a Bill

There may be times when you are billed for services you receive, depending on your coverage and copayments. Your provider cannot bill you unless he or she tells you that you will have to pay for the service before you get the service.

If you receive a bill for services that you believe should be covered by Health Partners Essential, please call Member Relations.

Explanation of Benefits

Except for pharmacy claims, Health Partners Essential will provide Explanation of Benefits (EOB) information to members. The EOB information will be available within 45 days of payment or denial of a claim. The EOB information will specify the services paid or denied; including the description, date of service, place of service, provider name and ID, and the amount paid, and contact information for questions you may have about the EOB.

Fraud and Abuse: Special Investigations Unit

The Health Partners Plans Special Investigations Unit (SIU) looks into the behavior of Health Partners Plans doctors and other providers, Health Partners Plans members, and Health Partners Plans employees. The SIU checks for cases where these people may have acted in a way that is not legal or is unethical (wrong).

Members who believe that providers, other members or Health Partners Plans employees have acted in a way that is not legal or is not ethical should call our SIU Hotline at 1-866-477-4848.

This hotline is for reporting the behavior of members, providers and employees. You do not need to tell us your name or phone number when you call our hotline, just share with us what you would like about the actions that you think may be wrong and any other details that you feel will help us look into your concerns.

You can also send an email to us at:

- SpecialInvestigationsUnit@hpplans.com

  or

- Fraud_AbuseReporting@hpplans.com

These are some examples of behavior that is not legal or is not ethical:

- Providers who submit claims for services they did not provide
- Providers who submit a bill for a more expensive service than the one he or she actually did
- A provider who pays a member to see him or her
- Providers who submit more than one bill for the same service
- Providers who perform services that are not necessary or that a patient does not need done
- Providers who abuse a patient physically, mentally, emotionally or sexually
- Providers who offer a member free services, equipment or supplies in exchange for the member's ID number and then use that ID number to bill Health Partners Plans for services never provided
- A pharmacist who pays providers for referrals
- A pharmacist who gives generic drugs but bills for brand name drugs
- Members allowing others to use their membership cards or ID numbers
- Members who sell medicines they receive through Health Partners Plans

Tips for Recognizing Fraud and Abuse Issues

When Receiving Services at a Provider's Office

When a medical procedure is recommended, make sure the doctor explains to you why you need the procedure.

When Filling Prescriptions

Ask the pharmacist how many pills are in the bottle to make sure that it is the same number the doctor prescribed for you.

When asking someone to take your prescription to be filled at the pharmacy on your behalf, make sure that you know and trust that person.

When Attending a Gym or Physical Therapy Facility

Make sure you initial or sign gym cards ONLY for completed visits. Do not allow someone to have you initial or sign for any visits that you are planning to complete, but have not yet completed.

Safeguards to Protect Your Health Partners Essential Member Identification Card

Keep your Health Partners Essential member ID card in a safe place. Check often to make sure that the card is not missing.

Show your Health Partners Essential member ID card or provide your Health Partners Essential ID number only to your healthcare providers or administrators and pharmacists.

Do not leave any documents showing your Health Partners Essential member ID number in public places.

When receiving your healthcare services, Health Partners Plans recommends that you:

- Be Cautious.
- Be Alert.
- Be Safe.

If you see or hear about any wrongdoing, please make a note of what you think is wrong and call the Health Partners Plans SIU Hotline at 1-866-HP-SIU-4U or 1-866-477-4848 (TTY 711). You can use our Health Partners Plans Hotline number to report any suspected wrongdoing about

doctors, providers, members and/or employees of Health Partners Plans. You can also report providers to the State's hotline at the phone number listed below for DHS.

MA Provider Compliance Hotline:

1-844-DHS-TIPS

The MA Provider Compliance Hotline, established by and located in the DHS Bureau of Program Integrity, is designed to provide easy access for reporting suspected fraudulent and abusive practices by providers in Pennsylvania's Medical Assistance and Private Coverage Options programs. The Hotline is staffed with medical professionals who are available from 8:30 a.m. to 4:30 p.m. (Eastern Time), Monday through Friday. Voice messaging is available outside these hours. Non-English speaking interpreter services are available to provide assistance to callers and TTY services for persons with hearing impairment are also available.

- Callers to the Hotline are not required to identify themselves.
- If a caller does not wish to speak to a Hotline representative directly, please leave a message outside the hours of operation.

Please have the following information when you call:

- Provider's name and address
- Description of the suspected fraudulent and abusive activity, including the time period, frequency of the events, recipient name, and recipient ID number
- Your name and telephone number where you can be reached if you want to be contacted

Other Contact Information for Fraud and Abuse Reporting

You can also report suspected provider noncompliance or substandard quality of care for services paid for under the Pennsylvania Medical Assistance or Private Coverage Option programs by:

- Telephone (includes TTY service): 1-844-DHS-TIPS (1-844-347-8477)
- Fax: (717) 772-4655 - Attention: MA Provider Compliance Hotline
- Electronically submitting the MA Provider Compliance Hotline Response Form (http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm)
- U.S. Mail:

  Bureau of Program Integrity
  MA Provider Compliance Hotline
  P.O. Box 2675
  Harrisburg, PA 17105-2675

Recipient Restriction Program

Health Partners Plans participates in the Recipient Restriction Program. The program calls for Health Partners Plans to monitor and identify Health Partners Essential members who improperly or excessively utilize PCO services. In cooperation with the *Healthy PA* PCO Committee, Health Partners Plans will refer members with suspected patterns of inappropriate utilization to the Recipient Restriction Program. These members may be restricted to a certain physician and/or

pharmacy. Restricted members are locked into a pharmacy and/or physician for five years. Providers requesting information on this program may contact the Health Partners Plans Pharmacy department at **215-991-4300**.

Restricted members can request a provider change. The request must be written. The restriction coordinator will complete the provider change request within 30 days, and notify the member. Provider change requests should be sent to:

Attn: Recipient Restriction Coordinator -- Pharmacy Department
Health Partners Plans
901 Market Street, Suite 500
Philadelphia, PA 19107

Members cannot file a complaint or grievance, but may ask for a DHS Fair Hearing about the recipient restriction program. A written request must be sent to:

Department of Human Services
Office of Medical Assistance Programs
Bureau of Program Integrity
Recipient Restriction Section
PO Box 2675
Harrisburg, PA 17105-2675

For More Information

If you have any questions or need more information about your benefits or any Health Partners Essential services, call our Member Relations department 1-855-215-7077 (TTY 711). You can ask for more written information about the Health Partners Essential plan and its policies.

This information includes:

- A description of the plan's confidentiality policy
- A description of the provider credentialing process for reviewing providers who want to participate in the Health Partners Essential network
- A list of participating providers affiliated with participating hospitals
- A list of participating PCPs, specialists, pharmacies and providers of ancillary services in an appropriate alternate format
- A copy of the plan's medical guidelines (utilization criteria) used in reviewing your request for care
- Whether a specific drug is covered
- A summary of how Health Partners Plans pays providers for their services
- A description of the plan's Quality Management program
- Information about the cost of health care covered by Health Partners Plans

Section 10: Legal Aid Contacts

Community Legal Services of Philadelphia

North Philadelphia Law Center
1410 W. Erie Avenue
Philadelphia, PA 19140
Phone: 215-227-2400

Center City Office
1424 Chestnut Street
Philadelphia, PA 19102-2505
Phone: 215-981-3700

Philadelphia Legal Assistance

The Cast Iron Building
718 Arch Street, Suite 300N
Philadelphia, PA 19106
Phone: 215-981-3800

Legal Aid of Southeastern Pennsylvania

Bucks County

1290 Veterans Highway
P.O. Box 809
Bristol, PA 19007
Phone: 215-781-1111

And

50 N. Main Street
Second Floor
Doylestown, PA 18901
Phone: 215-340-1818

Chester County

222 N. Walnut Street, Second Floor
West Chester, PA 19380
Phone: 610-436-4510

Delaware County

410 Welsh Street
Chester, PA 19013
Phone: 610-874-8421

Montgomery County

625 Swede Street
Norristown, PA 19401
Phone: 610-275-5400

And

248 King Street
Pottstown, PA 19464
Phone: 610-326-8280

Legal Aid of Southeastern Pennsylvania Advice and Referral Helpline for Bucks, Chester, Delaware and Montgomery Counties is 1-877-429-5994. The Helpline is available Monday through Thursday from 9:00 a.m. to 1:00 p.m.

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

Visit us at HealthPartnersPlans.com

Member Relations (24 hours)
1-855-215-7077 (TTY 711)

Healthy PA
PRIVATE COVERAGE OPTION

Health Partners Plans