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 ទទួលបានពត៌មាននេះ សូមទំនាក់ទំនងទូរស័ព្ទ័ដែលមានបំរើការ 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 17. If you do receive a bill for covered services, you can send it back. Just follow the instructions on page 60 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 60 days after you become a Health Partners Essential member, or up to 90 days if medically necessary.

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 60 days after you become a Health Partners Essential member, or up to 90 days if medically necessary. If your new PCP decides that you need the services beyond this time, 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 60 days from the date the provider stops participating with us, or 60 days from the date we notify you, whichever is later. This time frame can be extended to 90 days if medically necessary. To ask to continue seeing your PCP after he/she leaves Health Partners Plans, 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. If you have a medical question and are not sure if you need to call your PCP, health advice line professionals can help. They 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 health advice line, call toll-free, 1-866-825-6717. 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 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 60 additional days. This time frame can be extended to 90 days if medically necessary. Please call Member Relations to request additional time with a specialist. (Please see section on Continuity of Care, page 8.)

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 toll-free at 1-866-825-6717.

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

Benefits

The chart below provides a brief overview of your coverage with Health Partners Essential, and is followed by additional information about plan benefits and special programs. For any questions, please contact Member Relations.

Benefit	Limits/Notes	Copayment
Primary Care Visits	To treat illness or injury or for preventive care/screenings	$0
Specialist Visits	PCP referral required for most services	$0
Behavioral Health Services – Inpatient Psychiatric	Prior authorization required for inpatient services	$3 per day, up to $21 per admission
Behavioral Health Services – Outpatient Psychiatric and Outpatient/Rehab Substance Abuse Treatment	Services may be referred by physician or self-referred	$0
Chiropractic Care	For subluxation only; 20 visits per year	$1
Drugs – Preferred Generic, Brand and Specialty (In-network only) *Note: Specialty drugs must be dispensed through a network specialty pharmacy*	Refer to formulary for covered drugs, quantity limits, prior authorization, step therapy or other benefit requirements; includes diabetic supplies obtained from a pharmacy	$1 Generic $3 Brand $3 Specialty
Durable Medical Equipment (DME)	Prior authorization required for DME over $500	$0
Emergency Room and Emergency Ambulance Services	Emergency care and emergency transportation covered	$0
Eye Exam – Routine	1 exam every 24 months; no referral required for plan providers	$0
Inpatient Hospital Services (Hospital Stay)/Physician and Surgical Services	Prior authorization required	$3 per day, up to $21 per admission
Lab Services	Physician order required	$0

Outpatient Hospital Short Procedure Unit (SPU) and Ambulatory Surgical Center (ASC)	Physician order required	$3
Outpatient Maternity Services	Prenatal and postnatal care covered	$0
Outpatient Physical/ Occupational/Speech Therapy	Up to 30 Physical/Occupational Therapy visits and 30 Speech Therapy visits yearly; Prior authorization required through Landmark Healthcare	$0
Radiology (Advanced Imaging: CT/PET Scans, MRIs, Nuclear Cardiology)	Prior authorization required through MedSolutions	$1
Skilled Nursing Facility Care	Up to 120 days per year; prior authorization required	$0
X-rays	Physician order required	$1
Extra Benefits Provided by Health Partners Essential		
Acupuncture	Up to 20 visits	$5
Eyewear	$100 combined allowance for eyeglasses or contacts every 2 years	$0
Fitness	Covers annual membership; program requirements apply	$2 per visit for first 12 visits yearly
Weight Watchers®	Covers meetings for up to 50 weeks yearly; program requirements apply	$2 per meeting

Behavioral 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. You can also call Magellan directly at 1-800-424-3707 (TTY 1-800-424-3703) to arrange services, or if you have questions.

Mental Health Services

- Inpatient treatment
- Outpatient treatment
- Partial hospitalization

Alcohol/Drug Abuse Services

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

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.

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.

Family Planning Services - Female Contraceptives

Services and supplies that are provided to a member to prevent pregnancy are covered. 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.

This benefit does not cover a voluntary sterilization procedure that is not billed separately by the provider or is 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

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).

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.

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.

Lactation Support and Counseling Services (Comprehensive)

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.

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.

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.

Physical Exams (Routine)

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).

Prenatal Care

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).

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. (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."

Preventive Care and Wellness Visits

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 benefits described in this Preventive Care and Wellness Visits section, 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.

Preventive Care Immunizations

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.

Screening and Counseling Services

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

Alcohol and/or Drugs Misuse
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.

Cancer Screenings (Routine)
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.

Obesity
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

Tobacco Products Use
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.

Well Woman Preventive Visits

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.

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.

Vision Care

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

Weight Watchers®

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. Coverage is limited to one Weight Watchers meeting location, and online meetings are not covered. You are

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).

Special Programs from Health Partners Plans

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 8 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.

Health Advice Line

Health Partners Plans has a 24-hour health advice line, staffed by health professionals, available to answer your healthcare questions and concerns. You can call toll-free anytime at 1-866-825-6717.

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.

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).

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)
- 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 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 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).

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 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 about Health Partners Plans or care provided.

13. You have the right to file a request for a Department of Human Services (DHS) fair hearing if you are not satisfied with the Health Partners Plans decision of a second level complaint or an 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. The section in this Handbook titled "Complaints, Appeals and Fair Hearings" lists all of the steps that you can take to file a complaint.

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

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

At Health Partners Plans, we respect the confidentiality of your personal health information ("PHI," "Health Information" or "Information") and will protect your Information in a responsible and professional manner. We are required by law to maintain the privacy of your PHI and to send you this Notice. This Notice explains how we safeguard the privacy of your PHI and when we can share that information with others. It also informs you of your rights about your PHI and how you can exercise these rights.

When we talk about PHI or Health Information or Information in this Notice we mean the following:

- Information that identifies you (or could be used to identify you (e.g., your address, phone number, social security number, etc.).
- Any kind of Information that relates to your physical health condition, the delivery of health care to you or the payment for that care (e.g., your claims, prescription, and diagnosis information).

How we obtain, use and share PHI for General Purposes

Health Partners Plans engages in routine activities that result in the receipt or exchange of your Health Information from sources other than you. Where state or federal laws offer greater privacy protections, we will follow those more stringent requirements. We must comply with the rules governing the disclosure of Health Information related to HIV/AIDS testing and treatment, drug and alcohol abuse prevention or treatment, and mental health. In order to use or share PHI we must obtain your written Authorization except as described below.

As your managed care plan, we may use or share Health Information about you to ensure that you obtain health services and to operate Health Partners Plans. We may use or share your Health Information for the following purposes:

- Treatment: Manage your health care
  - We may use your Health Information so that we can manage your care. A doctor sends us Information about your diagnosis and treatment plan so we can arrange additional services.
  - We may disclose Health Information to professionals who are involved in your medical care. If you are in the hospital, we may give your hospital doctor access to your medical records sent to us by your doctor(s) who treated you in the past.

- Payment Disclosures: Pay for your health services
  - We may use your Health Information to help pay for your health services submitted to us by doctors and hospitals for payment.

- We may disclose your Health Information to determine your eligibility for one of our plans, and for reviewing services to determine medical necessity, performing utilization review, obtaining premiums, coordinating your benefits and collection activities.

- Health Care Operations: Operate Health Partners Plans
  - We use Health Information about you to develop better services for you. For example, we may use and disclose Information to make sure the care you receive from a hospital or doctor's office is of the highest quality.
  - Using your Health Information, we may conduct medical reviews, review the qualifications and performance of the providers you visit, and resolve complaints and appeals.

- Administer your Plan
  - We may disclose your Health Information to your health plan sponsor for plan administration. A company may contract with us to provide health benefits, and we may provide that company with certain statistics to explain the premiums we charge.

- Health and Wellness Information
  - We may use or share your Health Information to send you a reminder if you have an appointment with your doctor.
  - We may use or share your Information to inform you about alternative medical treatment and programs or about health-related products and services that may interest you, such as information about smoking cessation or weight-loss programs.
  - We may send materials to you if you meet certain age criteria to describe our products and an application form.

- Business Associates: Other organizations that help us
  - We may share your Health Information with subcontractors, agents, and vendors, known as "Business Associates," who perform activities on our behalf, such as dental and vision practice managers, auditors and software support vendors. These Business Associates must agree to protect your Health Information.

When we share your PHI for special purposes

Health Partners Plans is required or permitted to share your Health Information without your Authorization in other ways – usually in ways that contribute to the public good, such as public health and research or as required by law. We have to meet many conditions in the law before we can share your information for these purposes. For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. For instance, we may share your Information for the following purposes:

- Public Health and Safety
  - We may use or share your Health Information for certain types of public health or disaster relief efforts.

- We may report your Health Information to State and Federal agencies that regulate us such as the U.S. Department of Health and Human Services; the Centers for Medicare & Medicaid Services; the Pennsylvania Department of Health; the Pennsylvania Insurance Department; and the Pennsylvania Department of Human Services.
- We may share your Health Information for public health activities. For example, we may report Health Information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device problems.
- We may report your Health Information to public health agencies if we believe there is a serious health or safety threat.
- We may report your Health Information to a government authority regarding child abuse, neglect or domestic violence.

- Required By Law
  - We must use or disclose your Health Information when we are required to do so by law, such as to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws.

- Legal Process, Law Enforcement, and Other Laws
  - We may provide your Health Information to a court or administrative agency (for example, pursuant to a court or administrative order, search warrant or subpoena).
  - We may report your Health Information for law enforcement purposes. For example, we may give Health Information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
  - We may report your Health Information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
  - We may report information on job-related injuries because of the requirements of your state workers' compensation laws. We are permitted to use or share your Health Information about you for workers' compensation claims.

- Research, Death and Organ Donation
  - We may share your Health Information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law.
  - We may disclose a deceased member's PHI to family members, providers and others who were involved in the care or payment for care of the decedent prior to death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to us.
  - We may disclose your Information to a personal representative such as a family member if the information pertains to that surviving family member's health. A decedent's health information is no longer considered protected under HIPAA starting 50 years after death. We may also share your Health Information with a funeral director as necessary to carry out his/her duties.
  - We may use or share your Health Information for banking or transplantation of organs, eyes or tissue.

- Under certain circumstances, we may use and disclose Health Information for research. Before we use or disclose Health Information for research, the project will go through a special approval process. We also may permit researchers to look at records to help them identify patients who may be included in their research project as long as they do not remove or take a copy of any Health Information.

- With Your Authorization or at Your Direction
  - We will share your PHI with your Authorization. You can tell us your choices about what we share and how we share it. See the section "What Are Your Rights?" on the next page.
  - With your verbal or written permission, we may assist you in obtaining proof of immunization as required by a school for your child or minor for whom you have legal guardianship, or for yourself.

- Family and Friends
  - We may share Health Information that is directly related to your treatment with your family, close friends, or others involved in payment for your care:
    - When you are present prior to the use or disclosure and you agree; or
    - When you are not present or competent. For example if you are unconscious, we may share your Health Information with family members if we believe it is in your best interest.

- Personal Representatives, Power of Attorney
  - Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative is a person who has legal authority to act on your behalf regarding your health care or healthcare benefits, for example, an individual named in a durable power of attorney; a legal guardian for an incapacitated adult; or a parent or guardian of an unemancipated minor. A parent may also be a personal representative for a child who is a minor. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your Health Information. We may ask you or the individual you have designated to act for you to provide documentation. We will make sure the person has this authority and can act for you before we take any action.

- Communications to You: We will communicate Health Information about you to the address, telephone number or email we have on record for the "subscriber" (the head of household, enrollee, responsible party) of your health benefits plan. For example, a newsletter may be mailed to the subscriber. We will not mail letters to separate addresses or change an address on file unless we are requested to do so and are able to agree to the request.

- Marketing, Sales and Fundraising (if applicable): The law permits us to market to you, such as to give you information on new products, except under certain circumstances. We may ask for your permission to market to you. In no case will we sell your Health Information. We may use PHI about you, including disclosure to a foundation or a

Business Associate, to contact you for our fundraising purposes. You have the right to opt out of receiving such communications.

- Breach: If your Health Information has been breached, meaning your Health Information has been accessed or received by someone who is not authorized to do so, we will notify you as required by law.

- Genetic Information: We are prohibited from using or disclosing any PHI that is genetic information about you for underwriting purposes.

What are your rights?

When it comes to your Health Information, you have certain rights. This section explains your rights and some of our responsibilities to help you. **If you would like to exercise the following rights, please contact Health Partners Essential Member Relations at 1-855-215-7077. You can also write to: Compliance Department, HIPAA Unit, Health Partners Plans, 901 Market Street, Suite 500, Philadelphia, PA 19107 or email us at HPHIPAAPrivacyOfficial@hpplans.com.**

- **You have the right to ask us to limit what we use or share**. You may ask us not to use or share certain Health Information for treatment, payment, or our 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. This request must be made in writing to Health Partners Plans. Health Partners Plans has a standard form that can be requested. We are not required to agree to your request, and we may say "no" if it would negatively impact or affect your care, except:

    - **You have the right to ask your provider to restrict or limit your Health Information that you paid out-of-pocket.** If you paid out-of-pocket (or in other words, your provider has not billed us) in full for a specific item or service, you have the right to ask that your Health Information with respect to that item or service not be disclosed to us for purposes of payment or healthcare operations.

- **You have the right to request confidential communications.** You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. For example, if you believe that you would be harmed if we send your Information to your current mailing address (in situations involving domestic disputes or violence), you can ask us to send the Information by alternative means (for example, by fax) or to an different or additional address. We may say "no" to your request, but we will tell you why in writing within 60 days. This request may be made verbally or in writing. Health Partners Plans has a standard form that can be requested by calling our Member Relations department.

- **You have the right to get a copy of your health and claims records**. You may ask to see or get a copy of your health and claims records and other Health Information we have about you. The request must be made in writing and describe the Information you would like to

inspect. However, you do not have the right to access certain types of Information and we may decide not to provide you with copies of the following Information:

- Contained in psychotherapy notes (we do not create or maintain psychotherapy notes here);
- 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 Health Information, such as when disclosure may not be in the best interest of your health. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. **We may charge a reasonable, cost-based fee.**

- **You have the right to an electronic copy of Electronic Medical Records.** If your Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Health Information in the form or format you request, if it is available in such form or format. If the Health Information is not available in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. **We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.**

- **You have the right to ask us to correct health and claims records.** You may ask us to correct your health claims records if you think they are incorrect or incomplete. 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 60 days after we receive it.

  - We will notify you if there is a delay with respect to 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 get a list of those with whom we have shared Health Information.** You can ask for a list (accounting) of when we have shared your Health

  Information for six (6) years prior to the date of your request, who we shared it with, and why. We will include all the disclosures except for:

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

  We may require that your request be in writing. We will act on your request for an accounting within 60 days. **We will provide one (1) accounting within a twelve (12) month period for free but will charge a reasonable, cost-based fee if you ask for another one within the twelve (12) month period.** We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Effective date of notice

This Notice takes effect September 23, 2013. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to your Health Information.

Right to receive this notice, changes to this notice

You have a right to receive a copy of this Notice upon request at any time. You may also view a copy of the Notice and other information supporting the protection of your Health Information on our website at www.HealthPartnersPlans.com. We reserve the right to change the terms of this Notice and to make the new Notice effective for all Health Information we maintain. Once revised, we will provide the new Notice to you by direct mail and post it on our website.

Contact for questions or complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting Health Partners Plans Member Relations at 1-855-215-7077 (TTY 711). You can also send us questions by mail to: HIPAA Official, Health Partners Plans, 901 Market Street, Suite 500, Philadelphia, PA 19107; by email to HPHIPAAPrivacyOfficial@hpplans.com; or by telephone at 215-967-4575 or toll free at 1-855-215-7077 (TTY 711).

You can file a complaint with the U.S. Department of Health & Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate 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 users should call 711.

Complaints, Appeals and Fair Hearings

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

Complaints
What is a complaint?

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

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Health Partners Plans has approved.

What should I do if I have a complaint?
First Level Complaint

To file a complaint, you can:

- Call Health Partners Plans at 1-855-215-7077. TTY users should call 711.

Or

- Write down your complaint and send it to us at:

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

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

This is called a **first level** complaint.

When should I file a first level complaint?

You must file a complaint within **45 days of getting a letter** telling you that:

- Health Partners Plans has decided that you cannot get a service or item you want because it is not a covered service or item.
- Health Partners Plans will not pay a provider for a service or item you got.
- Health Partners Plans did not decide within 30 days about a complaint you told us about before.

You must file a complaint **within 45 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed on the chart on page 10.

You may file **all other complaints at any time.**

What happens after I file a first level complaint?

After you file your complaint, you will get a letter from Health Partners Plans telling you that we have received your complaint, and about the first level complaint review process.

You may ask Health Partners Plans to see any relevant information we have about your complaint. You may also send us information that may help with your complaint.

You may attend the complaint review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. Please let us know in advance if you'd like to attend, so that we can make the proper arrangements. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee of one or more Health Partners Plans staff who have not been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

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

What if I don't like the Health Partners Plans decision?
Second Level Complaint

If you do not agree with our first level complaint decision, you may file a second level complaint with Health Partners Plans.

When should I file a second level complaint?

You must file your second level complaint within 45 days of the date you receive the first level complaint decision letter. To file a second level complaint, you can:

- Call Health Partners Plans at 1-855-215-7077. TTY users should call 711. Tell us your second level complaint.

Or

- Write down your second level complaint and send it to us at:

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

What happens after I file a second level complaint?

You will receive a letter from Health Partners Plans telling you that we have received your complaint, and telling you about the second level complaint review process.

You may ask Health Partners Plans to see any relevant information we have about your complaint. You may also send information that may help with your complaint to Health Partners Plans.

You may attend the complaint review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. Please let us know in advance if you'd like to attend, so that we can make the proper arrangements. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee made up of three or more people, including at least one person who is not an employee of Health Partners Plans, who has not been involved in the issue you filed your complaint about, will review your complaint and make a decision. Your complaint will be decided no later than 45 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file a second level complaint that is hand-

delivered or postmarked within 10 days of the date on the first level complaint decision letter, the services or items will continue until a decision is made.

What can I do if I still don't like the Health Partners Plans decision?
External Complaint Review

If you do not agree with Health Partners Plans second level complaint decision, you may ask for an external review by either the Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve Health Partners Plans policies and procedures.

You must ask for an external review within 15 days of the date you received the second level complaint decision letter. If you ask, the Department of Health will help you put your complaint in writing.

You must send your request for external review in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Health & Welfare Bldg., Rm. 912
625 Forster Street
Harrisburg, PA 17120-0701
Telephone Number: 1-888-466-2787
Or

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Telephone Number: 1-877-881-6388

If you send your request for external review to the wrong department, it will be sent to the correct department.

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

You may be represented by an attorney or another person during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.
What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file an external complaint review that is

hand-delivered or postmarked within 10 days of the date on the second level complaint decision letter, the services or items will continue until a decision is made.

What can I do if my health is at immediate risk?
Expedited Complaints

If your doctor believes that the usual time frames for deciding your complaint will harm your health, you or your doctor can call Health Partners Plans at 1-855-215-7077 (TTY 711) and ask that your complaint be decided faster. You will need to have a letter from your doctor faxed to 215-991-4105 explaining how the usual time frame for deciding your complaint will harm your health.

If your doctor does not fax Health Partners Plans this letter, your complaint will be decided within the usual time frames.

Expedited Complaint

The expedited complaint will be decided by a licensed doctor who has not been involved in the issue you filed your complaint about.

Health Partners Plans will call you with our decision within 48 hours of when we receive the letter from your doctor explaining how the usual time frame for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review, whichever is sooner. You will also receive a letter telling you the reason(s) for the decision and how to file an external complaint, if you don't like the decision. For information on how to file an external complaint, see page 52.

What kind of help can I have with the complaint processes?

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

You may also have a family member, friend, lawyer or other person help you file your complaint. This person can also help you if you decide you want to appear at the complaint review. For legal assistance you can contact your local legal aid office. (See page 65 for the legal aid office closest to you.)

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

You or the person you choose to represent you may ask Health Partners Plans to see any relevant information we have about your complaint.

Persons Whose Primary Language is not English

If you ask for language interpreter services, Health Partners Plans will provide the services at no cost to you. Please contact the Member Relations department at 1-855-215-7077 (TTY 711) for more information.

Persons with Disabilities

Health Partners Plans will provide help to persons with disabilities in presenting complaints at no cost. This help includes:

- Providing sign language interpreters;
- Giving you information that Health Partners Plans plans to submit at the complaint review in an alternative format, before the review; and
- Providing someone to help copy and present information.

What if I don't like the Health Partners Plans decision?

Fair Hearings

If you do not agree with the second level complaint decision, you may file a request for a fair hearing with DHS. Refer to page 57 for a description of the DHS fair hearing process.

Appeals
What is an appeal?

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

An appeal is when you tell us you disagree with the Health Partners Plans decision.

What should I do if I have an appeal?

To file an appeal, you can:

- Call Health Partners Plans at 1-855-215-7077. TTY users should call 711. Tell us your appeal.

Or

- Write down your appeal and send it to us at

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

- Your provider can file an appeal for you if you give your provider consent in writing to do so.

NOTE: If your provider files an appeal for you, you cannot file a separate appeal on your own.

When should I file an appeal?

You have 180 days from the date you receive the letter (notice) that tells you about the denial, decrease or approval of a different service or item, to file your appeal.

What happens after I file an appeal?

After you file your appeal, you will get a letter from Health Partners Plans telling you that we have received your appeal and about the appeal review process.

You may ask Health Partners Plans to see any relevant information we have about your appeal. You may also send us information that may help with your appeal.

You may attend the appeal review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. Please let us know in advance if you'd like to attend, so that we can make the proper arrangements. If you decide that you do not want to attend the appeal review, it will not affect our decision.

A committee of one or more Health Partners Plans staff, including a licensed doctor, who has not been involved in the issue you filed your appeal about, will review your appeal and make a decision. Your appeal will be decided no later than 30 days after we receive your appeal.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped, and you file an appeal that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you the services or items will continue until a decision is made.

Refer to page 57 for a description of the Department of Human Services fair hearing process.

You may call Health Partners Plans toll-free at 1-855-215-7077 (TTY 711) if you need help or have questions about complaints and appeals. You can contact your local legal aid office (see page 65 for the office closest to you) or call the Pennsylvania Health Law Project at 1-800-274-3258.

What can I do if my health is at immediate risk?
Expedited Appeals

If your doctor believes that the usual time frames for deciding your appeal will harm your health, you or your doctor can call Health Partners Plans at 1-855-215-7077 (TTY 711) and ask that the appeal be decided faster. You will need to have a letter from your doctor faxed to 215-991-4105 explaining how the usual time frame for deciding your appeal will harm your health.

If your doctor does not fax Health Partners Plans this letter, your appeal will be decided within the usual time frames.

Expedited Appeal

The expedited appeal will be decided by a licensed doctor who has not been involved in the issue you filed your appeal about.

Expedited Appeal and Expedited Fair Hearing

A committee of three or more people, including a licensed doctor and at least one Health Partners Essential plan member, will review your appeal. The licensed doctor will decide your expedited appeal with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your appeal about.

Health Partners Plans will call you with our decision within 72 hours of when we receive the letter from your doctor explaining how the usual time frame for deciding your appeal will harm your health. You will also receive a letter telling you the reason(s) for the decision and how to file an expedited fair hearing, if you don't like the decision.

What kind of help can I have with the appeal process?

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

You may also have a family member, friend, lawyer or other person help you file your appeal. This person can also help you if you decide you want to appear at the appeal review. For legal assistance you can contact your local legal aid office. (See page 65 for the legal aid office closest to you.)

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

You or the person you choose to represent you may ask Health Partners Plans to see any relevant information we have about your complaint or appeal.

Persons Whose Primary Language is not English

If you ask for language interpreter services, Health Partners Plans will provide the services at no cost to you. Please contact the Member Relations department at 1-855-215-7077 (TTY 711) for more information.

Persons with Disabilities

Health Partners Plans will provide help to persons with disabilities in presenting appeals at no cost. This help includes:

- Providing sign language interpreters;
- Giving you information that we plan to submit at the appeal review in an alternative format, before the review; and
- Providing someone to help copay and present information.

Fair Hearings

Once you have exhausted Health Partners Plans' internal appeal process, you can ask the Pennsylvania Department of Human Services (DHS) to hold a hearing because you are unhappy about or do not agree with something Health Partners Plans did or did not do. These hearings are called "fair hearings." You need to receive our decision on a second level complaint or on an appeal before you can file a request for a fair hearing.

How do I ask for a fair hearing?

You must ask for a fair hearing in writing and send it to:

Department of Human Services
Office of Medical Assistance Programs —
Healthy PA
Complaints and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

Your request for a fair hearing should include the following information:

- Member name;
- Member social security number and date of birth;
- A telephone number where you can be reached during the day;
- If you want to have the fair hearing in person or by telephone; and
- Any letter you have received about the issue you are requesting your fair hearing for.

What happens after I ask for a fair hearing?

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

You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing.

Health Partners Plans will also go to your fair hearing to explain why we made the decision or explain what happened.

If you ask, Health Partners Plans must give you (at no cost to you) any records, reports and other information we have that is relevant to what you requested your fair hearing about.

When will the fair hearing be decided?

The fair hearing will be decided no more than 90 days after DHS gets your request.

If you are unhappy because…	**You must ask for a fair hearing…**
1) Health Partners Plans decided to deny a service or item because it is not a covered service or item;	within 30 days of getting a letter from Health Partners Plans telling you of this decision.
2) Health Partners Plans decided not to pay a provider for a service or item you got and the provider can bill you for the service or item;	within 30 days of getting a letter from Health Partners Plans telling you of this decision.
3) Health Partners Plans did not decide within 30 days about a complaint you told us about before;	within 30 days of getting a letter from Health Partners Plans telling you that we did not decide your complaint within the time we were supposed to.
4) Health Partners Plans decided to deny, decrease, or approve a service or item different than the service or item you requested because it was not medically necessary;	within 30 days of getting a letter from Health Partners Plans telling you of this decision or within 30 days of getting a letter from Health Partners Plans telling you its decision after you filed a complaint about this issue.
5) Health Partners Plans did not provide a service or item by the time you should have received it. (The time by which you should have received a service or item is listed on page 10 of this handbook).	within 30 days from the date you should have received the service or item.

If your fair hearing is not decided within 90 days from the date DHS receives your request, you may be able to get your services until your fair hearing is decided. You can call DHS at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you Health Partners Plans' decision about your second level complaint or your appeal, your services or items will continue until a decision is made.

If you have been notified that you are being placed in the Recipient Restriction Program and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the notice, the restriction will not be put in place until the fair hearing decision is made.

What can I do if my health is at immediate risk?
Expedited Fair Hearing

If your doctor believes that using the usual time frames to decide your fair hearing will harm your health, you or your doctor can call DHS at 1-800-798-2339 and ask that your fair hearing be decided faster. This is called an expedited fair hearing.

You will need to have a letter from your doctor faxed to 717-772-6328 explaining why using the usual time frames to decide your fair hearing will harm your health. If your doctor does not send a written statement, your doctor may testify at the fair hearing to explain why using the usual time frames to decide your fair hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within 3 business days after you ask for the fair hearing.

If your doctor does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date you asked for the fair hearing.

If your doctor sent a written statement or testifies at the hearing, the decision will be made within 3 business days after you asked for the fair hearing.

You may call Health Partners Essential toll-free at 1-855-215-7077 (TTY 711) if you need help or have questions about fair hearings, or you can contact your local legal aid office (see page 65 for the office closest to you) or call the Pennsylvania Health Law Project at 1-800-274-3258.

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. DHS 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 plan 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, 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

HPE-444-15 3/15